Health Information and Quality Authority
Social Services Inspectorate

Regulatory Monitoring Visit Report
Designated centres for older people

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	St. Brigid's Nursing Home (Crooksling)
Centre ID:	0472
Centre address:	Crooksling Brittas Co. Dublin
Telephone number:	01 4582123
Fax number:	01 4582209
Email address:	eileen.maher1@hse.ie
Type of centre:	☐ Private ☐ Voluntary ☒ Public
Registered providers:	Health Service Executive (HSE)
Person in charge:	Eileen Maher
Date of inspection:	29 November 2011
Time inspection took place:	**Start:** 08:30 hrs **Completion:** 18:00 hrs
Lead inspectors:	Angela Ring
Support inspectors:	Mary O'Donnell
Type of inspection:	☐ Announced ☒ Unannounced
Purpose of this inspection visit:	☐ Application to vary registration conditions ☐ Notification of a significant incident or event ☐ Notification of a change in circumstance ☐ Information received in relation to a complaint or concern ☒ Regulatory Monitoring Visit Report

About the inspection

The purpose of inspection is to gather evidence on which to make judgments about the fitness of the registered provider and to report on the quality of the service. This is to ensure that providers are complying with the requirements and conditions of their registration and meet the Standards, that they have systems in place to both safeguard the welfare of service users and to provide information and evidence of good and poor practice.

In assessing the overall quality of the service provided, inspectors examine how well the provider has met the requirements of the Health Act 2007, 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*.

Additional inspections take place under the following circumstances:

- to follow up on specific matters arising from a previous inspection to ensure that the action required of the provider has been taken
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Social Services Inspectorate that a provider has appointed a new person in charge
- arising from a number of events including information received in relation to a concern/complaint or notification to the SSI of a significant event affecting the safety or wellbeing of residents
- for centres that have not previously been inspected within a specific timeframe, a one-day regulatory monitoring visit may be carried out to focus on key regulatory requirements.

All inspections can be announced or unannounced, depending on the reason for the inspection and may take place at any time of day or night.

All inspection reports produced by the Health Information and Quality Authority will be published. However, in cases where legal or enforcement activity may arise from the findings of an inspection, the publication of a report will be delayed until that activity is resolved. The reason for this is that the publication of a report may prejudice any proceedings by putting evidence into the public domain.

About the centre

Description of services and premises

St. Brigid's Nursing Home was originally a Tuberculosis hospital opened in 1935 and it was modified to provide short-term emergency housing for older people in 1959. The centre is set on a hill in the countryside and has landscaped gardens and extensive grounds with mature trees. The grounds are home to many wild animals including deer.

There are two separate buildings which provide residential services. There is a day-care centre in front of the main building providing a service to older persons from the local community. There is also a small church situated between the two residential buildings.

The centre has 89 places for female residents, the majority of whom have dementia and there are six beds used for people admitted for respite care. The residential centre used to consist of five units but now consists of four units due to the recent closure of the Tara unit. Three units, Ruben, Bethany and Beech, are situated on the ground floor of the main two storey building known as "The House". There is no dining area in the main building and sitting room accommodation is provided in enclosed verandas which are referred to as solariums.

This building also has administration offices, physiotherapy and occupational therapy departments, a kitchen and a staff dining room. There is overnight accommodation for staff on the first floor.

Ruben Unit with 22 beds was refurbished and redecorated since the last inspection. It now consists of two five-bedded rooms, two four-bedded rooms, one three-bedded room and one single bedroom. There is a new kitchenette on this unit. There are four accessible toilets, one staff toilet, three showers and one bath in this unit.

Bethany Unit accommodates 22 residents in one ten-bedded room, one eight-bedded room and a four-bedded room, four of these beds are used for respite. There is one accessible toilet, one staff toilet, two showers and one assisted bath in this unit.

Beech unit has 22 beds and this was refurbished and redecorated since the last inspection, it now consists of seven three-bedded rooms and one single room. There is a new kitchenette on this unit. There are two accessible toilets, one staff toilet, two showers and one bath in this unit.

The fourth unit, Blaithin with 23 beds is in a building known as "The Hill" which is on an incline approximately 200 meters from the main building. Accommodation consists of one ten-bedded room, one eight-bedded room and one five-bedded room - two of these beds are used for respite. There are eight toilets and three assisted bathrooms. There is a large dining room and three separate living areas which are bright and spacious, a visitors' room and a smoking room.

There are car parking spaces close to the units and in front of the day centre.

Location

St Brigid's is located between Tallaght and Blessington in Brittas, County Dublin and is accessed from the main road by a long steep avenue. There is a bus stop at the gate.

Date centre was first established:	1959
Number of residents on the date of inspection:	81

Dependency level of current residents	**Max**	**High**	**Medium**	**Low**
Number of residents	68	13	0	0

Management structure

St Brigid's is a service run by the Health Service Executive (HSE). Evelyn Hempenstall, General Manager, is the person nominated to represent the HSE. She also has a reporting relationship with the Integrated Services Area Manager (ISA) Manager, David Walsh on strategic issues. The Person in Charge, Eileen Maher reports to the General Manager. The person in charge is supported by the Hospital Manager, Margaret Ashe, two Assistant Directors of Nursing (ADON), Clinical Nurse Managers (CNM), nurses, care assistants, an infection control nurse and a range of administrative, clerical and ancillary staff. The allied health professionals such as physiotherapists and occupational therapists are line managed by their respective community managers but they also have a reporting relationship to the person in charge who is their operational manager.

Staff designation	**Person in Charge**	**Nurses**	**Care staff**	**Catering staff**	**Cleaning and laundry staff**	**Admin staff**	**Other staff**
Number of staff on duty on day of inspection	1	17	14	11 (also responsible for cleaning and laundry)		3 plus a hospital manager	1 Pharmacist 2 porters

Summary of findings from this inspection

This was an unannounced inspection carried out by the Health Information and Quality Authority (the Authority). The provider issued formal notification to the Authority of their intention to close St Brigid's Nursing Home over the coming months. This inspection was carried out to monitor the ongoing care and safety of residents during their remaining time in St Brigid's.

Inspectors found that the provider met many of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 and provided good quality care. Inspectors met with residents, relatives, staff and the person in charge over the course of the inspection. Inspectors reviewed documents including policies, care plans, staff rotas, medication records and staff files.

Overall, inspectors found that the centre continues to be well run and some of the actions from the previous inspection were addressed by the provider and person in charge. The person in charge demonstrated effective leadership in her approach to the management of the centre The provider and person in charge were committed to providing a good level of care to residents and promoting the safety of residents. Staff were knowledgeable about fire safety and the prevention and response to elder abuse. The health and social needs of residents were met. Care plans were in place for all residents and they were quite person-centred. The quality of residents' lives was enhanced by the provision of activities, many of which were tailored to suit each resident and the type and severity of dementia.

At the last inspection, there were significant improvements required in the premises. Inspectors found that despite the improvements made since the last inspection, there were still significant deficits in the premises. These included an insufficient number of toilets and bathrooms, a high number of multi-occupancy bedrooms, steep ramps in one of the units and limited secure accessible outdoor space for residents in "The House".

Improvements were also required in care planning, the use of restraint, records required for staff files and complaints management. Areas for improvement are discussed further in the report and are included in the Action Plan at the end of the report.

Comments by residents and relatives

Inspectors met with some residents and a small number of relatives. Most of the feedback received was positive, residents said they felt safe in the centre and all agreed that they enjoyed their meals.

Governance

Article 5: Statement of Purpose

Inspectors found that the statement of purpose did not meet the requirements in the Regulations. For example, it did not include the room sizes and the arrangements made for consultation with residents.

Article 15: Person in Charge

The person in charge was a registered general nurse, had the relevant necessary experience and worked full-time in the centre for several years. She demonstrated an adequate knowledge of her responsibilities as outlined in the Regulations and demonstrated good organisational skills. She was supported in her role by two Assistant Directors of Nursing who deputised in her absence. Inspectors found that the person in charge was knowledgeable about residents' needs and was observed engaging well with residents throughout the day of inspection.

Article 16: Staffing

Inspectors randomly examined the files of staff members and found that they did not contain all of the information required by the Regulations. Three references were not available and there was no photographic identification or medical declaration. The failure to meet this requirement was highlighted at the last inspection and this issue was not addressed satisfactorily.

Inspectors found that there were adequate staffing levels to meet residents' needs. This included the appointment of specific staff members allocated to meet the needs of two particular residents who had specific high dependency needs. Staff, residents and relatives agreed that there were adequate staff on duty.

Inspectors found that although no staff had been recruited recently due to the moratorium, there was no recruitment policy available in the centre. The person in charge explained that this was due to recruitment being processed at the central Human Resources department within the HSE.

Inspectors carried out interviews with staff members and found that most were knowledgeable of the residents' individual needs, the centre's policies, fire procedures and the procedures for reporting alleged elder abuse. Inspectors found that staff had a good knowledge of residents' needs and observed them communicating with residents in a kind and respectful manner.

The person in charge explained that there were several educational courses available for staff and this was confirmed when speaking with staff. There were records to indicate that most staff had received training on fire procedures, the prevention, detection and response to elder abuse and manual handling. Several staff attended

training on dementia-specific care and there was evidence of this training being implemented at unit level with residents. Staff also received training on infection control, catheterisation, medication management, falls prevention, wound care and pressure ulcer prevention, end of life care and nutrition.

Article 23: Directory of Residents

Inspectors found that although there were records maintained electronically and in hard copy of residents' details, there was no overall main directory of residents maintained with the information specified in Schedule 3 of the Regulations.

Article 31: Risk Management Procedures

Inspectors found that practice in relation to the health and safety of residents and the management of risk promoted the safety of residents, staff and visitors. Inspectors reviewed the emergency plan and found that it was sufficient to guide to staff in the event of an emergency and staff were aware if it's content.

There was a health and safety statement for each unit and a health and safety audit completed for each unit. These audits highlighted the risks and potential risks in the units. For example, there were steep ramps in Blaithin unit which posed a health and safety risk and there were risk assessments completed with measures identified to reduce the associated risk.

There was a risk management policy in place, which addressed the risks identified in the Regulations such as violence and aggression, assault, residents going missing, and accidental injuries to residents and staff with the exception of self-harm.

Inspectors reviewed the incidents that occurred since the previous inspection and found that there were a relatively low number of falls during the previous months, with four resulting in serious injury to residents. Incident forms were completed for each incident and there was evidence that residents were monitored following an incident. Inspectors found that risk assessments were completed, and care plans developed for residents with preventative strategies identified such as environmental precautions. There was a system in place for the overall analysis of falls to determine patterns and areas for improvement and to determine if the preventative measure put in place were effective. Therefore, there was a system in place for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents.

Inspectors found that the safety of visitors was considered due to the location and remoteness of the centre and specific measures were taken to minimise the risks to visitors such as security cameras and lighting.

Inspectors found that there was documentary evidence that residents were checked every hour at night. Inspectors noted that this was implemented since the last inspection.

Article 39: Complaints Procedures

Improvements were required in complaints management. The HSE "Your Service Your Say" leaflets were displayed. However, the centres specific complaints policy was not prominently displayed. Inspectors reviewed the recently revised complaints policy and found that it did not clearly identify the independent appeals person who could be contacted should a complainant be dissatisfied with the outcome of their complaint.

Inspectorss reviewed a sample of the complaints records that were present in each of the four units. Verbal complaints were recorded from residents and relatives and there was evidence of some complaints being appropriately responded to by the unit manager or a senior nurse to the satisfaction of the complainant. However, there was no documentary evidence of follow up on some complaints that were referred to senior nursing administration.

Article 36: Notification of Incidents

Improvements were required in notifications to the Authority. Inspectors noted that a Grade 2 pressure ulcer was not notified to the Authority as required by the Regulations.

Resident Care

Article 9: Health Care

Inspectors found that residents had good access to a medical practitioner who visited the centre each day. The previous inspection highlighted the many benefits of having an occupational therapist and physiotherapist employed full-time in the centre. Inspectors found that this service had been removed from the centre with residents now having limited access to these allied health professionals. There was evidence that residents also had access to mental health services, optician, dental and dietetic services when required.

Inspectors reviewed a sample of residents' care plans and observed that they were not stored in a safe and secure place. Inspectors noted that nursing assessments and clinical risk assessments were carried out for all residents. There was a record of the resident's health condition and treatment given, completed on a daily basis and signed and dated by the nurse on duty. There was some very person-centred information about each resident and reference to their likes, dislikes and preferences. Care plans were in place which identified residents' needs. However, inspectors noted that three-monthly reviews were not completed for all residents. Improvements were also required in updating residents care plans after review by a member of the multi-disciplinary team to ensure continuity of care and to keep staff informed of the plan of care.

Inspectors noted that there were a small number of residents with tube feeding on the day of inspection and there were adequate records to guide care. There were a small number of residents with wounds - inspectors found that there were adequate records maintained on the treatment plan for these wounds. There was a wound care committee established to review all wounds in the centre to ensure that the optimum care was being given and to monitor the progress of each wound.

Inspectors found that there was a wide range of specialised chairs and mattresses available. The person in charge told inspectors that each resident had a seating assessment with the occupational therapist and physiotherapist and were provided with suitable chair since the last inspection. Inspectors did not see evidence of several residents being left in bed for long periods which was identified as a problem at the last inspection. Staff told inspectors that this practice was not carried out.

There were some residents with behaviours that challenged. As already stated, several staff had attended dementia training and this helped them to promote a person-centred approach to minimise the occurrence of behaviours that challenge. Inspectors observed that residents were occupied to prevent boredom. There was evidence that residents had an activity assessment and to identify suitable interventions to promote occupational engagement and to meet their social needs. Some residents were engaged in doll therapy and domestic tasks such as folding tea towels. Staff also provided residents with soft toys and textured items to provide tactile stimulation, they offered hand massage and they actively engaging on a one-to-one basis with residents to meet their emotional needs. Inspectors observed staff members sitting with residents throughout the day and residents displayed evidence of high levels of wellbeing. Inspectors reviewed the nursing notes of some of these residents and found that behavioural logs were maintained to record behaviours and there was documentary evidence of the triggers to the behaviour, a description of the behaviour and the measures to be taken to respond to the behaviour. There was a challenging behaviour policy in place and staff had received training on responding to behaviours that challenge during their training on dementia. Inspectors observed staff responding appropriately to residents with behaviours that challenged. Inspectors also found evidence that some of the residents were reviewed by a Psychiatrist in Later Life and a Consultant in Geriatric Medicine where necessary.

There was quite a low incidence of the use of restraint and inspectors noted that there were a relatively small number of bedrails used for residents. The person in charge told inspectors that she was aware of the new HSE policy on the use of restraint and she had plans in place to update the centre's policy in line with the new national policy and to provide training to staff. Inspectors reviewed files for a sample of these residents and found that there was an assessment completed for the use of the restraint and there was documentation on the frequent release of the restraint. There was evidence of alternative strategies being tried prior to the use of restraint, such as low beds, mattresses on the floor, bed alarms and increased supervision by staff. However, there were some improvements required in the use of restraint. There was limited documentation on the use of the alternatives to restraint, there was no evidence that the risks of using restraints were considered and most importantly there were inadequate procedures in place to review the ongoing use of restraint when a resident had a near miss associated with a bedrail.

Inspectors saw documentary evidence that residents' weights were recorded each month and the person in charge monitored any changes such as significant weight loss. Nutritional risk assessments were used to identify residents at risk. There was evidence of residents being reviewed regularly by a dietician when the staff were concerned about weight loss or weight gain. Inspectors noted that nutritional supplements were prescribed and appropriately administered.

Improvements were made in the provision of meaningful activities for residents since the last inspection. Inspectors found that staff had received specific training on providing meaningful activities for residents with dementia and this training was being carried out in practice. There were several opportunities for all residents to participate in activities appropriate to his or her interests and capacities. Inspectors met with four activity coordinators who worked full-time in each of the units. Inspectors saw residents engaged in activities such as music, exercises, newspaper reading, reminiscence, doll therapy, art and knitting. The activity coordinators knew the residents well and were seen responding to each of them as individuals. They provided individual sessions for residents with high dependency needs and these included massage, Sonas (a therapeutic activity based on communication) and a chat.

The patio area in Blathin was reconstructed to provide residents with free access to a secure outdoor area. Relatives and staff confirmed that the secure garden was used by residents and visitors when the weather was fine. There was a small secure patio area for residents to access if they wished from the Beech unit. However, there was very limited access to outdoor space for residents to engage in outdoor activities or exercise. Although some residents attended the day centre located on the grounds of the centre, the location and layout of the centre did not make it possible for many residents to leave the units to go for a walk, to visit a shop or church due to the steep inclines and remote location.

Article 33: Ordering, Prescribing, Storing and Administration of Medicines

Inspectors found evidence of good medication management practices. There was a comprehensive medication management policy which provided guidance to staff. Inspectors reviewed medication audits completed by the on-site pharmacist and found that areas for improvement had been identified and measures taken to improve practice. Staff told inspectors that the pharmacist provided training on medication issues and specific types of medication relevant to older people. Inspectors observed a nurse as she administered medication and found the procedures she followed to be in line with best practice guidelines. There was a Drugs and Therapeutic committee meeting every month, where residents' medication was discussed.

There was a medication fridge with daily temperature checks. Medications that required special control measures were carefully managed and kept in a secure cabinet in keeping with the Misuse of Drugs (Safe Custody) Regulations, 1984. Nurses kept a register of controlled drugs. Two nurses signed and dated the register and the stock balance was checked and signed by two nurses at the change of each shift.

Inspectors noted that an improvement was required in the prescribed timing of some medication as current practices resulted in antibiotics prescribed as three times daily being administered within a 12 hour period. Inspectors found evidence of a lack of adequate follow up and review of a resident who nurses reported as having potential side effects of her medication.

Article 6: General Welfare and Protection

Inspectors found that measures were in place to protect residents from being harmed or abused. An ADON attended a training course for the prevention, detection and response to elder abuse and was responsible for providing training to staff. There were records to indicate that most staff had received a training course on identifying and responding to elder abuse. However, there were a very small number of staff who had not received training and did not have sufficient knowledge of their responsibilities. Inspectors found that most staff were aware of the types of elder abuse and their responsibilities in reporting suspected elder abuse to the person in charge. Residents spoken to confirmed to inspectors that they felt safe in the centre.

Inspectors reviewed the centres policy on the prevention, detection and response to elder abuse and found that it gave guidance to staff on the types of abuse and the procedures for reporting alleged abuse. However, the policy did not give adequate guidance to staff on the procedures to follow when investigating an allegation of elder abuse.

Article 20: Food and Nutrition

Inspectors were satisfied that residents received a nutritious and varied diet that offered choice. Mealtimes were unhurried social occasions that provided opportunities for residents to interact with each other and with staff.

Inspectors spent time in the central dining room in Blainthin during lunch and found that it was quiet, unhurried and relaxed. There were several visual cues to prompt residents with pictures of food on menus in addition to the text. Residents were seen to enjoy the social dining occasion. Inspectors noted that meals were hot, well presented and tasty. Staff were seen assisting residents discreetly and respectfully if required. Residents confirmed that they enjoyed the food. Meals were served on trays from a heated trolley in the dining room and staff told inspectors that some residents liked to choose their food directly from the trolley. Inspectors saw residents being offered drinks throughout the day.

Inspectors spoke with the chef and found that she had a good knowledge of resident's dietary needs and preferences. Residents who needed their food served in an altered consistency, such as pureed, had the same menu options as others and the food was presented in appetising individual portions. The chef told inspectors that a dietician had reviewed the menus and made some alterations to ensure they were of optimum variety and nutritional value.

Environment

Article 19: Premises

The centre was clean and warm throughout. Inspectors found that some improvements were made in the premises since the last inspection, these included the following:

- refurbishment of Ruben and Beech units
- an increased number of wash-hand basins in Ruben and Beech units
- the bath and bedpan washer in Blaithin Unit had been repaired and were fully operational
- improvements were made in developing a system for maintaining equipment
- there was appropriate assistive equipment available such as hoists, pressure relieving mattresses, cushions, wheelchairs and walking frames
- there were cleaning rooms in Beech and Ruben and locked cleaning presses for cleaning chemicals in all other units
- there were specific procedures in place for washing mop heads
- there was a new sluice room in the Ruben unit
- improvements made in reducing the number of commodes left at the bedsides
- new staff changing facilities were provided with an electric shower
- some residents were provided with locked storage facilities for their belongings

Despite the improvements outlined above since the previous inspection, there were significant deficits in the physical environment. These deficits include the following:

- the units were institutional in nature with multi-occupancy bedrooms
- there were an inadequate number of wash-hand basins, toilets and bathrooms to meet residents' needs, including a lack of accessible toilets and bathrooms
- the bedrooms were not very personalised and there was inadequate storage space for some residents' belongings including lockable storage space
- there was very limited secure outdoor space for residents to access
- the solariums were the only communal and dining space for residents in Ruben, Bethany and Beech
- there was no visitors' room in Rubin, Bethany and Beech units
- the laundry room was very old and required upgrading as there was no sluicing sink or wash-hand basin
- the waste management area required a complete upgrading. The floor surfaces were unsuitable and could not be cleaned.

There were significant deficits in Blaithin unit. One multi-occupancy bedroom was located internally, had no natural ventilation, no natural light and no wash-hand basin. There were two toilets off the day room that had no natural ventilation and opened directly into the day room. There was no call bell facility for residents to use to alert staff if they required assistance. There were no wash-hand basins in the visitors' room or the staff toilets in Blaithin.

Inspectors found that there were several ramps throughout the centre, some of which were too steep and could only be used safely by residents with assistance from staff. Although risk assessments had been completed for these ramps and measures were identified to reduce the associated risk, inspectors found that the ramps remained a hazard and a hindrance to residents.

Inspectors found that there were regular infection control audits completed, including hand hygiene audits. The results of the audits revealed that infection control practices continued to improve. However, the structural deficits made it difficult to implement best practice especially the lack of wash-hand basins.

Article 32: Fire Precautions and Records

The procedures for fire detection and prevention were in place. Inspectors reviewed service records which showed that the fire alarm system, emergency lighting and fire equipment were monitored regularly. Inspectors read records which showed that daily inspections of fire exits were carried out and the fire exits were unobstructed. Inspectors read the training records which confirmed that all staff had attended training on fire prevention and response and inspectors found that staff spoken with were clear about the procedure to follow in the event of a fire.

Closing the visit

At the close of the inspection visit a feedback meeting was held with the person in charge, acting assistant director of nursing, clinical nurse managers, senior staff nurses and the hospital manager to report on inspectors' findings, which highlighted both good practice and where improvements were needed.

Acknowledgements
Inspectors wish to acknowledge the cooperation and assistance of the residents, relatives, provider and staff during the inspection.

Report compiled by:

Angela Ring

Inspectors of Social Services
Social Services Inspectorate
Health Information and Quality Authority

7 December 2011

Health Information and Quality Authority
Social Services Inspectorate

Action Plan

Provider's response to inspection report*

Centre:	St. Brigid's Nursing Home (Crooksling)
Centre ID:	0472
Date of inspection:	29 November 2011
Date of response:	16 December 2011

Requirements

These requirements set out what the registered provider must do to meet the Health Act, 2007, 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*.

1. The provider has failed to comply with a regulatory requirement in the following respect:

The units were institutional in nature with multi-occupancy rooms.

There were an inadequate number of wash-hand basins, toilets and bathrooms to meet residents' needs including a lack of accessible toilets and bathrooms for dependent residents.

There was a lack of hand-washing facilities for staff throughout the centre.

The bedrooms had inadequate locked storage space for some residents' belongings including lockable storage space.

There was very limited secure outdoor space for residents to access.

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

The solariums were the only communal and dining space for residents in Rubin, Bethany and Beech.

There was no visitors' room in Rubin, Bethany and Beech Unit.

There were several ramps throughout the centre, some of which were too steep and could only be used by residents with assistance from staff.

Many aspects of the building required upgrading including sluice rooms, laundry, and waste management area.

In Blathin, one bedroom was located internally, had no natural ventilation, no natural light and no wash-hand basin.

There were two toilets off the day room that had no natural ventilation and opened directly into the day room.

There was no call bell facility in Blaithin for residents to use to alert staff if they required assistance.

Action required:

Provide adequate private accommodation for residents.

Action required:

Provide sufficient numbers of toilets, and wash-basins, baths and showers fitted with a hot and cold water supply, which incorporates thermostatic control valves or other suitable anti-scalding protection, at appropriate places in the premises.

Provide a sufficient number of toilets which are designed to provide access for residents in wheelchairs, having regard to the number of residents using wheelchairs in the designated centre.

Provide a sufficient number of assisted baths and showers, having regard to the dependency of residents in the designated centre.

Action required:

Provide suitable storage facilities for the use of each resident.

Action required:

Provide and maintain external grounds which are suitable for, and safe for use by residents including the ramps.

Action required:

Provide suitable communal space for residents for the provision of social, cultural and religious activities appropriate to the circumstances of the residents.

Provide suitable facilities for residents to meet visitors in communal accommodation and a suitable private area which is separate from the residents' own private rooms.

Action required:

Ensure the physical design and layout of the premises meets the needs of each resident, having regard to the number and needs of the residents.

Action required:

Ensure the premises are of sound construction and kept in a good state of repair externally and internally.

Action required:

Provide ventilation and lighting suitable for residents in all parts of the designated centre which are used by residents.

Action required:

Make suitable adaptations, and provide such support, equipment and facilities, including call bells for residents, as may be required.

Reference:

Health Act, 2007
Regulation 19: Premises
Standard 25: Physical Environment

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response:	
The HSE is contemplating making a decision to close St. Brigid's Home. A consultation process is now commencing with residents and families which will inform the decision. The consultation process will take 12 weeks.	31/03/2012
Hand gel dispensers have been fitted beside beds where wash-hand basins are a distance away.	Immediately
A visitor's room has been identified for each unit, beside the palitative care room in both Ruben and Beech Units and on the corridor of Bethany Unit.	Immediately

2. The provider has failed to comply with a regulatory requirement in the following respect:

The statement of purpose did not contain of all matters listed in Schedule 1 of the Regulations.

Action required:

Compile a Statement of purpose that consists of all matters listed in Schedule 1 of the Regulations.

Reference:

Health Act, 2007
Regulation 5: Statement of Purpose
Standard 28: Purpose and Function

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Current Statement of Purpose to be reviewed and updated to include all matters listed in Schedule 1 of the Regulations.	31/01/2012

3. The provider has failed to comply with a regulatory requirement in the following respect:

The policy on the prevention, detection and response to elder abuse did not provide sufficient guidance on the procedure to follow when investigating an allegation of abuse.

There were inadequate arrangements in place, to ensure that staff were fully aware of the centres measures to prevent residents being harmed or suffering abuse.

Action required:

Put in place a policy on and procedures for the prevention, detection and response to abuse.

Action required:

Make all necessary arrangements, by training staff or by other measures, aimed at preventing residents being harmed or suffering abuse or being placed at risk of harm or abuse.

Reference: Health Act, 2007 Regulation 6: General Welfare and Protection Standard 8: Protection	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Review and update current Elder Abuse Policy. Training of all grades of staff on the detection and management of Elder Abuse.	 31/01/2012 Immediately

4. The provider has failed to comply with a regulatory requirement in the following respect: The risk management policy did not cover the precautions in place to control the risks associated with self-harm.	
Action required: Ensure that the risk management policy covers the precautions in place to control the risks associated with self-harm.	
Reference: Health Act, 2007 Regulation 31: Risk Management Procedures Standard 26: Health and Safety	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Review and update Risk Management Policy to include precautions to control the risks associated with self-harm.	 31/01/2012

5. The provider has failed to comply with a regulatory requirement in the following respect: Each resident's care plan was not kept under formal view as required by the resident's changing needs or circumstances and were not always updated after review by a member of the multidisciplinary team to ensure continuity of care and to keep staff informed of the plan of care.

Action required:

Keep each resident's care plan under formal review as required by the resident's changing needs or circumstances and no less frequent than at three-monthly intervals.

Put a plan in place to ensure that residents' care plans are updated after review by a member of the multidisciplinary team to ensure continuity of care and to keep staff informed of the plan of care.

Reference:

Health Act, 2007
Regulation 8: Assessment and Care Plan
Standard 10: Assessment
Standard 11: The Resident's Care Plan

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response:	
All care plans to be reviewed every three months and/or when circumstances of the resident change. Audits of Care Plans to commence.	15/01/2012
Care plan communication document to be placed on all units, identifying review dates for assessments.	31/01/2012

6. The provider has failed to comply with a regulatory requirement in the following respect:

The complaints procedure did not contain an independent appeals process, the operation of which is included in the designated centre's policies and procedures.

The complaints procedure was not displayed in a prominent position in the designated centre.

There were inadequate records maintained of all complaints detailing the investigation and outcome of the complaint and whether or not the resident was satisfied.

Action required:

Ensure the complaints procedure contains an independent appeals process, the operation of which is included in the designated centre's policies and procedures.

Action required: Display the complaints procedure in a prominent position in the designated centre.
Action required: Maintain a record of all complaints detailing the investigation and outcome of the complaint and whether or not the resident was satisfied.
Reference: Health Act, 2007 Regulation 39: Complaints Procedures Standard 6: Complaints

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Review and update Complaints Policy. Procedure will be displayed prominently on all units. Complaints log book to be updated and reviewed at multi-disciplinary team meetings on a monthly basis.	 31/01/2012 04/01/2012

7. The provider has failed to comply with a regulatory requirement in the following respect: All required notifications were nut submitted to the Authority.
Action required: Give notice to the Chief Inspectors without delay of the occurrence in the designated centre of any serious injury to a resident.
Reference: Health Act, 2007 Regulation 36: Notification of Incidents Standard 29: Management Systems Standard 30: Quality Assurance and Continuous Improvement Standard 32: Register and Residents' Records

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: All future incidents to be reported to the Chief Inspector.	 Immediately

8. The provider has failed to comply with a regulatory requirement in the following respect: Residents' records were not stored in a safe and secure place.	
Action required: Keep the records listed under Schedule 3 (records in relation to residents) and Schedule 4 (general records) up-to-date and in good order and in a safe and secure place.	
Reference: Health Act, 2007 Regulation 22: Maintenance of Records Standard 32: Register and Residents' Records	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: When residents are relocated to new unit records will be locked in Ward Manager's Office. While residents remain in Crooklsing records will be placed in locked filing cabinet.	23/12/2011

9. The provider has failed to comply with a regulatory requirement in the following respect: The use of restraint was not in line with evidence based nursing practice.	
Action required: Provide a high standard of evidence based nursing practice.	
Reference: Health Act, 2007 Regulation 6: General Welfare and Protection Standard 13: Healthcare Standard 18: Routines and Expectations	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Review and update our local restraint policy in line with National Guidelines. HSE National Guidelines distributed to all Units and staff education on same to be arranged.	31/03/2012

10. The provider is failing to comply with a regulatory requirement in the following respect:

There were no written policies and procedures relating to the recruitment, selection and vetting of staff available in the centre.

Staff files did not contain all of the documents specified in Schedule 2 of the Regulations.

Action required:

Put in place written policies and procedures relating to the recruitment, selection and vetting of staff.

Action required:

Put in place recruitment procedures to ensure no staff member is employed unless the person is fit to work at the designated centre and full and satisfactory information and documents specified in Schedule 2 of the Regulations have been obtained in respect of each person.

Reference:

Health Act, 2007
Regulation 18: Recruitment
Standard 22: Recruitment

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: HSE Recruitment Policy to be consulted and implemented for St. Brigid's Home. HSE policies and Regulations will be complied with in full.	31/01/2012

11. The person in charge has failed to comply with a regulatory requirement in the following respect:

There were inadequate procedures in place to maintain an up to date directory of residents which includes the information specified in Schedule 3 of the Regulations.

Action required:

Establish and maintain an up-to-date directory of residents in relation to every resident in the designated centre in an electronic or manual format and make this information available to inspectors as and when requested.

Action required: Ensure that the directory of residents includes the information specified in Schedule 3 of the Regulations.	
Reference: Health Act, 2007 Regulation 23: Directory of Residents Standard 32: Register and Residents' Records	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: A new residents directory/log to be formulated/designed specific to the St Brigid's Home and sent for printing.	31/03/2012

Recommendations

These recommendations are taken from the best practice described in the *National Quality Standards for Residential Care Settings for Older People in Ireland* and the registered provider should consider them as a way of improving the service.

Standard	Best practice recommendations
Standard 15: Medication Monitoring and Review	Put procedures in place to ensure that the condition of the resident on medication is monitored and subject to review at three-monthly intervals or more frequently of there is a change in the resident's condition. Put procedures in place to ensure best practice is adhered to for the timing of medication.

Any comments the provider may wish to make:

Provider's response:

Timing of medication issue discussed with GP and rectified - Immediately. New medication booklets on order will have a medication review page - 31/01/2012 - which will be signed off by GP and Pharmacist on a three-monthly basis or if there is a change in the Resident's condition. At the drug and therapeutic meeting, held monthly, individual resident issues will be raised, discussed and documented in care plan.

Provider's name: Evelyn Hempenstall
Date: 16 December 2011