Health Information and Quality Authority
Regulation Directorate

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

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

Centre name:	Brabazon House
Centre ID:	0017
Centre address:	2 Gilford Road Sandymount Dublin 4
Telephone number:	01-2691677
Email address:	admin@brabazontrust.ie
Type of centre:	☐ **Private** ☒ **Voluntary** ☐ **Public**
Registered provider:	The Brabazon Trust Committee
Person authorised to act on behalf of the provider:	Graham Richards
Person in charge:	Susan Anderson
Date of inspection:	7 August 2013
Time inspection took place:	**Start:** 08:45 hrs **Completion:** 19:45 hrs
Lead inspector:	Deirdre Byrne
Support inspector(s):	N/A
Type of inspection	☐ **announced** ☒ **unannounced**
Number of residents on the date of inspection:	47
Number of vacancies on the date of inspection:	3

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 10 of the 18 outcomes were inspected against. The purpose of the inspection was:

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

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

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

This monitoring inspection was unannounced and took place over one day. As part of the monitoring inspection, the inspector met with residents, and staff members. The inspector observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files.

The purpose of this inspection was to examine how the provider was meeting 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.*

The inspector also followed up on areas of non compliance and actions from the previous inspection. Of the ten actions required, six had been fully completed, and four remained uncompleted. These included:

- the identification and management of risk
- the arrangements in place to manage adverse events involving residents
- updating residents care plans
- staff documentation

The inspector found staff were familiar with residents' health care needs. The residents had good access to the services of a general practitioner (GP) and allied health professionals. There was evidence of good systems in place for the management of fire safety, the protection of vulnerable adults and review of the quality and safety of care provided to residents.

However, there were areas where improvements were required. These related to medication management, risk management, care planning, the management of complaints, and staff documentation. A small number of structural deficits in relation to two multi-occupancy rooms and storage were also identified.

These are discussed in the body of the report and are included in the Action Plan at the end of the report.

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 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

The inspector was satisfied the centre was managed full-time by a suitably qualified nurse, with experience in the care of the elderly. This person will be referred to as the person in charge.

She demonstrated familiarity with the Regulations, and her requirements there in. For example, she understood the notification process, and records to be maintained for residents.

She demonstrated good leadership and organised her staff well. For example, she regularly met staff and held meetings every six weeks, a sample were read which outlined a variety of areas discussed, and the action taken to address them.

The person in charge continued her education and learning, and records confirmed she had completed a FETAC (Further Education and Training Awards Council) Level 6 certificate in gerontology, and training in dementia care.

She was supported in her role by an assistant director of nursing (ADON), who deputised in her absence.

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

The inspector was satisfied that measures were in place to protect residents from being harmed or suffering abuse.

There was a policy which provided direction to staff. It contained details of the types of abuse, and the arrangements to be followed should an investigation of suspected abuse be required.

The inspector found staff were provided with training on a regular basis, and were knowledgeable of the types of abuse and the reporting arrangements should they suspect abuse.

The person in charge was clear of the arrangements in place to carry out an investigation into an allegation of abuse.

There were safeguarding measures in place to prevent financial abuse. A sample of residents monies held in safe keeping were followed up by the inspector. The details of transactions were recorded, and the balance counted and found to be correct.

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 arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents.

Inspection findings

The inspector found systems were in place to protect and promote residents health and safety. However, they were not robust enough in relation to risk assessment, and the arrangements in place to investigate adverse events involving residents.

A safety statement dated March 2013 was seen by the inspector. An action from the previous inspection was met, as the risk management policy now identified and assessed risks occurring in the centre. However, a number of risks had not been fully identified, as follows:

- hoists were stored in a bathroom, which could lead to a risk of cross infection
- a door to a hot water treatment room on the first floor was unlocked, which may result in a resident being potentially scalded
- a door leading onto a stairwell on the first floor had had not been risk assessed to maintain residents safety
- there were bins stored in an unsecure area of the garden which could pose a risk to residents.

An action from the previous inspection in relation to the management of hot radiator surfaces had been addressed. The person in charge confirmed that all radiators would be assessed for risk of scalds, and controls measures would be implemented.

The inspector found policies and procedures on infection control were in place, which provided direction to staff. Records seen confirmed staff had completed training. However, as outlined above, there appeared to be a lack of awareness amongst staff regarding the storage of hoists and laundry bags in a communal bathroom and the risks involved with this practice. Disposable aprons, gloves, and hand gel dispensers were available throughout the centre.

The inspector found the arrangements in place to identify investigate and learn from serious incidents or adverse events involving residents were not adequate. For example, they were not covered in the risk management policy, and, they were not robust enough to manage all adverse events in involving residents specifically in relation to medication errors. This is outlined in more detail in outcome 8.

The policy contained the precautions in place to manage specified risks such as self harm and aggression and violence. This had been an action in the previous inspection and was addressed.

There was an emergency plan in place, which outlined alternative accommodation and transport arrangements if an evacuation occurred.

There was safe flooring provided. Handrails we in place in hallways and grab rails in toilets and showers. A visitors' book was used to monitor movement of people to and from the centre.

The inspector reviewed records which confirmed all staff had up-to-date training in the movement and handling of residents. Staff were clear of the best practices to follow in the movement and handling of residents.

The provider had precautions in place to manage the risk of fire. The staff had received up-to-date and regular training in fire safety. Drills were incorporated into training sessions which took place at least twice a year. The inspector found staff spoken to were knowledgeable of the procedures to follow in the event of a fire.

The inspector reviewed records which confirmed fire fighting equipment was regularly serviced. The inspector saw daily checks of fire exits and exits were unobstructed. There were fire orders prominently displayed throughout the centre. Each resident had a personal emergency evacuation plan on their file, which outlined how they would be safely evacuated in the event of an emergency.

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:

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

Inspection findings

The inspector found significant improvements were required in the management of medication practices to ensure residents' were protected.

Improvements were required in the overall response to the management of medication errors. The inspector found a high number of errors had occurred since January 2013, with seventeen errors recorded. The error details were recorded and, the person in charge described the investigation taken carried out, along with the preventative measures. However, there was no record of the investigation, the actions and preventative measures put in place for learning and to prevent future errors. These matters were discussed with the person in charge, who undertook to investigate all of the errors. Following the inspection, the person in charge confirmed additional control measures put in place to monitor, document and learn from the investigation of errors.

The inspector reviewed a sample of resident's prescription and administration sheets, and generally good practices were observed. However, an area of improvement was identified. A medication was not administered at the correct time by nursing staff, contrary to the centres policy and professional guidelines. This was an additional medication error which had not been identified by the person in charge. The inspector discussed the matter with the person in charge, who confirmed the matter would be fully investigated.

The inspector found monthly medication audits were carried out. The inspector viewed the findings of the June 2013 audit, and noted that it included actions to be taken for areas such as the storage and disposal of medications. However, the audit was not effective in picking up on all medication errors such as the one identified above.

The review of residents' medications by their GP required improvements. The inspector found inconsistent evidence of medication reviews.

The inspector found there were polices for the ordering, prescribing, storing and administration of medication. However, improvements were identified. For example, the procedures for the disposal of unused and out-of-date medications were not centre-specific. The procedure in place reflected only the practices of the pharmacy on receipt of unused or out of date medications from the centre. It did not provide guidance to staff in the centre on disposal of medications. The inspector was later shown procedures developed for these areas. An action from the previous inspection was completed, with procedures for prescribing medication now in place.

The staff informed the inspector they had completed medication management training, and records confirmed all staff attended training in February 2013.

The inspector found safe, secure storage was in place, and procedures followed for temperature controlled medications and the management of medications that required strict controls.

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 inspector was satisfied that a record of all incidents that occurred in the centre was maintained and the Chief Inspector was notified where required.

A record of each incident was maintained and filed in a designated folder. The inspector found notifiable incidents were notified to the Chief Inspector within three working days. A report was also submitted each quarter to the Chief Inspector, providing details on incidents where relevant.

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

Action(s) required from previous inspection:

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

Inspection findings

The inspector was satisfied there was a system in place to review and monitor the quality of care and experiences of the residents. However, a small area of improvement was identified.

The person in charge had developed a system of auditing a variety of clinical and non clinical areas. This had been an action from the previous inspection and was completed. The inspector was shown a schedule of audits and the designated staff responsible. Audits carried out since the previous inspection included infection control, falls, wound management, and complaints, along with a report of the findings. The person in charge explained the audits would be discussed at staff meetings, to inform staff to ensure improvements. Work was in place to commence auditing in other areas such as restraint, care planning, and nutrition when staff had completed training.

The inspector viewed an audit on the management of wound care. It outlined the total number of wounds that month, which residents had wounds, type of wound, if care plans were in place, the conclusion and recommendations. Recommendation included, implementing and maintaining care plans for residents at risk of developing pressure ulcers. The inspector read minutes of staff meetings which confirmed the reports of the audits were discussed.

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

Action(s) required from previous inspection:

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

Inspection findings

The inspector found the management of residents' health care needs were met by a high standard of nursing care. However, improvements were required in the assessments and care planning process.

The inspector reviewed a sample of care plans. Residents were regularly assessed for a range of clinical risks, with care plans generally in place when a need was identified. However, some care plans were not revised to reflect a change in a resident's current needs, and some did not contain sufficient information that reflected the practices and intervention of staff. The inspector found not all residents had an up-to-date record of consultation of their care plan.

The inspector good practices in the management of falls. However, an area of improvement was identified. While a high number of falls had occurred since the previous inspection, the person in charge promoted independence and education. She had developed an information leaflet and posters were distributed in the centre. Each resident was regularly assessed, with care plans developed. However, not all care plans reflected the most up-to-date information if a fall occurred. An action from the previous inspection was completed and neurological observations were carried

out after un-witnessed falls. A post falls assessment, and incident forms were also completed.

The inspector found good practices in the management of wounds. However, an area of improvement was identified. There was a policy to provide direction to staff. Where wounds developed, an assessment and treatment chart was completed at each dressing. However, the care plan for one resident with a wound did not clearly outline the treatment and dressing regime. The inspector found residents were regularly assessed for skin integrity and care plans put in place to prevent the development of pressure ulcers.

The inspector found good practices in the management of nutrition. The residents were regularly assessed for their nutritional needs, and monitored frequently where required. Care plans were in place and there was evidence of review by their GP, and speech and language therapy (SALT). Recommendations were reflected in the care plans. Residents were prescribed supplements where required.

There were good practices found in the management of restraint, however an area of improvement was identified. Staff said they were actively considering and using alternatives, yet there was no evidence of these considerations as they were not documented. At the time of the inspection 12 residents used bedrails, with no other forms of physical restraint used. There was a restraint policy in place which provided direction to staff. The inspector found records were maintained of discussions on the use of bedrails and evidence of regular review.

There was evidence of good practice in the management of behaviours that challenged. The inspector read the file for one resident and noted the care plan outlined the potential triggers to the behaviours, along with the suitable interventions to be followed by staff. The inspector spoke to a number of staff who were familiar with the resident and his/her needs, and described the interventions as reflected in the care plan. This had been an action from the previous inspection and was now addressed.

The inspector found residents retained the services of their own GP, and a locum service was available for out of hours and weekend calls. The residents had access to a range of allied health professionals, letters of referrals and appointments were seen on their files. The staff had a good understanding of the care needs of the residents.

The person in charge ensured that residents had opportunities to participate in activities appropriate to their interests and capacities. There was a relaxed, sociable environment in the centre. There were a variety of comfortable, nicely decorated areas where residents could relax or get involved in activities. There was an activities coordinator who facilitated a range of group and individual activities, which included exercises, arts and crafts and memory games. There were also external people who attended the centre to provide entertainment for the residents.

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:

No actions were required from the previous inspection.

Inspection findings

The inspector found parts of the building will not meet the requirements of the Standards. These issues were discussed with the person in charge during the inspection. She was aware of the requirements, and assured the inspector that a plan would be put in place to address the structural deficits in the building. There was no costed plan available. The issues identified included:

- two three-bedded rooms which will not meet the requirements of the Standards
- the general storage space was minimal and laundry equipment and hoists were stored in, communal toilets and en suite bathrooms.

The centre was pleasantly decorated, and felt warm and comfortable to be in. There were a number of sitting areas, and a smaller sitting room off the reception area, where residents could meet visitors in private. A spacious dining room was located off the kitchen.

The centre was kept to a high standard of cleanliness and maintained to a good standard of repair both internally and externally.

The residents' bedrooms were well decorated, and many residents' brought furniture from their home to decorate their rooms. Each bed was provided with a functioning call bell.

There were two sluice rooms located in the centre, which were provided with suitable sluicing facilities.

There was assistive equipment provided such as hoists and a lift. Servicing reports were read by the inspectors and confirmed they had been recently serviced and were in good working order.

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(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

The inspector found complaints were listened to and there was an effective complaints process in place however, an area of improvement was required.

The inspector saw the complaints policy which and written procedures were prominently displayed in the reception area. These included details of the complaints officer and appeals process.

A complaints log was maintained for written and verbal complaints. A sample of complaints was reviewed. However, they did not include the outcome of the investigation.

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:

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

Inspection findings

The inspector found there were adequate staffing levels and skill mix on the day of inspection. However, improvements were required regarding the documentation and information to be in place for all staff before they commenced work.

The inspector examined a number of staff files, including a sample of agency staff files. A sample of agency staff files reviewed did not meet the requirements of the Regulations. For example, one did not contain any references, and another had only two references. This was an action from the previous inspection was not completed.

The person in charge kept a record of all staff and the training they had completed. All staff had received up-to-date mandatory training. A range of training in various clinical areas had been provided since the previous inspection such as management of behaviours that challenged, management of restraint, wound and dementia care.

A number of volunteers and outsourced service providers attended the centre and provided social activities and services. There was appropriate Garda Síochána vetting in place as required by the Regulations. This had been an action from the previous inspection and was completed.

The inspector confirmed that up-to-date registration numbers were in place for nursing staff. The inspector reviewed the roster which reflected the staff on duty and, the person in charge told the inspector that staffing levels were based on the number of residents and their dependency levels. The inspector was satisfied that there was sufficient staff on duty to adequately provide care to the residents. The staff were knowledgeable about residents and the inspector saw them responding to residents' needs in an informed way.

Most care assistants had FETAC Level 5 training. Some staff had commenced training and plans were in place to ensure remaining staff completed training.

Closing the visit

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

Acknowledgements

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

Report compiled by:

Deirdre Byrne
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

9 August 2013

Health Information and Quality Authority
Regulation Directorate

Action Plan

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

Provider's response to inspection report *

Centre Name:	Brabazon House
Centre ID:	0017
Date of inspection:	7 August 2013
Date of response:	13 September 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: 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:

Some risks were not identified in parts of the centre, such as storage of equipment in bathrooms, unlocked hot water treatment room and an open stairwell.

The arrangements in place for the management of adverse events involving residents were not adequate and not outlined in the risk management policy.

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.

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

Action required: Ensure that the risk management policy covers the precautions in place to control the following specified risks: the unexplained absence of a resident; assault; accidental injury to residents or staff; aggression and violence; and self-harm.	
Reference: Health Act, 2007 Regulation 31: Risk Management Procedures Standard 26: Health and Safety Standard 29: Management Systems	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: We do have a specific storage room for our hoists. As stated on the day of the inspection one hoist was in an assisted bathroom. This issue has been addressed and all hoists are now stored in the designated room when not in use and nowhere else. Since the inspection we have addressed the issue of unlocked doors to rooms which contain hot water tanks and also an open stairwell which is not secure. Locks will be fitted to both doors and the door to the stairwell will be locked but connected to the fire alarm system. This stairwell acts as a fire escape and the locked door will release in the event of a fire. Following our inspection we have ensured that all bins are stored in one area only, that is in a designated area away from the places frequented by our residents. This area is enclosed and will be increased in area in the coming weeks, this area will be properly secured. Following our inspection we have reviewed our Risk Management Policy and are in the process of inserting details of the procedure staff should follow in the event of adverse events/serious incidents involving our residents. This procedure will be discussed at our monthly staff meetings, details of which will be minuted.	Completed. 30th September 2013. 30th September 2013. 30th September 2013.

Outcome 8: Medication management

The provider is failing to comply with a regulatory requirement in the following respect: A number of medication errors were identified which had not been investigated. A medication had been administered at times different to the prescribed time.

The procedures for out of date medications were not adequate.	
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.	
Action required: Put in place suitable arrangements and appropriate procedures and written policies in accordance with current regulations, guidelines and legislation for the handling and disposal of unused or out of date medicines and ensure staff are familiar with such procedures and policies.	
Reference: Health Act, 2007 Regulation: 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: Since our inspection a medication error investigation form has been introduced. This form will be used to review any errors, show the investigations carried out the lessons learned and the responses made. As has always been the case medication errors will be discussed at our regular staff nurse meedings. Medication training will be provided for all staff nurses and medication round audits will be carried out by management and feedback given to all staff nurses. It is our aim to eliminate medication errors and recognise that the best way of doing this is by ongoing education and reviewing. Following consultation with various general practitioners nutritional supplements have been prescribed and signed as prn with the maximun daily allowance written. This will ensure the residents precsribed these drinks/puddings can have them at an appropriate time during the day which will ensure they get their value without spoiling their appetite or if they are unable to eat a meal provided. This new practice will ensure no drug is signed at an incorrect time. On the day of our inspection our policy for the correct disposal of unused or out of date medication was rewritten to reflect the fact	Part completed. Training complete: 30/09/13 Ongoing Completed. Completed.

that it is centre specific and following best practice. This amendment was shown to the inspector at the time.	

Theme: Effective care and support

Outcome 11: Health and social care needs

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

Care plans were not consistently updated to reflect all residents' most current health care needs.

There was no up-to-date record of consultation with residents on their care plan.

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:

Revise each resident's care plan, after consultation with him/her.

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: On the day of our inspection the care plan in question was reviewed and appropriate changes were made to reflect that the resident had recently been reviewed by a Speech and Language Therapist. This update was shown to the inspector. Following our inspection we have put in place a system where the staff nurse in charge on a daily basis is responsible for ensuring any changes made in a resident's care regime are entered onto their care plan immediately. We will continue our current system of Care Plans.	Completed. Ongoing.

We are now in the process of reviewing and updating all care plans in association with our residents and or their representative. We are printing out a copy of each and they are being signed by the resident or their representative to demonstrate that they are factually correct and person-centred. This process will be repeated every three months or more often to reflect any changes in the resident's condition.	30th September 2013. Ongoing.

Outcome 12: Safe and suitable premises

The provider is failing to comply with a regulatory requirement in the following respect: A number of structural deficits in the centre do not meet the requirements of the Regulations and the Authority's Standards: ▪ there was unsuitable storage space provided for equipment ▪ there were two three-bedded rooms.	
Action required: Ensure suitable provision for storage of equipment in the designated centre.	
Action required: Provide adequate private accommodation for 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: Further in-house training has been provided for staff using equipment, specifically addressing the issue of storage. We do have storage areas for this equipment; these have been cleared and the equipment now is being stored correctly. Staff have been instructed not to leave hoists in any other location when they are not in use. All staff are aware of the location of the hoist storage room, a room on the dining room corridor. We accept that our two three-bedded rooms do not comply with Standard 25 in spite of the fact that they were constructed on best advice and at considerable cost to the Charity in 2006.	Completed. Timescale for a concrete proposal 30th November 2013.

We have now instructed our Architect, who has considerable experience in designing Nursing Homes, to prepare alternative plans and costings which will then be considered by the Charity's Trustees and advised to HIQA. We can say that the 2 three bedded rooms will cease to exist once the decision has been made and the necessary works undertaken which we anticipate will be completed by the end of March 2014. Our Architect has already visited Brabazon and has carried out a preliminary assessment of space, fire safety etc.	Completion of work expected by 31st March 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 investigation outcome was not recorded for each complaint, as required by Regulations.

Action required:

Maintain a record of all complaints detailing the investigation and outcome of the complaint and whether or not the resident was satisfied.

Reference:

Health Act, 2007
Regulation: 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: We have reviewed all our complaints and all have been updated to reflect that they have been investigated, acted on and a report is made as to the resident's satisfaction with the investigation and resolution of the issue.	Completed.

Theme: Workforce

Outcome 18: Suitable staffing

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

A number of staff files reviewed did not contain all the documentation required by Schedule 2 of the Regulations, for example a minimum of three references.

Action required: Put in place recruitment procedures to ensure no staff member is employed unless the person is fit to work at the designated centre and full and satisfactory information and documents specified in Schedule 2 of the Regulations have been obtained in respect of each person.	
Reference: Health Act, 2007 Regulation 18: Recruitment Standards 22: Recruitment	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: On the day of our inspection our inspector reviewed staff files and found some of contract workers files were incomplete. Since the inspection this issue has been addressed. In addition companies who supply us with agency/contract staff have been requested to furnish us with a letter stating that all their staff have an employment file which complies fully with regulation 18.	30th September 2013. 30th September 2013.