Health Information and Quality Authority
Social Services Inspectorate

Compliance Monitoring Inspection Report
Designated Centres under Health Act 2007

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

Centre name:	Annabeg Nursing Home
Centre ID:	0005
Centre address:	Meadow Court Ballybrack, Co Dublin
Telephone number:	01-2720201
Email address:	care@annabeg.com
Type of centre:	☒ **Private** ☐ **Voluntary** ☐ **Public**
Registered provider:	Annabeg Enterprises Ltd
Person authorised to act on behalf of the provider:	Brendan O Connell
Person in charge:	Sinead Beirne
Date of inspection:	1, 2, 3 and 4 October 2012 Follow-up inspection 16 October 2012
Time inspection took place:	**Day-1 Start:** 16:00 hrs **Completion:** 17:45 hrs **Day-2 Start:** 07:15 hrs **Completion:** 18:20 hrs **Day-3 Start:** 08:30 hrs **Completion:** 18:10 hrs **Day-4 Start:** 09:00 hrs **Completion:** 18:15 hrs **16 October** **Start:**16:00 hrs **Completion:** 18:30 hrs
Lead inspector:	Linda Moore
Support inspector(s):	Finbarr Colfer
Purpose of this inspection visit:	☒ to monitor ongoing regulatory compliance ☒ following a notification
Type of inspection	☐ **announced** ☒ **unannounced**

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

- to monitor compliance with regulations and standards
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Social Services Inspectorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or well-being of residents

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.

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 inspection report sets out the findings of a monitoring inspection, in which ten of the 18 outcomes were inspected against. The purpose of the inspection was:

☐ to inform a registration decision
☐ to inform a registration renewal decision

☒ to monitor ongoing compliance with regulations and standards
☐ following an application to vary registration conditions
☒ following a notification of a significant incident or event
☐ following a notification of a change in person in charge
☐ following information received in relation to a concern/complaint

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

Outcome 1: Statement of Purpose	☐
Outcome 2: Contract for the Provision of Services	☐
Outcome 3: Suitable Person in Charge	☒
Outcome 4: Records and documentation to be kept at a designated centres	☒
Outcome 5: Absence of the person in charge	☐
Outcome 6: Safeguarding and Safety	☒
Outcome 7: Health and Safety and Risk Management	☒
Outcome 8: Medication Management	☒
Outcome 9: Notification of Incidents	☐
Outcome 10: Reviewing and improving the quality and safety of care	☐
Outcome 11: Health and Social Care Needs	☒
Outcome 12: Safe and Suitable Premises	☐
Outcome 13: Complaints procedures	☒
Outcome 14: End of Life Care	☐
Outcome 15: Food and Nutrition	☒
Outcome 16: Residents' Rights, Dignity and Consultation	☒
Outcome 17: Residents' clothing and personal property and possessions	☐
Outcome 18: Suitable Staffing	☒

This monitoring inspection was unannounced and took place over four days. As part of the monitoring 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.

Whilst evidence of good practice was observed in many aspects of the service, significant improvements were required in some aspects of supervision of residents. This significant issue required the urgent attention of the provider and the provider submitted an immediate action to address the risks. The Authority received a prompt response from the provider in respect of these issues.

Inspectors found that the health care needs of residents were met. Residents had access to general practitioner (GP) services and to a range of other health services.

Inspectors found that improvements had been made in eight of the areas of non compliance identified in the previous inspection. These included the development of the elder abuse policy, additional staff on duty and the provision of training to staff. Further improvements were still required in the development of the medication management policy, fire drills and aspects of the premises.

A follow-up inspection was carried out on the 16 October 2012. The purpose of this inspection was to review progress made on the actions identified in the immediate action plan which was issued to the provider following the monitoring inspection on the 1, 2, 3 and 4 October 2012. The inspector found that these areas were satisfactorily addressed.

Section 41(1)(c) of the Health Act 2007
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*.

Theme: Governance, Leadership and Management *Effective governance, leadership and management, in keeping with the size and complexity of the service, are fundamental prerequisites for the sustainable delivery of safe, effective person-centred care and support.*

Outcome 3 *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
Outstanding action(s) required from previous inspection: No actions were required from the previous inspection.

Inspection findings

The post of person in charge was full time and held by a registered nurse who had the required experience in the area of nursing older people.

The person in charge's knowledge of the Regulations and the *National Quality Standards for Residential Care Settings for Older People in Ireland* and her statutory responsibilities was sufficiently demonstrated during the inspection. She was very familiar with residents and staff. She was an organised person in charge and provided strong leadership while she was in the centre.

However, inspectors reviewed the arrangements for when the person in charge was not on duty and found that measures that were being implemented while the person in charge was on duty were not being implemented when she was not in the centre. This did not ensure that residents received a consistent and quality service. These issues related to the supervision of residents by staff and medication management arrangements. These are discussed further under Outcomes seven and eight.

Outcome 4

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:

Regulations 21-25: The records to be kept in a designated centre
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:

Residents' Guide

Substantial compliance ☒ Improvements required * ☐

Records in relation to residents (Schedule 3)

Substantial compliance ☒ Improvements required * ☐

General Records (Schedule 4)

Substantial compliance ☒ Improvements required * ☐

Operating Policies and Procedures (Schedule 5)

Substantial compliance ☐ Improvements required * ☒

Inspectors read a sample of the policies and found that they did not reflect the actual practices in the centre, and did not provide guidance on what to do in the centre.

Directory of Residents

Substantial compliance ☐ Improvements required * ☐

The directory of residents was not viewed on this inspection.

Staffing Records

Substantial compliance ☐ Improvements required* ☒

The provider had not obtained the required documentation to demonstrate that temporary staff are fit to work in the centre. There were no staff files for four of the

temporary staff nurses and the provider had not obtained all of the required information for these nurses as required by the Regulations.

Medical Records

Substantial compliance ☒ Improvements required* ☐

Insurance Cover

Substantial compliance ☐ Improvements required* ☐

Not viewed on this inspection.

Theme: Safe care and support

Safe care and support recognises that the safety of service users is paramount. A service focused on safe care and support is continually looking for ways to be more reliable and to improve the quality and safety of the service it delivers.
In a safe service, a focus on quality and safety improvement becomes part of a service-wide culture and is embedded in the service's daily practices and processes rather than being viewed or undertaken as a separate activity.
To achieve a culture of quality and safety everyone in the service has a responsibility to identify and manage risk and use evidence-based decision-making to maximise the safety outcomes for service users.

Outcome 6

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

Outstanding action(s) required from previous inspection:

The action required from the previous inspection was satisfactorily implemented.

Inspection findings

Inspectors found that measures were in place to protect residents from being harmed or abused.

Inspectors found that all of the staff spoken to on the day of inspection were aware of the types of elder abuse and their responsibilities in reporting suspected elder abuse to the person in charge. There were records to indicate that staff had received training on identifying and responding to elder abuse.

Residents spoken to confirmed that they felt safe in the centre. Inspectors reviewed the centre's policy on the prevention, detection and response to elder abuse and found that it had been revised since the previous inspection; it gave guidance to staff

on the types of abuse, the procedures for reporting alleged abuse and the procedures to follow when investigating an allegation of elder abuse. At previous inspections the provider and person in charge demonstrated that they were knowledgeable on how to respond to allegations of abuse. The provider was a Train-the-trainer in elder abuse and he provided this training to staff.

Outcome 7
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

Outstanding action(s) required from previous inspection:

The risk management policy did not meet the requirements of the Regulations or guide practice.

Inspection findings

Inspectors found that that there were systems to promote the health and safety of residents, staff and visitors. However, there were areas that required significant improvement. Inspectors found that the supervision of residents was inadequate. Poor manual handling practices were observed and staff knowledge of fire procedures also required improvement.

Risk Management

Inspectors had significant concerns regarding the supervision of residents.

Inspectors found that supervision arrangements, particularly in the day room, were insufficient. While staff looked in on residents, inspectors found that this was not sufficient to meet the needs of residents, particularly very dependent residents, and there were long periods of time when staff were not present with residents in the room. In addition, inspectors spoke with staff and they were not clear on the supervision arrangements.

The provider had failed to ensure that the new arrangements for the supervision of care for residents had been implemented at all times. While inspectors observed the new arrangements being implemented during the inspection, inspectors reviewed closed circuit television (CCTV) footage of the evening meal time on the 30 September 2012 and found that the new supervision arrangements were not being adhered to in the absence of the person in charge.

The provider was required to take immediate action in relation to this risk. A response was received from the provider on 05 October 2012 and was found to be

satisfactory. An inspection was carried out on 16 October 2012 to review this issue and the inspector found that supervision arrangements were satisfactory.

Inspectors observed staff using poor manual handling practices on a number of occasions during the inspection which placed residents and staff at risk.

Inspectors read policies on the risks specified in the Regulations such as violence and aggression, assault, residents going missing, self-harm and accidental injuries to residents and staff. While in practice the person in charge was identifying, recording, investigating and learning from serious or untoward incidents or adverse events involving residents the risk management policy did not guide practice. This had been identified as an area for improvement at the previous inspection and while some action had been taken to address this, it was not satisfactory.

The person in charge, on behalf of the provider, had developed a risk register to identify and manage the risks in the centre. The risk management policy also included other risks in the centre and the control measures to manage those risks. Minutes of staff meetings showed that risks were discussed with staff.

Detailed records were maintained of all accidents and incidents. All of the records were dated and signed by a staff member and by the person in charge. Information relating to each incident was readily available and all follow up actions were recorded, dated and signed. The person in charge reviewed the reports for each resident to determine the root cause and preventative measures were being taken to prevent reoccurrence, such as medication review.

However, while this was good practice, inspectors found arrangements to manage risk were not being implemented in the absence of the person in charge. There was no system to ensure that the review of incidents would happen in the absence of the person in charge to ensure the ongoing continuity of care and safety of residents. Inspectors read of one serious incident which had been recorded but had not been reviewed and no action had been taken to identify the cause and prevent the recurrence. The ADON said that she had not read the risk management policy and did not update the risk register or review incidents in the absence of the person in charge.

The risk management policy was developed with the support of a consultant in June 2012 but it had not been implemented. The policy included the risks specified in the Regulations. However, the policy identified the person in charge as having overall responsibility for risk in the centre, which does not comply with the requirements of the Regulations.

Fire Safety

Overall fire safety was managed by the provider but there were areas for improvement. Records indicated that all fire fighting equipment had been serviced. Fire orders were displayed throughout the centre. All means of escape were found to be unobstructed and daily checks on means of escape were documented.

Inspectors found that while staff had been provided with fire training, some of the staff, including night duty staff were not knowledgeable regarding evacuation

procedures in the event of fire. This issue was brought to the attention of the provider and person in charge. Fire training was provided to staff as planned during the inspection. Although the provider referred to fire drills being completed, these were information sessions and did not involve an actual drill, simulated evacuation or practicing the use of fire equipment. Staff who were interviewed were not able to tell inspectors about how to use the fire fighting equipment such as the evacuation chair provided at the stairs.

Residents care plans identified the need for residents to be evacuated with the use of ski sheets, but these had not yet been provided for residents use. The person in charge stated that these were on order and said she expected to receive delivery within the week following the inspection.

Outcome 8
Each resident is protected by the designated centres' policies and procedures for medication management.

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

Outstanding action(s) required from previous inspection:

The medication policy was not being implemented and medication administration practices required improvement.

Inspection findings
Overall, inspectors found evidence that medication management practices placed residents at risk and impacted on their dignity. The policy on medication management did not guide the practice.

There was a medication management policy in place which provided some guidance to staff. The policy was not centre specific and did not provide clear direction to staff on how to manage medication in the centre. This had been identified at the previous inspection as an area for improvement and while some action had been taken to review the policy, it did not include directions for staff on the prescribing and administration of Warfarin or insulin.

Inspectors observed poor practice in the administration of medication which impacted on the safety of residents. Care staff co signed medication administration of insulin, when they had not reviewed the prescription or observed the practice of administration. Staff nurses did not adhere to best practice in infection control when administering injections to residents.

On three separate occasions, inspectors observed poor practice in the administration of medication which impacted on the dignity of residents. Inspectors observed nursing staff administering abdominal injections to residents in front of other residents in communal areas and in the dining room while residents were preparing to eat their meal. Inspectors brought this to the attention of the person in charge

and provider who took immediate action by providing training to staff nurses to minimise the risk of a reoccurrence. An inspection was carried out on 16 October 2012 to review this issue and the inspector found that the administration of medication was satisfactory.

The inspector found that each resident's medication was reviewed regularly by the GP and pharmacist and saw documentary evidence to support this.

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

Theme: Effective care and support

The fundamental principle of effective care and support is that it consistently delivers the best achievable outcomes for people using a service within the context of that service and resources available to it. This is achieved by using best available national and international evidence and ongoing evaluation of service-user outcomes to determine the effectiveness of the design and delivery of care and support. How this care and support is designed and delivered should meet service users' assessed needs in a timely manner, while balancing the needs of other service users.

Outcome 11

Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. 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

Outstanding action(s) required from previous inspection:

A high standard of contemporary evidence based nursing care was not delivered in relation to the use of restraint. Care plans did not set out the residents needs.

Inspection findings

Overall, the healthcare needs of residents were met. Staff spoken with were very knowledgeable about the residents in their care. While there was evidence of good practice in the management of behaviours that challenge, falls management and the management of restraint, some improvements in these areas were required. The policies on restraint, falls, nutrition and behaviours that challenge did not guide staff in the delivery of care.

Residents had access to GP services and out of hours medical cover was provided. Physiotherapy was available within the centre, as required by residents. A full range of other services was available on referral including speech and language therapy (SALT) and dietetic services. Chiropody and optical services were also provided. Inspectors reviewed residents' records and found that residents had been referred to these services and results of appointments were written up in the residents' notes.

Inspectors reviewed a sample of residents' care plans and noted that nursing assessments and clinical risk assessments were carried out for all residents. This had been identified as an area for improvement at the previous inspection and there had been improvements. The residents were assessed and the care plans were reviewed every month. Inspectors found that care plans were generally updated when there was a change in the resident's condition. There was a record of the residents' health condition and treatment given completed on a daily basis. Residents and/or relatives were involved in the development of their care plans and the care plans were available to the residents.

Inspectors found that the nursing staff monitored the nutritional status of residents. Residents' weights were recorded monthly. Nutritional risk assessments were used to identify residents at risk and care plans were in place. All residents at risk were referred to the GP if required and there were treatment plans in place. Inspectors reviewed the nutrition policy and found that it did not reflect the practices in the centre and did not provide direction to staff on the management of nutrition issues in the centre. The policy included a note that it was due for review in January 2011 but this review had not yet been carried out.

While there was good practice in the management of residents with behaviours that challenge, there was a comprehensive policy on the management of behaviours that challenge, but this did not guide the care delivered.

Residents' records included the identification of triggers that prompted behaviours and the behaviour itself was recorded using the ABC model. Residents were frequently reviewed by the GP and the psychiatric services. Inspectors were informed that training in responding to behaviours that challenge had been provided to staff and staff could describe the interventions they used to manage the residents behaviour.

While the staff recorded all incidents that occurred, staff had not completed the assessment process set out in the centre's policy. Staff could clearly describe the

care that was delivered but the care plans did not reflect the practice of staff and did not adequately guide care.

While there was good practice in the use of restraint, the centre's restraint policy had not been updated to reflect the recent national policy from the Department of Health on promoting a restraint free environment and it did not guide the practice. Inspectors reviewed the care plan documentation and noted that ten residents were using bedrails. Restraint assessments had been carried out for residents. These included the alternatives tried prior to the use of bedrails. However, there was no evidence of why the alternative had not been successful and the rationale for the use of restraint was not clearly documented. Risk assessments for the use of restraint were not consistently completed for all residents. While residents did have a care plan for restraint, these were not specific enough to guide the care delivered. Residents were checked hourly over night.

Three of the staff had received training on the use of restraint since the previous inspection. The person in charge said that training would be delivered to all staff.

There was a falls policy in place which did not guide practice. All residents at risk of falls had a falls risk assessment completed and a care plan in place. Inspectors reviewed the care plans of five residents who had fallen and noted that two did not have a post falls assessment completed when they had fallen. Again while three of these residents' care plans were updated to reflect their changing needs following a fall, this was not in place for two residents who had fallen. Inspectors noted that when one resident had fallen in 2012 and sustained a head injury, the GP had provided instructions to staff on the care of the resident and there was no evidence to demonstrate that these instructions had been implemented.

While nursing staff had access to the required resources to monitor residents with suspected head injuries i.e. a comprehensive neurological chart and pen torch, these observations had not been consistently completed when a resident had an unwitnessed fall or a fall resulting in a head injury. Neurological observations are an important aspect of the care of a resident following an unwitnessed fall or suspected head injury.

Inspectors found evidence of good practice in the provision of activities and social engagement for residents. There was an activity programme based on the assessed needs of residents. Various activities were carried out each day and there was a part time activities staff member assigned to provide structured programmes. In addition other staff provided activities on a session basis. Residents who were confused or who had dementia related conditions were encouraged to participate in the activities. The person in charge had ensured that these residents were provided with opportunities for personal growth and were included in the daily life of the centre. Residents told the inspectors they really enjoyed the many things to do in the centre.

Theme: Person-centred care and support

Person-centred care and support has service users at the centre of all that the service does. It does this by advocating for the needs of service users, protecting their rights, respecting their values, preferences and diversity and actively involving them in the

provision of care. Person-centred care and support promotes kindness, consideration and respect for service users' dignity, privacy and autonomy.

Outcome 13
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

Outstanding action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings
The complaints process met the requirements of the Regulations. Complaints and feedback from residents were viewed positively by the provider and the person in charge and used to inform service improvements.

The complaints procedure was displayed in a prominent location in the centre as required by the Regulations. Inspectors reviewed the complaints folder and found that complaints were generally well managed. However, inspectors found that one complaint had not been followed through in line with the centre's policy.

The most recent recorded complaint did not contain sufficient detail and the seriousness of the issue in the complaint was unclear. The provider stated that this issue would be investigated immediately.

Residents spoken to knew who to speak to if they wished to make a complaint. Residents spoken to said that they never had any reason to complain and said they were very happy with the care they received.

Outcome 15
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 discrete and sensitive manner.

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

Outstanding action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

Inspectors were satisfied that residents received a nutritious and varied diet that offered choice. However, inspectors observed that clinical supervision in the dining room required improvement.

Overall mealtimes were unhurried social occasions that provided opportunities for residents to interact with each other. Residents who required assistance were supported. Staff were seen assisting residents discreetly and respectfully if required. A review of the centre's CCTV footage showed that issues with regards to dignity and assistance of residents with meal times, that had been previously identified, had been addressed.

Inspectors noted that meals were hot, well presented and tasty and all expressed satisfaction with their meals.

Inspectors spoke with the chef and found that she had very good knowledge of resident's dietary needs and preferences. There was also documentary information of residents' requirements maintained in the kitchen.

Outcome 16
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

Outstanding action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

Inspectors found that residents' privacy and dignity was respected by staff in most regards but there were two areas for improvement. Medication management practices previously discussed and the way in which some staff addressed residents was inappropriate and these issues impacted on the privacy and dignity of residents.

Generally, inspectors observed staff responding well to residents needs. Staff engaged well with residents with complex needs. However, inspectors heard staff using terms such as the "feeds" to describe residents who required assistance at

meal times. Staff also called residents by terms such as “love” and “chicken” as opposed to their preferred name.

Theme: Workforce
The workforce providing a health and social care and support service consists of all the people who work in, for, or with the service provider and they are all integral to the delivery of a high quality, person-centred and safe service. Service providers must be able to assure the public, service users and their workforce that everyone working in the service is contributing to a high quality safe service.

Outcome 18
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

Outstanding action(s) required from previous inspection:

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

Inspection findings

While inspectors did not have concerns about the numbers of staff on duty during the inspection, improvements were required in relation to the organisation of staff as this would to ensure the safety of residents. Furthermore, improvements were required in relation to staff turnover and arrangements to ensure temporary, part time staff were suitable to work in the centre and the staff rosters.

The person in charge informed inspectors that she used the dependency levels of residents and her clinical judgement to decide staffing levels and skill mix. She also informed inspectors that staff were allocated to care for residents in specific parts of the building.

As discussed under Outcome 7, inspectors found that staffing allocation/supervision arrangements were not being implemented when the person in charge was absent from the centre. As a consequence, inspectors observed times when the care of residents was not being supervised in the dining and sitting rooms. Residents in the sitting and dining room were very dependent and this increased the risk to residents. The provider was required to take immediate action to address this issue and ensure

staffing arrangements provided consistent supervision and support to residents. The provider took action immediately and submitted a satisfactory action plan to the Authority within the specified timeframe following the inspection. An inspection was carried out on 16 October 2012 to review this issue and the inspector found that supervision arrangements were satisfactory.

Inspectors found that there had been a high turnover of staff in the centre during 2012. This may have contributed to issues such as the consistency of care and the establishment of good working practices in relation to areas such as medication management and supervision of care. There was no system to ensure that the part time staff were appropriately inducted, competent and supervised similar to the permanent staff. The provider said that he was making arrangements to recruit new staff nurses.

The provider was using part time, temporary nurses to cover night duty in the centre while there were staff shortages. Inspectors found that these staff had not had adequate induction training and were not sufficiently knowledgeable about the centre and the residents. Inspectors reviewed staff files and found that the provider had failed to obtain the required documentation to ensure that these staff were suitable to work in the centre including confirmation of their current registration with An Bord Altranais, three references, Garda Síochána vetting, photographic identification or full employment history.

Inspectors reviewed the staff roster and found that it did not provide information on staff working in the centre. The staff rota for the week of the 24 – 30 September 2012 did not show which nurse was on night duty on the 29 and 30 September 2012. The person in charge was not aware of who had been on duty on these nights and read the signatures in the progress notes to confirm this.

Since the previous inspection, an additional care staff had been employed for three hours in the evening to respond to residents' needs. The provider had increased nursing cover in response to a serious incident in September 2012.

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 cooperation and assistance of the residents, relatives, provider and staff during the inspection.

Report compiled by:

Linda Moore

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

9 October 2012

Health Information and Quality Authority
Social Services Inspectorate

Action Plan

Provider's response to inspection report *

Centre Name:	Annabeg Nursing Home
Centre ID:	0005
Date of inspection:	1, 2, 3 and 4 October 2012
Date of response:	26 November 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*.

Theme: Governance, Leadership and Management

Outcome 4: Records and documentation to be kept at a designated centre

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

Many of the policies did not reflect the actual practice in the centre and did not guide practice. The policies on restraint, falls, nutrition and behaviours that challenge did not guide the care.

Action required:

Put in place all of the written and operational policies listed in Schedule 5 of the Regulations.

Reference:

Health Act, 2007
Regulation 27: Operating Policies and Procedures
Standard 29: Management Systems

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

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: While our policies have been revised we are currently having same reviewed by an external consultant. A number of training days have been organised by the director of nursing to roll out same. The first such training day was held on 31 October 2012 last with two subsequent training days organised for 05 and 06 December 2012. In-house audits will be conducted in relation to each policy to monitor compliance with same. These audits will be conducted by members of the clinical governance committee.	28 February 2013

Theme: Safe care and support

Outcome 7: Health and safety and risk management

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

Suitable and sufficient care was not being provided to residents at meal times. Very dependant residents were left without support or supervision for long periods of time which placed them at risk. The new supervision arrangements were not being implemented in the absence of the person in charge which placed residents at risk.

The provider was required to take immediate action.

Action required:

Put in place suitable and sufficient care to maintain each resident's welfare and wellbeing, having regard to the nature and extent of each resident's dependency and needs.

Reference:

Health Act, 2007
Regulation 6: General Welfare and Protection
Standard 13: Health Care

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: We implemented a new supervision of resident's policy with	Completed

immediate effect. Residents are now supervised at ALL times during mealtimes with a nurse providing clinical supervision during mealtimes. Residents are also supervised in the communal rooms. Adherence to the above policy was observed by an inspector on a subsequent visit to Annabeg. Additional staff were recruited for peak times in a supervisory capacity to enhance resident safety. Compliance with our supervision policy is monitored by the director of nursing, assistant director of nursing and the provider.	

The provider has failed to comply with a regulatory requirement in the following respect: Inspectors observed poor manual handling practices on many occasions throughout the inspection.	
Action required Take all reasonable measures to prevent accidents to any person in the designated centre and in the grounds of the designated centre.	
Action required Provide a high standard of evidence-based nursing practice.	
Reference: Health Act, 2007 Regulation 31: Risk Management Procedures Regulation 6: General Welfare and Protection Standard 13: Healthcare 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: It is planned going forward to provide basic handling and moving training on recruitment or as soon as is reasonable practicable afterwards, with refresher training provided annually for all staff. Increased supervision by the director of nursing , assistant	31 January 2012

director of nursing and nurse in charge for all staff will take place to ensure that risk assessments are being carried out prior to carrying out handling and moving tasks. It is intended to encourage all staff to use best available evidence when handling and moving. A handling and moving course has taken place using the services of an outside contractor on 21 November 2012 with a second training day to be confirmed. All staff will attend one training session as a refresher to previous training. A policy training day was held on 31 October 2012 and our handling and moving policy was included in this session. Further policy training sessions will be held on 5 and 6 December 2012 with an audit of practices to take place once the training is complete. This will allow for learning and identify where to target the refresher training going forward.	

The provider is failing to comply with a regulatory requirement in the following respect: The risk management policy had not been implemented. This policy identified the person in charge as having overall responsibility for risk in the centre, which does not comply with the requirements of the Regulations. The arrangements to manage risk were not being implemented in the absence of the person in charge. For example, the ADON had not read the risk management policy, did not update the risk register and did not review incidents in the absence of the person in charge.	
Action required: Put in place a comprehensive written risk management policy and implement this throughout the designated centre.	
Reference: Health Act, 2007 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: We have since inspection revised our risk management policy with our external safety consultant to include revision of our risk register which will be reviewed monthly at our governance meetings. The assistant director of nursing has received a copy of and is aware of our risk management	Partially completed. Full completion December 31st 2012.

policy .We have introduced a form whereby all incidents/ accidents/ near misses will be formally risk assessed to include identifying our weaknesses and implementing any actions required on foot of our evaluation. In house training in policies to include our risk management policy will be held on 5 and 6 December 2012 with all staff attending one session. To ensure that the care delivered to our residents is of the highest quality Sinead Beirne and Brendan Connell have identified governance and risk management as sustaining the ethos of Annabeg and the care it provides to its residents. It is intended to set up a governance committee to meet monthly commencing 05 December 2012 to manage risks both clinical and non clinical within Annabeg. It is envisaged that this will provide a pathway for learning and encourage a learning culture and increase an awareness of the risk identified within Annabeg. It will assist in defining clear lines of accountability and responsibility. It will allow the risk management policy and procedure to be implemented and further revised as required to include all untoward incidents or adverse events involving residents and staff. It will ensure that the risk management policy and procedure will reflect the current arrangements that are in place for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents and staff. The governance group when established will review and discuss all incidents or near misses to residents and staff, with plans put in place to prevent reoccurrence. The learning outcomes from the governance committee will be used for the purpose of improving the quality of service and safety of residents and staff. It is intended to audit the risk management process to determine where changes or improvements may be required. Currently all residents are risk assessed with a personal emergency evacuation plan (PEEP) in place for each resident.	

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

The fire training was not suitable as some staff were not knowledgeable regarding evacuation procedures in the event of fire.

Although the provider referred to fire drills being completed, these were information sessions and did not involve an actual drill, simulated evacuation or practicing the use of fire equipment.

Residents care plans identified the need for residents to be evacuated with the use of

evacuation sheets, but these were not yet provided for residents use.	
Action required: Provide suitable training for staff in fire prevention.	
Action required: Ensure, by means of fire drills and fire practices at suitable intervals, that the staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire, including the procedure for saving life.	
Action required: Take adequate precautions against the risk of fire, including the provision of suitable fire equipment.	
Reference: Health Act, 2007 Regulation 32: Fire Precautions and Records Standard 26: Health and Safety	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Following the recent inspection our system for the evacuation of resident's staff and visitors at Annabeg Nursing Home has been reviewed and updated. We are in the process of establishing a governance committee. This will allow us to investigate and learn from training and evacuation. It will further ensure that all our systems are up to date. We confirm that best international evidence-based practice is in place in relation to the evacuation in the event of fire. We carried out a comprehensive fire risk assessment of the building and its surroundings, with the advice of an external consultant. We aim at all times to ensure that each resident and staff member visitor and contractor attains a place of safety in the least possible time. Our extensive review included arrangements for evacuation and the development of a Personal Emergency Evacuation Plan (PEEP) assessment form for each resident. The aim of the fire risk assessment is 1. To identify the fire hazards that may exist or are likely to exist for each resident and to reduce the risk of those hazards causing harm. 2. To determine what physical fire precautions and management arrangements are necessary to ensure the safety of the resident	Completed.

and to provide an evacuation plan for each resident in the event of fire. All identified risks were rerecorded in the residents care plan. The fire risk assessment is now a component of each residents care plan and will be updated if and when required and on a minimum of a three monthly basis. All new residents will have a fire risk assessment carried out on admission by the staff nurses carrying out the admission. Training has been provided for staff nurses in fire risk assessment. All staff will be aware of The P.E.E.P. for each resident. There has been a total review of the means of detecting, containing and extinguishing fire. Additional fire precautions and evacuation equipment have been put in place. The fire policy and procedure and audit tool is currently being revised and should be completed by 31 December 2012. A comprehensive training programme has been developed and this has been delivered to all staff currently working in Annabeg Nursing Home. All staff are now up to date on the prevention, detection, and containment of fire. All staff were made aware of their responsibilities in relation to fire prevention, detection and containment and in particular the importance of ensuring that all means of escape including fire doors were to be kept clear at all times. A new evacuation procedure has been developed and all residents will be evacuated if necessary from the assembly point to a local nursing Home in Dun Laoghaire, Co Dublin. The staff nurse on duty is the designated Nurse in charge on each shift. There is also a fire support person nominated to ring the fire brigade should the fire alarm activate, and to support the nurse in charge. All beds are now fitted with evacuation sheets and these will now be used in the event of evacuation. The use of the evacuation chair has been discontinued. We have decided to include fire evacuation training as a component of our handling and moving training as an extra update for staff on evacuation, prevention and controlling of fire at Annabeg. Fire training has to date been provided by an external fire training consultant every six months with the provider running further fire training sessions every month. Following a fire risk assessment by Sinead O Beirne and Brendan O'Connell with a consultant it was decided to review the training programme, a new training programme was developed in line with the risk identified and this new fire training was held in	

house by the external consultant on 3 and 4 October 2012. We have reviewed our monthly training sessions to include simulated evacuations with residents. Staff will complete an examination in our fire procedure bi-monthly.	

Outcome 8: Medication management

The provider is failing to comply with a regulatory requirement in the following respect: The policy on medication management did not guide the practice. Inspectors observed poor practice in the administration of medication which impacted on the safety and dignity of residents.	
Action required: Put in place appropriate and suitable practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents and ensure that staff are familiar with such policies and procedures.	
Reference: Health Act, 2007 Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines Standard 14: Medication Management	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: On foot of our inspection we responded immediately. We consultant externally to ensure that we are following best practice and complying with regulatory requirements. An external consultant provided an in house Medication Management course on Saturday 6 October 2012 last. All nurses have now completed a further medication management course and have been competency assessed in this area. Competency Assessments will be conducted monthly with all nurses by the director of nursing. It is mandatory for all nurses to attend a medication management course while employed in Annabeg. Our medication management policy has been revised to include warfarin and insulin administration and all nurses have received a copy of same. A procedure is being developed and will contain best and evidence-based practice and this will assist that to ensure that best and evidence-based practice is being followed.	Completed. Procedure for completion 31 January 2013.

Theme: Effective care and support

Outcome 11: Health and social care needs

The person in charge is failing to comply with a regulatory requirement in the following respect:

The care plans did not consistently reflect the assessed needs of residents in the areas of:

- restraint
- behaviour that challenges
- falls management

Action required:

Set out each resident's needs in an individual care plan developed and agreed with the resident.

Action required:

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

Reference:

Health Act, 2007
Regulation 8: Assessment and Care Plan
Standard 13: Healthcare
Standard 18: Routines and Expectations
Standard 10: Assessment
Standard 11: The Resident's Care Plan

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: All care plans have been updated to reflect any changes in residents conditions. A meeting with held with all nurses on 23 November 2012 last to discuss nursing documentation. Care plans are reviewed monthly at Annabeg. All staff are aware of the necessity to ensure that care plans reflect the current status of each resident and that they are up to date. Continuous education and updating will be provided for all staff. It is intended that the director of nursing will audit the care plans on a regular basis where gaps in information will be identified and this will allow for learning to take plan and ensure that the care plans are up to date.	30 November 2012

Theme: Person-centred care and support

Outcome 13: Complaints procedures

The provider is failing to comply with a regulatory requirement in the following respect: One complaint was not followed through in line with the centre's policy. The seriousness of the complaint could not be clearly identified from the complaint record and it had been almost three weeks since the complaint was made and no action had been taken.
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 complaint in question has been fully investigated to the satisfaction of the complainant and our complaints log updated accordingly.	Completed.

Outcome 16: Residents' rights, dignity and consultation

The provider is failing to comply with a regulatory requirement in the following respect: The terms used by staff to refer to and address residents was inappropriate at times and impacted on the dignity of residents. Some medication practices impacted on the privacy and dignity of residents.
Action required: Put in place adequate arrangements to ensure the operations of the designated centre are conducted with due regard to the sex, religious persuasion, racial origin, cultural and linguistic background, and any disability of residents.
Reference: Health Act, 2007 Regulation 10: Residents' Rights, Dignity and Consultation

Standard 18: Routines and Expectations	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: A number of training sessions on our in house policies are currently being organised by the director of nursing. These sessions commenced on 31 October 2012. This training session included training in our residents privacy and dignity policy. It is intended to provide further training sessions on in-house policies on 5 and 6 December 2012. Feed back from the sessions will be discussed at the governance committee meetings going forward.	31 December 2012

Theme: Workforce

Outcome 18: Suitable staffing

The provider is failing to comply with a regulatory requirement in the following respect: There was no system to ensure that the part time staff are appropriately inducted, competent and supervised pertinent to their role.	
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: We are currently seeking further documentation from our bank staff to complete their personnel files. An induction checklist has been introduced and is currently being provided for all bank staff. The director of nursing from time to time works on night duty. This allows her to assess staff competencies and to provide training if and where required and to provide guidance where necessary.	31 December 2012

Outcome 18: Suitable staffing

The provider is failing to comply with a regulatory requirement in the following respect: The provider had failed to obtain the required documentation to ensure that temporary staff were suitable to work in the centre including confirmation of their current registration with An Bord Altranais, three references, Garda Síochána, photographic identification or full employment history.	
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 have been obtained in respect of each person.	
Reference: Health Act 2007 Regulation 16: Staffing Standard 23: Staffing Levels and Qualifications Regulation 18: Recruitment Standards 22: Recruitment	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: As stated above we are currently seeking further documentation from bank staff to complete their personnel files. Garda Síochána has been submitted for all bank staff.	Processing of Garda Síochána vetting forms will take 10 to 12 weeks by An Garda Síochána.

Outcome 18: Suitable staffing

The person in charge is failing to comply with a regulatory requirement in the following respect: The staff rota did not show which nurse was on night duty on the 29 and 30 September 2012.
Action required: Maintain a planned and actual staff rota, showing staff on duty at any time during the day and night.
Reference: Health Act, 2007 Regulation 16: Staffing

Standard 23: Staffing Levels and Qualifications	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: An error was made while amending the planned rota to reflect the actual rota. All rotas are now checked by two persons.	Completed.

Any comments the provider may wish to make:

Provider's response:

The provider wishes to express his commitment and unswerving resolve to provide the highest quality of care for the residents of Annabeg. This dedication is shared by the staff in Annabeg and we will work assiduously to ensure that we deliver against our own standards and that laid down by the Health Information and Quality Authority (the Authority). We repeat our desire to ensure that we respond positively and expediously to all demands and requirements from the Authority and maintain a relationship that is both positive and congruous.

We wish to sincerely thank our staff for their exceptional dedication and wonderful commitment in providing care to the residents of Annabeg.

Provider's name: Brendan O'Connell

Date: 26 November 2012.