Health Information and Quality Authority
Social Services Inspectorate

Inspection report
Designated centres for older people

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

Centre name:	Glebe Nursing Home
Centre ID:	0039
Centre address:	Glebe Road Enniskerry Road Kilternan, Dublin 18
Telephone number:	01 2063382
Fax number:	01 2078989
Email address:	ctuliao@cowpercare.ie
Type of centre:	☒ **Private** ☐ **Voluntary** ☐ **Public**
Registered providers:	Cowper Care Centre Ltd
Person in charge:	Cheryl Tuliao
Date of inspection:	9 December 2011
Time inspection took place:	**Start:** 09:00 hrs **Completion:** 14:30 hrs
Lead inspector:	Fiona Whyte
Support inspector:	N/A
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 ☒ Follow-up inspection

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 matters arising from a previous inspection to ensure that actions required of the provider have been taken
- following a notification to the Health Information and Quality Authority's Social Services Inspectorate of a change in circumstance for example, 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
- 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

Glebe Nursing Home is owned by Cowper Care, a body with charitable status and part of the Church of Ireland diocese of Dublin and Glendalough. The centre provides 48 places for residential, respite, palliative and convalescence care to older people. There were 47 residents and one vacancy at the time of inspection. It is a single-story, purpose-built building on two acres of grounds which became operational in 2007. Alongside, there are retirement bungalows with accommodation for 22 residents.

The main entrance and reception area is to the front of the building and leads to a central open-plan area. This area comprises of the dining room, sitting room, nurses' station and office. There are three other smaller sitting rooms which residents and visitors use.

Bedroom accommodation is provided in three separate wings which project from the open plan living area. There are 35 single, two twin, and three three-bedded rooms, all with shower and toilet en suite facilities. There are three additional assisted bathrooms. There are also seven additional toilets, two in each of the three wings and one adjacent to the recreational/day care room.

Separate staff facilities include two showers, two toilets and separate toilet facilities for kitchen staff.

There is a separate dementia care unit with places for 16 residents. All bedrooms are single with en suite shower and toilet facilities. The layout of the unit allows residents to walk unimpeded, and residents who need to wander were free to do so. The dementia care unit has views of the outdoor secure courtyard, which residents can access easily.

The centre has two separate dining rooms, one in the dementia care unit and one in the main unit. There is a prayer room for residents' prayer and reflection. There is ample parking at the front and side of the centre.

Location

Glebe Nursing Home is located three miles from Stepaside village on Glebe road which is off the main Dublin to Enniskerry road. There is an hourly bus service from Dublin to the centre, and it is five minutes by car from the Sandyford Luas stop.

Date centre was first established:	2007
Number of residents on the date of inspection:	47
Number of vacancies on the date of inspection:	1

Dependency level of current residents	Max	High	Medium	Low
Number of residents	15	14	12	6

Management structure

Cowper Care Centre Limited is the Provider and there are three centres in the group. Seamus Shields is the Chief Executive Officer and the named person on behalf of the Provider for all three centres. The Person in Charge for the three centres is Cheryl Tuliao and the General Manager of support services for the centres is Guy Kilroy. They both report to the Provider. Lloyd Mutandwa is the Director of Care and reports to the Person in Charge while an Assistant Director of Care reports to the Director of Care. Staff nurses supervise the care assistants and they report to the Director of Care. The kitchen manager and housekeeping staff report to the General Manager of support services.

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	0*	4**	8	1 chef 1 catering assistant	1 laundry 2 cleaning	1	1***

* The person in charge was not on duty in this centre on the day of inspection but came in to be available during the inspection
** Including director of care and assistant director of care
*** The provider attended the centre for a short time during the inspection.

Background

Glebe House was first inspected by the Health Information and Quality Authority's (the Authority) Social Services Inspectorate on 11 and 12 May 2010 and it was an announced registration inspection.

The provider and person in charge demonstrated good leadership and commitment to developing and improving the service for the residents the healthcare needs of residents were met and risks were appropriately managed. Aspects of the service were audited and information was used to track trends, promote learning and inform continuous improvements. The care planning process was of a good standard, medication was administered safely and residents had access to healthcare services.

The centre was purpose-built and of a high standard. The inspectors found that the premises, fittings and equipment were very clean and well maintained. The dementia care unit was appropriate for residents who lived there.

However, inspectors found that staffing levels were inadequate with an over reliance on staff overtime. This impacted on the quality of life and safety for residents as staff had little time to devote to the social aspects of care.

The inspection report can be found at www.hiqa.ie.

Summary of findings from this inspection

This additional inspection report outlines the findings of a follow up inspection that took place on 9 December 2011. The purpose of this unannounced inspection was to review progress on the actions of the registration inspection of 11 and 12 May 2010.

Overall, the inspector was satisfied that the provider had implemented most of the actions required from the previous inspection within the agreed timeframes. The provider and person in charge were positive in their attitude and were committed to ensuring ongoing improvements.

The key measures taken by the provider since the previous inspection were as follows:

- additional staff recruited and a bank of staff provided for relief work
- additional staff hours were provided
- increased activity provision based on social assessment of residents
- residents' committee established.

The inspector identified improvements required in relation to protection of residents, complaints management and infection control. These issues are discussed further in the report and addressed in the Action Plan at the end of the report.

Issues covered on inspection

Complaints Management

Information was received prior to this inspection relating to the care of a resident. The provider was required to submit a copy of the investigation undertaken into the complaint. The investigation submitted did not outline the outcomes, recommendations made, whether the complainant was satisfied or not or if there was any learning as a result of the complaint being made. The inspector discussed this issue with the person in charge and reviewed the systems in place for managing complaints including the complaints log, complaints policy and how learning was ensured following complaints. The inspector was concerned that the management of complaints was not in line with the centres own policy or the Regulations. The person in charge did not manage complaints as a means for learning and improving the service instead complaints were considered as negative and were not encouraged.

The inspector reviewed a number of complaints, none of which recorded outcomes, recommendations or whether the complainant was satisfied or not. There was no evidence of learning as a result of complaints made. Meetings were generally held between the person in charge and the complainant to discuss the complaint and minutes were maintained. The person in charge also wrote to the complainant following any investigation of a complaint. However, the inspector found that the minutes of these meetings and the letters to the complainant did not include outcomes, whether the complainant was satisfied or not and did not indicate how the person in charge would ensure learning in order to prevent recurrence.

Verbal complaints were not managed the same as for written complaints in that complainants were required to put complaints in writing before an investigation would be conducted.

Protection of Residents

The inspector had serious concerns around the management of allegations of abuse and the safeguarding of residents. The inspector noted in the complaints log details of two allegations of abuse, one allegation of sexual abuse by a male resident to a female resident and one allegation of physical abuse of a resident by a staff member. Neither allegation had been notified to the Chief Inspector as required by the Regulations. Neither allegation had been appropriately investigated and managed despite the allegation of sexual abuse having been witnessed and reported by a relative of another resident. The person in charge was requested to submit a report detailing what measures were put in place following this allegation to ensure that all residents were safe in the centre.

Infection Control

A notification was received in advance of this inspection relating to an outbreak of the Norovirus infection in the centre. Nineteen residents and five staff members were affected. The inspector reviewed the infection control policy and practices in the centre. The policy in place was the national policy on healthcare associated infections which was comprehensive and provided clear guidance to staff in the event of an outbreak of an infectious disease. However, the policy did not inform practice for

example, the policy stated clearly that two or more residents presenting with vomiting or diarrhoea should be considered as an infectious outbreak and infection control measures should be implemented immediately. On the first day of this outbreak seven residents presented with vomiting and diarrhoea. However, infection control measures were not implemented immediately in accordance with the policy and resulted in an increased number of residents and staff being affected.

The person in charge, director of care and staff told the inspector that during this infectious outbreak the provider attended the centre daily for the handover in order to provide support and ensure clear communication on procedures to be followed. While during the outbreak the day-to-day communication was good, following the outbreak there was no evidence of discussion and learning from the event and there was no site-specific procedure developed in the event of another outbreak in this centre.

Actions reviewed on inspection:

1. Action required from previous inspection:

Put in place the numbers of staff and skill-mix of staff are appropriate to the assessed needs of residents.

This action was completed and was being reviewed on an ongoing basis.

The inspector reviewed the staffing rosters and the actual staff on duty. On the day of inspection the inspector was satisfied that there was sufficient staff on duty to meet the healthcare needs of the residents. There were two nurses and eight care assistants on duty - one care assistant was allocated to carry out activities with residents. The director of care was also on duty. Since the previous inspection the work organisation was reviewed and one care assistant hours had been increased by two hours daily. Residents' dependency levels were also being assessed on a monthly basis and used to inform staffing levels. As a result of an increase in dependency levels an additional care assistant was now on duty from 8.00 am to 2.00 pm daily. These additional hours were agreed temporarily and are subject to review based on residents' dependency levels.

Two care assistances were nominated care supervisors. One care supervisor was allocated to the dementia unit and the second to the general unit. They were provided with two hours weekly protected time to review the quality of care, activity provision, mobility charts, staff compliance and key worker responsibilities. They completed a house management check list and reported back to the nurse on findings.

The person in charge stated that three care assistants had left the service in the previous 12 months and they had been replaced through recent recruitment. There was a bank of relief staff available to cover leave at short notice negating the need for permanent staff to work increased hours. This also meant that there was no

reliance on agency staff for cover. This was confirmed by staff and reflected in the staff roster.

2. Action required from previous inspection:

Put arrangements in place to provide suitable and sufficient care to maintain the resident's welfare and wellbeing, having regard to the nature and extent of the resident's dependency and needs as set out in their care plan.

This action was completed and referred to staff providing care in a hurried fashion, leaving little time for staff to interact with residents.

Additional staff hours were provided as outlined in Action 1 and work organisation was reviewed. For example, one care assistant was now allocated to provide refreshments to residents, this allowed for interaction and conversation with residents.

One care assistant was allocated daily for the provision of activity and additional activity had been arranged such as holistic therapy on a weekly basis.

On the day of inspection staff did not appear to deliver care in a hurried manner and residents were being communicated and interacted with.

3. Action required from previous inspection:

Provide adequate laundry services to include the washing, drying and ironing of residents' clothes.

This action related to insufficient staff hours devoted to laundry services and this was completed. However, further improvement was required.

Since the previous inspection the laundry hours were increased. The hours had increased by two hours to 8.00 am to 4.00 pm Monday to Friday. The provider had also now provided a laundry service on Saturdays. This was confirmed by staff and the staff rosters.

The inspector noted when reviewing the complaints log that some residents' personal clothing going missing was an issue. This was discussed with the person in charge who told the inspector that in an effort to address this issue, laundry staff from all three centres rotated to look at various practices and ensure learning and improvements. She stated she would monitor this issue closely.

4. Action required from previous inspection:

Maintain records of any occasion on which restraint is used, the nature of the restraint and its duration.

This action was completed.

Eighteen residents were using bedrails while one resident was using a lap belt. The inspector reviewed the care plans of some residents using restraint. A comprehensive assessment for the use of restraint was in place, alternatives tried were documented and consent was sought from either the resident or relative. A risk balance tool was also in place to assess the risk of using restraint against the risk of not using the restraint. A release register was available which recorded the release times. Care plans were in place which were detailed to ensure the safety of residents. For example, one resident's care plan stated that his daily routine was to get up early but because he had bedrails in place there was a risk identified that he might climb over them, staff were alerted to attend to his needs first to minimise this risk.

5. Action required from previous inspection:

Put systems in place that provides freedom for residents to exercise choice in relation to personal activities such as showering/bathing.

Put in place arrangements to facilitate consultation and participation in the day-to-day running of the centre. Ensure all residents rights, needs and wishes are sought and facilitated. Careful consideration must be given to seeking the views of residents who have difficulty communicating.

Carry out appropriate consultation with residents in the ongoing review of CCTV usage.

This action was completed.

The person in charge stated that residents' had choice in the daily routines of life. They could choose to have a bath or shower on any day of their choice. She stated that any bath/shower lists were not in use to enforce institutional practices but used as a guide only. The inspector noted residents' preferences in their files and saw no evidence of bath/shower lists on the day of inspection.

A residents committee had been established and meetings held on a three-monthly basis. The inspector read the minutes of these meetings which were detailed and saw where any actions identified were followed up at the next meeting. The chairperson appointed was independent from the service. Relatives were also invited to attend and the person in charge stated she spoke to relatives of residents who had a cognitive impairment to ensure their views were sought. The details and minutes of the meetings were displayed on resident notice boards in the centre. The

inspector was concerned that the resident meetings were not held frequently enough to ensure residents had an opportunity to give feedback and participate in the day-to-day organisation of the centre. The person in charge stated she would review the frequency of meetings.

Service satisfaction surveys had been conducted and suggestion boxes provided.

There was also a key worker system in place where a group of residents were allocated a key worker. They could speak to their key worker about any issue of concern and residents spoken to were aware of this key worker system.

CCTV was provided in communal areas only as a safeguarding measure. Potential residents were informed of this in advance of admission in the information pack they received. A policy was in place for the use of CCTV.

6. Action required from previous inspection:

The registered provider shall ensure that all appropriate healthcare is facilitated and that each resident is supported on an individual basis to achieve and enjoy the best possible health.

This action was completed and related to a relative informing the inspector at the previous inspection that her relative was not taken for a walk.

All exercise and daily activities were recorded.

Report compiled by:

Fiona Whyte

Inspector Manager of Social Services
Social Services Inspectorate
Health Information and Quality Authority

20 December 2011

Chronology of previous HIQA inspections	
Date of previous inspection	**Type of inspection:**
11 and 12 May 2010	☒ Registration ☐ Scheduled ☐ Follow up inspection ☒ Announced ☐ Unannounced

Health Information and Quality Authority
Social Services Inspectorate

Action Plan

Provider's response to inspection report *

Centre:	Glebe Nursing Home
Centre ID:	0039
Date of inspection:	9 December 2011
Date of response:	9 January 2012

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 inspector had serious concerns around the management of allegations of abuse and the safeguarding of residents. The complaints log detailed two allegations of abuse. Neither allegation had been appropriately investigated and managed.
Action required: Put in place all reasonable measures to protect each resident from all forms of abuse.
Action required: Put in place a policy on and procedures for the prevention, detection and response to abuse.

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

Action required: Take appropriate action where a resident is harmed or suffers 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: There is a policy in place with a comprehensive training programme through induction and refresher training. We will now amend this to clarify what might be considered as abuse and would not, up to now, be considered as such. Appropriate action in line with our own policy will be taken where a resident is harmed or is suspected to have suffered abuse. A record of the investigation, actions taken and outcome will be kept on the resident's file. A post mortem on each reported event will be conducted involving all persons concerned. There is a 'whistle blowing' policy in place protecting staff who highlight any instance or suspected instance of abuse. We will continue to closely supervise residents with severe cognitive impairment who exhibits potential risk to self or other residents.	Complete

2. The person in charge has failed to comply with a regulatory requirement in the following respect: Two allegations of abuse had not been notified to the Chief Inspector as required by the Regulations.
Action required: Give notice to the Chief Inspector without delay of the occurrence in the designated centre of any allegation, suspected or confirmed abuse of any resident.
Reference: Health Act, 2007 Regulation 36: Notification of Incidents Standard 29: Management Systems

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: Checks are now in place to ensure such omissions do not occur in the future.	Complete

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

The management of complaints was not in line with the centres own policy or the Regulations. The person in charge did not manage complaints as a means for learning and improving the service instead complaints were considered as negative and were not encouraged. There were no recorded outcomes, recommendations or whether the complainant was satisfied or not and no evidence of learning.

Verbal complaints were not managed the same as for written complaints in that complainants were required to put complaints in writing before an investigation would be conducted.

Action required:

Investigate all complaints promptly.

Action required:

Maintain a record of all complaints detailing the investigation and outcome of the complaint and whether or not the resident was satisfied.

Action required:

Inform complainants promptly of the outcome of their complaints and details of the appeals process.

Action required:

Make a person available, independent to the person nominated in Regulation 39(5), to ensure that all complaints are appropriately responded to and that the person nominated under Regulation 39(5) maintains the records specified under Regulation 39(7).

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: The care manager is the designated person under regulation 39(5). That position will be clarified in our policies to remove any perceived ambiguity. Independent of that person the Clinical Director, under regulation 39(10), reviews procedures and ensures a) all complaints are properly responded to and that b) the person nominated under 39(5) maintains the records specified under regulation 39(7). Meetings with complainant are held after the complaint has been dealt with to further discuss areas in the response that the complainant is unclear on or is not satisfied with. Complaints and measures that are in place to address them are discussed in team management meetings. Necessary changes in practice as outcome of complaint are communicated in daily handover and staff meetings. We will amend our practice by including the outcomes and recommendations to improve the service in our response to the complainants. This will be documented and kept as part of complaints log. Verbal complaints are dealt with as any other complaint as per complaints procedure. It has been our practice to invite complainant to put their complaints in writing if they wish to do so in the event that further investigation is required. Each complaint, whether verbal or written, has and will continue to be investigated.	Complete

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

There was an outbreak of the Norovirus infection in the centre with 19 residents and 5 staff members affected. While there was a national policy in place, it did not guide practice.

There was no evidence of discussion and learning from the event and there was no site specific procedure developed in the event of another outbreak in this centre.

Action required:

Put in place written operational policies and procedures relating to the health and safety, including food safety, of residents, staff and visitors.

Action required:

Ensure that the risk management policy covers the arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents.

Reference:

Health Act, 2007
Regulation 30: Health and Safety
Regulation 31: Risk Management Procedures
Standard 26: Health and Safety
Standard 29: Management Systems

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: A written and operational policy and procedure is in place relating to health and safety, including food safety of residents and staff and visitors. A local policy and procedure on infection control is also in place. Our risk management policy covers the arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents. Our incident reporting form covers all of these areas including preventive measures to reduce occurrence of similar incidents or events. Improvement on documentation and learning from each experience has since been highlighted to management and staff.	Complete

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

The inspector noted from the complaints log that residents' personal clothing going missing was an issue.

Action required:

Put in place written operational policies and procedures relating to residents' personal property and possessions.

Action required: Provide adequate facilities for each resident to appropriately store, maintain and use his/her own clothes.	
Reference: Health Act, 2007 Regulation 7: Residents' Personal Property and Possessions Standard 4: Privacy and Dignity	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: A written operational policy and procedure relating to residents' personal property and possessions is in place. A tagging system for larger clothes and mesh bags for small personal items are provided for all residents to address issues on missing personal clothing. Each resident has adequate facilities to store their clothes including a lockable cabinet for their valuables. Some family members have opted, at admission, to remove clothing for laundering/dry cleaning. We have no control of events in these situations.	Complete

Any comments the provider may wish to make:

Provider's response:

None received.

Provider's name: Seamus Shields
Date: 9 January 2012