Health Information and Quality Authority
Social Services Inspectorate

Regulatory Monitoring Visit Report
Designated centres for older people

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

Centre name:	Belmont House Nursing Home
Centre ID:	0014
Centre address:	Galloping Green Stillorgan, County Dublin
Telephone number:	01-2782895
Fax number:	01-2782895
Email address:	info@belmontcare.ie
Type of centre:	☒ Private ☐ Voluntary ☐ Public
Registered providers:	Belmont Care Ltd.
Person in charge:	Margaret Wafer
Date of inspection:	6 and 7 June 2012
Time inspection took place:	**Day-1 Start:** 09:00 hrs **Completion:** 18:15 hrs **Day-1 Start:** 22:00 hrs **Completion:** 23:15 hrs **Day-2 Start:** 10:05 hrs **Completion:** 20:00 hrs
Lead inspector:	Gary Kiernan
Support inspector:	Linda Moore
Type of inspection:	☐ Announced ☒ Unannounced
Purpose of this inspection visit:	☐ Application to vary registration conditions ☐ Notification of a significant incident or event ☐ Notification of a change in circumstance ☐ Information received in relation to a complaint or concern ☒ Regulatory Monitoring Visit Report

About the inspection

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

In assessing the overall quality of the service provided, inspectors examine how well the provider has met the requirements of the Health Act 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

Additional inspections take place under the following circumstances:

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

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

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

About the centre

Description of services and premises

Belmont centre is a residential centre providing 161 places for people over 18 years of age, including many residents with dementia. It opened in 1997 and is run by Belmont Care Ltd. The centre has seven levels that consist of 85 single en suite bedrooms, 29 twin en suite bedrooms, three three-bedded rooms, one four-bedded room and one five bedded room.

On entering the centre, at ground floor level, there is a spacious reception area staffed from 09:00 until evening time. This floor has a large spacious dining room and three recreational rooms, including a library and two sitting rooms, one of which overlooks a terraced area. The visitors' room is off the reception area and it has a computer which residents can access. Other amenities include a hairdressing salon, vending machines and a coffee shop. The person in charge, provider and the nurse in charge of the first floor wing each have an office on this floor. The main kitchen, treatment room and staff facilities are also located on this floor.

The Evergreen unit on the lower ground floor is a self-contained, secure unit, designated for residents assessed by the person in charge as high dependency. These residents require a greater degree of supervision and support and may have a diagnosis of dementia. It provides accommodation for 32 residents. It has two single rooms and six twin rooms, all of which have en suite bathrooms. All en suites in the building have a shower, wash basin and toilet. There are also three three-bedded rooms with a shower-room in close proximity, one four-bedded room with en suite bathroom and an assisted bathroom nearby. There is also one five-bedded room with en suite bathroom and with two shower rooms adjacent. The unit has a large open plan sitting cum dining room, which is partitioned into distinct sitting and dining areas. The nursing station overlooks the sitting room area by means of glass viewing panels. There is a quiet sitting room where residents can meet their visitors in private and a sensory room for aromatherapy. There is direct access from the sitting room to a secure courtyard area. There is also access to a separate secure terraced patio area that is designated for smoking. For safety, access to and from the unit, is by means of doors which are fitted with a coded key-pad lock system. A kitchenette, sluice room and the laundry are also situated on the lower ground floor.

The Maple unit is also a separate unit which is located on part of the first floor and the entire second floor. This unit is also designated for residents with varied dependencies requiring increased supervision and support. The entrance doors to the first floor section of the Maple unit are fitted with coded key-pad lock systems. The nurses' station for this unit is located on the first floor and overlooks the recreational room which has sitting and dining facilities. This recreational room opens onto a secure terrace. The Maple unit provides accommodation for 23 residents. Ten single en suite bedrooms are provided on first floor, 11 single en suite bedrooms and one twin en suite bedroom are provided on the second floor.

The remaining bedrooms are on a first floor wing and the third, fourth, and fifth floors which are accessible by stairways and two lifts. The accommodation is as follows:

- the first floor wing provides accommodation for 20 residents with varied dependencies. It contains two single en suite bedrooms and nine twin en suite bedrooms
- the third floor provides accommodation for 34 residents with varied dependency. It has 12 single en suite bedrooms, 11 twin en suite bedrooms, a nursing office, and sluice room
- the fourth floor provides accommodation for 28 residents with varied dependency. It has 24 single en suite bedrooms and two twin en suite rooms. It also contains a dining room, a kitchenette, a nursing office and a linen room
- the fifth floor provides accommodation for 24 residents with varied dependency needs, including residents requiring convalescent care. It has 24 single en suite bedrooms. It has a spacious dining room and a sitting room with access to a rooftop garden. It has a kitchenette, a nursing office and a storage room
- all floors have a sluice room with bedpan washer.

There is car parking available to the front of the centre. There is closed-circuit television (CCTV) in public areas.

Location

The centre is located off the N11. It is close to Stillorgan shopping centre and Cornelscourt shopping centre in south Dublin. Nearby facilities include restaurants, libraries, community halls, and Cabinteely Park.

Date centre was first established:	1997
Number of residents on the date of inspection:	143
Number of vacancies on the date of inspection:	18

Dependency level of current residents	**Max**	**High**	**Medium**	**Low**
Number of residents	52	24	45	22

Management structure

The Provider is Belmont Care Ltd and Albert Connaughton is the Managing Director and its representative. The Person in Charge is Margaret Wafer and she reports directly to the Provider. The Person in Charge is supported by an Assistant Director of Nursing (ADON) and the Clinical Nurse Manager 2 (CNM2). There is a full time Physiotherapist who reports to the Person in Charge. The staff nurses report to the CNM2, the ADON and the Person in Charge. The senior carer and the care staff

report to the staff nurse on duty. The housekeeping staff, maintenance person, laundry and kitchen staff report to the Housekeeping Supervisor who in turn reports to the Person in Charge.

Staff designation (Day 08:00-20:00)	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	6	28	3	7	1	7*

* The following staff were also on duty during the inspection:

- the provider
- ADON (Day 1 only)
- CNM2 (Day 2 only)
- the physiotherapist
- the activities coordinator
- the hairdresser
- the coffee shop assistant
- the maintenance person

Staff designation (Night 20:00-08:00)	Person in Charge	Nurses	Care staff	Catering staff	Cleaning and laundry staff	Admin staff	Other staff
Number of staff on duty on night of inspection	0	6	9*	0	0	0	0

*two out of the nine care staff worked a twilight shift between 20:00 hrs and 23:00 hrs

Summary of findings from this inspection

This was the third inspection of Belmont House Nursing Home by the Health Information and Quality Authority (the Authority) Social Services Inspectorate. This was an unannounced regulatory monitoring inspection which focussed on areas of improvement identified at the inspection on the 6 April 2011 and assessed compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

Inspectors met with residents, relatives, provider, person in charge and staff members. Records were examined including care plans, medical records, staff training records, staff files and policies.

In advance of the inspection information was brought to the attention of the Authority in relation to the following:

- the number of staff on duty at night and staff supervision
- care staff carrying out domestic activities such as laundry duties for long periods at night
- long waits for resident call bells to be answered
- staff training in the use of alarmed mats for the management of falls.

During the course of the inspection these matters were examined and are commented on in the body of the report.

The previous inspection indicated that there was a good level of compliance with the regulations. Two areas for action were identified. Inspectors found that the provider and person in charge had addressed the action in relation to the provision of sluicing facilities. However the action relating to fire safety was found to be partially addressed as inspectors noted that two staff members did not know the correct procedure to follow in the event of a fire.

Improvements made since the last inspection included:

- the continued development of an internal auditing system
- training of staff in auditing
- conducting a new survey of relatives
- increased staff numbers
- improved access to the sluice room on the third floor.

Overall, inspectors found that the person in charge and the staff were committed to complying with the regulations and to providing for the needs of residents in a caring and comfortable environment. The person in charge was committed to continually improving the centre and it was evident that she knew the residents and her staff well.

Inspectors found that while data was routinely collected and monitored in relation to some areas of clinical risk, the processes and structures in place to identify emerging risks and to fully implement the risk management policy could have been improved.

An immediate action plan was issued verbally which required the provider and person in charge to address the following areas of immediate risk:

- increased supervision of residents and the deployment of staff at night
- re assessment on the use of bed rails for one resident
- meeting the needs of a resident who required specialised seating
- unsafe transfer of residents using inappropriate equipment
- correctly regulating the mattress pressure for a resident who spent most of the time in bed and who had chromic pressure ulcers.

Inspectors saw that most of these matters were addressed during the course of the inspection. Where this was not possible the provider and person in charge provided the Authority with a satisfactory plan, in writing, detailing how the issues would be addressed.

Other areas for improvement were identified. These included care planning, the management of behaviours that challenge and nutritional management.

All areas for improvement are discussed further in the report and in the Action Plan at the end of the report.

Comments by residents and relatives

Inspectors met with some residents and relatives. Much of the feedback received was positive, residents said they felt safe in the centre and all agreed that they enjoyed their meals. Many spoke about the kindness of the staff and they were aware of whom to speak to if they were dissatisfied with any aspect of their care. A small number resident's told inspectors that there were occasions when they had to wait a long time for their call bells to be answered. Some relatives commented that they believed that more staff were needed in the centre. This is further discussed in this report under Article 16.

Governance

Article 5: Statement of Purpose

Inspectors reviewed the statement of purpose and discussed it with the person in charge. Inspectors found that it provided information about the centre and was available to residents and relatives.

However, the statement of purpose was not kept under review. It did not clearly describe the services offered in the Evergreen unit. The existing statement of purpose described this unit as a high dependency unit. However the person in charge stated that the majority of residents in this unit had a diagnosis of dementia. The facilities and services provided for these residents was not described.

Information was not included in the statement of purpose in relation to the correct age range of residents to be cared for.

The arrangements made for residents to attend religious services of their choice, were not described.

Article 15: Person in Charge

The person in charge was a registered general nurse, with a post-graduate diploma in gerontology who worked full time in the centre and had the relevant necessary

experience in managing residential centres for older people. Inspectors found that she was very committed to meeting the needs of the residents in her care and to improving the service. She demonstrated a good knowledge of her responsibilities as outlined in the Regulations. Since the previous inspection the person in charge maintained her general professional knowledge through reading clinical documents, through attending mandatory training and attending training in risk management, dementia care and cardiac pulmonary resuscitation.

She knew the staff and residents well. She was knowledgeable about individual residents and when asked could describe their needs and preferences. She made herself aware of issues within the centre by communicating with the staff nurses on each unit/floor every morning before the end of the night shift and by visiting each floor throughout the day. She also assisted at lunch time in the main dining room.

She had developed a weekly reporting system which allowed her to gather clinical information about the health needs of residents and to monitor risks within the centre such as residents at risk of developing pressure sores. The person in charge said that she did regular spot checks throughout the day and at night to observe care practices.

The provider supported the person in charge and met with her, the ADON, CNM2 and the housekeeping manager on a daily basis. There were adequate arrangements in place with the ADON and CNM2 to provide cover for the person in charge when she was absent from the centre.

Article 16: Staffing

Inspectors had concerns about the numbers of staff on duty and the supervision arrangements of residents given the layout, size and structure of this building. Inspectors reviewed rosters and discussed staffing levels with the person in charge and the CNM2. The person in charge told inspectors that she used the assessed dependency levels of the residents to inform the numbers and skill mix of staff on the roster. However, inspectors found that sufficient numbers of staff were not available to meet the needs of residents. Inspectors observed a period in the afternoon when there was no staff member on the first floor for a period of 45 minutes. During this time inspectors observed a resident who was emotionally upset and required reassurance from staff.

Residents and relatives stated that there were insufficient numbers of staff to provide care at times during the day and night and a small number of residents stated that they frequently had to wait a considerable length of time for the call bell to be answered. Inspectors set off a call bell and noted that seven minutes passed before it was answered. Inspectors also found that the bedroom of one resident who spent all of the day in bed, due to her condition, was uncomfortably hot and noted that an electric heater was plugged in, even though it was a warm day. Inspectors spoke to the resident who indicated that she was very warm. Inspectors recorded a temperature of 27^{o}C in this room. Inspectors brought this to the attention of the nurse in charge who could not explain why the room was being maintained at such a

high temperature or if this was what the resident preferred. Inspectors observed that steps were subsequently taken to provide a more comfortable room temperature.

Staff confirmed that two residents could not be safely supervised on two different floors where they resided. As a result these residents, who had cognitive impairment, were moved each day to the lower ground floor to the Evergreen unit. These residents did not have access to their bedrooms during the day should they desire this. The person in charge agreed that this practice was not person centred and did not respect the rights of residents to choice. Following the inspection the person in charge provided written confirmation that a plan was in place to move these residents to more suitable bedrooms so that they could receive the supervision they required and have access to their bedrooms if they wished. This would be done in consultation with the residents and their families.

Inspectors assessed staffing levels and supervision during the night shift and were particularly concerned about care delivery and supervision of residents at times. There was one staff nurse and one care assistant assigned to each floor and the Maple unit. One staff nurse and two care assistants were assigned to the Evergreen unit for 31 residents. Overall this provided for a ratio of one staff member to 11 residents.

However, inspectors saw that care assistants were carrying out domestic duties during the night shift. Inspectors noted that at this time some residents were still up and call bells were ringing frequently. Both nursing and care staff confirmed that there was a schedule of domestic duties for all care staff to carry out during the night shift which included organising linen, assembling breakfast trays, making porridge and working in the laundry. In the case of the Maple unit this resulted in one staff member providing care for 22 residents who were located over two floors. The nurse on duty on this floor said that she used CCTV to monitor the residents on the upper floor during these periods.

Inspectors spoke to two care assistants working in the kitchen during the night inspection. These staff members confirmed that they would be away from their floors for more than two hours. This resulted in one staff member caring for 28 residents on the third floor for this period. This was an issue on all floors throughout the centre including the Evergreen unit. In this unit both of the care assistants were scheduled to carry out other duties away from the unit. This left one staff member supervising and providing care to 31 residents. Night staff stated that the staffing levels were insufficient. Monitoring forms, used to record the details of hourly checks on residents, were in place but inspectors noted they were not being completed contemporaneously on two floors which could affect the accuracy of the information provided. The person in charge also confirmed that these documents should be completed contemporaneously in order for accurate information to be provided to day staff at the hand over meeting each morning. Another resident required three hourly vital signs observations. A “Vital Signs Observations Sheet” was being used to record this information. However inspectors noted that the 21:00 check had not been recorded. The nurse stated that she had completed the observations but she had not had the time to record this information and would complete it later in the night.

One relative said that there was insufficient staffing at meal times. Some relatives said that they had brought this matter to the attention of the nursing home by means of the recent survey questionnaire which had been posted to relatives. Inspectors reviewed the results of this survey and noted that the person in charge had provided some additional staff in response to the feedback received.

Before leaving the centre, inspectors were given assurances that staffing levels and supervision would be reviewed and addressed. In particular the person in charge and the provider assured inspectors that no floor would be left unsupervised. Following the inspection the Authority was provided with information that two additional staff members had been employed to carry out work in the laundry from 17:00 to 23:00, seven days per week. The person in charge confirmed that this arrangement would negate the need for care assistants to work in the laundry at night time.

Inspectors reviewed the policy on the recruitment, selection and vetting of staff and a number of staff files. The policy was in line with the Regulations. Staff files reviewed contained the required documentation including evidence that the person was physically and mentally fit for the purposes of the work that they were to perform. Inspectors requested information with regard to the professional registration status of all rostered nursing staff and found that all were registered with An Bord Altranais for 2012.

Inspectors reviewed the files of two newly recruited staff members and found that there were good induction arrangements for newly employed staff and staff performance was monitored. Inspectors saw evidence that staff were supported through the use of staff appraisals which were maintained on their files.

Communication systems were in place, which included daily hand over meetings and staff meetings. Inspectors reviewed the minutes of the staff meetings and found that they were used to keep staff informed and to bring about improvements such as improvements to the mealtime experience.

There was a training plan in place for the current year. Records showed that staff had attended a broad range of training in 2012 including fire safety, moving and handling, challenging behaviour, medication management and falls prevention. Records showed that further training was scheduled in 2012 including risk prevention training and use of restraint.

Article 23: Directory of Residents

Inspectors examined the directory of residents and found that it was designed to capture all of the information required by the Regulations. For the most part, it was kept up to date. However, it had not been updated following the recent return of a resident from hospital.

Article 31: Risk Management Procedures

Overall inspectors observed that the safety of residents, staff and visitors was promoted, however areas for improvement were identified.

Inspectors reviewed the emergency plan and found that it was not comprehensive enough to guide staff on the procedures to follow in the event of an emergency. While another nursing home had been identified as the place of evacuation in the event of a serious incident, the plan did not provide details of the evacuation arrangements.

Inspectors were provided with a copy of the new health and safety statement which was in the process of being finalised with the aid of an external consultant. The person in charge and the house keeping manager knew the statement well and both were involved in developing it. There was a risk management policy in place, which addressed the risks identified in the Regulations such as resident absent without leave and accidental injuries to residents and staff.

The centre had developed a comprehensive package of internal policies which were used to guide practice in areas of risk, including clinical risk, such as medication management, peg feeding and infection control. There was a system in place to ensure that each policy was audited at least once per year and the person in charge confirmed that six members of staff were trained in auditing. Inspectors reviewed a range of audit reports which had been generated and noted that they included recommendations for change and each one was signed off by the person in charge. Inspectors reviewed certification showing that this quality management system had been externally accredited to an internationally recognised standard.

The person in charge was routinely gathering data in relation to a number of areas of predefined clinical risk including falls, residents with infections and numbers of wounds. The person in charge also reviewed information on clinical risk which was contained in the weekly reports which she received from the staff nurses. Inspectors saw evidence that, on some occasions, further investigations and audits were carried out on foot of this information. For example, inspectors saw that an increase in the number of wounds resulted in an in depth analysis of the matter by the person in charge. This was documented and detailed instructions were issued to staff as a result of this.

Inspectors were concerned that there was inadequate monitoring and recognition of day-to-day clinical risks. The risk management policy stated that risk identification was the responsibility of all staff, in their area of work. However, inspectors identified a number of risk related issues during the course of the inspection which had not been identified by staff. These issues included the inappropriate use of hoists, failure to monitor neurological signs after falls and residents consuming food which was not of the correct consistency. These matters are discussed under Articles 9, 20 and 31 in the report.

Inspectors noted that the procedure for assessing and reviewing certain risks could have been improved. For example, inspectors identified a resident located on the upper floors who was at risk of wandering. Staff were aware of this risk and confirmed that this resident had been frequently found wandering on the corridor. Staff were carrying out certain interventions to manage this risk such as frequent checks at night. However, in accordance with the centre's risk management policy an

action plan to review this risk should have been put in place and reviewed on a monthly basis. Inspectors found that this was not happening. .

While inspectors saw that staff had been provided with training in correct moving and handling techniques, this training was not put into practice. The person in charge stated that the recent safety alert, issued by the Authority, regarding the safe use of hoists and slings, had been brought to the attention of all staff.
However, inspectors observed care staff using a standing hoist to transfer a resident who required a full body hoist transfer. The practice put the resident at risk of injury. The care staff stated that the hoist for full body transfer assigned for use in this unit, was broken. When questioned the CNM2 showed inspectors the correct hoist in an adjacent room. It was not broken but the battery had not been charged. There were a number of additional hoists available for use throughout the centre if required.

Inspectors found that the system for the identification, recording, investigation and learning from serious or untoward incidents involving residents was not robust enough. Inspectors reviewed the number of incidents that occurred in the previous months. Incident forms were completed for each incident and there was evidence of residents being monitored following an incident. However, inspectors observed that neurological signs were not monitored following each fall which involved an impact to the head. Inspectors saw that a resident who fell and sustained a head injury on 7 June 2012 did not have neurological signs checked. Another resident who was found on the floor on two occasions on the night of 7 February 2012 did not neurological signs monitored. The incident report form which was in use did not prompt the recording of this information. The person in charge modified the incident form to include this information and disseminated it to the staff during the course of inspection.

There were good systems in place to manage residents at risk of falling. A number of residents had been provided with alarmed mats, chair alarms and low-low beds in an effort to prevent falls. The person in charge had also implemented the “Catch a Falling Star” programme which is a preventative system of managing the risk from falls. Inspectors found that risk assessments for falls were completed on admission and environmental precautions put in place. A folder identifying those residents at risk of falling was maintained on each floor. Care plans were developed for residents with preventative strategies identified for example some care plans instructed carers to place the walking frame close to the chair. The person in charge gathered information in relation to the number of falls each month in order to identify trends and identify residents at risk of falling frequently. The person in charge stated that a post falls assessment was carried out by the physiotherapist following a fall and inspectors observed that these were in place in the sample of files reviewed.

Inspectors noted that infection control practices were adequate. The premises were maintained in a clean condition throughout. There were arrangements in place for the segregation and disposal of waste including clinical waste. Nursing staff and care assistants were observed following correct hand hygiene and using gloves, hand gels and aprons appropriately. There were adequate sluicing facilities on each floor. Wall mounted dispensers containing hand sanitising gel were located throughout the building. Inspectors spoke to staff who were caring for an individual with a suspected infection and found that appropriate evidence-based guidance was being followed.

Inspectors saw the details of an audit on the use of bedpan washers which documented a high level of compliance with the centre's own policy on infection control.

Inspectors visited the laundry and noted that there was adequate space and systems in place to segregate clean and soiled clothes. The person working in the laundry was knowledgeable about infection control and the appropriate temperature settings for soiled clothing. Clothing items were clearly marked with the name of the resident.

Article 39: Complaints Procedures

Inspectors found that the person in charge had a system in place to record and investigate complaints however this system did not meet with the requirements of the Regulations. Inspectors found that there was no structured format for recording the satisfaction of the complainant with the outcome of a complaint investigation.

A complaints policy had been developed and it was displayed in a prominent position in accordance with the Regulations. The person in charge was identified as the nominated person to respond to complaints. The complaints policy was also detailed in the statement of purpose and the Residents' Guide. However this policy did not meet fully with the requirements of the Regulations. An independent person was not identified to oversee the complaints process and it identified the Authority as a body responsible for investigating complaints.

Article 36: Notification of Incidents

Practice in relation to the notification of incidents was satisfactory. The provider and person in charge appeared knowledgeable with regard to the legal requirement to notify the Chief Inspector of those incidents and accidents prescribed in the Regulations. Inspectors were satisfied that all incidents which should have been notified to the Authority were notified within the timeframes set down in the Regulations.

Resident Care

Article 9: Health Care

Inspectors found that the residents had diverse needs. Some were highly dependent and required full assistance while other residents were quite mobile and independent. Inspectors found that in some areas healthcare needs were well met, yet inspectors had concerns around the use of restraint, care planning and the management of behaviours that challenge.

Residents had access to appropriate medical and allied healthcare. Inspectors found that there was good access to medical practitioners in the local area and there was evidence that residents were regularly reviewed by their general practitioner (GP).

Records showed that residents had regular access to the in-house physiotherapist and regular speech and language therapy (SALT). There was also evidence of regular access to the dietician, chiropody services and occupational therapist (OT) as required. Inspectors reviewed care plans and they contained details of referrals and appointments with the various allied health services. Staff promoted the residents' health by encouraging them to stay active. Residents were seen taking exercise during the day.

The person in charge stated that a general audit of all care plans had been carried out by a number of staff in March 2012. However this process was not used to check that the care plan accurately reflected residents' needs and guided the care in all cases. Care plans were also being signed off as having been reviewed on a monthly basis however, while assessments were updated to identify residents' needs many care plans were being updated by the night staff. Staff spoken to said that staff on night duty would not always know the residents well enough to carry out this review and as a result some of the care plans did not reflect the needs of the residents'. Inspectors were also concerned that this process did not lend itself to the involvement of residents and their families in the design of a meaningful care plan.

In the case of a resident who presented with behaviours that challenge inspectors found that the care plan did not guide staff on how best to manage this behaviour. The behaviour placed the resident at risk of injury. This resident was seen carrying equipment and approaching residents in way which could frighten them or cause distress. The care plan did not follow the centre's own policy on managing behaviours that challenge in that a system of monitoring antecedents, behaviours and consequences had not been initiated.

Inspectors saw examples where poor care planning led to inconsistent care being delivered. This was evident in the area of nutrition management. One resident who had a recorded weight loss of six kg in six months did not have a dietary intake record commenced in line with the centre's own nutritional policy. Another resident who had been seen by the dietician had two separate conflicting care plans in relation to nutrition. The staff spoken to did not know which one was the most up-to-date care plan. Another resident who required full assistance with feeding had a care plan which stated that he "prefers to feed himself". His nutritional assessment dated 7 June 2012 was incomplete. Therefore his care plan did not reflect his needs and could not guide staff in how to care for him. Another resident who had been seen by the dietician did not have the recommendations of the dietician included in the resident's care plan.

Inspectors found poor practice in relation to the use of bedrails and restraint. As a result one resident was placed at risk of injury. A register of residents using restraint and bedrails was maintained on each floor. Some residents were using lap belts for wheel chair transfers and a number of residents were using bedrails. A restraint assessment was carried out before bedrails were used. Inspectors were concerned that one resident was using bed rails even though the care plan had identified that this resident was likely to climb over them posing a risk of injury and had done so twice in one night. Therefore the continued use of bedrails put this resident at

greater risk than if the bedrails were not in use. The care plan for this resident did not document if any alternatives had been trialled.

In the case of another resident who was using a recliner chair, inspectors found that use of this chair seriously restricted the resident's movement. While the care plan stated that the chair was used for comfort reasons staff confirmed that this chair was used to prevent the resident from falling. This resident had no restraint assessment carried out. While staff stated that he was mobilised from the chair regularly the care plan did not provide sufficient guidance for the use of this chair and there was no documentation to support the mobilisation of this resident. Inspectors were concerned that this resident appeared uncomfortable and at times distressed in this chair. His feet and ankles were not supported and the resident could not verbalise pain or discomfort. On further examination of the care plan for this resident, inspectors saw where both the OT and the physiotherapist had assessed this resident for seating. They recommended further assessment however the additional assessment or suitable seating had still not been provided for this resident.

There were a small number of residents with wounds on the day of inspection. The person in charge was aware of the status of all wounds and had carried out a review which was shown to inspectors. Inspectors found that there was a wound management policy in place and there was evidence of residents being reviewed by specialists in wound care when necessary. Inspectors reviewed the care plans of a number of residents who had pressure ulcers and wounds and found that there were interventions specified for the management of wounds such as frequent turning and appropriate use of dressings. The wounds were monitored to track changes in the size and presentation and to monitor overall progress. There was also evidence that supplements were prescribed and given when needed. However inspectors were concerned that the need to regulate mattress pressures correctly had not been considered as part of preventing pressure ulcer development. Inspectors observed a resident who spent most of the time in bed. This resident had a body weight of 50 kg, yet the mattress setting was set for a person of 90 kg. As a result this placed the resident at additional risk of developing pressure sores. The nurse in charge of this floor did not know how to set this mattress correctly and stated that she did not normally work on that floor. During the inspection the person in charge designed a form to monitor all pressure relieving mattresses on a daily basis. She stated that it would be implemented immediately.

Inspectors observed many residents participating in meaningful activities appropriate to their interests and preferences throughout the two day inspection. The weekly schedule of activities was widely displayed on all floors throughout the building. Residents were observed participating in music, singing, poetry and exercise classes. Mass was also celebrated within the centre three times per week. Inspectors noted that social assessments were undertaken with residents. Residents said that they were happy with the schedule of activities and that they enjoyed the exercise classes and the singing in the dayroom. The centre contracted the services of a full time person to coordinate and run activities. This person also acted as an independent advocate for the residents. Inspectors reviewed the minutes of residents' advocacy meetings and found that they were well attended and discussed issues pertinent to living in the centre such as food choices, bedroom furnishings and noise. Inspectors saw that the person in charge responded to the findings of these meetings in writing.

Inspectors noted that additional people were employed to support the activities coordinator and to provide a variety of activities such as baking and pet therapy. The person in charge was enthusiastic about making the provision of activities the responsibility of all care staff and not just the activities coordinator. Inspectors observed staff encouraging residents to attend activities on many occasions.

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

Overall, inspectors found evidence of good medication management practices but some improvements were required.

There were comprehensive medication management policies in place which provided clear guidance to staff in areas such as medication administration, medication review, "as required" (PRN) medications and medication errors. Inspectors found that each resident's medication was reviewed regularly by the GP and there was a GP signature for each medication including discontinued drugs and drugs which required crushing.

Inspectors accompanied nurses on a medication round and discussed medication management practices. During this process inspectors noted a medication error. The administration sheet recorded that one resident had received an incorrect, increased dose of anti coagulation medication. The nurse involved and the person in charge were made aware of the situation and the procedure for managing and investigating medication errors was initiated. After the inspection the person in charge provided written confirmation to the Authority that this resident had been reviewed by the GP and no adverse effects were reported. Inspectors reviewed the medication errors which had been documented for 2012. Inspectors were satisfied that they had been appropriately investigated and recorded and that corrective action and learning had taken place.

Inspectors reviewed a medication audit which was carried out by the pharmacist in February 2012. An action plan was put in place to address the audit findings and there was evidence that changes were made to improve practice. However, inspectors did notice that a medication fridge was left unlocked in one of the nurses' stations. This was addressed at the time of inspection.

Medications that required special control measures (MDA) were carefully managed and kept in a locked medicinal cupboard in keeping with the Misuse of Drugs (Safe Custody) Regulations, 1984. Nurses kept a register of controlled drugs. Two nurses signed and dated the register and the stock balance was checked and signed by two nurses at the time of administration and the change of each shift. Inspectors checked the stock balances for two controlled medications and found them to be accurately accounted for.

Article 6: General Welfare and Protection

Inspectors reviewed the centres policy on the prevention, detection and response to elder abuse and found that it gave guidance to staff on the types of abuse, the

procedures for reporting alleged abuse and the procedures to follow when investigating an allegation of elder abuse.

Inspectors found that measures were in place to protect residents from being harmed or abused. Inspectors reviewed records which showed that all nurses and care assistants had received training in the prevention, detection and response to elder abuse. The person in charge and staff said that the showing of an elder abuse DVD was also part of the induction process. All of the staff spoken to were aware of the types of elder abuse and their responsibilities in reporting suspected elder abuse to the person in charge. Residents confirmed to inspectors that they felt safe in the centre. The person in charge knew the process for investigating and reporting allegations of abuse.

Article 20: Food and Nutrition

Inspectors were satisfied that residents received a nutritious and varied diet. Residents were encouraged to be independent with eating and assistance was provided in a dignified manner. Residents confirmed that they enjoyed the food. The menu was prominently displayed and inspectors noted that the main lunch time meal was served at a relaxed pace and this was a very social occasion in the main dining room which had a restaurant-like atmosphere. Inspectors noted that residents in the main dining room were offered choice by showing them both main course options at the table.

While there were some examples of good practice inspectors were concerned that there was insufficient supervision of residents at mealtimes in the Evergreen Unit. Inspectors saw that there was a choice of food offered to those who required altered consistency or pureed diets. Inspectors saw that a dietary information sheet was used to keep a record of the types of diet and fluids required by each resident. Staff in the dining room were observed referring to and checking this sheet during the mealtime. Inspectors also observed staff sensitively encouraging residents to eat. In the Evergreen Unit the meal time was organised into two sittings. Inspectors saw that a resident who required a pureed diet was removing and eating solid food from another resident's plate. This resident was therefore at risk of choking however no staff member noticed this and staff had to be alerted by inspectors to the potential risk. Another resident was being assisted to eat while seated in a recliner chair. During the meal the resident was not placed in the recommended upright position to promote a safer and more comfortable dining experience for the resident. Staff supervising this meal again did not notice this and inspectors had to bring it to the attention of the staff and person in charge. Inspectors noted that these issues were addressed on day two of the inspection.

Inspectors reviewed a series of meal time audits which the person in charge had recently carried out. Detailed recommendations were made as part of this process with the aim of improving the experience of residents.

Environment

Article 19: Premises

The premises were found to be clean and bright throughout and it was decorated to a good standard. There was access to secure outdoor spaces. Residents confirmed that they liked to use these areas in warm weather. Residents had access to the coffee shop in the bright and spacious lobby. Inspectors noticed that this facility was well utilised and many residents were observed meeting family and friends in this area over the two day inspection. The hair dressing salon was also well utilised and many residents commented on the good service which was provided.

Many residents chose to personalise their rooms through the provision of pictures, photographs and plants. There was personal storage space available in bedrooms and there was private lockable space to store personal valuables. Rooms were provided with call bells and light switches adjacent to the beds.

In general, the premises were maintained in good condition. There were records to show that assistive equipment such as hoists, baths and mattresses had been serviced regularly. There were also records to show that the lift had been serviced. The previous inspection report identified the need for improved access to the sluicing facilities on the third floor. Inspectors visited this area and found that a new lobby had been provided to improve access and infection control.

Inspectors noticed a lack of ventilation on the lower ground floor. An unpleasant odour was noted on one of the bedroom corridors on both days of inspection.

There was good space for storage in the centre and it was noted that assistive equipment such as hoists, specialised beds, mattresses and chairs were appropriately stored and did not hinder the movement of residents in hallways or bedrooms.

There was adequate communal space for residents and space for them to meet their visitors in private if they wished. The communal spaces varied in terms of size and decoration and many were domestic in appearance which gave a homely atmosphere. The spacious library was well stocked with a range of different books which had recently been donated by a local library.

Article 32: Fire Precautions and Records

Overall, inspectors found that procedures for fire detection and prevention were in place. However improvements were identified with regard to fire safety training for a small number of staff. Inspectors reviewed service records which showed that the fire alarm system, emergency lighting, automatic door releases and fire equipment were serviced regularly. Inspectors read records which showed that daily inspections of fire exits were carried out and the fire exits were observed to be unobstructed during the course of inspection. There was a record of monthly checks on the fire alarm system and record of weekly checks for door release mechanism. Inspectors saw evidence that fire drills were regularly carried out on a monthly basis and this included a drill which was carried out with night staff in February 2012.

The training records confirmed that staff had attended training on fire safety and response and the most recent training had been given in February 2012. However, inspectors noted that that one staff member did not have up to date fire safety training. A further two staff members could not describe the correct procedures to follow in the event of a fire.

Closing the visit

At the close of the inspection visit a feedback meeting was held with the provider, the person in charge and the CNM2 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:

Gary Kiernan

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

15 June 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:	Belmont House
Centre ID:	0014
Date of inspection:	6 and 7 June 2012
Date of response:	12 July 2012

Requirements

These requirements set out what the registered provider must do to meet the Health Act, 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

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

There were insufficient numbers of staff on some floors during the day and night.

Residents were not adequately supervised at all times.

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
Standard 23: Staffing Levels and Qualifications

* 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: Staffing: Two new staff members have been employed to do residents personnel laundry from 17:00 hrs to 23.00 hrs, this now means that night care staff no longer have an allocation to be in the laundry in the early hours of the morning. During the night a member of the night staff sits on the first floor and one staff member sits on the second floor in the Maple unit so as to ensure that no floor is left unsupervised in this unit. One of the two residents identified during the inspection to be sleeping in the main house and spending their day in the Evergreen Unit have now been permanently moved to the Maple Unit and the second resident will be moved to the 1st floor of the Maple unit as soon as a bed becomes available. In the afternoon, care staff no longer restock linen presses so therefore this allows them the time to be back on their floors and available to assist residents.	Immediate

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

The management of bed rails and restraint and in the case of one resident, the management of behaviours that challenge was not adequate.

The regulation of mattress settings for pressure ulcer prevention was not adequate.

Neurological signs were not monitored following each fall.

The care plans did not comprehensively set out each resident's needs. Residents were not consulted in the development and review of care plans.

The needs of a resident requiring specialised seating were not being met.

Residents who were are risk of poor nutrition, were not adequately monitored.

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.

Action required: Set out each resident's needs in an individual care plan developed and agreed with the resident.	
Action required: Provide a high standard of evidence-based nursing practice.	
Reference: Health Act, 2007 Regulation 6: General Welfare and Protection Standard 13: Healthcare Regulation 8: Assessment and Care Plan Standard 10: Assessment Standard 11: The Resident's Care Plan	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The resident whose bed rails were raised as a concern during the inspection has had her bed rail risk assessment reassessed and this is now done every 24 hours along with her care plan being updated to reflect any changes in the resident's condition. A meeting was held with the family and the resident's GP and from these risk assessments and the family meeting it has been found that the resident is no longer able to attempt to climb over bed rails but does present a very high risk of rolling and did roll out of bed during a recent trial without bed rails. Therefore we have agreed to continue to nurse this resident using bed rails in conjunction with these daily risk assessments. This residents' care plan has been updated to reflect this residents' current needs and has been discussed and agreed with the next of kin. The management of challenging behaviour: All staff have received challenging behaviour training and the care plans of the residents presenting with challenging behaviour have been reviewed and updated to meet the needs of residents in question. The residents presenting with challenging behaviour have had their care plans updated to reflect their current needs and they have been discussed and agreed with the next of kin. In the case of one resident, there is only one next of kin and this person is in USA on holiday and a meeting is due to take place on their return. The regulation of mattress settings: All mattress settings are checked and documented on each floor	03 July 2012 19 July 2012 7 June 2012

on the day and night shift by the staff nurse on duty. Neurological observations post a fall: The accident report form was amended at the time of inspection to include neurological observations for all falls witnessed or unwitnessed and this is completed every time a fall occurs. Care Plans: All care plans are reviewed on a monthly basis. We are currently carrying out a full review of all care plans in order to ensure they fully reflect the needs of the residents and that the resident and their next of kin are involved in this process. We are using Roper, Logan and Tierney's nursing model along with the care planning package created by Nursing Homes Ireland. As a member of the NHI nurses committee we are aware of the current review of a single assessment tool and should this be approved we will look at this care planning tool. As always our care plans are reviewed on an at least 3 monthly basis or sooner should the need arise. Care plans are reviewed by both day and night staff and this has led to greater communication between both shifts and a more in-depth knowledge for staff of residents both during the day and night. This new system is working well as staff have ownership of their care plans. Specialised seating: The resident requiring specialised seating has had a second OT assessment and is in the process of trialing the three chairs suggested by the OT, a decision has now been made with the agreement of the next of kin regarding this resident's seating and the new chair is now on order. Nutritional risk: Any resident with a weight loss of two kilogrammes or more is on an intake and output chart, the resident's weight and MUST score are recorded and any resident with a MUST of two or more is referred to the dietician. The resident in question on the inspection is on an intake and output chart, his weight on the day of inspection was 66.10Kg and it is now 67.70Kg, his MUST score is 1 and he was reviewed by the dietician on the 29th of June and his target weight is to be between 67-69Kgs, he is also prescribed Ensure plus fibre. Staff looking after the gentleman felt his weight loss was caused by agitation but he has also been reviewed by Psychiatry of Old Age 30/5/2012 and commenced on Ebixa 5mg and this has been incresed slowly as per instructions by Psychiatry of Old Age to 20mgs OD and this has resulted in reduced agitation for the resident and an improvement in his weight.	7 June2012 19 July 2012 19 July 2012 3 July 2012

3. The provider has failed to comply with a regulatory requirement in the following respect: Systems were not in place to identify day-to-day emerging risks on an ongoing basis. The centre's risk management policy was not implemented for all identified risks.	
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: Staff have received further training on the correct use of the correct hoist for the correct resident by an outside company and also by our in house physiotherapist who is our manual handling instructor. All resident's mobility risk assessments have been reassessed and updated to include a photograph of the type of hoist and sling that should be used with that particular resident and this is updated monthly. All staff are acutely aware of what hoists and slings are to be used and this is being closely monitored by management. Neurological signs are now included on our accident report for all falls. Residents consuming food that is not the correct consistency: The resident in question does have cognitive impairment and is also very mobile, so therefore she is being supervised during meal times so as to ensure that she does not take food from another resident's plate which may result in her consuming the incorrect consistency foods. Resident at risk of wandering on upper floor: This resident has been identified by Belmont House as a risk of wandering and numerous family meetings have been held. However, her family do not wish for this resident to be transferred to our High Dependency Unit at this time but are waiting on a bed on the first floor of our medium dependency	3 July 2012 7 June 2012 3 July 2012 As soon as a bed is available

unit as it is secure. This resident is on hourly checks day and night and she also has a falls sensor mat in place which will alert staff as soon as she gets out of bed. This resident will be moved to a more suitable location as soon as a bed becomes available. Risk management: All staff are responsible for the identification of risks in their area of work. Where risks are identified by staff, these are reported back to management for further risk assessment and action. There are daily risk assessments which are undertaken and documented, for instance the daily inspection of escape routes and the daily updating of the maintenance book. Where emerging risks are identified, these are discussed with management and with staff so that the appropriate action may be taken to reduce or eliminate the risk.	

4. The provider has failed to comply with a regulatory requirement in the following respect: The emergency plan was not detailed enough to guide staff in the event of an emergency.	
Action required: Put in place an emergency plan for responding to emergencies.	
Reference: Health Act, 2007 Regulation 31: Risk Management Procedures Standard 26: Health and Safety	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider' Response Belmont House has an agreement with a neighbouring nursing home that we may evacuate to this home in the event of a serious emergency until more suitable arrangements can be made. Belmont House in conjunction with some of our local neighbouring nursing homes are in the process of putting a group evacuation plan in place.	31 August 2012

5. The provider has failed to comply with a regulatory requirement in the following respect: One member of staff was identified who did not have up to date fire safety training and not all staff members were aware of what to do in the event of a fire.

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.

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: The part-time nurse that had not attended fire training has now done so on the 15 of June 2012 and the 2 staff members that were found to be unsure of the fire procedure have been reinstructed regarding what to do in the event of a fire. It should be noted that all our staff are trained in Progressive Horizontal Evacuation which is provided by a former member of the Dublin Fire Brigade. As part of this training staff are told that the Fire Brigade should be with us within fifteen minutes should they be called out. During the inspection when the inspector was questioning a night staff nurse about the fire procedure she said to the staff nurse 'ok the fire brigade aren't coming, what next'. This completely threw the staff nurse and while she did know the procedure for Progressive Horizontal Evacuation, she didn't understand what the inspector was looking for. All staff have been reissued with instructions in writing as to what to do in the event of a fire.	10 July 2012

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

The complaints policy did not identify an independent person to oversee the complaints process.

The investigation of complaints did not include information as to whether or not the resident was satisfied with the outcome of a complaint.

Action required:

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

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: Our complaints policy has been updated to provide the above information.	12 July 2012

7. The provider has failed to comply with a regulatory requirement in the following respect: The statement of purpose was not kept up to date to reflect the services available in the centre.
Action required: Compile a statement of purpose that describes the facilities and services which are provided for residents.
Action required: Make a copy of the statement of purpose available to the Chief Inspector.
Reference: Health Act, 2007 Regulation 5: Statement of Purpose Standard 28: Purpose and Function

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The statement of purpose and function has been updated and approved by the Health Information and Quality Authority following each of the last two inspections. We are currently reviewing the statement of purpose and function in light of the comments made during this inspection and we will revert when this review is completed.	31 July 2012

8. The provider has failed to comply with a regulatory requirement in the following respect: The directory of residents did not contain all of the required information.	
Action required: Ensure that the directory of residents includes the information specified in Schedule 3 paragraph (3) of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 as amended.	
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 resident that had come back from hospital the night before the 1st day of inspection was added in on the day of inspection and the register is up-to-date.	6 June 2012

9. The provider has failed to comply with a regulatory requirement in the following respect: There was a foul odour on one of the lower ground floor corridors.	
Action required: Provide ventilation, heating and lighting suitable for residents in all parts of the designated centre which are used by residents.	
Reference: Health Act, 2007 Regulation 19: Premises Standard 25: Physical Environment	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: There are two new toilets near the entrance to the High Dependency Unit on the lower ground floor. These toilets do not	3 July 2012

get a lot of use as there are also two directly above on the ground floor. This smell seems to have been caused as a result of the waste trap drying up and so allowing waste odour to escape through the trap. Although the toilets are cleaned daily, the wash hand basins may not be flushed out. The cleaning staff are now flushing the wash hand basins out as part of the cleaning process and so making sure that the waste trap is intact. It should be noted that we have not experienced this smell in this location either before or after the inspection. We will monitor the situation closely.	

Any comments the provider may wish to make:

Provider's response:

None supplied.

Provider's name: Belmont Care Ltd
Date: 23 July 2012