Health Information and Quality Authority
Regulation Directorate

Compliance Monitoring Inspection Report
Designated Centres under Health Act 2007, as amended

Centre name:	Newbrook Nursing Home
Centre ID:	0074
Centre address:	Ballymahon Road Mullingar, Co Westmeath
Telephone number:	044-9342211
Email address:	admin@newbrooknursing.ie
Type of centre:	☒ **Private** ☐ **Voluntary** ☐ **Public**
Registered provider:	Newbrook Nursing Home Limited
Person authorised to act on behalf of the provider:	Phil Darcy
Person in charge:	Denise Hilton
Date of inspection:	25 and 26 March 2013
Time inspection took place:	**Day-1 Start:** 14:40 hrs **Completion:** 20:00 hrs **Day-2 Start:** 09:15 hrs **Completion**: 16:05 hrs
Lead inspector:	Geraldine Jolley
Support inspector:	Bríd McGoldrick
Type of inspection	☒ **unannounced Day 1** ☒ **announced Day 2**
Number of residents on the date of inspection:	51
Number of vacancies on the date of inspection:	1

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

Summary of compliance with 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*.

This inspection report sets out the findings of a monitoring inspection, in which 13 of the 18 outcomes were inspected against. The purpose of the inspection was:

- ☐ to inform a registration decision
- ☐ to inform a registration renewal decision
- ☒ to monitor ongoing compliance with Regulations and Standards
- ☐ following an application to vary registration conditions
- ☐ following a notification of a significant incident or event
- ☐ following a notification of a change in person in charge
- ☐ following information received in relation to a concern/complaint

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

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

This monitoring inspection took place over two days. Day one was unannounced and day two was announced. During the inspection the inspectors met with residents and staff members. Inspectors observed the delivery of care, reviewed documentation such as care plans, medical records, policies and procedures and undertook a partial inspection of the premises.

This was the seventh inspection conducted by the Authority's inspectors. During the initial stages of the inspection the inspectors found indicators that the care and welfare of residents was not being managed to a satisfactory standard in the areas

of diabetic care, when residents lost weight, dementia care and when residents returned from hospital.

There were 51 residents accommodated during the inspection - 33 residents were assessed as having maximum or high dependency care needs, 15 were assessed as medium dependency and the remaining three had low care needs. There was a substiantial level of admission and discharge activity noted. In the five month period from November 2012 there were 16 admissions to the centre, 22 discharges of which three were discharges home and 19 were discharges to hospital. Fourteen residents discharged to hospital returned to the centre, one resident remains in hospital care and four residents died in hospital. There were a futher six deaths in the centre during this period. The centre provides care to a resident group with a wide range of care needs and health problems. From the information provided to inspectors 26 residents had problems related to confusion or dementia, six residents had mental health problems and there were some residents identified as having challenging behaviours such as shouting, being resistant to care or exhibiting high levels of distress.

Inspectors were concerned on the first day of the inspection that staff could adequately assess and provide appropriate care within the context described above. There were specific healthcare needs that the inspectors identified that needed attention without delay as they presented risks to residents. The inspectors were not satisfied from the arrangements that they reviewed that appropriate safe care was being provided. The following improvements are required in order to comply with current legislation:

- nutritional assessment and management of unintentional weight loss
- review of fall management
- reviewing the environment to ensure it is conducive to providing care in line with best practice in dementia care and design
- the assessment and management of residents with diabetes
- follow-up care and monitoring following hospital admissions
- pain assessment and monitoring
- end of life care
- medication management
- assessment and care planning

Inspectors found that residents who were losing weight were not monitored systematically and that residents were not offered food in a regular planned manner outside of the main meal times to ensure that diabetic care, residents with weight loss and dementia could be managed in accordance with good practice guidance. Records of food provided were not maintained in a manner that met the requirements of Regulation 22 and Schedule 4 that requires the maintenance of a “record of the food in provided for residents in sufficient detail to enable any person inspecting the record to determine whether the diet is satisfactory in relation to nutrition and otherwise and of any special diets prepared for individual residents”.

The safe management of residents who had epilepsy was also a concern and planning for end of life care and for care and treatment at end of life were also areas that were found to need improvements to ensure safe outcomes for residents.

The inspectors observed that interactions between staff and residents were positive with staff taking time to acknowledge and greet residents when they met and when entering communal and bedroom areas. There were a range of evidence-based assessment tools to determine residents' care needs and there was evidence that some plans were reviewed at three month intervals. However, not all assessment documentation was fully complete and it was not clear that reviews involved the resident, their family or other members of the multidisciplinary team and it was also unclear what aspects of care had been reviewed in the sample files viewed. Medical reviews were noted to focus on critical events and changes in health care identified by nursing staff.

The inspectors described the failures and concerns to the provider and the person in charge during the feedback meeting at the conclusion of the inspection. The provider and person in charge were reminded of their statutory responsibilities and of the Authority's concerns regarding the risks posed to residents' safety and the ongoing non-compliance with the Regulations. There was an acknowledgement that the level of activity in the centre and the complexity of care issues being addressed and this had led to shortcomings in care practice. The person in charge indicated that she would suspend admissions to enable work to be undertaken to comply with the Regulations and both the provider and person in charge were committed to achieving this.

The inspectors were also concerned that the deployment of staff particularly qualified nurses was not appropriate to meet the needs of residents, particularly over week end periods. While there were four nurses on duty during weekdays including the person in charge, there were only two nurses available on weekend day as the person in charge and clinical nurse manager both worked Monday to Friday. There had been a requirement in all inspection reports for the provider to ensure that the numbers and skill-mix of staff were appropriate to the needs of residents taking into account the size and layout of the centre.

These issues are discussed further in the body of the report.

While the inspectors found that there were some aspects of good practice and residents were in general satisfied with the care they received, they also found that the centre did not meet the requirements of 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* in several critical areas as described earlier.

Summary of Regulatory Activity

Regulatory activity had identified persistent failures to meet the provisions 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*. There has been an ongoing lack of compliance with the Regulations in the area of governance, management, assessment of risk, the provision of adequate staff in numbers and skill mix to meet the needs of residents and resident care in the centre between the first inspection conducted in March 2010 and October 2011 leading to the Chief Inspector issuing a proposal to cancel registration on 26 october 2011. The summary below outlines the regulatory activity undertaken to date and summarises the breaches in legislation identified during inspections.

Inspection History

24 March 2010

The centre was first inspected on 24 March 2010. This was an unannounced inspection and 31 actions referencing 20 breaches of the Regulations and two recommendations were outlined for attention. The areas where deficits were noted included medication management, risk assessment and management, dementia care, care planning and consultation with residents and aspects of the provision of food and nutrition.

8 and 9 March 2011

The second inspection was the registration inspection and this was announced. The actions from the previous inspection were reviewed and it was found that 14 actions had been satisfactorily completed and the remainder had been completed to varying degrees. Actions not fully completed included, residents' involvement in care planning, medication management, access to healthcare, end of life procedures, appropriate review of quality and safety of care and inadequacy of policies and procedures. Following this inspection an immediate action letter was issued requiring the provider to urgently address areas such as:

- elder abuse prevention training and evidence that staff employed were Guarda Síochána vetted
- medication management
- wound management including the management of a stage four pressure wound and residents access to healthcare
- complaints management.

As a result of inspectors' concerns outlined above, the provider was requested to attend a formal meeting with the Authority. This took place on 22 March 2011.

The action plan from the inspection of 8 and 9 March 2010 was returned to the Authority on 21 April 2010 and required one revision to achieve agreement with the inspectorate. There were 31 actions referencing 25 breaches of the Regulations and 9 recommendations outlined. Many actions were repeated failures which had not been resolved to a satisfactory standard since the first inspection undertaken by the Authority.

30 June 2011
An inspection was undertaken to conducted a fit person interview with person in charge and to do a follow-up inspection to assess compliance following the issue of the immediate action letter and report from March inspection.

29 August 2011
The inspectors found that of the 31 actions, five were satisfactorily completed, 14 were partially completed and 12 were not satisfactorily completed. The same legislative breaches were still evident with ongoing deficits from the registration inspection and immediate action plan continuing to present concerns. The legislativfailures included insufficient staffing, poor supervision of staff, inadequate medication management procedures and failures to protect residents.

Proposal to cancel registration
The centre was issued with a proposal to refuse and cancel registration by the Chief Inspector on 26 October 2011. This decision was based on repeated failure to progress action plans to a satisfactory standard and the Authority were not satisfied that the provider and person in charge demonstrated an adequate level of “fitness” as decribed in the Health Act 2007.

A representation was received by the Authority on 18 November 2011 and this included a change in the nominated person to act as provider from Sarah Ann McGivney to Phil Darcy and a change in person in charge to Denise Hilton both changes effective from 26 October 2011. An external consultancy company with expertise in the nursing home sector were engaged to provide assistance and support to address ongoing failures to satisfactorily meet the Authority’s actions.

6 December 2011
An inspection against the representation was carried out. While there were 15 actions identified from findings by inspectors, there was good evidence of progress with addressing deficits highlighted in previous action plans.

8 and 9 March 2012
A monitoring inspection was undertaken and inspectors found a range of areas of concern. The deficits were discussed with the provider and person in charge and the inspectors issued an immediate action letter that required action to be taken to address failures in the following areas:

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

The provider responded by increasing staffing levels immediately and by making changes that led inspectors to conclude that the remaining immediate actions were being addressed or addressed to a satisfactory standard by 12 April 2012, the second day of this inspection. A more wide ranging training programme had been provided for staff and better systems for supervising and reviewing practice had been put in place.

October 2012
During this inspection, the inspector found that the provider, person in charge and staff team had sustained the improvements that had been made between March and April 2012. There were 14 actions outlined for attention at this inspection. These included improvements in areas previously identified for attention in reports and included record keeping, risk management, medication management and staff deployment. This action plan was not fully reviewed during this inspection due to the range of critical care issues that were identified and needed attention. A monitoring report will also be requested from the Provider to assure the Chief inspectors that matters outlined in the report are appropriatedly attended to. The Provider was also made aware that the chief inspector will examine inspection findings and may take further regulatory action.

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

Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

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

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

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

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

The profile of the residents reflected the information outlined in the statement of purpose. The majority of residents accommodated had significant care needs

associated with old age, dementia and mental health problems. Staff knew residents as individuals and could describe their personal preferences and choices. However, there were factors such as the significant admission and discharge activity, the layout of the premises that did not provide an appropriate secure environment for the number of residents with dementia care needs accommodated that compromised how staff could deliver high quality evidence based safe care in accordance with the aims and objectives outlined in the statement of purpose.

The inspectors concluded from the findings of this inspection and the evidence that was collated that the provider and person in charge were failing to meet the care needs of residents as outlined in the statement of purpose.

Outcome 2
Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

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

Action(s) required from previous inspection:

Ensure each resident's contract deals with the care and welfare of the resident in the designated centre and includes details of the services to be provided for that resident and the fees to be charged.

Inspection findings

This action was complete. Two contracts of care were reviewed during this inspection. The fee to be charged including the residents contribution was clearly stated. The notice period for termination of the contract was four weeks. The contracts had been signed by the resident or their representative.

Outcome 3
The designated centre is managed by a suitably qualified and experienced nurse with authority, accountability and responsibility for the provision of the service.

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

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

This report outlines a range of failures in the management of clinical care many of which were the responsibility of the person in charge. She demonstrated a good knowledge of her legislative responsibilities and told inspectors that she would cease admission activity until the critical problems such as care planning, management of residents with weight loss and other critical events that had been identified were rectified.

Outcome 4
The records listed in Part 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

References:
Regulations 21-25: The records to be kept in a designated centre
Regulation 26: Insurance Cover
Regulation 27: Operating Policies and Procedures
Standard 1: Information
Standard 29: Management Systems
Standard 32: Register and Residents' Records

Inspection findings:
**Where "Improvements required" is indicated, full details of actions required are in the Action Plan at the end of the report.*

Records in relation to residents (Schedule 3)

Substantial compliance ☐ Improvements required * ☒

Many records in relation to residents were found to be incomplete and were not maintained in a manner so as to ensure completeness, accuracy and ease of retrieval.

General Records (Schedule 4)

Substantial compliance ☐ Improvements required * ☒

Daily progress notes described aspects of physical care only and did not convey the full range of care provided on a daily basis such as the social and psychological support provided to ensure residents wellbeing. Nurses' entries were not timed which is contrary to best practice guidelines from An Bord Altranais agus Cnáimhseachais na hÉireann (Nursing and Midwifery Board of Ireland).

Operating Policies and Procedures (Schedule 5)

Substantial compliance ☐ Improvements required * ☒

Not all Schedule 5 policies were reviewed. The end of life policy required review – this is discussed under Outcome 14. Polices such as risk management and food and nutrition monitoring were not implemented and deficits identified are discussed under Outcome 7. A requirement for this report is the provision of a policy on safe management of epilepsy. This is discussed in Outcome 11.

Medical Records

Substantial compliance ☐ Improvements required * ☒

Copies of transfer letters with regard to transfer to and from the acute hospital were not available in the centre.

Action(s) required from previous inspection:

Maintain an adequate nursing record of the persons health and condition and treatment given, completed on a daily basis and signed and dated by the nurse on duty in accordance with any relevant professional guidelines.

Inspection findings

This action was not complete and continued to need improvement. The inspectors found that information in some medical records was poorly organised and that the recording of medical reviews was inconsistent. In general, there was a lack of comprehensive reviews of medical problems and healthcare matters. Doctors visiting the centre were often reacting to a specific medical problem and there appeared to be no system for a comprehensive review of healthcare needs. The handwriting in some medical and nursing files was difficult to read, was completed in blue ink, did not state the time the record was complete and some nursing and medical records were not legible.

The daily notes completed by nurses described progress in relation to physical health care needs, however, the records did not fully reflect assessments and care plans and did not give a clear picture of the range of care delivered over the 24 hour period.

Theme: Safe care and support

Safe care and support recognises that the safety of service users is paramount. A service focused on safe care and support is continually looking for ways to be more reliable and to improve the quality and safety of the service it delivers.

In a safe service, a focus on quality and safety improvement becomes part of a service-wide culture and is embedded in the service's daily practices and processes rather than being viewed or undertaken as a separate activity.

To achieve a culture of quality and safety everyone in the service has a responsibility to identify and manage risk and use evidence-based decision-making to maximise the

safety outcomes for service users.

Outcome 6
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse.

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

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

This outcome was not fully reviewed. The policy and procedure to guide staff on the prevention, detection and response to abuse had been updated in June 2012 and it included the measures to be taken should an allegation of abuse be made about any employee in the organisation including senior staff.

The inspector found that measures were in place to protect residents from being harmed or suffering abuse. An inspector found during discussions with staff that they were able to describe the prevention of elder abuse policy, explain the different categories of abuse and state what they would do if they suspected abuse.

Outcome 7
The health and safety of residents, visitors and staff is promoted and protected.

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

Action(s) required from previous inspection:

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.

Ensure that the risk management policy covers the precautions in place to control the following specified risks accidental injury to residents or staff.

Provide safe floor covering in the oratory area.

Inspection findings

The deficits identified during the last inspection in relation to flooring in the oratory was viewed. The inspector found that the flooring now in place was safe, level and provided an appropriate surface.

Falls Management

There was a falls risk assessment completed in all files reviewed by inspectors. However, inspectors found that reassessments had not taken place when residents sustained falls and associated care plans had not been updated following each fall to reduce the risk of reoccurrence. In one instance a review of the falls risk assessment had not been carried out when a resident sustained a fall and the resident's care plan was not updated to include the interventions to be taken to minimise the risk of a re-occurrence. This resident had sustained a head injury and while staff had reported the incident to the GP, she was not seen until 23 March 2013 when she presented with an additional problem. Her respiratory function deteriorated and she was seen by the out of hours medical service over the weekend and transferred to hospital. This was her second admission to hospital in three months.

Infection Control

The management of infection had been an area identified for improvement in the immediate action letter issued by inspectors following the inspection in March 2012. The inspector found that the improvements made to address the deficits had been sustained.

The measures in place to control the spread of infection included the provision of adequate supplies of personal protective equipment, training for staff in infection control and the availability of policies and procedures on the more regularly encountered infections such as norovirus, influenza, clostridium difficile (c.diff) and Methicillin-resistant *Staphylococcus aureus* (MRSA). The environment was noted to be clean and staff were observed to undertake cleaning in a systematic and organised manner during the inspection days.

The Authority was notified of an outbreak of norovirus in February 2012. This had impacted on 20 residents. The inspectors were told that precautions such as restricted visiting, additional cleaning and notices alerting visitors had been put in place. The inspectors were also told that staff had training on infection control in January 2013. In view of the number of residents impacted and information supplied during this inspection that indicated that many residents suffered weight loss consequent to this infection it is a requirement of this report that a review of this incident is completed to ensure that any learning from the management of the outbreak is identified and circulated to staff as part of good practice in risk management and learning from untoward incidents.

There were five residents with MRSA. The inspector talked to household staff about the management of infection and the procedures that were adopted to prevent the spread of infection. They said that they were informed by nurses when residents had infectious illness and could describe good infection control practice such as using

personal protective equipment, disposing of it after individual use and ensuring high levels of cleanliness.

Risk management
The management of risk had been identified for improvement in all inspection reports for this service and the inspectors again found that risk management continued to need significant improvement to protect residents, staff and visitors. While accidents and incidents were recorded and risks were identified, there were risk factors in relation to care practices that were not identified or managed effectively. These included:

- the impact of staff deployment and the significant reduction in nurses available to care for residents at weekends
- the admission and discharge activity to the centre is significant and information is not provided or obtained on all aspects of care needs to enable the delivery of safe care. For example, the inspectors noted that a resident who had been prescribed an anticonvulsant medication had not been identified for blood tests as required for appropriate administration of this medication
- the management of residents with weight loss was not appropriately assessed, monitored and measures put in place to address weight loss were not rigorously followed through to improve outcomes for residents
- residents information such as a report of an x-ray taken, and in another case blood results (resident on INR) were not available in the centre.

The inspectors also noted that some visitors entered and left the centre without signing the visitors record which presented a risk for residents and staff.

Pain assessment and monitoring
While assessment of the requirement for pain relief was taking place there was no process in place for monitoring the effectiveness of the analgesia administered.

Fire Procedures
Fire safety procedures were not fully inspected on this inspection. However, inspectors noted on occasions where they walked around the building that fire exits were unobstructed. Inspectors spoke with staff who could explain the procedures to ensure safe placement of residents in the event of fire. Inspectors were given information showing the equipment required by residents should the need for evacuation arise. Inspectors spoke with the fire warden who kept this information up to date. On the first day of inspection the fire panel indicated a fault, inspectors were told that a specialist repair person had been contacted. This was remedied by the end of the first day.

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

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

Action(s) required from previous inspection:

Put in place appropriate and suitable practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents and ensure that staff are familiar with such policies and procedures.

Inspection findings

This action was partially complete. Medication prescribed on an "as required" basis did not have the maximum dose to be administered in a 24 hour period identified on medication administration charts at the last inspection. This was found to be addressed.

Each residents medication is stored in a locked cupboard in their rooms. Nurses reported that the system worked well as it enabled them to devote time to residents when giving medication as they spent time in the residents room with them rather than moving around a medication trolley.

The provider stated in his response to the action plan of the last report that every three months the clinical nurse manager (CNM) and pharmacist review all prescriptions and highlightlight any changes that could be made. The general practitioner (GP) is then contacted by the CNM and the proposed changes discussed. The CNM and the pharmacist have a further consultation. The pharmacist then prints out the prescription. In some cases the GP visits the centre and signs the prescription. In other cases the prescriptions are brought by the CNM to the GPs surgery for signing. In all cases the GP reviews the prescriptions with the CNM.

The inspectors were concerned to find that there continued to be issues of concern in relation to the management of medication in this centre. One medication chart was found not to have been reviewed within the required three month interval.

Medication was also prescribed on faxed prescriptions which were not always written up within a reasonable time frame.

The inspectors found that there were significant hazards in some aspects of medication management particularly where medication required special precautions and arrangements did not meet best practice as described in An Bord Altranais agus Cnáimhseachais na hÉireann guidance. The inspector found that medications that needed alteration in response to blood results was not always prescribed appropriately. The medication chart indicated the drug should be given in accordance with the blood result record but the blood results were not recorded systematically in the record viewed which created a risk.

Outcome 9
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

References:

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

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

The required notifications were supplied to the Authority within the required time frames.

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

Outcome 10
The quality of care and experience of the residents are monitored and developed on an ongoing basis.

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

Actions required from previous inspection:

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

Inspection findings

This action was not reviewed and is included in the action plan of this report to enable the provider to update the Authority on the actions taken to address this requirement.

Outcome 11
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests

and preferences. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

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

Actions required from previous inspection:

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.

Provide a high standard of evidence-based nursing practice and ensure that restraint measures are only put in place following assessment of residents dependency and that the least restrictive options are tried before measures such as bedrails are put in place.

Inspection findings

The above actions continued to need attention and were not complete. While there was a good range of evidence-based assessments in use that were completed and used to inform care plans, the inspectors found that many assessments were not kept up-to-date and did not reflect residents changing needs or critical care issues. The assessments in use included mini mental state examination, falls risk assessments, pressure area assessments, nutritional assessments, communication and behaviour assessments. Nursing and care staff could describe residents personal care needs and it was evident from the conversations the inspectors had with them that they knew residents well and identified changes promptly and sought medical advice. However, there were serious deficits in the management of aspects of care and the documentation that supported care practice.

The inspectors found that while aspects of healthcare practice, such as wound care management, were generally managed effectively with good outcomes for residents as some reported wounds had healed well and no longer presented problems. However, two notifications of wounds had been provided to the Authority the week preceeding the inspection which caused concern. One wound had been sustained

following the introduction of a new chair which had a seat that did not provide appropriate support to the resident and the other wound was sustained when a residents mobility level had decreased but the change had not been fully assessed and appropriate actions had not been identified to ensure that pressure area problems did not develop. A resident who had a grade three pressure sore, repeated problems with constipation and who presented a range of challenges to staff when they endeavoured to provide care did not have an appropriate care in place that described the difficulties encountered or risks that presented due to the way care had to be managed. Consideration was required regarding the degree to which the risk of an intervention, action or omission is taken in the best interest for each resident. Inspectors requested a full medical and nursing review for this resident.

The inspectors found that the management of many aspects of healthcare needed considerable improvement to reflect evidence-based practice and to ensure safe and appropriate outcomes for residents. The following areas were identified as in need of immediate attention:

- the assessment and follow up care of residents admitted to hospital and returning to the centre
- the assessment, care and management of residents with epilspsy
- the management of residents with weight loss
- the assessment, care and management of residents with diabetes
- the assessment care and management of residents with dementia care problems
- the assessment and management of challenging behaviour.

The management of admissions/discharges and health care changes

The inspectors found that where residents were admitted and discharged from hospital and new care issues emerged such as the management of seizures that care plans were not updated to reflect this significant change. The inspectors saw that a resident had been admitted to hospital because of seizure activity, had been prescribed medication to control this but no care plan had been compiled to inform staff on the assessment, care and management of seizures. The inspectors noted that this resident was on an anti-convulsant medication but there was no evidence in the medical or nursing file of the monitoring process with regard to this. This resident had returned from hospital on 15 February 2013 but was not seen by a doctor until 22 February 2012, five days after returning to the centre. The inspectors found that while there was a “Return from hospital checklist” this had not been completed for this resident. A decision was recorded that this resident was not for resuscitation by hospital staff, however, this decision had not been reviewed since his return to the nursing home and it was unclear what actions staff should take in the event of a medical crisis.

There were no procedures in place on the safe management of epilepsy. The inspector noted from examination of medication charts that two residents were on anti convulsant medication. The inspector discussed this with the senior nurse who confirmed that two residents had epilepsy. However, there was no specific care plan in place on safe management of epilepsy to guide staff on the specific interventions to manage seizure activity. The residents were not prescribed emergency medication should uncontrolled seizure activity arise. There was no policy made available to the inspector on safe management of epilepsy.

Residents with weight loss and fluctuating weight

The inspectors were particularly concerned about the management and review of residents with low weights or weight loss. There were 11 residents whose weight was between 40 and 50 kilogrammes. While some residents had been seen by a dietician and were on enriched diets or supplements, the inspectors found that the systems in place to monitor and prevent further weight loss were wholly inadequate.

There was inadequate monitoring of weights, poor record keeping in relation to food and nutrition and the arrangements for providing food outside of main meal times were found to be inconsistent and did not ensure that where residents needed additional foods that these were supplied in accordance with their needs. For example, the main meal times were 08:00 hrs to 09:000 hrs: breakfast, 12:15 hrs to 13:30 hrs for lunch and tea was served at 16:00 hrs to 17:00 hrs. While there was a tea trolley with beverages and snacks taken around at 10:30a hrs and at 19:15, the inspectors were particularly concerned that residents were enabled to eat and drink appropriate to their needs at the night time round. Many residents were noted to be in bed and there was no supervision to ensure that residents who had weight loss problems had specialist attention at this time. The monitoring of weight loss was inconsistent.

The inspector noted that in once instance weight was recorded as reducing in August 2012 with a further reduction to 56.85 kilogrammes in October 2012. However, no weight was recorded for November and although the residents weight had increased in December 2012 no weight had been recorded since then. An instruction to record weight weekly in August 2012 appeared not to have been followed as weights were available on a monthly chart only. Another resident who had been seen by the dietician on three occasions during 2012, and who had lost over 10% of body weight was not compliant with diet and had a number of other conditions such as depression and anxiety. However, there were few references to how these problems impacted on the residents daily life or if they were a factor in her eating pattern. Another resident, who was seriously underweight at 38.95 kilogrammes, was not weighed in October or November and while her weight was unchanged when weighed in December 2012, there were no weights recorded for January or February 2013 to assess if her condition remained stable. No discussion had taken place with her doctor or with other professionals to determine if all possible care was being provided to ensure her health and well being. There was no care plan in place for weight management or monitoring of weight.

The inspectors found that nutritional assessments and scores that would inform staff on nutritional risk were not completed systematically. As a consequence of these findings the inspectors requested that all residents with significant weight loss and low weights are comprehensively reviewed to ensure that they are in receipt of appropriate safe care that ensures their well being.

The care of residents with diabetes

There were 10 residents who had diabetes, four of whom were diet controlled and six were on medication including one resident who was on insulin. The inspectors were told that blood sugar monitoring was undertaken by night staff. Residents with diabetes did not have appropriate care plans in place. As described earlier, the

inspectors were concerned that while three meals were provided each day and these were noted to be of good variety and content the arrangements to ensure that residents with diabetes and other complications were provided with food of adequate nourishment outside of the main meal times.

Dementia care

The inspector found that there were assessments to describe the extent of memory problems and cognitive difficulties. Staff conveyed good knowledge of where residents needed additional assistance because of this or because of challenging behaviour. However, care plans did not convey adequate details on the specialist care needs of residents with dementia or mental health problems. For example, there were few reflections on residents residual abilities, what memory capacity was still evident or if they recognised family, friends and staff. The training records indicated that staff had ongoing training in dementia care and other staff had attended short courses relevant to dementia such as sonas training which equips staff with skills to provide meaningful activities for residents who have impairered cognitive abilities. The inspectors concluded that due to the prevalence of dementia care needs that the centre needed to have more specialist expertise in this area to ensure that residents received high quality evidence-based care and were enabled to maintain their maximum level of functioning. The premises were also unsuitable for the provision of high quality dementia care as there was no designated area for this purpose, no signage to guide and prompt residents except in one instance where a bedroom was identified by a photograph and staff were deployed across the centre at varied times of the day which did not provide continuity of care in accordance with good dementia care practice.

The management of challenging behaviour

The inspectors noted a number of residents presented challenges such as exhibiting resistance to care and lack of cooperation with treatment plans. The inspectors found that these behaviours were poorly recorded in some instances. For example, where a resident was resistant to care and was presenting significant concern there had been no discussion with professionals in the mental health team that may be able to help advise and guide staff. The inspectors found that there were some residents who had no next of kin and legal representatives had not been accessible when the person in charge had tried to contact them. No alternative arrangements had been explored and the inspectors found that these arrangements did not ensure the welfare of residents was fully protected.

General comments

The inspectors noted that there were areas of good practice. The inspectors reviewed six care files in detail and aspects of other care files were reviewed in relation to specific issues. All residents had care plans for most problems identified. Assessments were carried out with a standard set of assessment tools used to inform staff on areas such as nutrition and nutritional risk, falls risk assessments, moving and handling assessment, cognitive conditions and communication. There were good review systems in place for residents with mental health problems who were seen regularly by the mental health team and community mental health nurse. The activity provision was also good with interesting and varied activities available each morning and afternoon in two sitting areas. Residents were also enabled to follow their own

choices and spend time on their own pursuing their own interests such as reading quietly and watching television if they wished.

Some care documentation was completed to a good standard by some nurses. However, there was overall a range of deficits that required attention:

- some of the information detailed in the residents' progress/evaluation notes did not include information on how the residents spent their day. They mainly focused on clinical care and did not outline the activities that residents took part in or their level of participation during activity or in their contacts with staff
- assessment outcomes were not reflected in the care plans
- some care plans were not person centred and were generic in nature
- there was poor evidence available of consultation with the residents or their representatives in the development and review of the care plan. Reviews of care and evaluations of care plans appeared to be completed by nursing staff. Reviews were not undertaken at three monthly intervals and were not updated in response to the changing needs of residents. Some reviews had not taken place since November 2012. Where there had been a review there was no narrative available of a discussion between the resident and/or their significant other with regard to the care plan as to whether they agreed, disagreed or wished to make any comment with regard to the care plan. Consequently, care plans did not convey individual residents' choices and preferences in all aspects of their care. Where person-centred care wishes are recorded and incorporated into care plans, this gives guidance to staff on how to provide daily routines and ensures residents have choice over day to day life and how their care is delivered
- care plans were not linked to give an overall view of the residents care. For example, assessments of skin integrity, nutrition, mobility and pressure area care were not linked to provide an overall view of care needs. The inspectors noted that while a high vulnerability to pressure area problems or a pressure ulcer might be receiving attention the need for appropriate nutrition or risk if appropriate nutrition was not provided was not identified.

In the absence of clear care plans, it is not possible for the provider to ensure that suitable and sufficient care to maintain the resident’s welfare and wellbeing, having regard to the nature and extent of the resident’s dependency and needs as set out in their care plan is delivered.

Pain assessment and monitoring

While assessment of the requirement for pain relief was taking place there was no process in place for monitoring the effectiveness of the analgesia administered.

Restraint management

This action was complete. The practice in relation to the use of restraint was reviewed and aspects of restraint management had been improved since the last inspection. Restraint measures in place were bedrails and specialist chairs. The inspector found that there were assessments that underpinned restraint use and the reasons for consideration of the restraint were identified. In three records examined the reason for the restraint was identified as protection from falls or injury and in one instance to protect the resident when using a specialist chair. The inspectors saw

that low low beds, mattresses by beds and alarms were used to protect residents at risk of falls and to alert staff so they could provide appropriate assistance.

Outcome 12
The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

References:
Regulation 19: Premises
Standard 25: Physical Environment

Action(s) required from previous inspection:

Provide ventilation, heating and lighting suitable for residents in all parts of the designated centre which are used by residents.

Keep all parts of the designated centre clean and suitably decorated.

Make suitable adaptations, and provide such support, equipment and facilities for residents, as may be required.

Inspection findings

The inspectors found that the level of heating remained variable throughout the centre. Some areas that had been noted as cool during the last inspection such as sitting areas were now adequately warm. Window seals had been replaced where required. However, there were still some areas where the temperature was notably cool such as the Church View meeting room/activity area, the smoking area and a toilet near the oratory where the temperature on day two of the inspection was recorded by the inspector as 17 degrees. Some bedrooms had been supplied with additional heaters. The maintenance man told the inspector that the underfloor heating was now supplied by gas which had improved effectiveness. The inspector was told that when the activity room was used by residents that additional heating was supplied.

The areas that needed decoration were repaired. The flooring in the oratory was level and did not present a trip hazard.

Wheelchairs were noted to have footplates in place and to be in good condition. The current décor of the centre lacks distinctive visual elements to assist residents with dementia and residents with cognitive difficulties. The "unit" where most residents who have dementia are cared for needs to incorporate dementia specific design features which encourage and aid residents' independence through appropriate use of design features such as contrasting colours, lighting and cue s to aid memory. Fixtures and fittings to aid and promote reminiscence practice and

assist in orientating residents to time and place are required to ensure that appropriate care is provided to this resident group.

There was assistive equipment provided to meet the needs of residents, including, hoists and specialised mattresses.

Theme: Person-centred care and support
Person-centred care and support has service users at the centre of all that the service does. It does this by advocating for the needs of service users, protecting their rights, respecting their values, preferences and diversity and actively involving them in the provision of care. Person-centred care and support promotes kindness, consideration and respect for service users' dignity, privacy and autonomy.

Outcome 13
The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

References:
Regulation 39: Complaints Procedures
Standard 6: Complaints

Action required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

The inspectors reviewed the complaint record for 2013. One complaint about lost laundry had been recorded and this had been appropriately addressed.

The inspectors found that the nominated persons to address complaints needed review as some of the nominated persons did not have the authority to address and investigate complaints comprehensively.

Outcome 14
Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.

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

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

The inspectors found that practice in relation to care at end of life needed improvement in several aspects. A resident who had recently had a hospital admission was described in hospital as “not for resuscitation”. However, this status had not been reviewed on his return to the centre and it was not clear from the records maintained if this instruction still applied.

The file of a resident who had died recently was reviewed. The inspectors were told that end of life care had been managed well and that she had recieved appropriate analgesia to manage her pain when required. The inspectors were concerned that there was a discrepancy between some medical information in the records examined. Hospital staff had indicated that the resident should be seen by the hospice service/palliative care team as required. However, this service had not been contacted. Inspectors discussed the process for verification of death and procedure for reporting deaths to the coroner. There was no clear procedure for verification of death by nurses and reporting of deaths to the coroner. While the cause of death is recorded in the centre, the information communicated to the coroner and decision to perform or not to perform post mortem was not evident. Nurses verify death but the procedure is not recorded. The person in charge gave a firm verbal commitment that she would address this area immediatedly.

Outcome 15
Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discreet and sensitive manner.

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

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

As described earlier the inspectors were concerned that the arrangements for the provision of food outside of main meal times was appropriate to meet the needs of all residents particularly those with specialist dietary requirements. It is a requirement of this report that additional measures are put in place by the person in charge to ensure that the requirements of Regulation 20 are appropriately met, ensure the well being of all residents and that residents with specialist dietary needs have appropriate nutrition. Where residents had unintentional weight loss there was no review of the residents or the care plan to try and elicit a cause for the loss of weight and to put procedures in place to prevent further weight loss. This is outlined in detail in Outcome 7. Intake and outputs were not totalled therefore it was difficult to evaluate care provided.

Theme: Workforce

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

Outcome 18

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

References:

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

Action(s) required from previous inspection:

Ensure that the numbers and skill mix of staff are appropriate to the assessed needs of residents and the size and layout of the designated centre.

Inspection findings

This action was not complete. The inspectors were concerned that the deployment of qualified nurses particularly over weekend was adequate to address the complex care needs of residents. As outlined throughout this report there was evidence that assessment, monitoring and delivery of aspects of clinical care did not meet appropriate standards. During the week there were four nurses on duty including the person in charge and clinical nurse manager. The clinical nurse manager was supernumery and her role was to supervise the delivery of care and support the person in charge. Both worked 09:00 hrs to 17:00 hrs on weekdays. There was an administrator on duty during weekdays to support the operation of the centre, answer the telephone and greet and guide visitors. The two household staff finished duty at 16:00 hrs and 17:00 hrs respectively and the inspectors were told that carers undertake any cleaning duties that were required after this time. Catering staff were on duty throughout the day from 08:00 hrs until 20:00 hrs.

The total daily deployment of care staff allowed for two nurses and nine carers during the morning and early afternoon. After 14:00 hrs there were two nurses and seven carers on duty. The night duty allocation was two nurses and three carers with one carer finishing duty at 22.30 hrs. The inspectors formed the view that the night

duty allocation was appropriate but that the allocation of nurses devoted to direct nursing care particularly over the weekend period needed review to ensure that the care needs of residents were addressed appropriately.

Closing the visit

At the close of the inspection visit a feedback meeting was held with the provider, the person in charge, the clinical nurse manager and the quality manager for the company 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, the person in charge and the staff team during the inspection.

Report compiled by:

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27 March 2013

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report *

Centre Name:	Newbrook Nursing Home
Centre ID:	0074
Date of inspection:	25 and 26 March 2013
Date of response:	15 April 2013

Requirements

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

Theme: Governance, Leadership and Management

Outcome 1:Statement of purpose an quality management

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

The inspectors concluded from the findings of this inspection and the evidence that was collated that the provider and person in charge were failing to meet the care needs of residents as outlined in the statement of purpose.

Action required:

Keep the statement of purpose and function under review. Where risks are encountered, the service responds to this and iniates changes to the service to ensure safe delivery of quality care.

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

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: All admissions have ceased and we have initiated changes to the service provided to ensure safety and twenty four hour orientation for residents with dementia. Further details of these changes are outlined below.	30 April 2013

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

The provider / person in charge is failing to comply with a regulatory requirement in the following respect: All required records were not maintained in a manner that ensured accuracy and ease of retrieval. Some records could not be deciphered, were not timed and were completed in blue ink. Nurses' entries were not timed which is contrary to best practice guidelines from An Bord Altranais agus Cnáimhseachais na hÉireann.
Action required: Maintain the records listed under Schedule 3 (records in relation to residents) and Schedule 4 (general records) in a manner so to ensure completeness, accuracy and ease of retrieval.
Action required: Maintain an adequate nursing record of the persons health and condition and treatment given, completed on a daily basis and signed and dated by the nurse on duty in accordance with any relevant professional guidelines.
Reference: Health Act, 2007 Regulation 22: Maintenance of Records 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 have reviewed our record keeping and are making changes	15 May 2013

as necessary to ensure completeness, accuracy and ease of retrival of information. We will hightlight to the GPs the requirement that they make notes in "black" ink only. Our Nurses have been given a copy of the following guidelines: 1) Professional Guidance for Nurses Working With Older People (An Bord Altranais). 2) Recording Clincial Practice Guidance to Nurses and Midwives (An Bord Altranais). 3) What You Should Know About Data Quality (HIQA 2012). We have reviewed a sample of nursing notes and found that while the times were being recorded, they were not recorded in the time and date column. They were recorded in the narrative column. We will audit our records to ensure that the records are maintained in accordance with the legislation and best practice.	Completed 15 May 2013 15 May 2013

The provider is failing to comply with a regulatory requirement in the following respect: The daily notes completed by nurses described progress in relation to physical health care needs. However, the records did not fully reflect assessments and care plans and did not give a clear picture of the range of care delivered over the 24 hour period.	
Action required: Maintain an adequate nursing record of the persons health and condition and treatment given, completed on a daily basis and signed and dated by the nurse on duty in accordance with any relevant professional guidelines.	
Reference: Health Act, 2007 Regulation 25: Medical Records Standard 13: Heathcare	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Our Nurses have been given a copy of the following guidelines:	Completed

1) Professional Guidance for Nurses Working With Older People (An Bord Altranais). 2) Recording Clincial Practice Guidance to Nurses and Midwives (An Bord Altranais). 3) What You Should Know About Data Quality (HIQA 2012). We have reviewed a sample of nursing notes and found that while the times were being recorded, they were not recorded in the time and date column. They were recorded in the narrative column. We will audit our records to ensure that the records are maintained in accordance with the legislation and best practice.	15 May 2013 15 May 2013

The provider is failing to comply with a regulatory requirement in the following respect: The visitors record did not accurately reflect all persons in the centre. The inspectors saw that visitors entered and left the centre without signing the visitors record which presented a risk for residents and staff.
Action required: Maintain the records listed under Schedule 3 (records in relation to residents) and Schedule 4 (general records) in a manner so to ensure completeness, accuracy and ease of retrieval.
Action required: Maintain a record of all visitors to the centre including the names of visitors.
Reference: Health Act, 2007 Regulation 22: Maintenance of Records Standard 32: Register and Residents' Records

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Staff have been reminded to ensure that all visitors sign in the visitors' book. We are installing a pre-recorded voice reminder triggered by a motion sensor which will automatically remind people to sign in.	 Completed 30 April 2013

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

All policies listed in Schedule 5 of the Regulations were available but many required review to ensure they provided clear guidance to staff of the procedures to follow to ensure the delivery of safe quality care to residents.

The end of life policy did not include procedures for nurses to verify death or the procedure for reporting deaths to the coroner.

The risk management policy had not been implemented and deficits identified in practice were found.

Inspectors identified a requirement for policy on the safe management of epilepsy.

Action required:

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

Action required:

Review all the written operational policies and procedures of the designated centre on the recommendation of the Chief Inspector and at least every three years.

Reference:

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

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response:	
Our End of Life Policy references that the nurses verify that the resident has died. A Verification of Death Policy has been introduced to provide guidance for nurses on verifying death and reporting deaths to the Coroner.	Completed
We will ensure that the Risk Management Policy is fully implemented.	Completed
We are developing a policy on the safe management of epilepsy.	19 April 2013
We have introduced forms to record seizure events. All residents with epilepsy have had their anti-convulsant therapy levels checked and reviewed by their GPs.	Completed

Care Plans are being updated for residents with epilepsy.	Completed

The provider is failing to comply with a regulatory requirement in the following respect: The inspectors found that nutritional assessments and scores that would inform staff on nutritional risk were not completed systematically. Records of food and nutrition did not convey that the food and liquids provided to residents who were vulnerable to weight loss were adequate for their needs.	
Action required: Maintain records of the food provided to residents in sufficient detail to enable any person inspecting the record to determine if the diet is satisfactory , in relation to nutrition or otherwise and of any special diets prepared for individual residents.	
Action required: Maintain the records listed under Schedule 3 (records in relation to residents) and Schedule 4 (general records) in a manner so to ensure completeness, accuracy and ease of retrieval.	
Reference: Health Act, 2007 Regulation 22: Maintenance of Records Standard 19: Meals and Mealtimes	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: A comprehensive review of our system of recording weights, dietary intake and nutrition has been carried out. A copy of this review is enclosed with this action plan. The Key Nurses are aware of their responsibility to weigh their residents at least once a month and more often if required. This will be audited regularly to ensure compliance. All residents have been on "food diaries" for the past number of weeks. For the future the Carers have been instructed to record residents' dietary intake for residents whose MUST score is one or greater. Training has been scheduled for staff nurses in MUST assessments.	 Completed 19 April 2013 Completed Completed

The Dietician reviews each resident who has a MUST score of one or more. She has prepared fortified diets for nurses, carers and kitchen staff to follow. We will monitor this through regular review of the dietary record.	Completed
The nutritional assessments have been carried out.	Completed
The care plans will be updated to ensure that nutritional assessments are continuously carried out, weights are recorded systematically and that dietary requirements are being met.	15 May 2013

Theme: Safe care and support

Outcome 7: Health and safety and risk management

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

When residents sustained falls, associated care plans were not updated to identify risk factors and to reduce the risk of reoccurrence.

While accidents and incidents were recorded and risks were identified, there were risk factors in relation to care practices that were not identified or managed effectively. These included:

- the impact of staff deployment and the significant reduction in nurses available to care for residents at weekends
- the admission and discharge activity to the centre is significant and information is not provided or obtained on all aspects of care needs to enable the delivery of safe care. For example, the inspectors noted that a resident who had been prescribed an anticonvulsant medication had not been identified for blood tests as required for appropriate administration of this medication
- the management of residents with weight loss was not appropriately assessed, monitored and measures put in place to address weight loss were not rigorously followed through to improve outcomes for residents.

Action required:

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

Reference:

Health Act, 2007
Regulation 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:	
In every case where a resident sustains a fall we will reassess their falls risk and update their care plan.	Completed
The Director of Nursing has completed a review of falls from the 1st October 2012 to the 31st March 2013. The Inspector has been sent a copy.	Completed
Additional nursing hours have been rostered at week-ends from 08:00 to 16:00.	Completed
The GP of the resident on anticonvulsant medication has reviewed his file. The resident's blood was tested on the 9th April 2013.	Completed
A comprehensive review of our system of recording weights, dietary intake and nutrition has been carried out. A copy of this review is enclosed with this action plan.	Completed
The Key Nurses are aware of their responsibility to weigh their residents at least once a month and more often if required. This will be audited regularly to ensure compliance.	15 May 2013
The Carers have been instructed to record residents' dietary intake for residents whose MUST score is one or greater.	Completed
Training has been scheduled for staff nurses in MUST assessments.	Completed
The Dietician reviews each resident who has a MUST score of one or more. She has prepared fortified diets for nurses, carers and kitchen staff to follow. We will montior this through regular review of the dietary record.	Completed
The nutritional assessments have been carried out.	Completed
The care plans will be updated to ensure that nutritional assessments are continuously carried out, weights are recorded systematically and that dietary requirements are being met.	15 May 2013

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

There had been no review of the recent episode of norovirus that occurred in February. In view of the number of residents impacted and information supplied during this inspection that indicated that many residents suffered weight loss consequent to this infection the inspectors formed the view that a review of this

incident should be completed to ensure that any learning from the management of the outbreak is identified and circulated to staff as part of good practice in risk management and learning from untoward incidents.

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:

Undertake a review of the recent occurance of norovirus and provide the Authority's inspectors with a copy of the report.

Reference:

Health Act, 2007
Regulation 31: Risk Management Procedures
Standard 26: Health and Safety
Standard 29: Management Systems
Regulation 31: Risk Management Procedures

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: A review of the incident of norovirus has been carried out. A copy of this review has been forwarded to the Inspector.	Completed

Outcome 8: Medication management

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

Medications that needed alteration in response to blood results was not always prescribed appropriately. The medication chart indicated the drug should be given in accordance with the blood result record but the blood results were not recorded systematically in the record viewed which created a risk.

Medication was also prescribed on faxed prescriptions which were not always written up within a reasonable time frame.

Action required:

Put in place appropriate and suitable practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents and ensure that staff are familiar with such policies and procedures.

Reference: Health Act, 2007 Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines Standard 14: Medication Management	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Following an audit of medication charts all charts are now reviewed. With reference to the resident whose prescription was faxed: The resident's warfarin book contained a signed prescription which the resident brought home with her. While we did not have an original signed prescription on file, the resident's GP has now provided us with a signed prescription. The CNM and staff nurses have reviewed our warfarin policy so that they have refreshed themselves on the administration of warfarin.	 Completed Completed Completed

Theme: Effective care and support

Outcome 10:Reviewing and improving the Quality and safety of care

The provider is failing to comply with a regulatory requirement in the following respect: A report on reviews conducted for the purpose of Regulation 35 was not available.
Action required: Make a report in respect of any review conducted by the registered provider for the purposes of Regulation 35(1), and make a copy of the report available to residents and, if requested, to the Chief Inspector.
Reference: Health Act, 2007 Regulation 35: Review of Quality and Safety of Care and Quality of Life Standard 30: Quality Assurance and Continuous Improvement

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: A report will be prepared on the quality of care by the Practice Development Officer.	 30 April 2013

Outcome 11: Health and social care needs

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

The inspectors found a range of deficits in the assessment and care planning processes in the centre. These included deficits in care planning for critical medical and physical care problems such as:

- a resident who had a grade three pressure sore, repeated problems with constipation and who presented a range of challenges to staff when they endeavoured to provide care did not have an appropriate care plan in place that described the difficulties encountered or risks that presented due to the way care had to be managed
- a resident admitted to hospital because of seizure activity, had been prescribed medication to control this but no care plan had been compiled to inform staff on the assessment, care and management of seizures
- however, there was no specific care plan in place on safe management of epilepsy to guide staff on the specific interventions to manage seizure activity
- there was poor evidence available of consultation with the residents or their representatives in the development and review of the care plan. Reviews of care and evaluations of care plans appeared to be completed by nursing staff only
- care plans did not convey adequate details on the specialist care needs of residents with dementia or mental health problems
- care plans were not linked to give an overall view of the residents care. For example, assessments of skin integrity, nutrition, mobility and pressure area care were not linked to provide an overall view of care needs.

Action required:

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

Action required:

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

Action required:

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

Reference:

Health Act, 2007
Regulation 8: Assessment and Care Plan
Standard 3: Consent

Standard 10: Assessment Standard 11: The Resident's Care Plan Standard 17: Autonomy and Independence	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: We have reviewed all residents' care plans and addressed the issues raised as followed: 1) Each care plan will be discussed with the residents and/or next of kin. 2) A dementia specialist will commence on the 12th April 2013 who will mentor the staff nurses in developing care plans to meet the needs of residents with dementia. 3) A care plan is in place to guide staff in the management of a resident with epilepsy. 4) All residents with mental health issues have been reviewed by their GPs and assessed if referral to a physciatrist is necessary. 5) The resident with a grade three pressure sore has been seen by a Tissue Viability Nurse and her GP. Her GP has conducted a MMSE in which she scored twenty eight out of twenty eight. Her care plan has been updated to reflect these reviews. 6) Staff nurses are being mentored on the need to link the care plans to provide an overall view of the residents' care needs. Each residents' care plans will be reviewed as required at the earlier of three months or the changing needs of the residents.	 31 May 2013 31 May 2013 Completed Completed Completed 31 May 2013 15 May 2013

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

The inspectors found that nutritional assessments and scores that would inform staff on nutritional risk were not completed systematically. As a consequence of these findings the inspectors requested that all residents with significant weight loss and low weights are comprehensively reviewed to ensure that they are in receipt of appropriate safe care that ensures their well being. There were no care plans in place for weight management or monitoring of weight.

There were a number of residents with significant weight loss and low weights which present significant health risks.

One resident had a grade 3 pressure ulcer. Inspectors requested a review of this residents care and 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. Ensure that residents with weight loss are appropriately assessed and provided with suitable and sufficient care to meet their individual assessed needs.	
Action required: Facilitate all appropriate health care and support each resident on an individual basis to achieve and enjoy the best possible health. Undertake a review of all residents with weight loss and low weight and facilitate all appropriate healthcare to meet their needs.	
Action required: Facilitate all appropriate health care and support each resident on an individual basis to achieve and enjoy the best possible health .Undertake a review of care of and management of resident with a grade three pressure ulcer.	
Reference: Health Act, 2007 Regulation 6: General Welfare and Protection Standard 13: Health Care Standard 18: Routines and Expectations	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The weights of all residents have been reviewed and their care plans updated as necessary. A weight audit has been carried out and sent to the Inspector. Staff have been requested to supervise, in the evening, residents at risk of weight loss so that the residents are encouraged and assisted to eat snacks from the evening tea trolley. In addition to light snacks the tea trolley also includes milk puddings, buns, cakes and yogurts. Food diaries are being kept for all residents at present. In the future they will be kept for all residents determined to be at risk	 Completed Completed Completed Completed Completed

of weight loss. The resident with a grade three pressure sore has been seen by a Tissue Viability Nurse and her GP. Her GP has conducted a MMSE in which she scored twenty eight out of twenty eight. Her care plan has been updated to reflect these reviews.	Completed

The person in charge and provider is failing to comply with a regulatory requirement in the following respect: A number of residents presented challenges such as exhibiting resistance to care and lack of cooperation with treatment plans. The inspectors found that while staff respected the residents right to refuse treatment and care the matter and behaviours were poorly recorded in some instances.
Action required: Respect and document each resident's right to refuse treatment and bring the matter to the attention of the resident's medical practitioner.
Reference: Health Act, 2007 Regulation 9: Health Care Standard 13: Healthcare Standard 15: Medication Monitoring and Review Standard 17: Autonomy and Independence

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The resident who refused medical treatment has been seen by a GP and her care plan updated. A review of the Resident's care plan has been sent to the Inspector. Staff have been made aware that it must be documented if residents refuse treatment and the matter brought to the attention of the residents' GPs.	Completed Completed Completed

The person in charge and provider is failing to comply with a regulatory requirement in the following respect: The inspectors found that there were some residents who had no next of kin and legal representatives had not been accessible when the person in charge had tried to

contact them. No alternative arrangements had been explored and the inspectors found that these arrangements did not ensure the welfare of residents was fully protected.

Action required:

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

Reference:

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

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Of her own volition the resident has changed her legal representatives and has also made contact with a distant relative. Her GP carried out a MMSE which proved the resident capable of managing her own affairs.	 Completed Completed

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

A high standard of evidence based nursing practice was not in place in aspects of

- monitoring of fluid and food intake as fluid balance was not evaluated on a 24 hour period
- weight management was not in line with evidence-based practice
- pain management - assessment and monitoring the effectiveness of analgesia administered
- safe management of residents with epilepsy.

Action required:

Implement comprehensive guidelines for the monitoring and documentation of residents' nutritional intake.

Action required:

Provide a high standard of evidence-based nursing practice in relation to monitoring of fluid/fluid intake and weight monitoring pain management and epilepsy.

Action required:

Provide each resident with food and drink in quantities adequate for their needs, which is properly prepared, cooked and served; is wholesome and nutritious; offers choice at each mealtime; is varied and takes account of any special dietary requirements; and is consistent with each resident's individual needs.

Reference:

Health Act, 2007
Regulation 6: General Welfare and Protection
Regulation 20: Food and nutrition
Standard 19: Meals and Mealtimes
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:	
Food diaries are being kept for all residents at present. In the future they will be kept for all residents determined to be at risk of weight loss.	Completed
All residents with a MUST score of one or greater were reviewed by the Dietician on the 27 March 2013. Any recommendations which she made have been implemented and added to the residents' care plans.	Completed
All at risk residents are currently being weighed weekly.	Completed
Nurses have begun to monitor the effectiveness of analgesia.	Completed
We have developed a policy in relation to the management of epilepsy. A copy has been sent to the Inspector.	Completed
Staff have been requested to supervise, in the evening, residents at risk of weight loss so that the residents are encouraged and assisted to eat snacks from the evening tea trolley.	Completed
In addition to light snacks the tea trolley also includes milk puddings, buns, cakes and yogurts.	Completed

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

There were no procedures in place for the safe management of epilepsy .The residents were not prescribed emergency medication should uncontrolled seizure activity arise.

Action required:

Provide a high standard of evidence-based practice in relation to safe management of epilepsy.

Action required:

Develop and implement a policy on safe management of epilepsy.

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:	
Any resident on anti-convulsant drug therapy will have their blood tested at appropriate intervals. Their GP will be informed of the results.	Completed
We have updated care plans where residents have epilepsy.	Completed
Residents who are diagnosed with epilepsy have been reviewed by their GP and emergency medication ordered for them.	Completed
We have developed a policy in relation to the management of epilepsy.	Completed

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

Copies of transfer letters to and from other health establishments were not available.

Action required:

Provide all relevant information about each resident who is temporarily absent from the designated centre for treatment at another designated centre, hospital or other place, to the receiving designated centre, hospital or other place.

Action required:

On the return of a resident from another designated centre, hospital or other place, obtain all relevant information about the resident from the other designated centre, hospital or other place.

Reference: Health Act, 2007 Regulation 29: Temporary Absence and Discharge of Residents Standard 10: Assessment	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: We had implemented a new transfer form which was not being used at the time of the inspection. That is now remedied and a copy of the transfer form will in future be filed in the residents' care plans. Where residents are being transferred from hospitals a discharge letter does not always accompany the resident. In those situations we will contact the hospital to request a copy of the letter.	 Completed Completed

Outcome 12: Safe and suitable premises

The provider is failing to comply with a regulatory requirement in the following respect: There were some areas where the temperature was notably cool such as the Church View meeting room/activity area, the smoking area and a toilet near the oratory where the temperature on day two of the inspection was recorded by the inspector as 17 degrees.	
Action required: Provide ventilation, heating and lighting suitable for residents in all parts of the designated centre which are used by residents.	
Reference: Health Act, 2007 Regulation 19: Premises Standard 25: Physical Environment	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: A thermostat has been installed in the Church View Room which has regulated the temperature to at least 21 degrees celsius. The output of the Smoking Room heater has been increased. A heater has been installed in the toilet beside the Oratory.	 Completed Completed Completed

However, as the toilet is not used or required by the residents we will lock the toilet except during removals.	

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

The current décor of the centre lacks distinctive visual elements to assist residents with dementia and residents with cognitive difficulties. The “unit” where most residents who have dementia are cared for had no specific design features to encourage and aid residents’ independence in accordance with evidence based practice for dementia care.

Action required:

Provide suitable premises for the purpose of achieving the aims and objectives set out in the statement of purpose, and ensure the location of the premises is appropriate to the needs of residents.

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:	
Recommendations have been made by a Dementia Specialist on changes to the decor and premsies. We are currently implementing as many of those recommendations as is practical.	30 April 2013
We have forwarded a copy of the Dementia Specialist's report to the Inspector.	Completed
We have scheduled a meeting with residents to discuss the changes made to the Centre and to seek their feedback.	16 April 2013

Theme: Person-centred care and support

Outcome 13: Complaints procedures

The provider is failing to comply with a regulatory requirement in the following respect: The nominated persons to address complaints needed review as some of the nominated persons did not have the authority to address and investigate complaints comprehensively.
Action required: Provide written operational policies and procedures relating to the making, handling and investigation of complaints from any person about any aspects of service, care and treatment provided in, or on behalf of a designated centre.
Action required: Ensure the nominated persons to address complaints have appropriate authority to undertake this function.
Reference: Health Act, 2007 Regulation 39: Complaints Procedures Standard 6: Complaints

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The nominated persons in our complaints policy are the Director of Nursing and Clinical Nurse Manager. Both of those individuals have the authority to address and investigate complaints comprehensively.	Completed

Outcome 14: End of life care

The provider and person in charge is failing to comply with a regulatory requirement in the following respect: Practice in relation to care at end of life needed improvement in several aspects. A resident who had recently had a hospital admission was described in hospital as "not for resuscitation". However, this status had not been reviewed on his return to the centre and it was not clear from the records maintained if this instruction still applied. The inspectors were concerned that there was a discrepancy between some medical information in relation to end of life care in the records examined which could cause confusion for staff.

There was no procedure in place to guide nursing staff in the verification of death or th procedures to follow to report death to the coroner over the weekend when the person in charge is off duty.

Action required:

Put in place written operational policies and protocols for end of life care.

Action required:

Provide appropriate care and comfort to each resident approaching end of life to address his/her physical, emotional, psychological and spiritual needs.

Action required:

Provide a procedure to guide nursing staff in the verification of death.

Reference:

Health Act, 2007
Regulation 14: End of Life Care
Standard 16: End of Life Care

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response:	
We have reviewed our End of Life Policy.	Completed
The discrepancy referred to above in respect of medical information in relation to end of life care has been investigated. The "HSE" referral form for palliative care was in fact completed by the Director of Nursing. The resident's GP in consultation with the Palliative Care Nurse decided not to refer the resident at this time.	Completed
We have developed a policy on verification of death and are in the process of implementation.	19 April 2013

Outcome 15: Food and nutrition

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

The arrangements for providing food to residents particularly residents who had specialist dietary needs outside of main meal times were not adequate. There was inadequate monitoring of weights, poor record keeping in relation to food and nutrition and the arrangements for providing food outside of main meal times were

found to be inconsistent and did not ensure that where residents needed additional foods that these were supplied in accordance with their needs.

Action required:

Provide each resident with food and drink that takes account of any special dietary requirements and is consistent with each resident's individual needs.

Action required:

Provide appropriate assistance to residents who, due to infirmity or other causes, require assistance with eating and drinking.

Action required:

Provide meals, collations and refreshments at times as may reasonably be required by residents.

Action required:

Implement a comprehensive policy and guidelines for the monitoring and documentation of residents' nutritional intake.

Reference:

Health Act, 2007
Regulation 20: Food and Nutrition
Standard 19: Meals and Mealtimes

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response:	
The weights of all residents have been reviewed and their care plans updated as necessary.	Completed
A weight audit has been carried out and sent to the Inspector.	Completed
Staff have been requested to supervise, in the evening, residents at risk of weight loss so that the residents are encouraged and assisted to eat snacks from the evening tea trolley.	Completed
In addition to light snacks the tea trolley also includes milk puddings, buns, cakes and yogurts.	Completed
Food diaries are being kept for all residents at present. In the future they will be kept for all residents determined to be at risk of weight loss.	Completed
We will ensure that all staff implement our Nutrition Policy.	Completed

The provider is failing to comply with a regulatory requirement in the following respect: A high standard of evidence-based nursing practice was not in place in aspects of ▪ monitoring of fluid and food intake as fluid balance was not evaluated on a 24 hour period ▪ weight management was not in line with evidenced based practice ▪ Pain management - assessment and monitoring the effectiveness of analgesia administered.	
Action required: Implement comprehensive guidelines for the monitoring and documentation of residents' nutritional intake.	
Action required: Provide a high standard of evidence-based nursing practice in relation to monitoring of fluid/fluid intake and weight monitoring and pain management.	
Action required: Provide each resident with food and drink in quantities adequate for their needs, which is properly prepared, cooked and served; is wholesome and nutritious; offers choice at each mealtime; is varied and takes account of any special dietary requirements; and is consistent with each resident's individual needs.	
Reference: Health Act, 2007 Regulation 6: General Welfare and Protection Regulation 20: Food and Nutrition Standard 19: Meals and Mealtimes 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: We will ensure that all staff implement our Nutrition Policy. Food diaries are being kept for all residents at present. In the future they will be kept for all residents determined to be at risk of weight loss. All residents with a MUST score of one or greater were reviewed by the Dietician on the 27 March 2013. Any recommendations	 Completed Completed Completed

which she made have been implemented and added to the residents' care plans. All at risk residents are currently being weighed weekly. Nurses have begun to monitor the effectiveness of analgesia. Staff have been requested to supervise, in the evening, residents at risk of weight loss so that the residents are encouraged and assisted to eat snacks from the evening tea trolley. In addition to light snacks the tea trolley also includes milk puddings, buns, cakes and yogurts. We provide all residents with appropriate food and drink to meet their individual needs.	 Completed Completed Completed Completed Completed

Theme: Workforce

Outcome 18: Suitable staffing

The person in charge is failing to comply with a regulatory requirement in the following respect: The allocation of nurses devoted to direct nursing care particularly over the weekend period needed review to ensure that the care needs of residents were addressed appropriately and to ensure the adequate maintenance of nursing records such as care plans.	
Action required: Ensure that the numbers and skill mix of staff are appropriate to the assessed needs of residents and the size and layout of the designated centre.	
Reference: Health Act, 2007 Regulation 16: Staffing Standard 23: Staffing Levels and Qualifications	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: We have rostered additional nursing hours on Saturdays and Sundays from 08:00 hrs to 16:00 hrs.	 Completed

Any comments the provider may wish to make[1]:

Provider's response:

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

Provider's name: Phil Darcy on behalf of Newbrook Nursing Home Ltd
Date: 15 April 2013

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