Health Information and Quality Authority
Social Services Inspectorate

Inspection report
Designated centres for older people

Centre name:	Oakfield Nursing Home
Centre ID:	0259
Centre address:	Courtown Gorey Co Wexford
Telephone number:	053-9425679
Fax number:	053-9424563
Email address:	info@oakfieldnursinghome.com
Type of centre:	☒ Private ☐ Voluntary ☐ Public
Registered provider:	Patrick Shanahan
Person in charge:	Hilary Braham
Date of inspection:	5 October 2011
Time inspection took place:	**Start:** 11:45hrs **Completion:** 16:00hrs
Lead inspector:	Tom Flanagan
Type of inspection:	☐ 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 ☒ Follow-up inspection ☐ Announced ☒ Unannounced

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 well-being of residents
- to randomly "spot check" the service.

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

Oakfield Nursing Home was established in 2005. There were 64 residents living there on the day of inspection. The majority of residents were receiving general care of the older person. Services were also provided to younger people with physical and intellectual disabilities.

Oakfield Nursing Home is a three-storey building. The lower ground floor and the first floor can be accessed by lift or stairs. Residents' accommodation is provided in 24 single bedrooms and 18 twin bedrooms on the ground floor and in 11 single bedrooms on the lower ground floor. All bedrooms have en suite facilities with toilet, wash-hand basin and shower.

On the ground floor, there are two sitting areas inside the front door and two day rooms. There are three assisted toilets close to the reception and lounge areas. A bathroom also contains toilet facilities. There is a kitchen and there are two dining rooms. There is an oratory, a reception area, administration offices and staff facilities. There is a sluice room and several rooms for storage.

On the lower ground floor, a self-contained unit called the Darac Suite provides separate residential, day room and dining facilities for 11 residents. There is also access to an enclosed garden. A sluice room, the laundry and a boiler room are also located on this corridor.

On the first floor there is an activities room, a library, a beautician room, a gym and a health spa room. There is also a room containing an assisted bath. There are two offices, storage rooms, and 16 single bedrooms, most of which are not in use apart from two which are used for storage. There is a twin bedroom which is used for visitors. There are also four toilets located on the first floor.

There are extensive landscaped gardens and there is ample car parking to the front of the building.

Location

Oakfield Nursing Home is located in a rural setting approximately three kilometres from the village of Courtown, Co Wexford.

Date centre was first established:	25 August 2005
Number of residents on the date of inspection:	64
Number of vacancies on the date of inspection:	7

Dependency level of current residents	**Max**	**High**	**Medium**	**Low**
Number of residents	9	21	13	21

Management structure

The management team comprises Patrick Shanahan, the Registered Provider, Hilary Braham, the Person in Charge, Gráinne de Búrca, the Care Manager, and Gerard Hanratty, the Estates Manager. Healthcare assistants and nurses report to the Care Manager. Kitchen staff report to the Head Chef. Housekeepers and laundry assistants report to the Head Housekeeper. The Care Manager, Health and Estates Manager and other heads of department report to the Person in Charge who in turn reports to the Provider.

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	4*	10	4	5	2	1**

* Including the Care Manager
** Estates Manager

Background

This was the third inspection of Oakfield Nursing Home by the Authority. The first inspection took place on 24 August 2010 and 25 August 2010. The second inspection was carried out on 13 January 2011.

During the inspection of 13 January 2011, the inspector found that 30 of the 36 actions outlined in the report of the previous inspection had been satisfactorily completed. Six actions had not been fully completed.

The provider had reviewed the staffing levels and increased the number of nurses and care assistants on duty during the day. The statement of purpose, the Resident's Guide and the directory of residents had been updated. All the policies and procedures, including complaints, risk management and medication management had been reviewed and updated and new policies and procedures had been established. A system of audit and review had been put in place. A review of practice had taken place in the area of medication management and new documentation has been introduced. The activity programme had been further developed and improvements had been made in the maintenance of records, including daily nursing progress notes and the communication of residents' dietary needs to the kitchen staff. Residents had access to a safe supply of drinking water at all times. Improvements have been made to the smoking room.

Further improvements were also required. The care plans needed to be formally reviewed as required by the residents' changing needs or circumstances and no less frequently than at three-monthly intervals. Care plans needed to be developed and agreed with each resident and/or their representative. Further training was required in the areas of the prevention, detection and response to abuse and fire safety. The staff files were incomplete. Further links with the local community needed to be established.
The reports on the previous inspections are available to download on www.hiqa.ie.

Summary of findings from this inspection

The inspector met with the person in charge and the care manager and reviewed progress in relation to the actions outlined in the report of the inspection of 13 January 2011.

The inspector viewed staff rosters, personnel files, policies and procedures, residents' files, care plans, medical records, the results of audits and other documentation required by legislation. He also spoke informally to a number of residents throughout the day.

The inspector found that all of the actions outlined in the report of the previous inspection had been completed.

Since the previous inspection, the care plans had been updated and the person in charge had introduced a monthly audit of care plans to ensure that they were reviewed every three months or more often if required. She had also introduced a system of case conferences on each resident. Letters were sent to the next of kin of each resident who could not themselves sign their care plan and the level of involvement of residents and relatives in the development of care plans had increased. Staff files had been audited and updated to include all the information required by legislation. Training had been provided to all staff on the protection of residents and on fire safety. An information display had been installed to provide information on activities in the community and regular outings had been organised for residents to attend events in the local area. A performance development system had been introduced for staff. Training had been provided for staff in the areas of falls management and behaviour that challenges and new assessments and recording systems on these issues had been implemented in the residents' care. A new policy on the use of restraint had been implemented. The care manager attended a Train the Trainers course on the new policy and had begun to provide training for all staff.

Issues covered on inspection:

The findings of this inspection in relation to the actions the provider and/or the person in charge were required to undertake are set out below.

Actions reviewed on inspection:

1. Actions required from previous inspection:

(a) Ensure that the residents' care plans are kept under formal review as required by the residents' changing needs or circumstances and no less frequent than at three-monthly intervals.

(b) Review the care plans of all residents to ensure that the needs of each resident are set out in an individual care plan developed and agreed with each resident and/or their representative.

The inspector found that these actions had been completed.

Following the previous inspection, the person in charge had stated that all residents' care plans had been brought up to date by 23 February 2011, that they would be reviewed every three months or more often as indicated and that a regular monthly audit had been put in place to ensure this standard was maintained. The inspector viewed the care plans of four residents in detail. The care plans had been reviewed and updated within the previous three months. The blood pressure, weight, pulse and temperature of each resident had been taken monthly. The person in charge told the inspector that she had introduced a new system of staff meetings to review the care plans of residents. Each fortnight, the care plans of a number of residents were reviewed jointly by the person in charge, the care manager, the key nurse for those residents and some of the healthcare assistants involved in the care of these residents.

The inspector observed that the care plans set out the individual needs of the residents. In the case of one resident, staff of the centre had attended three case conferences with professionals from the Health Service Executive (HSE) to discuss the appropriateness of the resident's placement. There was extensive documentation to show that the staff had engaged with visiting professionals to address the residents' needs. In the case of another resident, there was evidence of recent visits by an occupational therapist and a dietician and staff were in the process of completing a comprehensive summary of the resident's condition and needs in preparation for a thorough review by the resident's general practitioner (GP).

The inspector viewed the results of audits which had been carried out each month on the care plans of residents and also observed that a number of residents and relatives had signed the care plans. The person in charge told the inspector that all residents who can do so have signed their care plans and that letters were sent to next of kin of other residents advising them of a named contact nurse in relation to their relative and that, where residents were not in position to discuss and sign their care plans, the residents' next of kin could view the care plan. She said that a large majority of relatives had

responded to discuss and sign the care plans. The inspector viewed the results of the monthly care plan audit through which the issue of residents'/relatives involvement in developing the care plans was monitored. The care manager told the inspector that she discussed the findings of the audit with nursing staff on an individual basis and at the nurses' meetings.

2. Actions required from previous inspection:

Ensure that the staff files contain all the information and documents specified in Schedule 2 of the regulations.

The inspector found that this action had been completed.

Following the previous inspection, the person in charge had undertaken to audit all the staff files and to ensure that they contained all the documents and information required by legislation by 2 May 2011. The inspector viewed a sample of four staff files, each of which contained all the information required by the regulations. The inspector also viewed the files of nursing staff and observed that the current professional registration details were maintained for each member of nursing staff.

3. Action required from previous inspection:

(a) Provide training for all staff in the prevention, detection and response to abuse.

(b) Ensure that all staff have access to training to enable them to provide care in accordance with contemporary evidence-based practice.

The inspector found that this action had been completed.

The inspector viewed the training records which showed that all staff had received training on the protection of residents. The training matrix for 2011 showed that training on the protection of residents had been conducted on seven separate days beginning on 10 January 2011 and that four refresher courses on this topic were scheduled for later in the year. The training was provided by the care manager, who had completed a Train the Trainers course on the subject. The inspector viewed the syllabus for this training and found that it was satisfactory.

The records also showed that fire safety training had taken place on two days in April 2011 and on one day in September 2011 and that all staff had now received this training. The training schedule showed that training had also been provided on behaviour that challenges, moving and handling and cardiopulmonary resuscitation (CPR). External consultants provided training to small numbers of staff in a number of areas, including nutrition and diet, incontinence and percutaneous endoscopic gastrostomy (PEG) insertion. Training on infection control was planned for 25 October 2011.

4. Actions required from previous inspection:

Ensure that each resident has access to information concerning voluntary groups, community resources and events.

The inspector found that this action had been completed.

The inspector observed that information display holders had been installed on a wall close to the residents' lounge. This contained information and leaflets on a variety of activities in the local community. The person in charge told the inspector that the centre's bus had been used to transport residents on frequent outings during the past few months. The records of residents' activities recorded that outings for residents had taken place one or two times per week.

Other issues reviewed on inspection:

Personal Development Reviews

The person in charge has introduced a system of performance development review in 2011. This involved the staff member engaging in a detailed review of their own performance, followed by a joint review with the person in charge which resulted in a personal development plan. The inspector observed that the completed documentation was maintained in the staff files.

Falls

The person in charge introduced a new policy on the assessment and management of resident falls on 1 June 2011. On admission, a falls risk screening assessment is carried out on each resident. When a significant risk of falling is identified, a falls prevention care plan is completed. This is reviewed every three months or if there is a fall or change in medication. The inspector viewed a resident's care plan in which the falls care plan was being used.

According to the person in charge, each fall is recorded, investigated by the care manager, and discussed at the fortnightly management meeting. The care manager conducts a quarterly audit of all serious incidents. The inspector viewed the results of audits for 2010/2011 and a falls data chart which showed that the number of falls with injury to residents has reduced within the past year. The care manager had introduced a falls workbook, which is used in the UK. She said that nursing staff have gone through the workbook and been assessed for their knowledge in this area. She said that this process is being used to increase staff awareness and develop their skills. She also said that this workbook has been introduced for those care staff who wish to avail of it and that the subject matter will be incorporated into annual training for staff.

Behaviour that Challenges

Training on behaviour that challenges was provided for staff on 19 January, 29 June and 17 August 2011. The inspector viewed the syllabus for the training and found that it was

satisfactory. The inspector observed that a behaviour log was maintained for a number of residents and that one resident was referred to a psychologist who had recommended a course of intervention. Medical investigations, pain management and environmental safeguards were also used as part of the response to behaviour that challenges. The inspector viewed records which showed that discussions took place with residents, families and GPs and the person in charge told the inspector that a community mental health nurse visited weekly to review a number of residents and that the consultant for Old Age Psychiatry also visited when required.

Restraint policy

The person in charge has adopted the newly developed national policy on the use of physical restraints. The care manager attended a Train the Trainer course on the new policy on 8 September 2011 and has commenced training. The first training session was held on 29 September 2011 and was attended by 10 staff.

Closing the visit

At the close of the inspection visit a feedback meeting was held with the person in charge and the care manager to report on the inspectors' findings, which highlighted both good practice and where improvements were needed.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of the residents, relatives, provider and staff during the inspection.

Report compiled by

Tom Flanagan
Inspector of Social Services
Social Services Inspectorate
Health Information and Quality Authority

28 October 2011

Chronology of previous HIQA inspections	
Date of previous inspection:	**Type of inspection:**
24 August 2010 and 25 August 2010	☒ Registration ☐ Scheduled ☐ Follow-up inspection ☒ Announced ☐ Unannounced
13 January 2011	☐ Registration ☐ Scheduled ☒ Follow-up inspection ☐ Announced ☒ Unannounced

Any comments the provider may wish to make:

Provider's response:

None given.

Provider's name: Patrick Shanahan

Date: 9 November 2011