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:	Leeson Park House Nursing Home
Centre ID:	0058
Centre address:	10 Leeson Park Ranelagh Dublin 6
Telephone number:	01 4976500
Fax number:	01 4964994
Email address:	leesonpark@silverstream.ie
Type of centre:	☒ **Private** ☐ **Voluntary** ☐ **Public**
Registered providers:	Shanid Ltd
Person in charge:	Veronica Lacey
Date of inspection:	30 May 2012
Time inspection took place:	**Start:** 09:00 hrs **Completion:** 18:00 hrs
Lead inspector:	Mary McCann
Support inspector:	Gary Kiernan
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

Leeson Park House Nursing Home is a Georgian period house in Dublin 6. Accommodation is provided over three floors and a mezzanine level. The centre is registered by the Health Information and Quality Authority (the Authority) to provide care for a maximum of 49 dependent persons.

There are two entrances, the front entrance is at the top of stone steps and a second wheelchair accessible entrance to the side of the steps which leads to the lower floor level is available. Access to all floors is provided by two lifts and stairs. On entry there is a reception office and a parlour on the right where residents can meet visitors. There is an activities room, a library a dining room and an open area on the corridor with seating and small tables to the left on this floor. There are eight single bedrooms and one twin bedroom, all with en suite toilet and wash-hand basin. There is an additional toilet and wash-hand basin and a bathroom. There is a staff kitchenette and dining room at the end of the corridor to the right of reception, and a toilet with wash-hand basin for catering staff.

The director of nursing's office and a staff toilet is on the mezzanine level. There is also a twin bedroom with en suite toilet and wash-hand basin.

On the second floor there is a nurses' station, a kitchenette and a small sitting room which overlooks the gardens. The hallway is wide and one area has comfortable seating for residents. The top floor has 12 single bedrooms with en suite toilet and wash-hand basin. Six of the bedrooms also have showers. There is one single bedroom with a wash-hand basin only, one twin room with en suite toilet and wash-hand basin and one three-bedded room with a wash-hand basin only. There is an assisted bathroom with bath, toilet and wash-hand basin.

The upper level is accessed by a short flight of steps and a chair lift. This has a twin bedroom with en suite toilet and wash-hand basin, a bathroom with a bath, shower, toilet and wash-hand basin and a staff toilet.

Access to and from the lower level is regulated by a door with a coded key pad. The person in charge stated that this was for the safety of some residents on the lower ground floor who had a tendency to wander. The kitchen, oratory, laundry and sluice rooms are on this floor. The large day room leads out to a landscaped enclosed garden and the nurses' station is in the day room. A second smaller sitting room is also available. The lower ground floor has eight single bedrooms with en suite toilet and wash-hand basin, five of which also have showers. There are three twin bedrooms with en suite toilet and wash-hand basin, two of which have showers and one triple room with a wash-hand basin only. There are two bathrooms with bath, shower, toilet and wash-hand basin on this floor.

Limited parking facilities are provided in the grounds of the centre and further parking is reserved for the centre nearby.

Location

The centre is in the residential area of Leeson Park in Dublin 6.

Date centre was first established:	1 March 1988
Number of residents on the date of inspection	44 + 2 in hospital
Number of vacancies on the date of inspection	5

Dependency level of current residents	**Max**	**High**	**Medium**	**Low**
Number of residents	6	12	22	6

Management structure

Shanid Ltd trading as Leeson Park House nursing home which is a subsidiary company of Silverstream Healthcare Ltd is the Provider. Joe Kenny, the Chief Executive Officer, is the nominated person on behalf of the Provider. The Person in Charge is Veronica Lacey and she reports to the Operations Manager, Gary Downey. She is assisted by two Assistant Directors of Nursing (ADONs). The nurses, care staff, household and catering staff and the administration staff report to the Person in Charge.

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	2	8	**	3	1	1*

* maintenance
** Catering staff, Leeson Park Nursing Home have a contract with an external company for the provision of catering to include staffing.

Background

This was the third inspection carried out by the Authority. The first inspection was a monitoring inspection in September 2010. At the time of this inspection improvements were required to care planning documentation, the risk management policy, the complaints policy, the statement of purpose and staffing documentation. Improvements were also required to safety measures for the management of clinical waste, storage of cleaning chemicals and access to the sluice room.

The second inspection was a registration inspection completed in April 2011. At the time of this inspection, inspectors found substantial compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*. Four of the six actions from the last inspection were completed, two were partially completed. Areas identified for improvement included the provision of fire training to all staff, risk assessments for the use of restraint, prescribing of crushed medications, staffing levels to meet the social needs of residents in the evenings, additional information in the statement of purpose, and care plans.

The reports from these inspections are available on the Authority's website - www.higa.ie under centre's identification number 0058.

Summary of findings from this inspection

This report set out the findings of an unannounced regulatory monitoring inspection, which took place on 30 May 2012. This inspection was scheduled to examine the progress made on the action plan from the follow up inspection in November 2010 and to monitor compliance with the Regulations and Standards. The centre is registered by the Authority.

The inspectors met with residents, the operations manager, person in charge, staff members and the pharmacy manager during the inspection. The inspectors observed practices and reviewed documentation such as care plans, assessment records, medical records, fire safety records, operational policies and procedures, health and safety documentation, staff files, accident and incident records, audit documentation and the complaints log. The inspectors undertook a general inspection of the nursing home environment.

Inspectors reviewed the actions from the previous inspection. Of the eight actions identified three had been completed and five were partially completed.

Inspectors saw that the health care needs of the residents were being met and there was good access to general practitioners (GP) and other allied health professionals. Staff members, spoken with, were knowledgeable about the individual care needs of residents. An emergency plan was available to guide staff in responding to untoward incidents.

However, the inspector found that improvements were required in some areas.These included:

- risk management practices
- verification of mandatory training
- evidenced based practice
- review of care plans

The Action Plan at the end of the report identifies the areas where improvements must be made to comply with the Regulations and the Standards.

Comments by residents and relatives

Residents consulted expressed high levels of satisfaction in regard to the quality of care, facilities and services provided in the centre. They responded to questions from the inspector with statements such as “I am looked after well”, “I enjoy the art”, “I am happy here”.

While some residents were unable to express their views due to the complexity of their cognitive impairment, some responded to questions by stating, that they were “looked after well”. Staff were described as caring and helpful. Residents stated meals provided were of a good standard. Residents told inspectors that they felt safe in the centre and they enjoyed the activities.

Governance

Article 5: Statement of Purpose

The statement of purpose required further revision in order to comply with the Regulations.

While the statement of purpose set out the services and facilities provided in the designated centre, it did not provide sufficient detail in many sections and failed to include all of the information required by Schedule 1 of the Regulations. For example, the experience and qualifications of the registered provider and the criteria for the supervision of specific therapeutic techniques were omitted. Further revision was also required to include the designated centre's policy for emergency admission.

The operations manager was aware of the provider's responsibility to keep the statement under review and confirmed that it would be made available to residents on admission, and following review.

Article 15: Person in Charge

The person in charge was in post since November 2010. She was a registered general nurse, having qualified in 1976. She had also completed a course in rehabilitation nursing and held a degree in Health Service Management and an MSc in Public Management.

She informed the inspector that she was working in St. Pappin's (a sister home to Leeson park) since 10 April 2012 to give support and supervision to the current person in charge at St. Pappin's. She stated that this was a temporary arrangement and that a new person in charge was to be appointed to St. Pappin's. In her absence the two assistant directors of nursing were delegated the responsibilities of the person in charge at Leeson Park.

Her registration personal identification number (PIN) was available and in date. She confirmed that she had completed manual handling training, training on the prevention detection and response to elder abuse and training in fire safety and evacuation. Her staff file also contained evidence of attendance at recent training on clinical governance and quality management in residential care settings for older people and person centred care planning. She had also completed the train the trainer course on the national policy on restraint management.

Article 16: Staffing

A registered nurse was on duty at all times. The inspector reviewed staffing rosters and discussed the staffing levels with the person in charge. She said she used the assessed dependency level of residents, resident numbers and her clinical judgment to inform her decisions on adequate staffing levels. The person in charge informed the inspector that leave was planned in advance. Where there were unplanned absences, part-time staff had been organised to work extra shifts which ensured that residents were familiar with staff and staff were knowledgeable of residents' needs. A staff handover occurred at the commencement of the morning and night shift.

It was detailed in the previous report that improvements were required to staffing levels as some residents and relatives commented that they enjoyed chatting with staff in the evenings but staff had less time to spend socialising with residents now. In response to this the provider had employed an extra carer from 5.00 pm to 8.00 pm and inspectors found this was in place. Residents raised no issues with regard to staffing levels with inspectors on this inspection.

Minutes of staff minutes were available. However, the inspector noted that the last meeting was in February 2012. There had been more regular meetings throughout 2011. Topics discussed included staff teams, quality of life issues and safeguarding vulnerable residents.

Four staff files were reviewed by an inspector. The authenticity of the staff references was not checked and some observed by the inspector were not on headed paper. Additionally some of the staff files failed to contain confirmation that the staff member was physically and mentally fit for the purposes of the work which they are to perform at the designated centre.

The person in charge and operations manager informed the inspectors that all staff had up-to-date training in fire safety, manual handling and adult protection. However, the inspector could not verify this due to the lack of certificates of attendance or sign in sheets on staff files. There was an action in relation to fire training in the last inspection report. The provider had replied that this would be completed by May 2011. Staff spoken with confirmed they had received training in these and other areas. It was noted by inspectors on one staff file reviewed that fire training was required to be completed by September 2011 but it was not completed by this staff member until May 2012. Training had been completed in palliative care, medication management, care planning, person-centred dementia care, hand hygiene and chemical safety, basic nutrition and behaviour that challenges. A schedule for further training was made available to the inspectors which included further sessions on challenging behaviour, restraint use and infection control.

The person in charge stated that they were going to complete a training matrix for all staff on all training to ensure adequate records were available to confirm staff had received education and training.

Article 23: Directory of Residents

A register of residents was available. An action in relation to maintaining the directory of residents in compliance with the requirements of the Regulations was contained in the previous report. At the last inspection there was no record available with regard to the referring body and no record of when a resident was transferred to another establishment. This was now available in the directory, however, omissions noted included the address of the general practitioner.

Article 31: Risk Management Procedures

Inspectors identified that the risk management policy did not comply with current legislation at the time of the first and second inspections. The provider had replied that a risk management policy would be put in place that complied with current legislation by January 2011. Inspectors found that this had not been completed at the inspection in April 2011. This action was included again in the action plan following the inspection in April 2011 and the provider had replied stating that this would be addressed by June 2011. However, inspectors found that this issue has not been addressed at the time of this inspection. The risk management policy covered areas such as accidents and infection control but failed to address precautions in place to control risks of residents absent without leave, assault, aggression and violence and self-harm and arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents. It also failed to reference other polices that were available in relation to risk.

The inspector found that there were systems and practices in place that were targeted at promoting the health and safety of residents, visitors and staff. There was a health and safety committee and a clinical governance committee. Minutes of these meetings were made available to inspectors who noted that the last meetings were held in February 2012. Monthly clinical audits are carried out and the results of these were discussed by the person in charge with the team leaders. Photographic identification was available for each resident in their medication records. The inspector found that hot water was dispersed at a safe temperature. The provider had developed an emergency plan which provided guidance on how to respond to a range of potential emergency situations. The plan included arrangements for transfer to a place of safety for residents if full evacuation of the centre was deemed necessary.

A health and safety statement was in place which incorporated the risk register. This was dated 13 April 2010. However, it did not reflect all risks in the centre, there was no window restrictor in place in a window on the first floor. The operations manager confirmed that there were window restrictors on all other windows and he would address this deficit immediately. The maintenance personnel informed inspectors that the roof terrace was not accessible to residents. However, the inspector noted that the doors to the roof terrace had a key in the lock. Inspectors noted that if residents accessed the roof terrace there were items that posed a risk such as a loose garden hose and cardboard boxes. The operations manager stated that he would have keypad lock installed on these doors as a matter of priority.

An inspector reviewed the process for recording incidents and accidents. Staff spoken with relayed a positive attitude towards reporting incidents. An inspector noted that an accident and incident record noted that a resident had 'hit her head' and neurological observations were not recorded. This resident fell on 7 April 2012 and was seen by the GP on 11 April 2012. When residents sustained a fall un-witnessed neurological observations were not recorded routinely to monitor residents to ensure that a head injury had not been sustained and that consciousness had not been affected. Information recorded included factual details of the accident/incident, date and time event occurred, name and contact details of any witnesses and whether medical treatment was required. While there was evidence that the GP had been informed, the form did not have a follow-up section as to record whether the GP had seen the resident. To confirm this, you had to track through the daily progress notes of the medical file which did not allow for the person in charge or staff to easily ensure that residents were receiving sufficient medical attention following a fall. There was evidence available that residents at risk of falling had low-low beds in place and alarm mats. There was no evidence available that staff had received training on falls management.

There was a visitors' log in place to monitor the movement of persons in and out of the building and a receptionist was on duty. The entrance area provided a pleasant welcoming space and systems in place promoted resident security.

Article 39: Complaints Procedures

The inspector revised the centre's complaints policy and found it complied with the requirements of the Regulations. Details of the complaints procedure was displayed publicly and described in the Residents' Guide and statement of purpose. The inspector reviewed the complaints log and found that the last recorded complaint was 20 July 2011. There was evidence of complaints being responded to by the provider. However, the assistant director of nursing confirmed that verbal complaints were not recorded. Documentary evidence of the outcome of the complaint and whether or not the complainant was satisfied was recorded.

No comprehensive audit of complaints received had been completed to promote continuous quality improvement.

Article 36: Notification of Incidents

The inspectors found that the person in charge was aware of the legal requirements to notify the Chief Inspector. The operations manager informed the inspectors that he had submitted an NF20 the previous day to the inspection to inform the Authority that the person in charge was temporarily absent from the centre. The person in charge confirmed that she had been working at a 'sister' centre since 10 April 2012. A notification was received for the sister centre on 29 May 2012 informing the Authority that the person in charge from this centre was deputising at the sister centre due to the absence of their person in charge.

Resident Care

Article 9: Health Care

The inspector found that generally, a good standard of nursing care was provided. Residents had access to all allied health professionals. There was good input from mental health services and this was reflected in documentation reviewed. A chiropodist and dental services attend the centre. Dietician, audiology and eye checks are arranged as required. The inspector saw that the health needs of residents were assessed and from the medical files reviewed there was evidence available that residents had access to general practitioner (GP) services. While there was not consistent evidence available that all residents had a medication review every three months, the inspector noted that the GP's were attending the clinical governance meetings and there was a protocol in place for reviews. The person in charge and supplying pharmacy manager who attends the centre daily informed the inspectors that the GP was on leave and that they had arranged with the surgery that he would complete the reviews on his return. Some charts had a signature from the GP that a review had occurred. The person in charge informed the inspector that the pharmacist, GP and person in charge met on a three-monthly basis to review residents' medication.

Care planning was an area that had been identified as requiring improvement in previous inspections. This related to review of care plans and consultation with the resident with regard to the care plan. The inspectors reviewed a sample of residents' care plans. While there was evidence available that the resident was being consulted with regard to their care plan there were some instances where care plans were not being reviewed three monthly as required by the regulations. Care files contained validated assessment tools covering such areas as falls risks, continence management, manual handling and pressure sore risk assessments. Nutritional risk assessments were used to identify residents at risk of malnutrition. Inspectors were informed that resident's meals were fortified and residents were also being prescribed supplements where necessary. Nursing staff informed the inspectors that weights were recorded monthly. However, on reviewing the care files weights were not consistently recorded monthly. A resident who had lost weight had not been weighed for two months. There was inadequate evidence of a formal review of the quality and safety of care provided to residents to promote continuous quality improvement.

There was a record of the resident's health condition and treatment given, completed on a daily basis. However, the nurses entry was not timed which is not in line with best practice guidelines from An Bord Altranais.

Assessment and documentation of pain management and of residents' response to analgesia did not comply with best practices as pain assessment charts were not observed to be completed thereby ensuring effective monitored pain relief. A resident who was prescribed analgesia and had a care plan in place with regard to

pain relief which stated ‘assess pain relief before any activity and reassess pain after giving analgesia’ but no pain assessment chart was in place.

An activity coordinator was in post. Social care assessments were completed. A programme of activities had been developed which included art, exercise classes, bingo, music, crafts and trips to the theatre. Staff promoted the residents’ health by encouraging them to stay active. The inspector found that many of the residents had managed to maintain their mobility. Residents were seen taking exercise during the day and a regular exercise class formed part of the activity programme. The activity coordinator was on study leave on the day of inspection. She was attending a conference on Sonas therapy (a group session involving stimulation of all five senses particularly useful for people with cognitive impairment) and this activity would be further developed at the centre. Dementia specific activities such as sensory activities, hand massage and reminiscing groups were available. The inspector spoke with residents while they were engaging in an art session. The Residents confirmed that they enjoyed art and attended this session every week which was facilitated by an external provider.

There were no residents receiving end of life care on the day of inspection.
There was a policy on end-of-life care and some of the staff had attended training on palliative care. The person in charge explained that they accessed the services of the local palliative services who provided support and advice when required. There was no problem with accessibility to this service.

Restraints in use included bed rails. Adequate measures were not in place to manage the use of restraint and practice was not reflective of evidenced based practice. The person in charge had attended the train the trainer course on restraint management and had trained one of the staff nurses on restraint management. The person in charge confirmed that staff had not been trained on the national policy on restraint. While risk assessments had been completed prior to the use of bedrails the inspectors found that improvements were required in the initial assessment for the use of restraint as there was no evidence of the risks of using restraints being considered or evidence of alternative less restrictive options being tried prior to the use of restraint. The centres restraint policy was in draft format. The person in charge informed the inspectors that there were using some bedrails as enablers and there was an enabling assessment, however, this was not available on any files reviewed by the inspectors.

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

There was a comprehensive medication management policy in place which provided guidance to staff. Medication administration practices observed by the inspector complied with An Bord Altranais guidelines. The staff nurse on the medication round was knowledgeable of the medications being administered and ensured that residents took the medication.

The medication administration charts were clear, legible and well maintained. All reviewed charts were signed by the prescribing doctor and had photographic identification of the resident. The person in charge described a good working relationship with the supplying pharmacy who attended the centre five days per week. This enabled the centre to obtain and return medicines swiftly.

The person in charge informed the inspector that a medication audit had been completed. This looked al all aspects of medication management. This found that there was a 98% compliance rate with practices.

Medication prescribing practices was an area that had been identified as requiring improvement in previous inspections. This related to ensuring the maximum dose of as required medication to be administered in a 24 hour period was detailed on the medication prescription, and to ensure that medication that was being administered crushed was prescribed as safe to crush on the prescription sheet. Inspectors found that that this action was completed on prescriptions reviewed. Residents' photographs were available on each medication chart. Medicines were being stored safely and securely. The temperature ranges of the medicine refrigerators were being appropriately monitored and recorded. The centre was recording details of medication errors and there were reviews to minimise the risk of this re-occurring.

Medications that required special control measures (MDA) were carefully managed and kept in a locked cupboard within in a locked 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.

Article 6: General Welfare and Protection

Overall, the inspectors were satisfied that measures were in place to protect residents from being harmed or suffering abuse but there were areas for improvement in relation to the training records of attendance at training on elder abuse and protection. Residents spoken with confirmed to the inspector that they felt safe in the centre. They attributed this to the staff being available to them at all times and the locking system on the entrance doors.

The person in charge informed the inspector that all staff had received training on identifying and responding to elder abuse. Records were not available to demonstrate that staff had attended the training. The person in charge on the day of inspection gave a copy of an email to inspectors that she had sent to the administrator on the day of inspection requesting she organise 'elder abuse training ' on 10 and 17 July 2012. The inspectors noted that elder abuse was discussed at the nurses and care staff meetings in February 2012. A policy was available on the protection of residents and another policy on responding to an allegation of abuse.

The inspector found that staff were aware of their responsibilities in reporting suspected elder abuse to the most senior person on duty. Residents confirmed to the inspector that they were well cared for and had no concerns at the current time. There were no allegations of abuse being investigated at the time of inspection.

Article 20: Food and Nutrition

The inspectors were satisfied that residents received a nutritious and varied diet. The inspector noted that meals were hot and well presented. The menus were displayed and residents told the inspector there was always a choice of three main courses at lunch time.

An environmental health food hygiene report dated 9 August 2011 was made available to inspectors. This detailed no major issues of concern. A food and nutrition policy was in place dated 18 October 2011. The catering staff met with the person in charge each day to discuss any concerns with regard to the food. One resident was on a modified consistency diet and there was a photographic reference guide as to how this should be presented. Catering staff stated that they are currently working on pictorial menus for all residents. The kitchen was staffed from 8.00 am to 8.00 pm. Catering staff attend the dining room each day to enquire directly from the resident their level of satisfaction with the food. The inspectors saw residents being offered drinks throughout the day and jugs of water were available in the bedrooms and communal areas. Residents told the inspector that they could have a drink and snacks any time they asked for them.

An inspector spoke with the chef who was knowledgeable of residents' likes, dislikes and special diets. All residents' dietary requirements were documented to ensure that staff provided the necessary dietary requirements. There was a good supply of fresh fruit and vegetables.

Environment

Article 19: Premises

The centre is operational since 1988 and is a three-storey construction. A reception area is located inside the main entrance where a receptionist is available to assist with enquiries. The nurses' station is located upstairs.

The premises were clean and decorated and furnished to a high standard. Residents had access to a pleasant well maintained secure outdoor patio space and garden. Residents commented how they enjoyed using this area when the weather was fine. Handrails were available on both sides of the corridors to assist residents with maintaining independence. A call bell system was in place at each resident's bed which was accessible to residents. Call bells were also available in communal areas and toilets. Staff were noted to respond to call bells in a timely manner during the course of the inspection.

Many residents had personalised their rooms with pictures, photographs and plants. There was personal storage space available in bedrooms and there was a lockable space to store personal items.

Inspectors found that there was inadequate storage space for assistive equipment. Wheelchairs were observed to be stored in a bathroom which could pose a tripping hazard to residents. This was an issue that was raised on the previous two inspections. The provider had replied stating that this issue had been addressed immediately following the previous inspection.

Inspectors found there was suitable and sufficient equipment such as hoists, pressure relieving mattresses and mobility aids available to meet residents' needs. There was a service contract in place which covered breakdown and repair for all beds, air mattresses and other equipment used by residents. Inspectors reviewed the records of servicing of equipment. Equipment was serviced in January and February 2012. Records showed that the lifts had been serviced on 14 May 2012. Hoists were serviced bi-annually.

There were separate staff changing and toilet facilities provided for nurses and catering staff. An inspector visited the kitchen and noted that it was clean, there were adequate stocks of food available and equipment was maintained in a good condition. A new cleaning room has been provided. This was a recommendation in the last inspection report.

A separate laundry room was available. This failed to provide adequate space to separate clean and dirty laundry. A recommendation to review laundry arrangements was contained in the last report. The provider had replied that this would be done by June 2011, however this had not occurred. The person in charge stated that this will occur when they commence renovation work which they plan to do to complete two new rooms. To mitigate this problem the centre operated a system whereby laundry

is segregated swiftly on entry to the laundry and clothes washed in a timely manner to prevent the build up of laundry and clean clothes were clearly labelled. No residents voiced any concern in relation to the care of their clothes.

The premises were maintained in good condition and a fulltime maintenance man was available. Inspectors were informed that tasks identified were carried out in a timely manner. The staff had a logging system to ensure that maintenance issues were addressed in a timely manner.

Article 32: Fire Precautions and Records

Procedures for fire detection and prevention were in place. Smoke detectors were located in all bedrooms and general purpose areas. An inspector reviewed service records which showed that the fire alarm system, emergency lighting and fire equipment were monitored regularly. Records were available that showed that daily inspections of fire exits were carried out. However, on arrival at the centre and checking the fire exits an inspector found that the stairs were obstructed with cardboard boxes, filled black sacks, a wheelchair and a laundry bin. The maintenance man who checks the fire exits each day stated that this was temporary while they cleaned out this bedroom. On checking later on these had been removed.

At the side of the building a fire exit leads to steps and there is a locked garden door behind these steps.

Fire drills to reinforce the theoretical training provided to staff to ensure they are confident of the procedure to be followed in the case of a fire were not carried out. The person in charge explained to the inspectors that they test the fire alarm weekly but do not complete fire drills. A weekly signed record was available that the fire detection and alarm system is tested - this was last tested on 25 May 2012 at 3.00 pm. Evidence was available that fire alarms were serviced quarterly. There is a signed daily inspection of fire escapes, and a weekly inspection of emergency lighting and service check was carried out biannually.

Inspectors found that all staff spoken with were clear about the procedure to follow in the event of a fire. Directional maps to the nearest exit in the event of a fire were posted prominently on each floor.

Closing the visit

At the close of the inspection visit a feedback meeting was held with the person in charge and the operations manager 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:

Mary McCann

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

20 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:	Leeson Park House Nursing Home
Centre ID:	0058
Date of inspection:	30 May 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 provider is failing to comply with a regulatory requirement in the following respect:

The risk management policy did not comply with the Regulations. It failed to adequately guide and inform staff of measures to take in response to a variety of risk situations, for example, residents absent without leave, assault, aggression and violence and self-harm and arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents. It also failed to reference other polices that were available in relation to risk.

The risk register did not reflect all risks in the centre, there was no window restrictor in place on a window on the first floor and this was not documented in the risk register.

There was inadequate storage space for assistive equipment; consequently wheelchairs were noted to be stored in a bathroom which could pose a tripping hazard to residents.

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

Action required: Put in place a comprehensive written risk management policy and implement this throughout the designated centre.	
Action required: Ensure that the risk management policy covers the precautions in place to control the following specified risks: the unexplained absence of a resident; assault; accidental injury to residents or staff; aggression and violence; and self-harm.	
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.	
Action required: Take all reasonable measures to prevent accidents to any person in the designated centre and in the grounds of 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: I attach a draft copy of the Risk Management Policy for Leeson Park Nursing Home. It covers identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents. All windows were checked for restrictors they are now in place in all the rooms Wheelchairs are kept in the resident's room or in an identified area below the stairs.	31/05/2012 Completed

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

The operations manager informed the inspectors that he had submitted an NF20 the previous day to the inspection to inform the Authority that the person in charge was temporarily absent from the centre. The person in charge confirmed that she was working at a 'sister' centre since 10 April 2012. No notification informing the Authority of this arrangement has been received by the Authority to date.

Action required:

Provide notice in writing to the Chief Inspector where the person in charge proposes to be absent from the designated centre for a continuous period of 28 days or more.

Action required:

Ensure that any notice provided under Regulation 37 (1) is given no later than one month before the proposed absence commences or within a shorter period as agreed with the Chief Inspector, except in the case of an emergency, specifying the length or expected length of the absence and the date of leaving and date of expected return.

Action required:

Notify the Chief Inspector of the return to duty of the person in charge not later than three working days after the date of his/her return.

Action required:

Give notice in writing to the Chief Inspector of the procedures and arrangements that will be in place for the management of the designated centre during the absence of the person in charge, setting out the matters contained in Regulation 38(2).

Reference:

Health Act, 2007
Regulation 38: Notification of the procedures and arrangements for periods when the person in charge is absent from a Designated Centre
Standard 27: Operational Management

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: In future the Chief Inspector will be informed when the person in charge intends to be absent from the designated centre as contained in Regulation 38(2). Notice will be given within three days of my return to the designated centre.	Immediate Effect

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

The provider had not ensured the provision of a high standard of evidence based nursing care in the areas of pain management, nutritional care, emergency care post an un-witnessed fall and restraint management.

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:

Provide a high standard of evidence-based nursing practice.

Reference:

Health Act, 2007
Regulation 6: General Welfare and Protection
Standard 13: Healthcare
Standard 18: Routines and Expectations

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: All residents receive high standards of care. Documentation is monitored more closely to ensure that evidence of this care is documented in a timely manner. Additional Neurological Observation Assessments will be completed for 24 hours following all unwitnessed falls. The Neurological Observation Chart will be attached to the accident/incident form for inspection by Director of Nursing.	Immediate Effect

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

Staff did not demonstrate sufficient knowledge to allow them provide a high standard of contemporary evidence based nursing care in restraint management, pain management, emergency care post an un-witnessed fall and nutritional management.

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: Continuous monitoring of the training and development needs of our staff will be scrutinised more closely. The evidence-based nursing care in the form of documentation such as Abbey Pain Scale Assessment Form have been commenced for residents with cognitive impairment. The staff nurse and GP in conjunction with the interdisciplinary team - Dietician, Speech and Language Therapist have protocol in place in the form of documentation to provide the evidence relating to Additional Supplements and Fortification. An updated policy in relation to restraint that complies with the HSE policy on physical restraint is in place and links in with the care plan ensuring the residents welfare and wellbeing are met.	Immediate Effect

5. The provider has failed to comply with a regulatory requirement in the following respect: There was incomplete record of complaints maintained at the centre.
Action required: Maintain a record of all complaints detailing the investigation and outcome of the complaint and whether or not the resident was satisfied.
Action required: Inform complainants promptly of the outcome of their complaints and details of the appeals process.
Action required: Record all complaints and the results of any investigations into the matters complained about. Ensure these records are in addition to and distinct from a resident's individual care plan.

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: Complaints Records are kept. Documentation outlining complaints, investigation process and outcome is in place and a register is kept. they are distinct from a residents care plan The need to document all verbal complaints no matter how trivial a staff member may perceive them has been highlighted to all staff for future reference.	Immediate Effect

6. The provider is failing to comply with a regulatory requirement in the following respect: The statement of purpose did not consist of all matters listed in Schedule 1 of the Regulations.	
Action required: Review the statement of purpose to ensure it consists of all matters listed in Schedule 1 of the Regulations.	
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 has been reviewed in accordance with Schedule 1 of the Regulations.	Completed

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

The care plans were not consistently reviewed on a three-monthly basis.

Action required:

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

Reference:

Health Act, 2007
Regulation 8: Assessment and Care Plan
Standard 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 director of nursing will ensure that all care plans are reviewed on a three-monthly basis and according to the residents changing needs.	Ongoing

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

The directory of residents did not contain the address of the general practitioner for each resident.

Action required:

Ensure that the directory of residents includes the information specified in Schedule 3 of the Regulations.

Reference:

Health Act, 2007
Regulation 23: Directory of Residents
Standard 32: Register and Residents' Records

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

Provider's response: A review of the residents directory has been carried out to ensure that all fields including the GP is completed.	Compliant

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

There was inadequate evidence of a formal review of the quality and safety of care provided to residents. No comprehensive audit of complaints received had been completed to promote continuous quality improvement.

Action required:

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

Reference:

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

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Clinical Governance is in place to review all systems and enhance the quality and safety of care provided ensuring a better quality of life for our residents.	Ongoing

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

All required documentation in relation to recruitment of staff employed in the centre was not available for inspection.

Action required:

Put in place recruitment procedures to ensure no staff member is employed unless the person is fit to work at the designated centre and full and satisfactory information and documents specified in Schedule 2 of the Regulations have been obtained in respect of each person.

Action required: Put in place recruitment procedures to ensure that no staff members are employed in the designated centre unless they are physically and mentally fit for the purposes of the work which they are to perform.	
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: A review of the personnel files is taking place to ensure that all requirements in relation to recruitment procedures are in place	27/08/2012

Any comments the provider may wish to make:

Provider's response:

We would like to thank the inspectors for the courteous way in which they carried out the inspection.

Provider's name: Joe Kenny
Date: 11 July 2012