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:	Ashbury Private Nursing Home
Centre ID:	0007
Centre address:	1A Kill Lane Kill O'The Grange Blackrock, Co. Dublin
Telephone number:	01-2841266
Fax number:	01-2892722
Email address:	info@anh.ie
Type of centre:	☒ Private ☐ Voluntary ☐ Public
Registered providers:	Robert Fagan
Person in charge:	Alison Woods
Date of inspection:	28 March 2012
Time inspection took place:	**Start:** 08:00 hrs **Completion:** 18:00 hrs
Lead inspector:	Linda Moore
Support inspector:	N/A
Type of inspection:	☐ Announced ☒ Unannounced
Purpose of this inspection visit:	☐ Application to vary registration conditions ☐ Notification of a significant incident or event ☐ Notification of a change in circumstance ☐ Information received in relation to a complaint or concern ☒ 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

Ashbury Nursing Home is a four-storey residence which in the past has been both a convent and a nursing home. The Fagan family purchased and re-established Ashbury as a nursing home in 2001. The centre is registered for 78 residents and there were 70 in residence on the day of inspection, two residents were in hospital. Due to a major refurbishment project and the removal of a bed from a three bedded room, accommodation available to residents had been reduced to 74 places.

The premises are divided into two parts the “Main House” and “Grange Wing”; there is an interconnecting corridor which linked the two buildings.

The main house is a four-storey building, with a lift to all floors. The first floor has a reception area, two sitting rooms, a dining area, a nurses’ station and treatment room. There is a laundry and sluice room facility on the ground floor and additional sluice room facility in the Grange wing.

Bedroom accommodation is on the remaining three floors. On the lower ground floor there are four single rooms, three of which have en suite shower facilities and three twin rooms one of which has an en suite shower. There are a further two three-bedded rooms one with en suite shower facilities. There are three assisted toilets and an assisted shower and bath on this floor.

Accommodation on the first floor is comprised of five single rooms with en suite shower facilities, one twin room and a four-bedded room without en suite facilities. There are an additional four assisted toilets and two assisted showers on this floor.

The second floor has seven single rooms - six have en suite showers, four twin rooms, two with en suite showers, one three-bedded room and two four-bedded rooms one with en suite shower facilities. There are a further two assisted toilets and an assisted shower and bath on this floor.

The original grange wing was vacated to facilitate major refurbishment work which was due for completion in 2012 and the provider had constructed a temporary building with 21 places to accommodate these residents. The interim accommodation, also called the grange wing, consisted of two storeys and accommodated 21 residents. The ground floor has three twin bedrooms with a sink and four single bedrooms with a sink. There are two bathrooms on the ground floor, one with toilet, assisted shower and a sink and one with toilet, a shower for mobile residents and a sink. There are three further toilets near the entrance. There is a kitchenette on this floor also. Accommodation on the first floor consists of four twin bedrooms with en suite shower and toilet and one three bedded room with sink.

There is a passenger lift between floors. Additional accommodation in the grange wing includes a spacious sitting room cum dining room and this leads into an attractive enclosed garden.

Location

Ashbury Nursing Home is located on Kill Lane, Kill O' The Grange close to the villages of Deansgrange and Blackrock, County Dublin.

Date centre was first established:	2001
Number of residents on the date of inspection:	70
Number of vacancies on the date of inspection:	*

* 4 vacancies and 3 beds closed due to the construction project and one three-bedded room used as a twin room

Dependency level of current residents	Max	High	Medium	Low
Number of residents	43	7	14	6

Management structure

Ashbury Nursing Home is one of two centres owned and run by the Fagan family. The Provider is Robert Fagan Junior. Alison Woods, the Person in Charge, is also the person in charge of Ailesbury Nursing Home and she reports to the Provider. The two Assistant Directors of Nursing (ADON) who deputise for the person in charge, the nurses, care managers (who supervise the care assistants) and care assistants report to the Person in Charge while the household and kitchen staff report to the Provider.

Staff designation	Person in Charge	Nurses	Care staff	Catering staff	Cleaning and laundry staff	Admin staff	Other staff
Number of staff on duty on day of inspection	1	6	20	2	6	3	5*

* the provider and three activity staff, maintenance personnel and driver

Summary of findings from this inspection

This was an unannounced inspection which monitored compliance with the Regulations and focused on areas identified for improvement at the registration inspection in September 2010. The inspector met residents, relatives, the person in charge, the provider, administrator and staff on duty. Records were examined including care plans, medical records, staffing records including training records, staff files and policies.

The inspector found that the provider and the person in charge were committed to providing a good service to residents. The inspector found that the healthcare needs of residents were met. Residents and relatives spoke very fondly of the staff and were very happy with the care delivered. Residents appeared well cared for and the person in charge and staff demonstrated a comprehensive knowledge of residents' needs. Staff were provided with access to an extensive range of training programmes in order to meet the ongoing needs of residents.

The provider was in the process of completing an extensive renovation programme since the previous inspection in order to comply with and the *National Quality Standards for Residential Care Settings for Older People in Ireland*. The residents and relatives were very satisfied with the ongoing daily communication about the project.

During the inspection it became apparent that the grange wing had been vacated and a new building, also called the grange wing had been erected to accommodate 21 of the residents in the interim until the construction work in the original "grange wing" was completed. This new building was completed to a good standard and provided residents with suitable interim accommodation. There were still a number of multi-occupancy rooms in the main building, which the provider planned to address by 2015.

The provider and person in charge had not prioritised the action plan from the previous inspection. The person in charge was now the person in charge in Ailesbury nursing home and spent two or three days each week in each centre. While there were no serous concerns for the welfare of residents, the high standard of governance evident at the registration inspection had declined since the last inspection. One of the seven actions identified at the registration inspection had been satisfactorily completed and there was now a robust procedure in place for the management of complaints. The timeframe had elapsed for completion of the other action plans and these had not been satisfactorily addressed. Fire training and other mandatory training was not provided to some staff, some staff files were not in line with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended). Restraint management was not fully addressed and the lack of storage was still an ongoing issue.

Systems to safeguard residents had been inadequately addressed. The preliminary investigation of an allegation of abuse against a staff member had not been documented or notified to the Authority. This investigation and notification was subsequently submitted to the Authority on 30 March 2012.

Improvements were still required to identify and manage clinical and non-clinical risk. Areas for improvement are discussed further in the report and are included in the Action Plan at the end of the report.

Additional Issues Covered on Inspection

Quality of Life and Communication

Information about the renovations and the new extension were effectively communicated to residents and relatives. Records maintained indicated that information such as residents' feelings about the possible move were discussed prior to the move and taken into consideration. The inspector spoke to some of the relatives of the residents who had been moved to other bedrooms to facilitate the building work and they confirmed that they were consulted at all times and were satisfied with their new bedrooms.

Governance

Article 5: Statement of Purpose

The inspector was satisfied that the statement of purpose accurately described the service provided in the centre at the registration inspection stage. However, the provider had not amended the statement of purpose to reflect the changes that had occurred since then, including the construction of the new wing. This was updated and submitted to the Authority after the inspection.

The inspector was satisfied that the statement of purpose was available to residents and relatives.

Article 15: Person in Charge

The person in charge was a registered general nurse who had previously worked as full-time person in charge in the centre and now worked as person in charge for Ashbury and Ailesbury Nursing Homes. She spent two to three days each week in the centre. She had more than the required level of experience in nursing older people. She was on duty on the day of the inspection and demonstrated an adequate knowledge of her responsibilities as outlined in the Regulations. She was supported in role her by two assistant directors of nursing (ADONs) who worked full-time. One ADON was based in the grange wing and one in the main house. The inspector found that the person in charge and the ADON on duty were very knowledgeable about residents' needs and their backgrounds. They were observed engaging effectively with residents on the day of inspection.

The person in charge is kept up-to-date through monthly management meetings with the ADONs. The minutes of these meetings demonstrated that welfare of residents and their ongoing needs were discussed at these meetings. The ADONs and the care managers also furnished the person in charge with a bi-monthly report with similar information. The person in charge told the inspector that she had planned to commence auditing the service but had not yet done so due to time constraints.

The high standard of governance evident at the registration inspection had declined since the last inspection. In addition to her managerial responsibilities as person in charge in two centres, the person in charge provided ongoing education including manual handling and elder abuse training to staff. The inspector found that the action plans from the registration inspection had not been completed and the person in charge acknowledged that she had insufficient time to provide the required training and engage in her management role.

Article 16: Staffing

The inspector found that there were adequate staff on duty to meet the resident's needs. The inspector examined the files of the two most recently recruited staff members and one long term staff member and found that the files contained most of the information required by the Regulations 2009. However, some required documents were not on file, such as evidence of medical fitness for three staff members and proof of identity for two staff members. The provider showed the inspector a list of outstanding documents for all staff members and said that since the previous inspection he had employed a full-time staff member to gather this information. This was raised at the previous inspection and was still not completed.

The inspector reviewed staffing rosters and the person in charge said she used the dependencies of residents and her clinical judgment to inform staffing levels. Staff and residents agreed that there were adequate staff on duty. The inspector found that there were good induction arrangements for newly employed staff members and staff appraisals had begun to be used to monitor performance and support staff.

The inspector carried out interviews with staff members and found that they were knowledgeable about the residents' individual needs, the centre's policies and the policies and procedures for safeguarding residents. The inspector saw staff interacting with residents and responding to residents' needs in a respectful manner. Staff told the inspector that they were supported by the provider and person in charge. The inspector saw evidence that systems of communication were appropriate to support staff to provide safe and appropriate care. In addition to daily handover meetings, the inspector reviewed minutes of staff meetings and found that resident's needs were discussed regularly with staff.

The person in charge explained that she and a named staff member were responsible for providing education to staff and external experts also provided training as required. The person in charge develops a weekly training schedule. Staff records showed and the person in charge explained that all of the care managers were currently completing a Further Education and Training Awards Council (FETAC) course in management. The person in charge had developed a dementia studies course and was rolling it out to staff. Some staff had undertaken training in medication management, cardio pulmonary resuscitation (CPR), taking bloods, continence promotion, nutrition management, wound management and HACCP training (Hazard Analysis and Critical Control Points), since the previous inspection. However, the inspector found that all mandatory training had not been provided as identified at the previous inspection. This placed residents at risk if staff were not trained and provided with regular updates on manual handling and fire safety. The training matrix shown to the inspector was incomplete and therefore the actual number of staff that had not received manual handling was not available. This matrix did show that nine staff who were due to attend manual handling training had not done so and the provider had not identified any dates for this training. See sections on general welfare and protection and fire safety.

Article 23: Directory of Residents

The inspector read the directory of residents and noted that it contained all of the information as required by the Regulations, but the register had not been updated when two residents were recently admitted to hospital.

Article 31: Risk Management Procedures

The inspector found that there were systems to identify and manage clinical risk and to promote the safety of residents, staff and visitors but these required improvement. There was no formal process to identify and assess non-clinical risks throughout the centre.

There were visitors' sign-in books located at the entrances to the centre. These allowed the staff to monitor the movement of persons in and out of the building and ensure the safety and security of residents. The inspector observed visitors' daily signatures in the sign-in books.

The safety committee was no longer operational. The provider, person in charge, safety representative and members of staff formed the safety committee which was a forum to identity and manage non-clinical risks. The person in charge said this committee had not met since the previous inspection in 2010.

The provider and person in charge said they managed risk in relation to the premises, but there was no documented environmental risk assessments undertaken. The provider said that risk assessments had been completed by an external company to develop the safety statement for the new wing but this was not available to the inspector as it was being completed by an external company. This was subsequently submitted to the Authority. The provider submitted the report from a visit from the Health and Safety Authority on 8 March 2012 and he said the two areas identified were being addressed.

There were systems to identify and manage clinical risk to ensure appropriate care was provided to residents but these were not formalised. The person in charge said she reported to the provider informally on a daily basis and formally on a weekly basis. The inspector read the bi-monthly reports completed by the ADONs and the care managers which included information about resident's health and social care needs, complaints, staffing, the care environment, operational systems and management issues. The provider said he used this document to track changes required in the centre and actions completed and to inform decisions about the allocation of resources.

The ADON showed the inspector the records of the clinical data that she collected monthly. The inspector noted that data such as residents with pain, restraint and falls was collected but this was not formally analysed and used to improve the quality of service and safety of residents.

Staff had moved from a paper based system to a computer system to record incidents and accidents. The inspector found the computerised system did not have a detailed account of the incident or information about the outcome for the resident. The person in charge was not aware that the staff were not completing the incident reports in hard copy. The inspector read the computerised records of incidents since January 2012 and found that while there was a low number of falls in that period, there was no analysis or audit of incidents completed by the person in charge. Therefore there was no evidence of a robust system to manage accidents and incidents or to use the information to improve the service and promote learning.

Article 39: Complaints Procedures

The inspector found evidence of good complaints management practices.

The complaints policy was read by the inspector and details of the complaints procedure were posted publicly and described in the Residents' Guide/statement of purpose. The procedure provided guidelines on how to make a complaint or express a concern, and how these would be addressed. A named complaints officer was identified as the nominated person to respond to complaints. The policy also identified an appeals process in the event that a complainant was not satisfied with the outcome.

The person in charge confirmed that she or one of the ADONs met with residents on a daily basis and usually resolved any issues which arose before they became a source of discontent.

The inspector reviewed the complaints log and saw that complaints from residents and relatives were documented including the outcome. There was evidence that complaints were appropriately responded to by the person in charge, to the satisfaction of the complainant. Residents said they were satisfied with the complaints procedure and would go to any staff member if they had a complaint.

Article 36: Notification of Incidents

Practice in relation to notifications of incidents was not entirely satisfactory. The person in charge was aware of the legal requirement to notify the Chief Inspector regarding accidents or injury to a resident. Failure to notify the Authority of an allegation of abuse was an issue at the previous inspection. Although a notification was later submitted, the inspector concluded that this action plan had not been satisfactorily completed. The inspector noted from a review of the incidents that the Authority had not been notified of an allegation of elder abuse by a resident which had arisen since the previous inspection. The notification was subsequently submitted to the Authority.

To inspector was satisfied that to date all relevant notifications had been submitted to the Chief Inspector by the person in charge.

Resident Care

Article 9: Health Care

The inspector found that the residents had diverse needs - some were highly dependant and required full assistance while other residents were quite mobile and independent. The inspector found a good standard of evidence-based nursing care and residents had access to appropriate medical and allied healthcare. However, the records did not show appropriate evidence of the care delivery.

The inspector 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 access to physiotherapy twice weekly and regular speech and language therapy. The staff said that there was access to the dietician and chiropody services as required. The inspector 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. Residents told the inspector they were satisfied with the health care delivered. Staff escorted residents on weekly day trips.

The inspector reviewed a sample of residents' care plans and noted that nursing assessments and clinical risk assessments were completed for all residents. There was a daily record maintained of the resident's health condition and any treatment given, completed by the nurse on duty. Care plans were in place which in some ways identified residents' needs and there were three-monthly reviews completed. The inspector noted that residents and relatives were involved where possible in the development and review of their care plans. While residents were reassessed every three months and the care plans changed as required in most regards, there were some residents whose assessment and care plans were not reflective of their current needs. For example, the inspector found that residents who were at risk of falling were provided with constant supervision but this was not reflected in their care plans.

The inspector saw documentary evidence to demonstrate that residents' weights were recorded each month and the person in charge monitored any changes such as significant weight loss. Nutritional risk assessments were used to identify residents at risk and there was evidence of resident's meals being fortified and residents were administered prescribed supplements where necessary.

Restraint management had been an issue at the previous inspection and this had not been addressed. The person in charge said that two staff members had attended training on the new HSE policy on the use of restraint and the centre's policy was in the process of being updated in line with the new national policy. There were plans to provide training to all staff but, the inspector noted that evidence based practice was not being adhered to in the use of restraint. There were a number of bedrails in use and seven residents used recliner chairs. The inspector reviewed files for a

sample of these residents and found that there was an assessment completed for the use of the bedrails and there was documentation on the monitoring of the bedrails. This monitoring form was completed two hourly by the staff. There was a consultation form for discussion about restraint completed by the residents and relatives where appropriate.

The inspector found that improvements were required in the assessment for the use of bedrails as there was no evidence of alternative strategies being tried for some residents prior to the use of restraint in line with the centre's policy. The inspector also found that there were risk assessments done for the use of lap belts or recliner chairs. While staff were recording the use of restraint and monitoring of residents in restraint, the residents care plan did not detail the care to be delivered.

Inspectors observed good practice in relation to falls management. However, this required some improvement. Falls records indicated that the number of falls in the centre in 2012 was low. Residents who were at risk had a falls risk assessment completed and a care plan to guide the care delivered. Residents at risk of falls were provided with appropriate interventions such as sensor alarms on their beds and hip protectors. Residents had daily exercise classes and were also seen walking about during the day. However, a review of residents' records showed that while a falls risk assessment was completed when a resident had fallen, this was not comprehensively completed and did not accurately describe the resident or their changing needs.

The inspector noted that there was an inconsistent approach to the management of behaviours that challenge. The inspector spoke to staff and noted that there were two residents who displayed behaviours that challenge. Inspectors reviewed these residents' files and noted that residents with behaviours that challenge did not have an assessment for their behaviour completed using a recognised assessment tool. Not all of the incidents were recorded on the incident reports. Residents' records did not include information regarding the triggers that prompted behaviours and the behaviour itself was not consistently recorded. Some staff recorded incidents in the residents progress notes while other staff recorded these incidents in the mood sheet. There were care plans for behaviours that challenge which would not direct the care in order to meet the specific needs, describing interventions to be taken.

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

Medications that required special control measures were carefully managed and kept in a secure cabinet in compliance with the Misuse of Drugs (Safe Custody) Regulations, 1984. These medications were counted at the time of administration and at the change of each shift. Nurses kept a register of controlled drugs and the stock balance was checked and signed by two nurses at the change of each shift. The inspector observed the staff nurse on the medication round and found evidence of good medication management processes.

Article 6: General Welfare and Protection

The inspector found that there were some measures in place to safeguard residents but they needed to be improved. The inspector found that staff spoken to were aware of the types of elder abuse and their responsibilities in reporting suspected elder abuse to the person in charge or ADON. Residents confirmed to the inspector that they felt safe in the centre. The person in charge and the ADON who deputised in the absence of the person in charge knew how to investigate a reported allegation of abuse. Despite this, the inspector reviewed the incident reports which showed that a resident had reported an alleged abuse by a staff member to the ADON in February 2012 but there was no record of the investigation that had taken place. The ADON said that she had undertaken a preliminary investigation which did not support the allegation but this had not been recorded. A report of this incident was submitted to the Authority on 30 March 2012 which showed that appropriate action was taken in response to this allegation of abuse. The person in charge told the inspector that elder abuse training was scheduled for 30 March 2012 and 13 April 2012. The inspector interviewed the ADON and found that she was knowledgeable about the investigation of an allegation of abuse but had failed to follow the policy and document the preliminary investigation on this occasion.

Article 20: Food and Nutrition

The inspector was 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 daily menu was displayed in the dining room. The inspector found that lunch was appropriately paced and a very sociable occasion. There were two sittings to accommodate all residents in the dining room. The meal was well presented and the inspector observed that residents, including those with cognitive impairment were involved in the conversations at each table. Following soup for a starter, residents had their main course and fresh vegetables and potatoes were provided.

The chef showed the inspector the weekly menus and was aware of all residents' dietary needs. All residents' dietary requirements were documented. Residents had input into menu planning and the chef showed the inspector where the residents chose to change the menu if they preferred an alternative on the day. There was daily contact between the chef and the management.

The inspector saw residents being offered drinks throughout the day. Residents told the inspector that they could have tea or coffee and snacks any time they asked for them.

Environment

Article 19: Premises

The centre was pleasantly decorated and homely throughout. The inspector found that the bedrooms were personalised with adequate space for belongings. Residents also had access to locked personal storage space in their bedrooms. The household staff were knowledgeable of the cleaning processes and the premises was observed to be clean.

There was a secure well maintained outdoor area which residents could access.

Residents could have their laundry processed in the centre. The laundry room was spacious and well equipped. All residents' clothes were folded and returned to their rooms. Residents told the inspector that they were satisfied with the laundry arrangements.

Aspects of the premises did not meet the requirements. There were a number of multi occupancy rooms which do not meet the guidelines as set out in the Standards. In order to address this, the provider was undertaking extensive renovations to bring the grange wing in line with the Regulations. A three-bedded room in the main house had been changed into a twin room but, there were still a number of multi-occupancy rooms in the main building which the provider said he aimed to address by 2015. The provider planned to modify aspects of the new building which was being used to accommodate residents in order to create additional residential accommodation in the future.

Staff told the inspector that residents were moved into the interim grange wing two weeks prior to the inspection. The provider and person in charge had not documented the measures required to facilitate the safe transfer of residents from the existing to the new building project. A transfer assessment had not been completed before and after residents had moved into the interim accommodation. The provider said this would be completed prior to transfer of the residents back to the original grange wing when construction work is completed. The provider was required to complete an operational plan as a priority. The Authority had not been notified of the move. The provider acknowledged that this was an oversight on his part.

Storage space for assistive equipment continued to be limited. Trolleys which had previously been stored on the corridors were now stored in the bathrooms. This was found to be unsatisfactory. The inspector observed that laundry trolleys, wheelchairs and commodes were stored in the bathrooms which limited accessibility for residents. The inspector could not use the sink in a bathroom on the ground floor, as access was blocked.

Article 32: Fire Precautions and Records

The provider and person in charge had not sufficiently prioritised the safety of residents in the event of fire as staff had not had mandatory fire training. This was identified at the previous inspection and had not been addressed. The inspector read the records which showed that daily inspections of fire exits were carried out. The fire panels were in order and the inspector noted that fire exits were unobstructed. The fire alarm check was carried out twice weekly. The provider furnished the Authority with a letter of confirmation of substantial compliance with fire and building control regulations from a competent person during the inspection.

The inspector read the training records which confirmed that all staff had not attended fire training. Records showed that two of the staff on night duty had not completed any fire training and four other night staff last attended fire training in 2010. This was brought to the immediate attention of the provider who agreed that these staff members would receive formal fire training on 2 April 2012 and additional staff training would be provided to update all staff members on 18 and 20 April 2012.

Staff explained that specific staff members were appointed as the designated fire wardens on each shift. The inspector found that while staff in the grange wing had completed fire drills twice weekly and were knowledgeable of the fire procedures, they had not been provided with instruction about the new evacuation procedures in the new grange wing.

Closing the visit

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

Acknowledgements

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

Report compiled by:

Linda Moore

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

29 March 2012

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Social Services Inspectorate

Action Plan

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

Provider's response to inspection report*

Centre:	Ashbury Private Nursing Home
Centre ID:	0007
Date of inspection:	28 March 2012
Date of response:	23 April 2012

Requirements

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

1. The provider is failing to comply with a regulatory requirement in the following respect: The centre's policy had not been complied with when a preliminary investigation into an allegation of abuse had not been documented.
Action required: Implement the policy on and procedures for the prevention, detection and response to abuse.
Reference: Health Act, 2007 Regulation 6: General Welfare and Protection Standard 8: Protection

* 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: All Staff have been re-educated about the regulations in relation to reporting and managing allegations of Elder Abuse. In the case of alleged abuse referenced in the report, a full investigation was carried out with the resident, their family and staff. Staff have been told that our policy must be followed by documenting all the interviews that are carried out and adjusting care plans accordingly.	Completed

2. The provider is failing to comply with a regulatory requirement in the following respect: Not all staff had received fire safety training and staff in the grange wing were not trained in the safe evacuation of residents from the new grange building.	
Action required: Make arrangements for persons working at the designated centre to receive suitable training in fire prevention.	
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: We arrange Fire Training every six months, with four to six sessions at each interval. All staff have now completed fire training. Whilst we have several training sessions every six months sometimes staff are unable to attend due to them being on leave.	Completed

3. The provider is failing to comply with a regulatory requirement in the following respect: Not all staff had received mandatory training in manual handling.	
Action required: Provide staff members with access to education and training to enable them to provide care in accordance with contemporary evidence based practice.	
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: Out of our 93 staff, nine staff were due to complete/update their manual handling. As explained to the inspector we have two in-house trainers and training takes place every two weeks.	Ongoing

4. The provider has failed to comply with a regulatory requirement in the following respect: The provider had not yet updated the statement of purpose to reflect a major redevelopment and the construction of a new interim grange wing.	
Action required: Update the statement of purpose to describe the facilities and services which are provided for residents.	
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: This was an oversight on our part. It was sent to the Authority immediately after the inspection.	Completed

5. The provider has failed to comply with a regulatory requirement in the following respect: Staff member's files did not contain all of the information required by the Regulations.
Action required: Put in place recruitment procedures to ensure no staff member is employed unless the person is fit to work at the designated centre and full and satisfactory information and documents specified in Schedule 2 of the Regulations have been obtained in respect of each person.
Reference: Health Act, 2007 Regulation 18: Recruitment Standards 22: Recruitment

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: We had photographic identification for the two staff but they had not been put on their files as they had only commenced their employment. This was an oversight on our part. We have obtained declarations from all staff members that they are fit for work. We have again requested all staff to obtain a declaration from their own GP on their next visit.	Completed Ongoing

6. The person in charge has failed to comply with a regulatory requirement in the following respect: The care plans did not comprehensively set out each resident's needs as agreed with the resident.
Action required: Set out each resident's needs in an individual care plan developed and agreed with the resident.

Reference: Health Act, 2007 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: We are in the process of auditing all of our care plans, and updating them with the specific individual needs of each resident, with a person-centred approach for each plan.	31/07/2012

7. The provider has failed to comply with a regulatory requirement in the following respect: A high standard of evidence-based nursing practice was not delivered in relation to restraint and behaviours that challenge.	
Action required: Provide a high standard of evidence-based nursing practice in relation to restraint management.	
Reference: Health Act, 2007 Regulation 6: General Welfare and Protection Standard 13: Healthcare	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: We are in the process of auditing all of our care plans and assessment documentation in relation to restraint and all will be updated with the relevant required documentation by the end of the audit.	31/07/2012

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

A transfer assessment and operational plan had not been completed before and after residents were transferred into the new interim grange wing.

Action required:

Ensure the physical design and layout of the premises meets the needs of each resident, having regard to the number and needs of the 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: All residents and their families were consulted prior to the transfer as referenced by the inspector in the report. As discussed with the Inspector we will have a transfer assessment and operational plan when residents are transferred back to the new Grange Wing.	November 2012

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

There was no formal process to identify and assess non-clinical risks throughout the designated centre and plans to implement the precautions in place to control the risks identified.

There was no safety assessment of the interim wing available for review.

Incidents reports were not fully completed and arrangements were not in place to identify, record, investigate and learn from incidents.

Action required:

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

Action required: Ensure that the risk management policy covers the arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents.	
Reference: Health Act, 2007 Regulation 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: Our Safety Committee Meetings have been scheduled to begin meeting on alternate months commencing 26 April 2012. An external company had completed a revised safety statement but it was not available on the day of the inspection as the company had not issued the updated document to us. It has since been sent to the Authority. We were operating both a paper and computer system to deal with incidents. We have now implemented a system to address these issues. We are also in the process of developing a Risk Register.	 26/04/2012 Completed Completed 31/07/2012

10. The person in charge has failed to comply with a regulatory requirement in the following respect: The directory of residents was not-up-to date.
Action required: Establish and maintain an up-to-date directory of residents in relation to every resident in the designated centre in an electronic or manual format and make this information available to inspectors as and when requested.
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: We were in the process of creating a new resident register as our current register was on both paper and computer. As shown to the inspector the new register is nearly complete and this should eliminate this issue of recording resident's transfers to hospitals on the resident's register.	31/05/2012

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

The process to ensure the Authority is notified of an allegation of abuse was not robust.

Action required:

Give notice to the Chief Inspector without delay of the occurrence in the designated centre of any allegation, suspected or confirmed abuse of any resident.

Reference:

Health Act, 2007
Regulation 36: Notification of Incidents
Standard 29: Management Systems

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: As per requirement 1 of our Action Plan, staff have been informed to follow our policy on Elder Abuse, and a monthly auditing system has been put in place.	Completed

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

There were a number of multi-occupancy rooms that did not meet the National Standards. The provider said this would be addressed by 2015.

Storage throughout the premises was limited.

Action required: Ensure the premises meets the requirements of the Regulations and Standards.	
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: We are aware of the physical requirements required by the Standards for 2015. Any modifications needed will be completed within the specified timeframe.	2015

Any comments the provider may wish to make:

Provider's response:

We would like to thank all our residents and families present in Ashbury on the day of the inspection and a special thank you to all the staff for their continued hard work and dedication.

We look forward to working with the Authority in the future.

Provider's name: Robert Fagan
Date: 23 April 2012