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:	Newbrook Nursing Home
Centre ID:	ORG-0000074
Centre address:	Ballymahon Road, Mullingar, Westmeath.
Telephone number:	044 934 2211
Email address:	donnb1@newbrooknursing.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Newbrook Nursing Home Limited
Provider Nominee:	Philip Darcy
Person in charge:	Denise Hilton
Lead inspector:	Catherine Rose Connolly Gargan
Support inspector(s):	Jillian Connolly
Type of inspection	Unannounced
Number of residents on the date of inspection:	52
Number of vacancies on the date of inspection:	0

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 judgements about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her 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
▪ to carry out thematic inspections in respect of specific outcomes
▪ 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. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.

Compliance with 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, the purpose of which was following receipt of unsolicited information. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
20 January 2014 11:00	20 January 2014 19:00

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

Outcome 01: Statement of Purpose
Outcome 02: Contract for the Provision of Services
Outcome 03: Suitable Person in Charge
Outcome 04: Records and documentation to be kept at a designated centre
Outcome 06: Safeguarding and Safety
Outcome 07: Health and Safety and Risk Management
Outcome 08: Medication Management
Outcome 11: Health and Social Care Needs
Outcome 12: Safe and Suitable Premises
Outcome 16: Residents Rights, Dignity and Consultation
Outcome 17: Residents clothing and personal property and possessions
Outcome 18: Suitable Staffing

Summary of findings from this inspection

This monitoring inspection was unannounced and was carried out in response to receipt of information by the Authority in respect to the governance arrangements in the centre. The details of the information received were discussed with the provider and the person in charge on the day of inspection who confirmed that the governance procedures were as stated in the centre's statement of purpose. The Authority found no evidence to support the content of the information received on this inspection. This inspection was the tenth inspection of the centre by the Authority.

During the inspection the inspectors also spoke with residents and staff members. Inspectors observed the delivery of care, reviewed documentation such as care plans, medical records, policies and procedures and aspects of the premises. The most recent inspection of the centre was a thematic inspection that reviewed two outcomes, food and nutrition and end of life care which took place on 11 October 2013 and previous to that inspection a monitoring inspection was carried out on 2 July 2013.

The inspectors found that progress observed by inspectors in July and October 2013 was sustained. The provider and person in charge continued to take strategic actions to improve the service and the quality of life of residents. Although not assessed on this inspection, the provider forwarded a copy of a report in respect of reviews conducted and improvements made in relation to the quality and safety of care provided to and the quality of life of residents in the centre.

There was ongoing work taking place in improving the environment to meet the needs of residents with dementia. The inspectors observed that review of the layout of the sitting room used mainly by this resident group and the internal garden required review to ensure best practice dementia care principles were in place.

Areas of non-compliant findings during this inspection included:
- While staff were knowledgeable, mandatory training of all staff was not achieved in the areas of fire safety, moving and handling and elder abuse recognition and management in line with regulatory requirements.
- Some improvements were necessary in medication management procedures to ensure all discontinued referenced signatory medical evidence.
- The provider and person in charge had procured a computerised documentation management system to enhance care assessment and planning record keeping and inspectors observed that the transition of residents' records from a paper based system to soft copy format was at an advanced stage and was supported by adequate on-going in-service assistance from the product provider. The person in charge was actively overseeing this to completion.
- Although residents had access to a variety of allied health professional services to meet their health care needs, referral to psychological support services was not of an adequate standard.

The inspectors found that while three of the eight actions required following the last monitoring inspection in July 2013 has been satisfactorily completed, five actions were partially completed. The action from the thematic inspection of October 2013 was not completed to date. Areas identified where improvements are required following this inspection include risk management policy, mandatory staff training, referrals to professionals for psychological care it and some aspects of the premises did not meet the needs of all residents with dementia care needs and at mealtimes.

The findings and required actions are outlined in the Action Plan at the end of this report. Findings from all inspections and the capacity to implement requirements will be considered and will influence judgments regarding the overall fitness of those involved in carrying on the business of the designated centre and the renewal of the registration.

Actions that were not satisfactorily completed are discussed in more detail under the relevant outcomes in this report. In addition to restating uncompleted actions from the last two inspections, further action plans have been developed from findings of new areas of non-compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) by the Authority during this inspection.

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.

Outcome 01: Statement of Purpose
There is a written statement of purpose that accurately describes the service that is 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.

Theme:
Leadership, Governance and Management

Judgement:
Compliant

Outstanding requirement(s) from previous inspection:
No actions were required from the previous inspection.

Findings:
The statement of purpose document dated October 2013 was reviewed by the inspection team and was confirmed by the provider to be the most recent version of this required documentation.

The statement of purpose accurately described the services and facilities provided to meet the diverse needs of residents accommodated in the centre. A copy of this version was forwarded to the Authority as required.

Outcome 02: Contract for the Provision of Services
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.

Theme:
Leadership, Governance and Management

Judgement:
Non Compliant - Moderate

Outstanding requirement(s) from previous inspection:
No actions were required from the previous inspection.

Findings:
An agreed contract of care was available for all residents dated and signed by the resident or their next of kin. The inspector reviewed a sample of three current resident contracts. Schedules of services which were free of charge to residents and included in the fees were detailed. The provider informed the inspector that the terms of the

services that incurred an additional charge were agreed privately between the resident or resident's family and the service provider for example, chiropody consultations, newspapers and hair dressing services. However, as these fees are not displayed within the centre or documented in the Residents' Guide, the provider agreed to review this finding to ensure residents were aware of the cost of these additional services. The provider did not require an additional charge for services provided by the centre, for example, physiotherapy or recreational activities.

The contract of care documents reviewed did not state details of the personal contribution of residents as a breakdown of their overall fee.

The provider acted as agent for three residents' social welfare pension. Although, the procedures in place in regard to this arrangement were transparent and audited, the resident's finances were managed in individual named sub accounts of the company accounts. Details of this arrangement were not included in the resident's contract of care document. The provider agreed to review this to ensure that the interests of the residents concerned were fully protected.

Outcome 03: Suitable Person in Charge
The designated centre is managed by a suitably qualified and experienced nurse with authority, accountability and responsibility for the provision of the service.

Theme:
Leadership, Governance and Management

Judgement:
Compliant

Outstanding requirement(s) from previous inspection:
No actions were required from the previous inspection.

Findings:
The person in charge is Denise Hilton. She was on duty during the inspection by the Authority. The inspectors found that the person provided leadership to the team of nurses and ancillary staff supported by evidence of strategic decision making in reference to making positive changes in how the service is provided to ensure residents' needs were met. Inspectors found her well informed regarding the areas in the premises that needed attention such as dining room space and she had overseen quality improvement works in mealtime arrangements and staff education informed by the needs of the resident population accommodated in the centre.

During the inspection she conveyed to inspectors that she knew residents and their care needs well. She was aware of residents who had specific needs and those that were particularly vulnerable to risks such as weight loss or falls. Residents told the inspector that they were familiar with the person in charge and knew her by her Christian name. The person in charge had completed a postgraduate qualification in gerontology nursing, She worked full-time and there was a suitably qualified senior nurse identified

to deputise and take charge in her absence.

Outcome 04: Records and documentation to be kept at a designated centre
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).

Theme:
Leadership, Governance and Management

Judgement:
Non Compliant - Minor

Outstanding requirement(s) from previous inspection:
No actions were required from the previous inspection.

Findings:
Some of the operating policies and procedures did not contain all required advisory information or were overdue for review, for example, self-harm and violence and aggression advisory documentation.

The duty rota did not reference all staff employed in the centre or their hours of work. A member of the catering staff and a member of the household staff were referenced in the duty rota by their first names only.

Outcome 06: Safeguarding and Safety
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.

Theme:
Safe Care and Support

Judgement:
Non Compliant - Moderate

Outstanding requirement(s) from previous inspection:
No actions were required from the previous inspection.

Findings:
There were systems in place to protect residents from being harmed or abused. Although staff spoken with were aware of the procedures that should be followed in

managing an incident of abuse and training in detecting, reporting and investigating elder abuse was organised on an ongoing basis, training records supplied to the Authority confirmed that four staff had not attended training as required. Residents told inspectors that they felt safe in the centre and that staff were responsive and gentle in their approach to meeting their needs. There was a policy and procedure in place to guide and inform staff on how to investigate and manage an incident of abuse.
The provider informed inspectors that he was undertaking a review of the procedures for entering the centre when the centre's receptionist was off duty to ensure no unauthorised access was possible.

The provider was an agent for three residents' pensions. The residents concerned had individual named accounts within the centre's business account which was not in line with recommended best practice. The residents concerned received three monthly statements of their account and transactions were reviewed by inspectors and found to be transparent and were subject to audit, While action was required to ensure these residents had individual bank accounts independent of the centre account in line with best practice, the provider informed the inspection team that he had been unsuccessful to date in achieving this and in the interim had ensured that all transactions were fully and clearly documented and audited to safeguard the interests of the residents concerned.

The centre also maintained small accounts on behalf of some residents for their personal utilisation on their day to day expenses. The inspectors reviewed the procedures in place with managing these resident accounts and found that transactions were fully transparent and correct. Signatory confirmation by the resident and the centre of transactions was available. Payments made for hairdressing and chiropody services were fully receipted. Residents with these expense accounts had full access to their money at all times.

Outcome 07: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Safe Care and Support

Judgement:
Non Compliant - Moderate

Outstanding requirement(s) from previous inspection:
No actions were required from the previous inspection.

Findings:
The inspectors found that the health and safety of residents, staff and visitors was proactively promoted and protected. A staff member was nominated as a health and safety representative for the centre. There was a risk management governance committee in place with meetings convened three monthly and chaired by the provider. The committee meetings were also attended by the person in charge, the health and

safety representative and representatives from nursing, carer, maintenance, catering and housekeeping staff. Agendas were developed for meetings which were minuted to assist with communicating proceedings with all staff. There was evidence from the meeting minutes of actions taken to mitigate risk. For example, an emergency bell was installed in the laundry to enable staff working alone in this area to seek emergency assistance if necessary.

The documentation detailing hazard identification, analysis and control procedures was found to be comprehensive; it logged all risks to residents, staff and visitors with clear control procedures stated to mitigate risks identified. There was also evidence that information gleaned from incident analysis informed the contents of the risk register. The emergency planning and evacuation policy was dated 25 November 2013 and which inspectors were told was undergoing review at the time of inspection.

The inspectors reviewed the risk management policy documentation and found that the policy advising procedures to be followed for managing potential or actual incidents of self-harm did not meet the needs of residents in the centre who were identified as being at risk. Although in practice monitoring procedures were actively in place for residents at risk of self-harm and internal efforts were made to support residents in this risk group, the policy did not inform staff on procedures for initiating appropriate timely referral of residents at risk to specialist psychological and counselling services to support them. The policy on managing violence and aggression was dated as due for review on 25 November 2011.

There were adequate precautions against the risk of fire in place. The last fire drill completed in January 2014 was reviewed by the inspectors; a comprehensive commentary record was in evidence. However, training records provided to the Authority did not reference participation of any staff at a fire drill since February 2013 and nine staff were recorded as not having attended annual fire safety training. All residents had detailed evacuation risk assessments completed that also highlighted eight residents with hearing impairment as being at additional risk. Weekly internal fire alarm checking was completed with evidence of additional quarterly inspections carried out by an external company.

Records confirmed that a missing person drill was completed on 18 September 2013 which included detailed commentary records. The records also confirmed that these drills are completed every three months to ensure all staff get an opportunity to practice this procedure to safeguard residents. Resident profiles were available if required to assist the emergency services in locating residents who were at risk of leaving the centre unaccompanied.

All residents had moving and Handling risk assessments completed. Procedures observed by inspectors were reflective of the controls stated in this documentation and were performed in line with best practice however, training records provided to the Authority referenced seven staff did not have up to date mandatory training in this area of practice. Residents had risk of fall assessments completed and those reviewed by inspectors were up to date. Care of residents who fell was detailed in a falls management policy and included review and rehabilitation by the physiotherapy service employed by the company. Review of incidents of resident falls included evidence of

physiotherapy involvement in their immediate and on-going assessment and care. Neurological monitoring of residents who had un-witnessed falls or sustained a head injury was completed.

Outcome 08: Medication Management
Each resident is protected by the designated centres policies and procedures for medication management.

Theme:
Safe Care and Support

Judgement:
Non Compliant - Minor

Outstanding requirement(s) from previous inspection:
No actions were required from the previous inspection.

Findings:
Each resident's medication was stored in a locked press in their bedrooms which inspectors were told promoted ownership of medications by residents and also reduced potential for incidence of medication error. There was arrangements in place to check that medication was prescribed appropriately, informed by blood test results for residents on anticoagulant therapy. The person in charge had measures in place to ensure the safety of medication administration including regular medication audits carried out by the clinical nurse manager. She was supported by the pharmacist who provided advice, guidance and education on evidence based medication management procedures. The training records confirmed that nursing staff had received training in medication management. The inspectors observed medication administration and found it met all professional and legislative requirements.

A medication management policy was available to inform practice in all aspects of medication management with the exception of self-administration of medications by residents. While no residents administered their own medication on the day of inspection, a policy was required to inform this practice should current or future residents wish to carry out this procedure.

Inspectors observed that improvement was required in ensuring discontinued medications were each signed and dated by the resident's GP.

Outcome 11: Health and Social Care Needs
Each residents 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 residents 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.

Theme:
Effective Care and Support

Judgement:
Non Compliant - Moderate

Outstanding requirement(s) from previous inspection:
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
The centre had recently introduced a computerised resident documentation management system and was in the process of transferring all paper based documentation records to the system. The person in charge had taken a lead role in this process to ensure there was no adverse impact on the continuity of residents care needs. There was evidence of a robust in-service education programme facilitated by the product supplier which all staff had attended. An on-going support programme was also in place by the product provider for additional support and assistance to staff during the transition phase of the project.

The opportunity to comprehensively reassess all residents' needs was taken with the transfer of their information to the new documentation management system. While the process was not completed on the day of inspection, a structured plan to achieve completion was available with each staff nurse assigned responsibility for the documentation of a designated group of residents.

A review of two residents' documentation was undertaken by the inspectors. Assessment of need was undertaken using accredited assessment tools and deficits in care identified were linked to comprehensive long and short-term care plans. Progress notes were in general satisfactory in that they were informed by the actions in the care plans. However, improvement was required in review documentation to reference what aspects of the care plan were changed and in addition record of involvement of the resident where possible or their next of kin in this process. An action from the inspection carried out by the Authority in July 2013 requiring the person in charge to facilitate all appropriate healthcare to achieve and enjoy the best possible health was completed in relation to residents with dementia care needs. However, improvement was required in relation to residents with psychological care needs. Inspectors found that while monitoring procedures were actively in place for residents at risk of self-harm and evidence of internal strategies were in place to support residents in this risk group,

referral to specialist psychological and counselling services to support them was not adequate.

Residents had satisfactory access to allied health professionals to support their needs. A physiotherapy and dietician was employed by the company who carried out resident consultations and treatment plans as part of the nursing home fee. One resident was identified as losing weight - a management plan was in place including fortification of dietary intake and weekly weight assessment. Three residents with a diagnosis of renal insufficiency were weighted weekly as part of their disease management to monitor body fluid levels. Residents also had access to occupational therapy and other services on a referral basis. There was evidence of referral and review by allied health professionals as appropriate in the residents' documentation records. For example, two residents had recently been provided with new assistive chairs to suit their needs.

Resident restraints in use were documented with concomitant risk assessments and monitoring procedures. There was evidence of good wound management. There was no evidence of skin tears on residents' skin. Two residents had pressure related skin injuries, one of which was present on one residents' admission and both were at a healing phase. Tissue viability services advice was used to inform these residents' wound care management. Pressure relieving measures were in place to prevent further pressure to vulnerable areas of these residents' skin.

Residents had opportunity to participate in recreational activities to meet their needs. Each resident had their interests assessed and a plan developed to ensure their needs were met in this area by the activity coordinator. Some residents told inspectors they enjoyed the programme on offer including the trips out on the bus. The centre had access to a sixteen-seated wheelchair accessible bus which was used for residents' outings. Residents with dementia care needs were facilitated to participate in sensory stimulation in meeting their social care needs.

Outcome 12: Safe and Suitable Premises
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.

Theme:
Effective Care and Support

Judgement:
Non Compliant - Moderate

Outstanding requirement(s) from previous inspection:
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
The interior of the building was visibly clean throughout and the areas inspected were appropriately furnished and warm. The exterior and garden areas were landscaped and contained items of with garden furniture. Many of the residents with dementia care needs were accommodated in one area of the premises. An action from the inspection by the Authority in July 2013 required the provider to review and upgrade the premises to ensure the physical design and layout of premises meets the needs of all residents but in particular meets the needs of residents with dementia care needs. Significant improvements had been made including improved signage, differently coloured bedroom doors and sections of corridor walls to assist with orientation, artwork and paintings on the walls, old-style furniture including dressers and crockery were in place. Other features that prompted reminiscence and orientation had been added such as table cloths on dining tables, bookcases with large print books and coat rails with scarves, hats and bags. This work although on-going was not fully completed in some areas which impacted on residents' quality of life on a day-to-day basis. For example, the layout of chairs arranged around the walls of the sitting room in this area was not in line with best practice dementia care principles. The internal garden required greater emphasis on sensory stimulation and review of the pathway arrangement to enhance the quality of life of this resident group. Access to the internal garden was also not directly from the sitting room but some distance from it.

There are two dining rooms located either side of the kitchen, the smaller room of the two was used as an area for residents to meet their visitors in private, have a meal with them or to rest in alone or in a group. The larger room was used by most residents at meal times. An action from a thematic inspection in October 2013 by the Authority that reviewed food and nutrition and end-of-life care required review of the space in the dining room for residents who wished to dine in this area. The inspectors reviewed the lunch-time dining experience on the day of this inspection and observed that the room was very confined and was not adequate to accommodate in comfort and safety the mobility equipment, residents and the staff required to assist residents at mealtimes. The provider and person in charge acknowledged this finding and had been working to remedy it since the last inspection. Inspectors were told that planning permission was at an advanced stage for an extension to the building that would also address adequate dining accommodation. In the interim, mealtimes are facilitated for residents by way of two sittings to meet their comfort and space requirements.

Outcome 16: Residents Rights, Dignity and Consultation
Residents are consulted with and participate in the organisation of the centre. Each residents privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence.

Theme:
Person-centred care and support

Judgement:
Compliant

Outstanding requirement(s) from previous inspection:
No actions were required from the previous inspection.

Findings:
This outcome was satisfactorily met. The inspectors found that arrangements were in place to ensure residents received dignified and respectful care and this area of resident care was subject to internal audit. Staff were observed to knock before entering residents' bedrooms and to maintain their privacy during personal care procedures by closing doors and closing bed screen curtains in twin rooms. Staff were observed engaging with residents in a respectful and patient way. Residents were facilitated and encouraged to exercise personal choices and autonomy. One resident told inspectors that she could lock her room if she wished.

The Residents' Guide informs residents that an advocate who is available to advocate on their behalf if required to assist residents with making choices and decisions.

Residents were given choices by staff through the many interactions observed by inspectors throughout the day. Staff were observed to be patient and encouraged residents' contribution. Residents were provided with access to newspapers, each resident had a television in their bedroom and access to their visitors without restrictions on visiting times. Many visitors were observed calling to see residents during the day of inspection.

A communication policy was available and informed best practice in communicating with residents who had deficits in ability in this area. Large print books were available in addition to signage and notices displayed to orientate and inform residents. Residents' care documentation reviewed evidenced access to optician and audiology services. Some residents spoken with had their own mobile telephones. A public telephone was also available.

A 'Golden Years' club met in the centre to facilitate residents to participate in the running of the centre which was minuted so residents who did not attend were kept informed. The minutes evidenced a broad discussion on a variety of topics that impacted on residents' quality of life in the centre. The provider and person in charge told inspectors that they welcomed and encouraged feedback on the service.

Outcome 17: Residents clothing and personal property and possessions
Adequate space is provided for residents personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.

Theme:
Person-centred care and support

Judgement:
Compliant

Outstanding requirement(s) from previous inspection:
No actions were required from the previous inspection.

Findings:
Residents had adequate storage for personal belongings. Clothing was labelled and was well looked after by the centre staff. Clothing was stored neatly, hanging in wardrobes and folded on shelves and in drawers as appropriate. The laundry was spacious and equipped with a hand-wash sink with sufficient worktop space for sorting clothing and segregation of infected linen. The laundry was located outside the centre which maximised the space within the centre for resident use.

A record of property and clothing was complied and kept updated by care staff as new personal items were added or discarded by residents or relatives. However, records of residents own assistive chairs were not included in their personal property list.

Residents had access to a safe lockable space in their rooms which they could have a key to if they wished in addition to a key to lock their bedroom doors.

Outcome 18: Suitable Staffing
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.

Theme:
Workforce

Judgement:
Non Compliant - Moderate

Outstanding requirement(s) from previous inspection:
No actions were required from the previous inspection.

Findings:
The inspectors found that the centre was well organised with an appropriate skill mix of staff available to meet residents care needs. The inspectors were told that staffing levels were reviewed on an on-going basis to meet the changing needs of residents and were increased where necessary to meet the needs of residents who were assessed as requiring high levels of care. Copies of staff rotas, training records and staff files as requested were reviewed to assess compliance with the legislation in each case. The duty rotas given to the inspectors for review referenced a member of the catering and a member of the housekeeping staff recorded by their first names only although the full name of all staff working in the centre is required. Not all staff working in the centre were recorded on the duty rota. The physiotherapist's or dietician's working hours in the centre were not recorded in the duty roster.

The inspectors found that the staff numbers and skill mix on the day of inspection was appropriate to meet the needs of residents accommodated in the centre. The staffing rota reviewed indicated that the person in charge position was staffed five days per week. Inspectors observed that staff grades were adequately supervised and staff nurses worked closely with care staff in care delivery procedures. Residents and their relatives spoken with spoke positively in relation to staff competence and skill in meeting their needs.

Recruitment procedures and policies were available and staff files contained the required documentation. Staff files reviewed contained all records in line with the legislative requirements.

There was an ongoing comprehensive programme of staff training on a range of healthcare topics relevant to their roles including challenging behaviour, infection prevention and control, care planning, skin care and medication management. However, not all staff had up to date mandatory training. For example, seven staff did not have up to date training in moving and handling. Nine staff did had not completed annual training in fire safety and none of the 62 staff had participated in a fire drill since February 2013. Four staff did not have up to date elder abuse recognition and management training.

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings, which highlighted both good practice and where improvements were required.

Acknowledgements

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

Report Compiled by:

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Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

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[1]

Centre name:	Newbrook Nursing Home
Centre ID:	ORG-0000074
Date of inspection:	20/01/2014
Date of response:	18/03/2014

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure Compliance with 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.

Outcome 02: Contract for the Provision of Services

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Contracts of care did not include full information on fees to be charged and the arrangements in relation to residents for whom the provider acted as an agent for collection of their social welfare pensions.

Action Required:
Under Regulation 28 (2) you are required to: Ensure each residents 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.

Please state the actions you have taken or are planning to take:
All contracts have been reviewed and contain details of the fees payable and by whom.

Where we act as agent for the residents' social welfare pension we are satisfied that we are appointed by the resident as his/her agent only where no other suitable person is

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

available. We have also notified the Inspector at the time of inspection, kept records of all incoming and outgoing payments and notified the Department of Social and Family Affairs at the time of the appointment. This is in line with Standard 9.4 (National Quality Standards for Residential Care for Older People).

We have enclosed documentation to support the above.

Fees payable by the residents to third party providers of services e.g. chiropody and hairdressing are displayed in the Centre on the residents' information board.

Proposed Timescale: 18/03/2014

Outcome 04: Records and documentation to be kept at a designated centre

Theme: Leadership, Governance and Management

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The duty rota did not reference all staff employed in the centre or their hours of work. A member of the catering staff and a member of the household staff were referenced in the duty rota by their first names only.

Action Required:
Under Regulation 24 (1) (c) you are required to: Maintain, in a safe and accessible place, appropriate weekly duty rosters covering 24 hour periods.

Please state the actions you have taken or are planning to take:
The physiotherapist's hours are now recorded on the roster. The Dietician is not an employee of the Provider as she works on a consultancy/referral basis.

The two employees whose first names only appeared on the roster now have their full names recorded.

Proposed Timescale: 18/03/2014

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some of the operating policies and procedures did not contain all required advisory information or were overdue for renewal, for example, self-harm and violence and aggression advisory documentation.

Action Required:
Under Regulation 27 (1) you are required to: Put in place all of the written and operational policies listed in Schedule 5.

Please state the actions you have taken or are planning to take:
The following policies are currently being reviewed; risk management, referrals, emergency planning & evacuation and self harm. The other policies in the Centre have been reviewed or will be reviewed in the near future.

Proposed Timescale: 30/04/2014

Outcome 06: Safeguarding and Safety

Theme: Safe Care and Support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Training records evidenced that four staff did not have up to date training in recognising and managing elder abuse.

Action Required:
Under Regulation 6 (2) (a) you are required to: Make all necessary arrangements, by training staff or by other measures, aimed at preventing residents being harmed or suffering abuse or being placed at risk of harm or abuse.

Please state the actions you have taken or are planning to take:
Of the four staff highlighted on the matrix; one had left, one is on long term sick leave for the past two years, one was the Director of Nursing (who is also the trainer and does not need to attend a separate session) and one was a new member of staff. The one staff member requiring training has now received it. The training matrix has now been updated.

The front door is now locked after 17:00 to protect our residents. The door bell must be pressed so that a staff member can admit visitors.

Proposed Timescale: 18/03/2014

Outcome 07: Health and Safety and Risk Management

Theme: Safe Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Training records provided to the Authority referenced seven staff did not have up to date mandatory moving and handling training.

Action Required:
Under Regulation 31 (4) (f) you are required to: Provide training for staff in the moving and handling of residents.

Please state the actions you have taken or are planning to take:
Of the seven staff highlighted on the matrix as not having training in manual handling; two have left, one is on long term sick leave for the past two years, one was on

maternity leave and one had training but this was not reflected on the matrix. The two staff members requiring training have now received it.

The training matrix has now been updated.

Proposed Timescale: 18/03/2014

Theme: Safe Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The risk management policy informing procedures to be followed in managing potential or actual incidents of self-harm did not meet the needs of residents who were identified as being at risk.

The policy did not inform staff on procedures for initiating appropriate timely referral of vulnerable residents to specialist psychological and counselling services.

The policy on management of violence and aggression required review.

Action Required:
Under Regulation 31 (2) (c) you are required to: 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.

Please state the actions you have taken or are planning to take:
The aggression and violence policy is currently being updated.

Proposed Timescale: 30/04/2014

Theme: Safe Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The training records provided to the Authority referenced nine staff as not having attended annual fire safety training.

Action Required:
Under Regulation 32 (1) (d) you are required to: Provide suitable training for staff in fire prevention.

Please state the actions you have taken or are planning to take:
Of the nine staff highlighted on the matrix as not having fire training; four have left and two are on long term sick leave. The three staff members requiring training have now received it. The training matrix has now been updated.

Proposed Timescale: 18/03/2014

Theme: Safe Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The last fire drill completed in January 2014 was reviewed - a comprehensive commentary record was in evidence. However, training records provided to the Authority did not reference participation of any staff at a fire drill since February 2013.

Action Required:
Under Regulation 32 (1) (e) you are required to: Ensure, by means of fire drills and fire practices at suitable intervals, that the staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire, including the procedure for saving life.

Please state the actions you have taken or are planning to take:
The fire drills were not being updated on the matrix. This was due to the fact that we were keeping a commentary of the event in the fire register. Consequently we felt that it was better to keep the record of fire drills in a separate folder. The folder for 2013 was filed away at the time of the inspection.

In 2013 there were nine fire drills carried out. The Inspector has been provided with a copy of those drills.

From January 2014 it is policy to carry out weekly fire drills. The training matrix will be updated monthly to ensure that each employee continues to receive at least two fire drills per year.

Proposed Timescale: 18/03/2014

Outcome 08: Medication Management

Theme: Safe Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all discontinued medications were signed and dated by the resident's GP. A policy was not available to inform self-administration by residents should they wish to undertake same.

Action Required:
Under Regulation 33 (1) you are required to: 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.

Please state the actions you have taken or are planning to take:
There is a policy in place on the self-administration of medication. The GPs have been requested to sign and date that medications have been discontinued.

Proposed Timescale: 18/03/2014

Outcome 11: Health and Social Care Needs

Theme: Effective Care and Support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Improvement was required in review documentation to reference what aspects of the care plan were changed and in addition a documented record of involvement by the resident where possible or their next of kin in this process was required.

Action Required:
Under Regulation 8 (2) (c) you are required to: Revise each residents care plan, after consultation with him/her.

Please state the actions you have taken or are planning to take:
Staff have been educated about referring in the progress notes to changes in the care plan.

On the Computer System there is a facility to document collaboration with family and all staff are trained to know how to do this.

Proposed Timescale: 18/03/2014

Theme: Effective Care and Support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
While monitoring procedures were actively in place for residents at risk of self-harm and evidence of internal strategies were in place to support residents in this risk group, referral to specialist psychological and counselling services to support them was not adequate.

Action Required:
Under Regulation 9 (2) (b) you are required to: Facilitate each residents access to physiotherapy, chiropody, occupational therapy, or any other services as required by each resident.

Please state the actions you have taken or are planning to take:
The self harm policy has been updated.

The resident referred to in the Report was referred to his GP who then referred him to a consultant in psychiatry of old age. The letter from the Psychiatrist has been sent to the Inspector.

We feel that all necessary steps have been taken for the resident. The resident is now interacting with the other residents.

Proposed Timescale: 18/03/2014

Outcome 12: Safe and Suitable Premises

Theme: Effective Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The layout of chairs arranged around the walls of the sitting room used by residents with dementia care needs was not in line with best practice dementia care principles. The internal garden required greater emphasis on sensory stimulation and review of the pathway arrangement to enhance the quality of life of this resident group.

Action Required:
Under Regulation 19 (1) you are required to: 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.

Please state the actions you have taken or are planning to take:
The "sunshine" sitting room used by the residents with dementia needs will be extended, subject to planning permission. This will allow the arrangement of chairs in line with nest practice dementia care principles.

The entrance to the internal garden from the Belvedere sitting room is thirteen feet from the sitting room door. Due to the physical structure of the Centre it is not possible to move the entrance closer to the sitting room.

A secure garden will be built outside the "sunshine" sitting room.

Proposed Timescale: 31/08/2014

Theme: Effective Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The dining area was very confined and was not adequate to accommodate in comfort and safety the mobility equipment, residents and the staff required to assist residents at mealtimes.

Action Required:
Under Regulation 19 (3) (a) you are required to: 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.

Please state the actions you have taken or are planning to take:
One of the dining rooms will be extended.

Proposed Timescale: 31/08/2014

Outcome 18: Suitable Staffing

Theme: Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all staff had up to date documented mandatory training recorded in the training records provided to the Authority. For example, seven staff did not have up to date training in moving and handling. Nine staff did had not completed annual training in fire safety and none of the 62 staff were recorded as having participated in a fire drill since February 2013. Four staff did not have up to date elder abuse recognition and management training.

Action Required:
Under Regulation 17 (1) you are required to: Provide staff members with access to education and training to enable them to provide care in accordance with contemporary evidence based practice.

Please state the actions you have taken or are planning to take:
Of the four staff highlighted on the matrix as not having elder abuse training; one had left, one is on long term sick leave for the past two years, one was the Director of Nursing (who is also the trainer and does not need to attend a separate session) and one was a new member of staff. The one staff member requiring training has now received it.

Of the seven staff highlighted on the matrix as not having training in manual handling; two have left, one is on long term sick leave for the past two years, one was on maternity leave and one had training but this was not reflected on the matrix. The two staff members requiring training have now received it.

The fire drills were not being updated on the matrix. This was due to the fact that we were keeping a commentary of the event in the fire register. Consequently we felt that it was better to keep the record of fire drills in a separate folder. The folder for 2013 was filed away at the time of the inspection.

In 2013 there were nine fire drills carried out. The Inspector has been provided with a copy of those drills.

From January 2014 it is policy to carry out weekly fire drills. The training matrix will be updated monthly to ensure that each employee continues to receive at least two fire drills per year.

Of the nine staff highlighted on the matrix as not having fire training; four have left and two are on long term sick leave. The three staff members requiring training have now received it. The training matrix has now been updated.

Proposed Timescale: 18/03/2014