Health Information and Quality Authority
Social Services Inspectorate

Inspection report
Designated Centres under Health Act 2007

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

Centre name:	Newbrook Nursing Home
Centre ID:	0074
Centre address:	Ballymahon Road Mullingar Co Westmeath
Telephone number:	044-9342211
Email address:	044-9342368
Type of centre:	☒ **Private** ☐ **Voluntary** ☐ **Public**
Registered provider:	Newbrook Nursing Home Ltd
Person authorised to act on behalf of the provider:	Phil Darcy
Person in charge:	Denise Hilton
Date of inspection:	8 March, 12 and 16 of April 2012
Time inspection took place:	**Day-1 Start:** 11:30 hrs **Completion:** 16:14 hrs **Day-2 Start:** 07:50 hrs **Completion:** 18:20 hrs **Day-3 Start:** 11:55 hrs **Completion:** 19:00 hrs
Lead inspector:	Catherine Connolly-Gargan
Support inspector:	Bríd McGoldrick (day 1) Ann Delany (day 2 and day 3)
Type of inspection	**Day 1 and 2:** ☒ **unannounced** **Day 3:** ☒ **announced**
Date of last inspection:	6 December 2011

About inspection

The purpose of inspection is to gather evidence on which to make judgements 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* under 18 outcome statements. The outcomes set out what is expected in designated centres.

Outcome 1 *There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the statement of purpose, and the manner in which care is provided, reflect the diverse needs of residents.*
Outcome 2 *The quality of care and experience of the residents are monitored and developed on an ongoing basis.*
Outcome 3 *The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure*
Outcome 4 *Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse.*
Outcome 5 *The health and safety of residents, visitors and staff is promoted and protected.*
Outcome 6 *Each resident is protected by the designated centre's policies and procedures for medication management.*
Outcome 7 *Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied healthcare. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.*
Outcome 8 *Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.*
Outcome 9 *Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discreet and sensitive manner.*
Outcome 10 *Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.*

Outcome 11 *Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence.*
Outcome 12 *Adequate space is provided for residents' personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.*
Outcome 13 *The designated centre is managed by a suitably qualified and experienced nurse with authority, accountability and responsibility for the provision of the service.*
Outcome 14 *There are appropriate staff numbers and skill-mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.*
Outcome 15 *The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.*
Outcome 16 *The records listed in Part 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).*
Outcome 17 *A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.*
Outcome 18 *The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.*

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

The inspection report is available to residents, relatives, providers and members of the public, and is published on www.hiqa.ie in keeping with the Authority's values of openness and transparency.

About the centre

Location of centre and description of services and premises

Newbrook Nursing Home is located on the same site as Newbrook Two Nursing Home. The two homes share the same gate entrance. Newbrook Nursing Home is located on the Ballymahon road, nearly two kilometres from Mullingar town centre, County Westmeath.

Newbrook Nursing Home is a purpose-built single-storey building. It has accommodation for up to 52 residents. The accommodation consists of 44 single bedrooms, 29 of which have en suite toilet, shower and hand-washing facilities. There are four two-bedded rooms, two of which have en suite shower, toilet and wash-hand facilities. There were also four bathrooms/showers of which two bathrooms met the standards for assisted or assisted wheelchair accessible bathing facilities. There were eight additional toilets available for residents' use of which seven were wheelchair accessible. Two wheelchair accessible toilets were located either side of the lobby area. Other toilet facilities were located throughout the centre and within close proximity of communal areas.

The laundry is located in a separate building. Administrative and maintenance resources are also shared between the two centres.

The site is adjacent to the canal which is securely fenced off. The site is landscaped with some seating and has pathways surrounding the lawned areas.

There were also two enclosed paved areas, each with suitable wooden seating which were each accessible from two different points of the centre. A visitors' room was available inside the front door. Seating is also available in the lobby area of the centre. Residents had access to two dining rooms, a sitting rooms and a recreation room.

The centre has an oratory, a kitchen, a treatment room and reception. Administration staff are located at a reception desk in the lobby area.

Date centre was first established:	22 July 1999
Number of resident places:	52
Number of residents on the date of inspection:	48

Dependency level of current residents as provided by the centre:	**Max**	**High**	**Medium**	**Low**
Number of residents	19	12	10	7

Gender of residents	Male (✓)	Female (✓)
	10	38

Management structure

Mr. Phil Darcy is the nominated Provider on behalf of the company. He is also the CEO of Newbrook Nursing Home Ltd. Denise Hilton is the Person in Charge appointed on 3 January 2012. The Person in Charge is supported in her role by a Clinical Nurse Manager (CNM), staff nurses, care attendants, kitchen, laundry, household, clerical and maintenance staff. She is also supported by the company's practice development coordinator and training officer.

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	1 CNM 2 staff nurses	10	2	2	1	1 activity coordinator 1 maintenance person

Summary of compliance with 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*.

This report set out the findings of a three day inspection which were unannounced on the first two days, 8 March and 12 April 2012. The third day of this inspection on 16 April 2012 was announced. As part of the inspection, inspectors met with residents, relatives, and staff members. Inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files.

Four inspections by the Authority had taken place prior to the Chief Inspector issued a 'notice of a proposal to refuse and cancel registration'. On the first day of this inspection, 8 March 2012, inspectors attended the centre to assess compliance with a number of key areas of the action plan developed from findings of inspection on 6 December 2011. Inspectors found that there were incidents of skin tears sustained during care procedures. There were also two incidents of pressure related skin injury indicating that the standard of care required improvement. There was evidence that staffing requirements were not adequate and therefore impacted negatively on the care and welfare of residents and on supervision of resident care practices by care staff. Staffing and staff supervision at night was also not of an adequate standard and nurses were working hours in excess of the recommended working week on a continuous basis. Medication management practices in relation to prescribing and administration of some medications placed residents at potential risk of injury.
In response on 8 March 2012, inspectors discussed findings with the provider and person in charge and issued an immediate action letter that required immediate address of the following areas:

- insufficient staffing levels and skill-mix
- insufficient staff supervision
- staff not been facilitated access to training necessary to meet residents needs
- not all staff had moving and handling training
- medication management and practices

The provider responded by rostering a second nurse on nights as and from the night of 8 March 2012 and an additional two senior staff nurses have been temporarily transferred from two of the other centres in the group to address immediate staffing deficits. Annual leave arrangements for all staff were put on hold. The remaining immediate actions were being addressed or addressed to a satisfactory standard by 12 April 2012, the second day of this inspection.

Other improvements included the provision of activities for residents with differing capabilities and to suit their varied interests. Improvements were also found meeting the communication needs of residents, end of life care and fire safety procedures.

There were twelve other areas where improvements had to be made to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended). These included appointment of a full-time person in charge, training of staff on restraint management, fire safety, recreational activity provision to meet the needs of all residents and end of life care were found to be now progressed.

Recruitment documentation was nearing completion. Medication management required address of prescribing in most respects as this area was not in compliance with the legislative requirements. Restraint management was being progressed to a satisfactory conclusion through an education drive with staff on best practice in this area.

Assessment documentation was being revised and refined to improve accessibility. This inspection occurred midway through this process and dual documentation was still in place for a number of residents. There was still some evidence of delay in GP review of residents in non acute situations.

Review of the Quality and Safety of Care and Quality of Life for residents was progressing well to completion. A lot of information had been collated which was been reviewed within a continuous quality framework.

Staffing, skill-mix, supervision and access to training, risk management, polices and procedures, ongoing painting and repair work to the premises and the residents' directory still required some improvement. Infection control and prevention had undergone significant improvement in response to the inspectors' findings on the second day of the inspection as discussed in Outcome 17 in this report.

The Action Plan at the end of this report identifies these areas where improvements must be made to meet the requirements the Regulations.

Compliance with 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. Statement of purpose and quality management

Outcome 1
There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the statement of purpose, and the manner in which care is provided, reflect the diverse needs of residents.

References:
Regulation 5: Statement of Purpose
Standard 28: Purpose and Function

Inspection findings
Inspectors found that the statement of purpose described the range of required information as outlined in Schedule 1 of Regulations. The provider and person in charge were aware that the current document should be kept under review to ensure that it reflected the service to be provided and to provide a copy to the Authority if changes in the service were made.

For resident's information a summary of the statement of purpose and function was included in the Residents' Guide which each resident had a copy of.

Outcome 2
The quality of care and experience of the residents are monitored and developed on an ongoing basis.

References:
Regulation 35: Review of Quality and Safety of Care and Quality of Life
Standard 30: Quality Assurance and Continuous Improvement

Inspection findings
The provider and person in charge provided evidence that although they were in the early stages of continuous quality improvement, they were committed to achieving this for the centre.

There was also evidence that quality of life audits had commenced which focused gaining insight into the experience of residents living in the centre led out by the activities coordinator. Findings included request for individual teapots to cater for individual tastes in the strength of the tea provided. Residents requested access to multichannel television access so they could foster their interests in sport.

Outcome 3
The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

References:
Regulation 39: Complaints Procedures
Standard 6: Complaints

Inspection findings
The complaints policy was redrafted and effective from 26 November 2011. It included an appeals process and was clearly displayed. There was a procedure for capturing verbal and written complaints. There was an appeals procedure available if required. No complaints were waiting for or in the process of investigation. Inspectors noted three complaints were logged for 2012 and were each addressed.

The person in charge and practice development coordinator confirmed that satisfaction was sought with the outcomes of all complaints which were in each case investigated thoroughly. However, the complaints log did not facilitate recording of investigations and therefore it could not be determined if the complainant was satisfied with the outcome in each case.

The nominated persons required by the legislation were documented on the complaints policy. However, in practice there was some confusion noted as to who these persons were. An audit of complaints was planned for 2012.

2. Safeguarding and safety

Outcome 4
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse.

References:
Regulation 6: General Welfare and Protection
Standard 8: Protection
Standard 9: The Resident's Finances

Inspection findings
Inspectors were provided with a copy of the centre's prevention, detection and response to elder abuse policy which also contained whistle blowing protection details. The policy was recently revised and was accessible to all staff. While the policy detailed procedures to follow in the event of receiving an allegation of elder abuse, the newly revised policy did not describe procedures to follow in the event of senior staff being implicated in an alleged incident of abuse.

There was evidence that all staff had attended training on elder abuse detection and prevention. Some staff working in the centre on the day were questioned by an inspector regarding the procedures to be followed in the event of an alleged incident of elder abuse in a number of scenarios and they were well informed.

Documentary evidence of attendance at elder abuse detection and prevention training was maintained for each staff member in a staff training matrix and a copy of the training certificate to certify completion was maintained on each staff member's file. Garda Síochána vetting was not fully completed for twelve staff. Evidence was available that application had been made and the provider was waiting for completion of same. The provider had been in contact with the relevant personnel in relation to tracking progress of vetting.

The centre was secure. Access to the centre was controlled and a receptionist was on duty five days per week. At all other times, staff controlled access of visitors to the centre. A visitors' record was maintained and completion was monitored by staff.

Outcome 5
The health and safety of residents, visitors and staff is promoted and protected.

References:
Regulation 30: Health and Safety
Regulation 31: Risk Management Procedures
Regulation 32: Fire Precautions and Records
Standard 26: Health and Safety
Standard 29: Management Systems

Inspection findings
There was a missing person policy in place which included clear procedures to guide staff should a resident be reported missing. Photographic identification was available for each resident in their care records.

There were controls in place to ensure the temperature of hot water was restricted to 43°C at outlets and the inspectors found hot water was dispersed at a safe temperature. Environmental temperatures were being measured throughout the centre and were noted to be within recommended parameters.

The inspectors found that while there were systems and practices in place that were targeted at promoting the health and safety of residents, visitors and staff, a number of areas requiring improvement were identified. The centre's risk register implemented in January 2012 was reviewed by inspectors. However, inspectors found that this document was not up-to-date in all respects as not all situations which currently posed a risk to residents in the centre were identified.

For example, potential risk to residents posed by communicable infection was not adequately identified. Actions to take for implementation of infection prevention and control practices in response to incidents of communicable infections that may occur in the centre were also not advanced.

Staff working additional hours beyond the recommended working week was identified as a low risk which did not reflect inspectors findings.

A risk management policy was in place effective from 9 January 2012 which advised on measures to take in response to a variety of risk situations. There were arrangements in place for recording and investigating untoward incidents and accidents. There was evidence that each incident was being followed up with corrective actions and discussed at staff and management meetings. Some adverse incidents recorded indicated that care and welfare of residents required improvement. The person in charge considered that the staffing shortfall had contributed to the findings. Both provider and person in charge were in the process of recruiting more staff.

The external grounds have undergone significant improvements from a safety perspective. External lighting has been replaced and visibility was noted to be of a higher standard as a result. Speed ramps are in place and had slowed the traffic significantly, reinforced by warning signage and signage to slow down. A pedestrian crossing was visible facilitating access from the centre across the path of traffic into and out of the centre. The provider was also observing traffic management and discussed how he had intervened where speed limits were exceeded by vehicles entering or exiting the site.

The fire register was found to be disorganised on the second day of inspection but was reviewed and well organised on the third of the inspection. Emergency lighting and evacuation signage was provided throughout the building. All fire exits were noted to be clear. Staff spoken with by an inspector were knowledgeable on the procedures they were required to follow in the event of the alarm sounding and evacuation procedures. Evacuation risk assessments had been completed for each resident and were easily accessible. An inspector viewed contracts of the servicing of fire alarms. The inspector also viewed records of fire drills which took place on a routine basis and found that routine inspection of the fire door closures and fire alarm panel were undertaken by maintenance staff to ensure they were operational. The most recent fire drill was carried out on 7 March 2012 and was attended by 24 staff. The inspector was told that the fire alarm panel was recently upgraded but a number of false alarms were noted in the fire book with one error not closed off. On the second day of inspection inspectors noted that this had been reviewed and a service was scheduled. All staff had attended fire training as documented on the training matrix.

Outcome 6
Each resident is protected by the designated centre's policies and procedures for medication management.

References:
Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines
Standard 14: Medication Management

Inspection findings
Six staff (50%) nurses had completed medication management training. Competency assessments were in progress carried out by the Practice Development Officer.

The medication administration system was being evaluated and a decision was made to install locked medication presses in each resident's room and to administer medications from original packaging to reduce the risk to residents of an adverse medication event.

An audit of medication management in the centre carried out on 27 January 2012 was incomplete, as it did not include review or tracking of medication prescriptions and administration practices or vice versa. This was an area noted for improvement by inspectors to ensure resident safety in all aspects. Once brought to the attention of the person in charge, she reviewed all residents' medications and noted deficits for which she was developing an action plan by the third day of the inspection, 16 April 2012.

Aspects of medication management again required improvement as evidenced from findings on this inspection.

Staff were administering medications from repeated fax prescriptions and all medications administered were not documented on a prescription sheet by a medical practitioner. However, the person in charge discussed how many of these inadequate practices could be tracked back to difficulties in getting all medication prescriptions signed at the time that medications commenced, dosages changed or medications were discontinued.

Medication prescribing practices were again found not to be in line with best practice in relation to high alert anticoagulation therapy. The process in place from taking a sample of residents' blood for analysis to prescription of the appropiate dose of medication continued to pose risk of error and subsequent injury to residents due to incomplete prescribing practices by the GP.

While the provider was in discussion with the GPs, the person in charge was pursuing other ways of ensuring that medication prescribing documentation could be completed by a doctor including taking the residents prescription sheets to the GPs for signing in some cases.

3. Health and social care needs

Outcome 7

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

References:

Regulation 6: General Welfare and Protection
Regulation 8: Assessment and Care Plan
Regulation 9: Health Care
Regulation 29: Temporary Absence and Discharge of Residents
Standard 3: Consent
Standard 10: Assessment
Standard 11: The Resident's Care Plan
Standard 12: Health Promotion
Standard 13: Healthcare
Standard 15: Medication Monitoring and Review
Standard 17: Autonomy and Independence
Standard 21: Responding to Behaviour that is Challenging

Inspection findings

Inspectors were satisfied that progress was being made in the area of care planning. Five residents care plans were reviewed by inspectors. The person in charge was in the process of removing old information as each new file was completed. The newly drafted documentation reflected improved assessment and identification of each resident's needs although work was still required on the standard of some nurses' documentation in order to improve communication of residents needs and progress. There was a clear record of evaluation in most cases and each resident was evidently encouraged to be involved in developing and reviewing their care plans. Some residents signed their own care plans. An arrangement was in place where each resident had a 'Key Worker' nurse and carer. While 33% (15) of staff had recently received training in care planning, the person in charge was working to ensure all nursing and care staff availed of this training. The Inspectors were told that an audit was planned to evaluate progress in respect of completeness and accuracy of content.

Residents had good access to peripathic services. A physiotherapist was employed on staff for the group and attended the centre twice weekly. GP services were available, there was evidence in the sample files reviewed by inspectors that there were gaps in the service provided and delays in seeing residents in the centre; one resident was waiting review of symptoms since 7 April 2012, this was a period of six days. Staff were told that these delays were due to surgery workload on a number of occasions. During these times staff reverted to requesting the emergency on-call service to complete prescribing and give advice on medication dosages. The provider stated

that he was endeavouring to resolve these findings which had been notified to him prior to the inspection by the person in charge.

The person in charge in the centre had completed a train the trainer course in restraint management and had trained 25 staff to date. Inspectors noted that bedrails were used for 34% (15) residents, although the majority were referenced as being 'enablers'. It was not clear how the bedrails viewed by inspectors at inspection fulfilled an enabling function as most spanned the full length of the residents' beds when in the engaged position. One resident had a lap belt fitted and six residents used recliner chairs which were assessed by an occupational therapist. Although the number of restraints has not significantly reduced since the inspection of 6 December 2011, the person in charge told inspectors that she had sourced low-low beds and mats and had commenced using them for one resident. Restraint documentation included full records, documentation in relation to monitoring and review required review. Some residents had signed their own consent for bedrail restraint, however, this assessment documentation did not clearly demonstrate consideration of less restrictive means in the files reviewed.

A varied and expansive programme of activities was provided to meet the needs of residents' individual abilities, likes and capabilities. The activity coordinator led out on assessing and planning the recreational needs of all residents in the centre which was at an advanced stage. There was clear evidence of greater focus on meeting the recreational needs of residents with conditions that caused cognitive impairment on this inspection. This was an area that was under development at the inspection on 6 December 2011 and was now progressed. The activity coordinator planned her daily schedule to include the needs of residents who remained in their rooms and had established individual Sonas sessions for residents unable to participate in group sessions. Inspectors also noted that there was a resident who was temporarily unable to leave their room due to their medical condition. Issues of loneliness were raised by this resident and were addressed to a good standard by staff. The person in charge was developing care plans to meet the psychosocial needs of residents who did not leave their room. The activities coordinator was coaching carers in some of the skills in this area. Nominated care staff were skilled up to a level where activity provision will be part of their work which was monitored and developed by the activity coordinator.

A list of the events scheduled for the day was clearly displayed on a large noticeboard to inform residents and empower them to plan their day. On the day of inspection, the centre bus was used to transport ten residents to a local public house to watch horse racing for the afternoon. Residents from this group told inspectors that they enjoyed their trip. Outings were scheduled weekly and were planned to suit all interests based on suggestions gathered at resident meetings. Some of the other outings went to the recent handover of archival material to Mullingar Library which involved a video presentation of the memories and life stories of older people in the area. Residents also visited the Garda barracks and were enjoyed a tour and refreshments hosted by the Gardai.

Outcome 8
Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.

References:
Regulation 14: End of Life Care
Standard 16: End of Life Care

Inspection findings
There were no residents in the centre on the days of inspection in receipt of end-of-life care. However, inspectors formed a view from review of a sample of resident files that end-of-life wishes were discussed with residents in a meaningful and sensitive way. Resident's wishes were clearly documented. Residents are provided with single accommodation where possible and relatives are facilitated to stay overnight if desired.

A policy document was available to inform staff of procedures to follow in providing end of life care to residents. A pain assessment tool and a palliative care assessment tool were also available for use in the event of residents requiring assessment in these areas. Religious personnel are available and attend the centre regularly and as requested. There is a large oratory in the centre which was accessible and available for use for religious services and quiet reflection.

Outcome 9
Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discreet and sensitive manner.

References:
Regulation 20: Food and Nutrition
Standard 19: Meals and Mealtimes

Inspection findings
A recognised nutrition assessment tool was in use and there was regular monitoring of residents' weights to assess fluctuations. Residents who were being monitored for weight changes had treatment plans in place which included recommendations made by the dietician following review. Inspectors viewed food and fluid intake records which were complete.

Residents told inspectors that the food served was very good and that they had varied meals that offered choice and variety. A varied menu was advertised on the noticeboard in the dining room. Mealtime arrangements consisted of two sittings for lunch and tea resulting in provision of better dining space and more emphasis on making meal times unhurried occasions. Residents were noted to interact with each other and with staff. Inspectors spoke to staff assisting and serving the meals in the dining areas and found they were knowledgeable about individual resident's individual dietary restrictions.

Each meal was served to the resident by a member of catering staff who served one plated meal at a time. Residents were observed to make special requests for food and fluids at varied times and staff provided the items requested without difficulty on each occasion.

Residents who required assistance at meal times were assisted appropriately and sensitively. Staff were noted successfully to use divertional techniques while assisting residents to eat who had challenging behaviour.

Inadequate practices in relation to the labelling and dating of residents' food and cleaning of fridges in communal sitting areas were resolved on the final day of the inspection and were then of an adequate standard in relation to cleaning maintenance and food labelling requirements.

A newly assigned area with a worktop, kettle, microwave and fridge was located in one of the dining rooms and was designed to facilitate residents to make refreshments for their visitors if they wished. However, inspectors noted that the flex of the kettle, microwave and toaster did not reach the electricity socket safely. This was notified to the person in charge during the inspection.

4. Respecting and involving residents

Outcome 10
Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

References:
Regulation 28: Contract for the Provision of Services
Standard 1: Information
Standard 7: Contract/Statement of Terms and Conditions

Inspection findings

The contracts detailed the services to be provided for each resident and were signed by the resident or their representative

A sample of four contracts was reviewed by inspectors. Each resident had a contract in place. Fees to be charged were not clearly documented in each case in relation to funding provided by the Nursing Home Support Scheme and contribution paid by the resident.

Outcome 11
Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence.

References:
Regulation 10: Residents' Rights, Dignity and Consultation
Regulation 11: Communication
Regulation 12: Visits
Standard 2: Consultation and Participation
Standard 4: Privacy and Dignity
Standard 5: Civil, Political, Religious Rights
Standard 17: Autonomy and Independence
Standard 18: Routines and Expectations
Standard 20: Social Contacts

Inspection findings
Development and implementation of a centre-specific external and internal communications policy and procedure had been done in January 2012 but did not specifically discuss communication with residents who had conditions that impaired their functional ability to communicate freely. For example, blindness, challenging behaviour, deafness and motor function as a result of stroke or brain injury. However, residents in the centre with these conditions had care plans that documented care to meet their assessed communication needs

Residents who had specialist care needs such as dementia were more appropriately assessed and supported than inspectors had noted on previous inspections. Sixty three percent of staff had been involved in person-centred care training, there were improved safety features in place, the assessment process included information on communication problems and the activity programme included options that were appropriate for people with memory loss problems.

Residents have free access to enclosed gardens with seating. There are a number of raised flowerbeds and planters in the gardens to enable residents ease of access to flowers and plants. Residents had adequate and a variety of rooms for recreation. These communal rooms were recently named and choice of names was decided by resident plebiscites. A refurbishment project in late 2011 was completed and focused on assisting residents with navigating their way around the centre.

Inspectors noted that residents with visual impairments had access to talking newspapers. Staff were aware of their difficulties in moving around the centre and appropriately guided them. There was ongoing communication with the National Council for the Blind in Ireland.

Feedback is sought from residents on many aspects of the service. The principal forum for discussion was the three-monthly resident meetings. The agenda is pinned to the notice board prior to the meetings inviting suggestions for inclusion from the residents themselves. Inspectors viewed a sample of the minutes and noted that they were consultative and rich with suggestions from residents on various aspects of the service, for example, organising a trip to knock and hens for the centre.

A resident's newsletter is published quarterly. Inspectors viewed the second edition published April 2012. It was informative, contained a crossword puzzle and numerous pictures of the residents and feedback on various outings and activities. There was also a piece introducing the new person in charge and clinical nurse manager plus information on the tradition of Easter eggs and why Easter Sunday changes each year. The Easter religious services for residents were also documented. Pharmacy information sessions were given for residents and their families.
The majority of staff was respectful and patient and afforded residents choice at all times. However, the inspector noted that improvement was required in respect of one staff member who was notified by the inspection team to the provider and person in charge at feedback.

Staff training on challenging behaviour was completed on 25 January 2012. Two training sessions have been allocated for this day to facilitate all staff to attend. Forty five per cent of staff attended this training.

Outcome 12
Adequate space is provided for residents' personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.

References:
Regulation 7: Residents' Personal Property and Possessions
Regulation 13: Clothing
Standard 4: Privacy and Dignity
Standard 17: Autonomy and Independence

Inspection findings
The introduction of a resident inventory listing was in progress and enabled residents' personal belongings to be accounted for and documented upon admission and regularly reviewed by health care assistants to ensure new property was listed.

The provider stated that the introduction of a key worker system in December 2011 has facilitated continuity in the documentation and maintenance of resident clothing and property inventory listings.

A sample of three residents' files was reviewed. Inspectors noted that each resident had an updated property list on their file.

5. Suitable staffing

Outcome 13
The designated centre is managed by a suitably qualified and experienced nurse with authority, accountability and responsibility for the provision of the service.

References:
Regulation 15: Person in Charge
Standard 27: Operational Management

Inspection findings

A new person in charge was appointed to the centre on 3 January 2012. The post of the person in charge was full-time and the newly appointed person in charge had the required experience working with older people for three years within the last six as defined by the Regulations.

The person in charge was supported in her role by a clinical nurse manager who also worked full-time and who took charge in her absence.

Inspectors interviewed the person in charge on the third day of the inspection in relation to progress she had made since the inspection on 8 March 2012 and the issuing of an immediate action letter by the Authority. The inspectors were satisfied that she was meeting the responsibilities of her role. There were no further episodes of skin tear or pressure related injury to residents in the centre. Staff supervision was improved by facilitating the clinical nurse manager to fulfil her role in this area on a supernummary basis.

Staff spoken with told inspectors that they were supported to do their work. There was human resource procedures in place which were used to ensure staff complied with the requirements of their role.

Outcome 14
There are appropriate staff numbers and skill-mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

References:
Regulation 16: Staffing
Regulation 17: Training and Staff Development
Regulation 18: Recruitment
Regulation 34: Volunteers
Standard 22: Recruitment
Standard 23: Staffing Levels and Qualifications
Standard 24: Training and Supervision

Inspection findings
There was evidence that staffing levels were not adequate which potentially impacted negatively on the standard of care practices and on supervision of resident care practices by staff nurses at the first day of this inspection. Review of staffing skill-mix and staff supervision at night has been a consistent requirement in the action plans developed by the Authority since the first inspection in March 2010. Various measures were undertaken in response to the Authority's action plans to improve staffing levels/supervision and skill-mix including incorporating a then closed dementia-specific care unit into the rest of the centre and scheduling an additional carer on nights. Supervision of vulnerable residents was improved by recruiting a trained activity provider with a team of care staff providing recreational input seven days per week up to 5.00 pm each day.

The rosters were reviewed in response by the provider and the person in charge to ensure a mixture of experienced and newly recruited staff as opposed to all newly recruited staff commencing work in the centre. Some of the newly recruited staff nurses employed were placed in centres throughout the group facilitating redeployment of more senior staff to this centre. The clinical nurse manager was supernummary from the second day of inspection. There has been no further skin injuries to residents reported.

Seven staff files were reviewed by inspectors, none of which had all the required information on file. For example, two staff members had unexplained gaps in their employment history. Two staff members had inadequate certification of physical and medical fitness. Garda Síochána vetting applications for two staff sent in April 2011 were not on file. The provider had followed this up by the second day of inspection and weekly follow up was in place until close out. Gaps in employment history were also addressed by the second day of inspection. A plan was instituted to audit the files on a six-monthly basis as part of the overall audit programme.

6. Safe and suitable premises

Outcome 15
The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

References:
Regulation 19: Premises
Standard 25: Physical Environment

Inspection findings
A review of residents' furnishing had taken place and were either repaired or replaced. The inspector noted no items of furniture in residents' rooms still requiring repair. However, some chair covers in the communal area were torn and required attention.

Building work was complete to the back of the centre to provide storage facilities and staff changing areas.

On the second day of the inspection, inspectors found that there were improvements required in relation to infection prevention and control procedures as a matter of priority to minimise risk of cross infection to other residents. Inspectors found that measures in place to control and prevent infection were not adequate in all respects. An infection control and prevention policy for the centre was not available but was being developed by the team to inform practice, inspectors were told.

There was an unpleasant odour throughout the centre which was related to an enteric infection. Infection control practices and care and cleaning staff knowledge in relation to recommended infection prevention and control procedures to take was not of an adequate standard. These practices placed other residents at risk of infection. The provider and person in charge were requested to develop and implement a plan as a matter of priority to address deficits noted. Inspectors returned to the centre on 16 April 2012 and found a comprehensive plan in place which involved a review of infection control and prevention equipment, processes, staff knowledge and staff practices. An education programme was introduced for staff led out by the person in charge and supported by the practice development coordinator. A comprehensive action plan was developed in response to an episode of potentially communicable infection in the centre. A member of staff was nominated as a link nurse in infection control and prevention in the centre. A plan was in place to provide her with a programme of education was being developed for this staff member to support her role.

Further measures put in place to monitor infection prevention and control procedures included weekly environmental audits were put in place. The waste contractor was contacted to increase frequency of service. An infection control review was carried out on 13 April 2012 by an independent company and an action plan developed. Education was put in place for staff on 18 and 19 of April 2012.

7. Records and documentation to kept at a designated centre

Outcome 16

The records listed in Part 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

References:

Regulation 21: Provision of Information to Residents
Regulation 22: Maintenance of Records
Regulation 23: Directory of Residents
Regulation 24: Staffing Records
Regulation 25: Medical Records
Regulation 26: Insurance Cover
Regulation 27: Operating Policies and Procedures
Standard 1: Information
Standard 29: Management Systems
Standard 32: Register and Residents' Records

Inspection findings

All of the written and operational policies listed in Schedule 5 of the Regulations were available in the centre except a health and safety policy. However, catering staff use a policy called 'safe catering guide document'. Although these were recently reviewed, some were not centre-specific. For example, the risk management policy referred to a two-storey building when in fact the centre is a one storey building. Other policies which were not centre-specific included the recruitment, selection and vetting of staff and temporary absence and discharge of residents.

Inspectors reviewed the directory of residents which contained all the required information with the exception of time and date of death in the case of residents who died.

A record of restraint use was maintained in the case of each resident assessed as requiring restraint.

Outcome 17
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

References:
Regulation 36: Notification of Incidents
Standard 29: Management Systems
Standard 30: Quality Assurance and Continuous Improvement
Standard 32: Register and Residents' Records

Inspection findings
The person in charge was aware of the timescales within which notifications must be forwarded to the Authority. She had preparations in place for submission of quarterly notification due by 31 April 2012.

Outcome 18
The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.

References:
Regulation 37: Notification of periods when the Person in Charge is absent from a Designated Centre
Regulation 38: Notification of the procedures and arrangements for periods when the person in charge is absent from a Designated Centre
Standard 27: Operational Management

Inspection findings
This outcome was not applicable on this inspection as the person in charge has not taken leave beyond 28 days. There is a deputising arrangement in place for the person in charge by a designated and suitably qualified nurse.

Closing the visit

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

Acknowledgements
The inspectors wish to acknowledge the co-operation and assistance of the residents, relatives, provider and staff during the inspection.

Report compiled by:

Catherine Connolly-Gargan

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

8 March 2012

Health Information and Quality Authority
Social Services Inspectorate

Action Plan

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

Provider's response to inspection report*

Centre:	Newbrook Nursing Home
Centre ID:	0074
Date of inspection:	8 March, 12 and 16 of April 2012
Date of response:	14 June 2012

Requirements

These requirements set out the actions that must be taken to meet 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*.

Outcome 2: Reviewing and improving the quality and safety of care

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

There was inadequate evidence of a formal review of the quality and safety of care provided to residents or use of information collated through record keeping to manage high risk areas.

Information collated in all audits was not analysed in all cases to identify trends, learning and to improve the quality of life and safety for residents.

A report on the quality and safety and quality of care of residents in accordance with regulation 35 was not available.

Action required:

Establish and maintain a system for reviewing the quality and safety of care provided to, and the quality of life of, residents in the designated centre at appropriate intervals.

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

Action required:

Develop a process where audits carried out are analysed as a means of reviewing the quality of life and safety of care provided for residents in the centre at appropriate intervals.

Action required:

Make a report in respect of any review conducted by the registered provider for the purposes of Regulation 35(1), and make a copy of the report available to residents and, if requested, to the Chief Inspector.

Reference:

Health Act, 2007
Regulation 35: Review of Quality and Safety of Care and Quality of Life
Standard 30: Quality Assurance and Continuous Improvement

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response:	
We are developing a system of quality and safety management.	Completed
At present weekly statistics are collected and collated. Audits have commenced over the past number of months and a schedule has been drawn up for carrying out regular audits on resident welfare and quality of life e.g. care plans, weight management, restraint management, specialist review and follow up from dietician and physio etc, medication management, GP follow up, activities provided etc.	Completed
Results of these audits, learning outcomes and follow up will be shall be scheduled for review at monthly management meetings, monthly clinical care meetings and monthly support service meetings to enhance resident safety and facilitate such discussions in a structured manner.	Completed
Where audits are carried out in relation to resident safety and welfare, the findings of same shall be discussed at monthly team meetings to ensure all findings are communicated to staff.	Completed

Outcome 3: Complaints procedures

2. The provider is failing to comply with a regulatory requirement in the following respect: The complaints log did not facilitate recording of investigations and it could not be determined if the complainant was satisfied with the outcome in each case.
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: The complaints log now records the outcome of the complaint and whether or not the complainant was satisfied. The complaints were recently reviewed to ensure compliance with our complaints policy and that the complaints were being closed out.	Completed

Outcome 4: Safeguarding and safety

3. The provider is failing to comply with a regulatory requirement in the following respect: While the policy detailed procedures to follow in the event of receiving an allegation of elder abuse, the newly revised policy did not describe procedures to follow in the event of senior staff being implicated in an alleged incident of abuse or the referral numbers for the elder abuse social worker.
Action required: Put in place a policy on and procedures for the prevention, detection and response to 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: The Elder Abuse Policy will be revised to detail procedures to follow in the event of senior staff being implicated in abuse. The contact details of the Elder Abuse Social Worker will be included.	31/05/2012

Outcome 5: Health and safety and risk management

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

Health and safety polices and procedures, including food safety, of residents, staff and visitors were not in place.

The risk management policy did not include the identification and assessment of all risks throughout the designated centre and the precautions in place to control the risks identified.

Action required:

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

Action required:

Ensure that the risk management policy covers, but is not limited to, the identification and assessment of risks throughout the designated centre and the precautions in place to control the risks identified.

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 "safe catering" plan is in place to protect the health and welfare of residents, staff and visitors. The risk management policy is being revised so that it covers the identification and assessment of risks and the precautions in place to control them.	 Completed 30/06/2012

Outcome 6: Medication management

5. The provider is failing to comply with a regulatory requirement in the following respect: Prescribing and administration practices in relation to wafarin medication and faxed prescriptions posed risks to the health of residents in the centre.	
Action required: Put in place appropriate and suitable practices and written operational policies in accordance with current regulations, guidelines and legislation in relation to prescribing and administration of wafarin in the centre and ensure staff are familiar with such procedures and policies.	
Reference: Health Act, 2007 Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines Regulation 31: Risk Management Procedures Standard 14: Medication Management	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Policy in respect of administering wafarin is place. Blood samples are sent to the laboratory along with the wafarin book. This is the only time that the wafarin book is removed from the residents' drug cardex. The GP at the wafarin clinic will prescribe the wafarin therapy in the residents' wafarin book. Then the wafarin book will be collected by a member of Newbrook staff. Within 24 hours a copy of the wafarin book prescription will be sent to the residents' GP. A form will accompany the copy of the wafarin book prescription which will give details of the INR result, the dose prescribed and contact details of the Clinic Doctor.	 Completed Completed Completed

Outcome 7: Health and social care needs

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

Some Residents experienced prolonged delays in review by their GP.

Assessment of the least restrictive means of restraint and monitoring and review documentation was not adequate in all respects.

Action required:

Facilitate all appropriate health care and support each resident on an individual basis to achieve and enjoy the best possible health in relation to the GP service.

Action required:

Restraint documentation in relation to monitoring and review and assessment of least restrictive means of restraint required review.

Reference:

Health Act, 2007
Regulation 9: Health Care
Standard 13: Healthcare

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response:	
We have spoken to the various GPs concerning their attendance at the Nursing Home. Whilst most GPs are very cooperative a small minority are not. Therefore we are exploring our options in relation to facilitating our residents' access to GP services.	30/06/2012
Restraint documentation will be reviewed to ensure that the least restrictive method of restraint is in use.	30/06/2012

Outcome 10: Contract for the provision of services

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

Fees to be charged were not clearly documented in each case in relation to funding provided by the Nursing Home Support Scheme and contribution paid by the resident.

Action required: Ensure each resident's contract deals with the care and welfare of the resident in the designated centre and includes details of the services to be provided for that resident and the fees to be charged.
Reference: Health Act, 2007 Regulation 28: Contract for the Provision of Service Standard 7: Contract/Statement of Terms and Conditions

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The Contracts of Care are being updated.	 31/05/2012

Outcome 11: Residents' rights, dignity and consultation

9. The provider and person in charge is failing to comply with a regulatory requirement in the following respect: The communications policy and procedure did not specifically discuss communication with residents who had conditions that impaired their functional ability to communicate freely. For example, blindness, challenging behaviour, deafness and motor function as a result of stroke or brain injury. Not all staff afforded residents choice about their daily routines and personal care.
Action required: Put in place practices that facilitate and encourage each resident to communicate.
Action required: Provide each resident with the freedom to exercise choice to the extent that such freedom does not infringe on the rights of other residents.
Reference: Health Act, 2007 Regulation 10: Residents' Rights, Dignity and Consultation Regulation 11: Communication Standard 17: Autonomy and Independence

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**

Provider's response: The Communication Policy will be reviewed so that it informs practices to enable residents who have impaired functions to communicate. The staff member mentioned in the report, who required improvement in respect of resident choice, has now been redeployed to a role that does not involve interacting with the residents.	 30/06/2012 Completed

Outcome 14: Suitable staffing

10. The provider and person in charge is failing to comply with a regulatory requirement in the following respect: All required documentation in relation to recruitment of staff employed in the centre was not available for inspection. Staffing levels and skill-mix required on-going review to ensure that the needs of residents were met.
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.
Action required: Ensure that the numbers and skill-mix of staff are appropriate to the assessed needs of residents, and the size and layout of the designated centre.
Reference: Health Act, 2007 Regulation 16: Staffing Regulation 18: Recruitment Standards 22: Recruitment Standard 23: Staffing Levels and Qualifications

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**

Provider's response: Recruitment Policy is in place which ensures that no staff are recruited unless their "Schedule Two" documentation is in place. Additional staff nurses have been recruited and have undergone induction. Additionally the skill-mix has been reviewed by the director of nursing and changes made to the roster where appropriate. We have an ongoing recruitment drive for staff nurses across the Newbrook Group which will hopefully fill all positions as they become available.	 Completed Completed Completed

11. The provider and person in charge is failing to comply with a regulatory requirement in the following respect: Staff required ongoing training in areas such as infection control, pressure area care and restraint management Supervision of staff was required at all levels to ensure residents' needs were met at all times.	
Action required: Provide staff members with access to education and training to enable them to provide care in accordance with contemporary evidence-based practice.	
Action required: Supervise all staff members on an appropriate basis pertinent to their role.	
Reference: Health Act, 2007 Regulation 17: Training and Staff Development Standard 24: Training and Supervision	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**

Provider's response: Ongoing training in infection control, pressure area care and restraint management has been/will be carried out. Supervision of staff has been strengthened and will be continually reviewed and monitored. The CNM, and occasionally the director of nursing, are on the floor observing and supervising care practices. The staff appraisals are ongoing. The staff nurses are being given "on the job" training on proper supervision of care staff. The CNM will work some weekends to supervise care practices.	 Completed Completed

Outcome 15: Safe and suitable premises

12. The provider is failing to comply with a regulatory requirement in the following respect: The internal premises required painting in some areas. Arrangements were not adequate to ensure the centre was kept clean at all times. Some resident equipment was not in good repair.
Action required: Ensure the premises are of sound construction and kept in a good state of repair externally and internally.
Action required: Keep all parts of the designated centre clean and suitably decorated
Action required: Maintain the equipment for use by residents or people who work at the designated centre in good working order.
Reference: Regulation 19: Premises Standard 25: Physical Environment Standard 28: Purpose and Function

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**

Provider's response: Painting has been carried out the past couple of months. The remaining unpainted rooms are scheduled to be painted. All cleaning staff have received appropriate training in infection control. Adequate cleaning staff are in place. A system of preventative maintenance by servicing equipment is in place.	 31/07/2012 Completed Completed

Outcome 16: Records and documentation to be kept at a designated centre

13. The person in charge is failing to comply with a regulatory requirement in the following respect: The directory of residents did not contain time and date of death of residents who died.	
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: The Residents' Directory has now been updated to record time and date of death.	 Completed

14. The provider is failing to comply with a regulatory requirement in the following respect: Did not ensure all of the written and operational policies listed in Schedule 5 of the Regulations were centre-specific and contained information to inform evidence-based practice in the centre. The policy advising on health and safety was not available.

Action required: Ensure that the range of policies, procedures and guidelines available in the centre have been updated to reflect the provisions of Schedule 5 of the Regulations.	
Reference: Health Act 2007 Regulation 27: Operating Policies and Procedures Standard 29: Management Systems	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The Policies and Procedures are being reviewed and updated.	 31/07/2012

Any comments the provider may wish to make:

Provider's response:

I would like to thank the Inspector for the professional, courteous and unobtrusive manner in which she conducted her inspection.

Provider's name: Phil Darcy on behalf of Newbrook Nursing Home Ltd
Date: 23 May 2012