

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Brindley Manor Private Nursing Home
Centre ID:	ORG-0000323
Centre address:	Letterkenny Road, Convoy, Donegal.
Telephone number:	074 91 47000
Email address:	brindleymanor@brindleyhealthcare.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	The Brindley Manor Federation of Nursing Homes
Provider Nominee:	Amanda Torrens
Person in charge:	Ann MacCombe and Ursula McGowan
Lead inspector:	Catherine Rose Connolly Gargan
Support inspector(s):	Geraldine Jolley
Type of inspection	Announced
Number of residents on the date of inspection:	37
Number of vacancies on the date of inspection:	6

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 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 to inform a registration decision. This monitoring inspection was announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 23 October 2013 09:00 To: 23 October 2013 18:30

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 05: Absence of the person in charge
Outcome 06: Safeguarding and Safety
Outcome 07: Health and Safety and Risk Management
Outcome 08: Medication Management
Outcome 09: 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

Summary of findings from this inspection

This inspection was announced and carried out in response to an application from the provider to renew registration of the centre. The current registration for this centre is due to expire on 26 March 2014. This was the fourth inspection of this centre undertaken by the Authority. The person in charge position was full-time by way of two nominated senior staff accepting the legal responsibilities of the position and each working in a part-time capacity to fulfil the full-time requirement. The provider and person in charge stated that they were committed to ensuring they were in substantial compliance with current legislation and that residents were safe and well cared for. They were able to provide requested information to the inspectors in a timely way and the operation of the centre were found to be well organised.

Prior to the inspection the inspectors reviewed written evidence, from a suitably qualified person confirming the building meets all the statutory requirements of the Fire and Planning Authority, with regard to the use of the building as a residential centre for older people. In addition all other documents submitted by the provider for the purposes of renewal of registration were reviewed prior to the inspection. Nine residents and four relatives completed a pre-inspection questionnaire on their experiences and satisfaction with the service provided. Overall, feedback from residents and relatives was generally complimentary with some comments on more assistance with 'walking', an option 'to go outside' the centre, a change of the breakfast menu to include a 'fry' occasionally and 'more room in the main sitting room'. As part of the inspection process, inspectors met with residents, relatives and staff members on the day of inspection. Inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files while on-site.

Although some improvements were found to be required to ensure all risks were identified and controls established, systems were in place to ensure a safe environment was provided to residents and that controls were in place to mitigate the impact of risks identified. For example, a risk management policy was available and a risk review was undertaken with monthly resident falls audits. Improvements were found to be required to ensure vulnerable residents were protected, for example, non alarmed final fire exit doors did not protect against inadvertent opening by residents who were assessed as at risk if left the centre unaccompanied and sluice rooms were not secured to prevent unauthorized access to this potentially hazardous area. At the time of this inspection there were 37 residents living in the centre with six vacant beds.

An unannounced monitoring inspection had previously been carried out by the Authority, in November 2012. An action plan detailing 13 actions over five outcomes which required review was forwarded to the provider post this inspection. These included:

- Ensuring the directory of residents contained all required information in line with current legislation.
- Review of the content of the elder abuse recognition and prevention policy.
- Review of the risk management policy to ensure identification of all risks in the centre with mitigating controls to prevent accidents to residents and others, resident falls management required review to ensure evidence based practice was in place, fire safety training and record keeping of testing of fire equipment including alarms required improvement and review of the infection control and prevention policy was required
- Medication management to ensure compliance with current legislation
- Establish a system for and produce a report on review of the quality and safety of care and quality of life of residents also produce a report on same.

The inspectors found that while seven of the actions required following the last inspection in November 2012 has been satisfactorily completed, five actions were partially completed and one action required the provider to produce a report on the findings of review of the quality and safety of the service and the quality of life for residents in the centre was not satisfactorily completed. 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 inspection, further action plans have been developed from findings of new areas of noncompliance with the legislation by the Authority during this inspection.

Areas identified where improvements are required following this inspection include review of the statement of purpose to reflect the service, contracts of care were not centre specific, insurance cover against loss of residents' personal property, filing of residents documentation in medical files, a number of policies and procedures were not adequate to advise staff including elder abuse recognition and prevention, health and safety and risk management and the medication management policy did not reflect all the practices in the centre. The menu required review to ensure residents had a choice of hot meal and were aware of the choice on offer. Staffing duty roster records required review to ensure all staff engaged in work with residents or otherwise in the centre were recorded in line with the legislation.

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.

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:

Non Compliant - Moderate

Outstanding requirement(s) from previous inspection:

No actions were required from the previous inspection.

Findings:

This outcome was not satisfactorily met. The statement of purpose had been reviewed by the provider in October 2013 and was given to the inspectors on the day of inspection as the most up to date version. The document includes the centres' aims, objectives and ethos of care. It describes the categories of care provided and level of needs that can be accommodated. The provider stated that the centre offers a day care service on occasion when required by local people and this service is referenced in the statement of purpose. However the maximum number of residents that the centre can provide day-care services for at any time was not stated.

The statement of purpose also requires revision to reflect the actual numbers of registered nurses, carers, kitchen staff and housekeeping staff. Two maintenance staff were not recorded. The provider reported that the person in charge role was filled by two members of staff who were involved in the management of the centre although with different role titles. While the Authority observed that both post-holders were engaged in the governance, operational management and administration activities in the centre on the day of inspection, the statement of purpose did not adequately describe or reflect this arrangement. The information recorded on the organisational organogram does not reference both post holders as the person in charge of the centre. For example, the assistant Director of Nursing position (reported as fulfilling the role of person in charge for 0.5% of the full-time requirement) is not represented on the centres' published organogram.

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 - Minor

Outstanding requirement(s) from previous inspection:

No actions were required from the previous inspection.

Findings:

This outcome was not satisfactorily met. All residents had been issued with a contract that described the services to be provided, the fee to be charged and any additional charges for services were clearly outlined. All residents' contracts were signed and dated. However, the contracts of care reviewed did not reference the name of the centre they were drawn up for.

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:

This outcome was satisfactorily met. The provider informed the Authority that the Person in Charge position was full-time, carried out by two people which is the Director of Nursing and the Assistant Director of Nursing. The duty rota evidenced that these two people worked on opposite days and together on one day each week which ensured there was a person in charge on duty on a full time basis. Inspectors met with both and confirmed that operationally on a day to day basis they were involved in the governance, operational management and administration activities in the centre.

However, the statement of purpose refers to the 'Director of Nursing' as the person with singular responsibility for the governance, operational management and administration activities in the centre and does not acknowledge the Assistant Director of Nursing as having equal responsibility and accountability as joint person in charge. The person in

charge is supported by a team of nursing staff, care assistants, catering, maintenance, and domestic staff.

Both persons occupying the person in charge role were assessed as appropriately qualified and experienced to be the person in charge of a designated centre at the time of registration. During the inspection they demonstrated that she had a satisfactory understanding of the legislation and standards and their responsibilities as person in charge of the centre. They both had an in-depth knowledge of the residents and their individual needs. Residents said that they knew them well and referred to them as being in charge of the centre.

The inspectors found that the Director of Nursing and the Assistant Director of Nursing provided leadership and guidance to the staff team and there were systems in place to communicate with staff daily through the handovers at shift changes and at team meetings. The inspectors were satisfied that the service was managed appropriately. The Director and Assistant Director of Nursing deputised in each other absence. There was adequate evidence that the provider is accessible and is a member of a senior management team known as the Brindley Emergency Response Team (BERT) that assists centres in the group during an emergency or untoward incident. Discussion by inspectors with staff confirmed that they were familiar with the organisational structure.

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 - Moderate

Outstanding requirement(s) from previous inspection:

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

Findings:

This outcome was not satisfactorily met. Records reviewed by inspectors on this inspection confirmed that general records as required under schedule 4 of the Regulations were maintained including accidents and incidents to residents and staff, nursing and medical records and operational policies and procedures as required by schedule 5 of the Regulations. The staff duty roster was incomplete and this finding is discussed further in Outcome 18 of this report.

Documentation referencing insurance for resident's personal possessions forwarded to the Authority as part of the required application for registration supporting documentation was not adequate. The insurance documentation provided does not reference cover against loss or damage to the property of residents with liability to any resident being a maximum of one thousand euro for any one item.

An action plan developed from findings at the last inspection of the centre on the 22 and 23 November 2012 in relation to the information recorded in the directory of residents. The directory was reviewed on this inspection and was found to meet the requirements of the legislation. Operating policies and procedures referencing health and safety in the centre in relation to hazard identification and control procedures was also found to be inadequate at the last inspection and was recorded in an action plan by the Authority for improvement. The inspectors found that while some improvements were made, not all hazards that presented risks to residents were identified, for example, final fire exit doors were not all linked into an alarm system that sounded when opened which presented a risk to residents who were vulnerable on leaving the centre unaccompanied. There was also a step down from the path to the road outside final fire exits and there was an area of roadway with an uneven surface at the back of the centre. This finding is discussed further in outcome 7.

Not all policies and procedures reviewed were centre specific, for example the communication policy did not advise on communication procedures for residents who were hard of hearing or who had difficulties with speech. The missing person policy or the emergency policy were not informative and did not adequately advise staff on procedures to take in either event. The Care of the dying policy did not provide satisfactory advice on the procedures to take if a resident wished to die in their own home although discussed to residents. This finding is discussed further in outcome 14. The elder abuse management policy did not adequately advise staff on management of all types of elder abuse. This was documented in an action plan by the Authority in the last inspection report for the centre. This finding is discussed further in Outcome 6 of this report.

The residents guide was found to contain all of the requirements of the legislation. In discussion with the provider inspectors were assured that updated copies of the most recent inspection reports and revised contract of care would be appended to the guide for informing residents and their relatives.

Staff employment records reviewed was fully compliant with the requirements of schedule 2 of the Regulations.

Overall, the records were found to be readily accessible and staff were familiar with the administrative and care record systems which were maintained electronically. Some loose leaf documentation referencing residents' medical treatments and investigations were not securely filed to ensure that no data was lost. The daily records of nursing care provided were adequate.

Outcome 05: Absence of the person in charge

The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:

Leadership, Governance and Management

Judgement:

Compliant

Outstanding requirement(s) from previous inspection:

No actions were required from the previous inspection.

Findings:

Neither of the two senior staff who fulfilled the person in charge role had not been absent from the centre for any prolonged period. The provider and both senior staff in the person in charge role were aware of the information that had to be provided to the Authority, deputising requirements and the time limits that applied if a notification for the absence of the person in charge had to be made.

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 - Minor

Outstanding requirement(s) from previous inspection:

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

Findings:

The inspectors found that staff spoken with were knowledgeable about protection of residents in the centre. They could describe examples of abuse situations and the procedures in place for the reporting and management of incidents of abuse. There was a policy in place that outlined the provider's commitment to the prevention of abuse and the indicators for the identification and reporting of an abuse situation. This was supported by a flow chart that provided a summary of the actions to take. Training records evidenced that all staff had attended training on adult protection. However, the elder abuse management policy did not provide advice to staff on the actions to take in response to an incident of sexual abuse or assault by another resident or the immediate care of residents in response to each type of abuse.

Residents interviewed during the inspection said that they felt safe, that staff were kind and respectful to them and that they could talk to carers, nurses or the management if they were worried or concerned about a problem. Residents told inspectors that staff always sought their choices in relation to all care and other interactions. Resident and relative questionnaires completed prior to this inspection and residents spoken with by inspectors on the day of inspection said they felt there were sufficient staff available and that they were satisfied with the service they received in the centre.

There were appropriate systems in place to manage residents' finances safely and securely. Any money or valuables held for safekeeping were recorded and staff were aware of the security measures in place to safeguard resident's belongings. Residents' personal property was listed, which were updated regularly.

Residents were also protected by the security systems in place which included a record of all visitors to the centre. This was available in a strategic location inside the front door and was noted to be up-to-date.

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:

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

Findings:

This outcome was not satisfactorily met. The centre had a risk management system in place which was supported by health and safety and risk management policies and procedures. All equipment used by residents was serviced on 24 September 2013 to mitigate risk of injury to residents from same. Although significantly improved from the last inspection in November 2012, hazard identification with associated controls did not document all hazards to residents in the centre. Sluice doors were not secured to mitigate risk of inadvertent entry by vulnerable residents or visitors to these potentially hazardous areas. An area of roadway at the back of the centre was uneven and was hazardous for vulnerable residents to walk on, a step down from the final fire exits at the back of the centre presented a risk of fall and non-alarmed final fire exit doors were not identified as areas of hazard to vulnerable residents in the risk management documentation. There were also steep ramps at some final fire exits which needed to be clearly identified to ensure the safety of residents and staff in the event of an evacuation of the centre being required.

While acknowledged that residents' independence was promoted, non-alarmed final fire exit doors did not adequately take the changing safety needs of some residents into account. For example fifteen residents had a documented diagnosis of progressive medical conditions which negatively impacted on their cognitive wellbeing. Inspectors were also told by staff that one vulnerable resident in the centre was at a stage of their illness where they were at risk of leaving the centre unaccompanied. While increased supervision was identified as required for this resident, not all final fire exit doors were connected to an alarm to alert staff if opened inadvertently. The policy documentation advising staff of procedures to take in the event of a vulnerable resident leaving the centre unaccompanied was not adequate as it did not comprehensively inform the steps to take in managing this emergency event to ensure the timely location and return to the centre. Resident photographs to be used to assist the emergency services in identifying and locating missing residents were in black and white format and were not of an adequate standard for this purpose. A separate hazard analysis was available for the kitchen and catering staff in accordance with environmental health legislation. The inspectors saw that areas of risk associated with care practice such as moving and handling procedures, risk of falls with associated management and the management of resident restraint including bedrails were identified with measures in place to mitigate risks. All staff had up-to-date moving and handling training and residents moving and handling requirements were individually assessed, reviewed at three month intervals or more frequently if their care needs changed.

Inspectors assessed fire safety management in the centre. Staff spoken with could describe the precautions in place against the risk of fire, including the provision of suitable fire equipment, use of equipment and where it is located. There were training records of staff participation in fire drills; however, there was no commentary record evaluating staff response available or of the content of the fire drill training. An audit of fire drill response had been completed in September 2013 but did not identify need to conduct a drill to the designated fire assembly area. Inspectors were told that fire drills focused on horizontal evacuation procedures and did not include the evacuation procedure to the fire assembly area. External directional signage was in place but required review to improve visibility and to clearly direct pedestrians to the designated fire assembly point if evacuation of the centre was required.

There was a action plan developed by the Authority from findings of the last inspection in November 2012 in relation to inadequate fire safety measures including recording of weekly fire alarm tests, responses of staff to fire alarm activation and daily checks of the fire exit doors and fire panel. Internal directional signage also required improvement. Inspectors reviewed progress with completion of this action plan and found that all actions were satisfactorily completed and embedded in practice with the exception of adequate documentation of response to weekly alarm activation and evacuation drills. Fire alarm, emergency lighting and equipment records provided evidence that required maintenance was carried out as required for 2013. Smoke detection units were fitted in all bedroom and general purpose areas. Fire escape routes and final fire exits were unobstructed.

There is an evacuation plan in place including an up to date list of residents, their moving and handling needs and staff telephone numbers. A declaration from the provider and a competent person that all the requirements of the statutory fire authority

have been complied with was forwarded to the Authority as part of the registration renewal application.

There was a record maintained of all accidents and incidents and these were of a satisfactory standard and noted to outline factual and substantiated information on the event and the actions taken by staff in response to ensure the well being of residents who fell including the maintenance of neurological observations where falls were not witnessed to promptly identify changes in the residents condition requiring intervention. Medical review was appropriately sought and completed in each case.

An action plan was developed by the Authority from findings during the last inspection of the centre in November 2012 that required review of the infection control and prevention policy document to include key public health staff contact details and maintenance of influenza vaccination details for residents and staff. Inspectors found that all residents had received seasonal influenza vaccination with the exception of those who choose not to receive it, which was respected. A staff vaccination register was in place. Inspectors reviewed the infection prevention and control policy in use to inform practices in the centre. Although informative in many areas, there was inadequate advice available relating to infection outbreak management including contact details during and outside of normal working hours, visiting protocols and arrangements to maintain contact between residents and their families in the event of visiting restrictions being required.

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 - Moderate

Outstanding requirement(s) from previous inspection:

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

Findings:

This outcome was not satisfactorily met. Failure to document residents' address or the centre address was the subject of an action plan developed by the Authority following the last inspection of the centre in November 2012. This action was found to be satisfactorily completed on this inspection. Medication management policies and procedures were reviewed by the Authority as part of this registration inspection. The centre has a medication policy and procedure in place to inform practice however, inspectors found that this documentation was not centre specific as it did not reflect all the medication arrangements and practices in the centre. Transcription of residents' medication prescriptions by means of typing was undertaken by registered nurses.

Transcribed prescriptions referenced to administer residents' medications were signed in each case by the residents' GPs as required. However, transcribed prescriptions were not signed by the nurse transcriber and by a second person who completed a 'check' procedure to ensure accuracy of the transcribed document against the original prescription as documented by each resident's GP. Inspectors also observed that medications controlled under the Misuse of Drugs Act (1977) legislation which requires documentation by a medical practitioner were transcribed by registered nurses.

Crushing of residents' medications was not consistently prescribed in line with best practice requirements and posed a risk of medication error and injury to residents involved. A 'yes' or 'No' tick box was located on the top of each prescription against 'crushed' or 'covert' administration. The inspectors observed that this practice did not restrict crushing of any of the oral medications on one resident's prescription even though some medications were not suitable for crushing for example, oxycontin preparations. A list of medications unsuitable for crushing prior to administration was not readily available for reference.

Controlled medications were secured in a locked press in a locked room. Controlled medications were dispensed on a named resident basis only in line with the legislation governing controlled medication management in private nursing homes. A controlled drug register was maintained and complete. Prescription levels stored were checked twice every 24 hours by two registered nurses to ensure balances were accurately accounted for.

While there was review of medication recorded at least every three months it was unclear from the records maintained how this was undertaken in practice. There was an audit of medication completed but the data was not analysed to identify areas of non-compliance or an action plan developed for quality improvement in non-compliant areas. There was a medication fridge in use which was operating at an appropriate temperature according to the daily temperature records recorded by nursing staff.

Outcome 09: Notification of Incidents

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

Theme:

Safe 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. All notifications had been forwarded to the Authority as required. This included pressure area problems that arose outside the centre either in hospital or at home that staff assessed on admission and treated.

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

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

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:

This outcome was not satisfactorily met and had been the subject of an action plan developed by the Authority from findings during the last inspection of the centre in November 2012. The inspectors found on this inspection that there were improvements required to systems in place to monitor and review aspects of the service and to elicit resident's experiences of the service. There was evidence that data was collated on more areas of the service. A satisfaction survey had been completed in September 2013, however the results of this survey were not available at the time of this inspection. Data was also collated on aspects housekeeping and hygiene, arrangements in place to meet residents' privacy and dignity needs, laundry services, challenging behaviour and infection control. The provider and person in charge told inspectors that they sought on-going feedback from resident meetings and daily communication with residents and their family members when visiting.

Records of incidents and accidents, a fire drill audit, an audit of resident falls, review of restraint use and complaints received and the management of medication were also completed. While there was evidence that quality improvement actions had been taken in response to some of the findings from these audits, there was inconsistent analysis of the data collated with associated development of quality improvement action plans. Therefore it was difficult to measure or evaluate quality improvement in the service in response to findings of audits or to develop a schedule to enhance the service. This information had not been formulated into a report as required by Regulation 35 to date however, the provider and person in charge said that it was their plan to complete same.

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:

Compliant

Outstanding requirement(s) from previous inspection:

No actions were required from the previous inspection.

Findings:

This outcome was satisfactorily met. There were thirty seven residents accommodated in the centre on the day of this inspection. These residents had varying assessed dependency levels and underlying medical conditions. Inspectors were told that residents with increased dementia related care needs were accommodated in another centre within the group located next door, where their needs could be met. However, the criteria for initiating transfer out of this centre to the centre next door were not clearly stated. On the day of inspection, 17 (46%) of the resident group were assessed as having maximum care needs, 10 (27%) had assessed high care needs, 9 (24%) had assessed medium and low needs and one resident was independent. 41% of the residents accommodated in the centre had some level of memory loss including dementia.

Assessment records, care plans and daily progress notes were maintained on a computerised system. The inspector found that the standard of care planning was satisfactory and that evidence based needs assessment tools informed care plans. Assessment tools were utilised to assess each resident's risk of falls and pressure related skin breakdown which informed appropriate risk mitigation actions including equipment and care regimes. Assessment was also completed to inform management problems with continence, manual handling, cognitive wellbeing, nutrition and personal care. There was good linkage between assessments of needs and care plans; however some improvement was required to ensure that daily narrative records fully evaluated care plans developed to ensure care deficits were addressed. The inspectors noted that assessments and care plans were reviewed regularly and that residents and/or their relatives had been consulted about their care and treatments and ongoing dialogue with families that kept them updated with resident's progress and treatments. These communications was also evidenced in the discussions by inspectors with residents/relatives and in pre inspection questionnaires completed.

Overall, inspectors found that residents' healthcare needs were met. Residents had access to general practitioner (GP) services, to a range of other allied health professional services and an active social care programme. The inspectors observed that residents had access to a social programme and that a variety of activities were available. The activity coordinator updated residents' care plans in relation to recreational needs and how residents participated. An inspector discussed the activity coordinator's role and work in the centre with her. She described how she has a schedule of recreational activities developed from discussions with residents and/or relatives to ascertain interests prior to residing in the centre. She also discussed how she kept the residents interests and capabilities under review and changed the recreational activity programme to suit the needs of all the residents including those who had communication or concentration problems. The activity coordinator described how her role required her to be imaginative to ensure all residents benefited for example, she was setting up a drama group to foster residents' expression and artistic interests. Recreational activities available included reminiscence, sonas therapy, an exercise programme, music and sing-along sessions. A resident under 65 years with an acquired brain injury attends a workshop programme three days each week external to the centre. There were linkages with a number of clubs and schools who visited the centre under the supervision of the activity coordinator. The centre had access to a bus which was used to transport residents on outings to local places or activities of interest. Outing destinations were decided on from feedback from residents.

Residents told inspectors that they keep up to date by reading local and national newspapers, copies of which were provided on a complimentary basis or some residents were facilitated to buy a personal copy. There was a visitor's room available where residents could meet their visitors in private if they wished. Some residents had radios in their rooms and most had television sets. Residents of differing faiths were facilitated to practice their religion with access to services on a monthly basis in the centre. Clergy from differing faiths visited the centre and could be contacted as required by residents.

The inspectors found that staff knew residents well and had a comprehensive knowledge of their care needs. Residents told inspectors in one to one conversations with them during the inspection and in pre inspection questionnaires that they valued the staff who cared for them and described areas of individual care activities that meant a lot to them including being able to get up late in the mornings and getting assistance with using the toilet during the night. Residents said that when they were up and about they could move freely around the centre and sit in the communal areas of their choice. Residents were observed to be adequately supervised by staff.

Care plans were noted to be up-to-date, reviewed within the required three months and when residents care needs changed. Residents who had mental health problems were reviewed regularly by the community psychiatric services who attended the centre routinely and on referral. Their care needs and responses to treatment were documented in care records. Care records reviewed evidenced referral of residents to allied health professional services including physiotherapy, occupational therapy, speech and language and the dietician. Tissue viability specialist advice was sought appropriately on residents' wound management. Audiology, chiropathy and optician consultations were availed of by appointment.

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:

Compliant

Outstanding requirement(s) from previous inspection:

No actions were required from the previous inspection.

Findings:

This outcome was satisfactorily met. The centre is a single storey building. The residents' accommodation is located in two suites 'Stewart' and 'Givney' consisting of 33 single and five twin bedrooms. With the exception of two single rooms that have wash hand sinks only, all others have full en-suite facilities of shower, toilet and wash hand basin for residents use. All rooms meet the minimum size requirement outlined in the National Quality Standards for Residential care Settings for older People. Residents' bedrooms had adequate furniture and storage space. Each bed space had a call bell fitted.

The inspector viewed some bedrooms, the communal areas used by residents, the sluice and laundry areas. The premises was found to be well maintained, decorated to a good standard and attractively furnished. Inspectors were told that the dining room was recently refurbished with input from residents regarding the décor. Residents were encouraged to personalise their bedrooms and many bedrooms had residents' personal photographs and ornaments displayed in addition to items of personal furniture. The centre was visibly clean throughout. There was hand hygiene gel dispenser units fitted at convenient intervals with advisory hand hygiene procedure instruction displayed. A supply of personal protective equipment was available for staff use.

Outcome 13: Complaints procedures

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.

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 complaints procedure was reviewed by inspectors and was found to be satisfactory. It reflected the management of complaints received. The procedure to make a complaint was displayed prominently in the centre, documented in the residents' guide and available in the policy format to inform staff of the procedure to be followed.

The nominated complaints officer was the director of nursing. A record of all complaints was available for inspection. There was one unclosed complaint which was nearing completion. The satisfaction of the complainant with the outcome was recorded in each case. An independent appeals system was in place.

Outcome 14: End of Life Care

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

Theme:

Person-centred care and support

Judgement:

Non Compliant - Moderate

Outstanding requirement(s) from previous inspection:

No actions were required from the previous inspection.

Findings:

Care records reviewed provided evidence that end of life wishes were discussed with residents and their families. There were no residents in receipt of end of life care on the day of inspection however inspectors were told that care plans were drawn up based on resident wishes ascertained from discussions with them. There were some records where residents and/or relatives had outlined particular wishes indicating that they did not wish to have life prolonging interventions. While these decisions had been recorded and witnessed sometimes by nurses there was a lack of information to support these decisions in medical records. This area required review to ensure that these decisions were underpinned by an evidence-based consent procedure and within a multidisciplinary framework that included the resident concerned.

Palliative care services were involved in the care of residents who were experiencing pain and a pain assessment tool was used to measure residents' pain levels as appropriate. Some staff had completed courses in end of life care which they said provided them with additional knowledge and skills to meet resident and family needs during the end of life stage of resident care. Family members were facilitated to stay with residents who were in receipt of end of life care. Beverages and food was also made available to relatives who remained with ill residents the inspectors were told. An

oratory and clergy were available to residents and their families.

Outcome 15: Food and Nutrition

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

Theme:

Person-centred care and support

Judgement:

Non Compliant - Moderate

Outstanding requirement(s) from previous inspection:

No actions were required from the previous inspection.

Findings:

The dining room was located off the foyer area of the centre making it easily accessible to all residents. Residents who did not wish to have their meals in the dining room were facilitated to dine in their bedrooms. Two sittings were arranged for mealtimes.

Residents told inspectors that they were satisfied with the food provided and that it was of a good quality. The catering service in the centre was managed by a catering manager who had catering service responsibility for a number of centres within the group. Residents knew the catering staff well and said that the chef and staff were familiar with their dietary needs. A list of residents dislikes was available in the kitchen which was consulted by staff there. All staff in the centre had completed a food hygiene course.

The menu was displayed on the outside of the dining room door and was not visible when the doors were opened. The dining room doors were ajar throughout the lunch and teatime meals. Inspectors attended one sitting of the lunch and teatime meals. Some residents were observed to be chatting with each other during their meals. There was satisfactory space between tables to enable residents with mobility equipment to move around in comfort and assistance was sensitively provided to residents who required it. An option of one main dish was available and displayed on the menu with reference to alternatives being available if desired however, no choice was offered by staff distributing the meals and residents all ate the dish on offer with the exception of one resident who ate potatoes with butter. One resident was expecting chicken and not the dish on offer. Inspectors were told by the catering manager that the menu was changed every quarter and were adapted to reflect the resident choices. Residents confirmed that they could have hot and cold drinks on request and also said that water and fruit juice was freely available and regularly offered to them outside of mealtimes.

There was a policy on the management of nutrition and this was available in the policy and procedure folder. When residents were frail or needed monitoring to ensure adequate nourishment, fluid and food records were maintained to determine the

adequacy of the diet and if specialist intervention from a dietician or speech and language therapist was required.

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 bed screen curtains in twin rooms. Staff engaged with residents in a respectful and patient way. Residents were facilitated and encouraged to exercise personal choices and autonomy supported by many examples observed by inspectors during the day of the inspections.

The provider, person in charge and staff told the inspectors how they valued resident's feedback and input into the service they provided for example, decisions on outings including to the cinema and the décor in the dining room. Residents meetings were held on a monthly basis and were well attended with evidence from the minutes of much discussion including on their experiences of the service. Although the residents guide informs residents that staff advocate on their behalf if required, an independent advocate was not available in the centre to assist residents with making choices and decisions.

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:

Non Compliant - Minor

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 adequately equipped with sufficient worktop space for sorting clothing and segregation of potentially hazardous 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 compiled when residents were admitted and kept updated by nurses and 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.

The centre kept small amounts of money in safekeeping for some residents. The inspector reviewed this procedure and found it to be satisfactory. Procedures were transparent and transactions were double signed as required. Residents had access to this money when they wished.

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 - Minor

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. There was evidence that staff had undertaken training on a

range of healthcare topics relevant to their roles.

The inspectors were provided with copies of the staff rotas, training records and staff files as requested which were reviewed to assess compliance with the legislation in each case. The duty rotas given to the inspectors for review referenced some staff 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 are recorded on the duty rota for example, the provider, the catering manager, the compliance and support person who were each working in the centre on the day of inspection. The physiotherapist's working hours in the centre were also not recorded in the duty roster. Staff files reviewed contained all records in line with the legislative requirements.

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. The person in charge was supported by an activity coordinator, administration and catering, housekeeping and maintenance staff.

Inspectors observed that staff grades were adequately supervised and staff nurses worked closely with care staff in care delivery procedures. This finding was confirmed by staff spoken with by inspectors who also said there was a good team spirit among staff of all grades. 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. There was an ongoing programme of staff training and all staff had up to date mandatory training in moving and handling, elder abuse recognition and prevention and fire safety according to the training record presented. Training had also been provided on restraint management, challenging behaviour, food hygiene, infection prevention and control, care planning and documentation, skin care and tissue viability and medication management.

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:

Catherine Rose Connolly Gargan
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Action Plan

Provider's response to inspection report¹

Centre name:	Brindley Manor Private Nursing Home
Centre ID:	ORG-0000323
Date of inspection:	23/10/2013
Date of response:	22/01/2014

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 01: Statement of Purpose

Theme: Leadership, Governance and Management

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

The statement of purpose did not contain the following required information:

- The maximum number of residents that the centre can provide day-care services for, at any time was not stated.
- The actual numbers of all staff grades employed in the centre with corresponding whole-time equivalent staffing levels.
- Clarity of the arrangements in place to meet the legislative requirements in relation to the person in charge position.

Action Required:

Under Regulation 5 (1) (c) you are required to: Compile a Statement of purpose that consists of all matters listed in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

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

Please state the actions you have taken or are planning to take:

The Statement of Purpose and Function has been revised to include the relevant information.

Proposed Timescale: 31/01/2014

Theme: Leadership, Governance and Management

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

A statement of purpose containing all the required information was not made available to the Chief Inspector

Action Required:

Under Regulation 5 (2) you are required to: Make a copy of the Statement of purpose available to the Chief Inspector.

Please state the actions you have taken or are planning to take:

The revised copy is attached and will be made available to the Chief Inspector following each review.

Proposed Timescale: 11/02/2014

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:

The residents' contracts reviewed did not contain the name of the centre the resident would receive agreed services in.

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:

Each contract now states Brindley Manor in addition to Brindley Healthcare.

Proposed Timescale: 31/01/2014

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 staff duty roster was incomplete as it did not contain names and hours worked by each member of staff in the centre.

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 duty rota will be maintained accordingly, copy attached.

Proposed Timescale: 31/01/2014

Theme: Leadership, Governance and Management

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

Some loose leaf documentation referencing residents' medical treatments and investigations were not securely filed to ensure that no data was lost.

Action Required:

Under Regulation 25 (1) (c) you are required to: Maintain, in a safe and accessible place, a medical record in respect of each resident with details of investigations made, diagnoses and treatment given, and a record of all drugs and medicines prescribed, signed and dated by a medical practitioner.

Please state the actions you have taken or are planning to take:

The system of maintaining medical notes is currently being reviewed to ensure security.

Proposed Timescale: 28/02/2014

Theme: Leadership, Governance and Management

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

Documentation referencing insurance for resident's personal possessions forwarded to the Authority as part of the required application for registration supporting documentation was not adequate. The insurance documentation provided does not reference adequate cover against loss or damage to the property of residents with liability to any resident being a maximum of one thousand euro for any one item.

Action Required:

Under Regulation 26 (2) you are required to: Put insurance cover in place against loss or damage to the property of residents including liability as specified in Regulation 26 (2).

Please state the actions you have taken or are planning to take:

Our insurance policy, which was available on the day of inspection, states that "The property belonging to residents is covered under this policy at a limit of up to E1000 for any one resident". See email attached for clarity.

Proposed Timescale: 27/01/2014

Theme: Leadership, Governance and Management

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

Not all policies and procedures listed in Schedule 5 were centre specific, for example the communication policy did not advise on communication procedures for residents who were hard of hearing or who had difficulties with speech. The missing person policy or the emergency policy were not informative and did not adequately advise staff on procedures to take in either event. The Care of the dying policy did not provide satisfactory advice on the procedures to take if a resident wished to die in their own home although discussed with residents. This finding is discussed further in outcome 14. The elder abuse management policy did not adequately advise staff on management of all types of elder abuse.

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:

Some of the policies mentioned have already been reviewed to include the details required, as outlined under outcomes 6, 7 & 14.

All schedule 5 policies are being reviewed this quarter and will be updated in line with best practice and National Guidelines.

Proposed Timescale: 31/03/2014

Outcome 06: Safeguarding and Safety

Theme: Safe Care and Support

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

The elder abuse management policy did not provide advice to staff on the actions to take in response to an incident of sexual abuse or assault by another resident or the

immediate care of residents in response to each type of abuse.

Action Required:

Under Regulation 6 (1) (b) you are required to: Put in place a policy on and procedures for the prevention, detection and response to abuse.

Please state the actions you have taken or are planning to take:

Our Elder Abuse policy was devised around the National Guidelines, however a review of policy, with specific flow charts required, has been completed.

Proposed Timescale: 31/01/2014

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:

Although the infection control and prevention policy document was informative in many areas, there was inadequate advice available relating to infection outbreak management including contact details during and outside of normal working hours, visiting protocols and arrangements to maintain contact between residents and their families in the event of visiting restrictions being required.

Action Required:

Under Regulation 30 you are required to: Put in place written operational policies and procedures relating to the health and safety, including food safety, of residents, staff and visitors.

Please state the actions you have taken or are planning to take:

The infection control policy has been reviewed to include the specifics required and is currently being implemented.

Proposed Timescale: 31/01/2014

Theme: Safe Care and Support

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

Hazard identification with associated controls did not adequately document all hazards to residents in the centre. Sluice doors were not secured to mitigate risk of inadvertent entry by vulnerable residents or visitors to these potentially hazardous areas. An area of roadway at the back of the centre was uneven and was hazardous for vulnerable residents to walk on, a step down from the final fire exits at the back of the centre presented a risk of fall and non-alarmed final fire exit doors were not identified as areas of hazard to vulnerable residents in the risk management documentation. There were also steep ramps at some final fire exits which needed to be clearly identified to ensure

the safety of residents and staff in the event of an evacuation of the centre being required.

Action Required:

Under Regulation 31 (2) (a) and (b) you are required to: 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.

Please state the actions you have taken or are planning to take:

The risks identified by inspectors on the day have been entered onto the risk register as follows:

- Sluice doors are now locked.
- Gravel area to the rear of the building which is hazardous and could pose a falls risk for residents is identified and appropriate signage put in place.
- Final, unalarmed exit doors have been entered into the Risk Register and residents risk assessed for risk of leaving the building through them.
- Ramps or steps at some final exit doors have been entered on the risk register and appropriate signage put in place.
- The ongoing process of hazard identification and control is covered in our Risk Management Policy, which is due for review this quarter.

Proposed Timescale: 31/01/2014

Theme: Safe Care and Support

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

Non-alarmed final fire exit doors did not adequately take the changing safety needs of some residents into account. The policy documentation advising staff of procedures to take in the event of a vulnerable resident leaving the centre unaccompanied was not adequate as it did not comprehensively inform the steps to take in managing this emergency event to ensure the timely location and return to the centre. Resident photographs to be used to assist the emergency services in identifying and locating missing residents were in black and white format and were not of an adequate standard for this purpose.

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 risks identified by inspectors on the day are being managed as follows:

- The risk associated with final exit doors has been identified and entered on the Risk Register.
- Residents have been assessed for risk of leaving the building through them.

- The policy on absconsion of residents has been reviewed and is currently being implemented.
- Colour photographs are in place for all residents on their missing person profiles.

Proposed Timescale: 31/01/2014

Theme: Safe Care and Support

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

There were training records of staff participation in fire drills, however, there was no commentary record evaluating staff response available or of the content of the fire drill training. An audit of fire drill response had been completed in September 2013 but did not identify need to conduct a drill to the designated fire assembly area. Inspectors were told that fire drills focused on horizontal evacuation procedures and did not include the evacuation procedure to the fire assembly area.

Action Required:

Under Regulation 32 (2) (a) you are required to: Maintain, in a safe and accessible place, a record of all fire practices which take place at the designated centre.

Please state the actions you have taken or are planning to take:

Fire drill post-mortems, detailing staff response, drill content and any outcomes requiring action, are now recorded weekly as they occur.

Our policy, training and guidance directs evacuation horizontally from compartment to compartment within the building. The design of the building giving a 2 hour protective fire break between compartments. We have been assured that within this time a fire brigade will arrive, from thereon the decision to evacuate externally will be made, directed and facilitated by the fire authority.

Following a Board of Management decision taken, we will be undertaking a simulated full evacuation of Brindley Manor.

Proposed Timescale: 31/07/2014

Theme: Safe Care and Support

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

External directional signage was in place but required review to improve visibility and to clearly direct pedestrians to the designated fire assembly point if evacuation of the centre was required.

Action Required:

Under Regulation 32 (1) (c) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires; giving warnings of fires; the evacuation of

all people in the designated centre and safe placement of residents; the maintenance of all fire equipment; reviewing fire precautions, and testing fire equipment, at suitable intervals.

Please state the actions you have taken or are planning to take:

Replacement signage to direct pedestrians to the assembly area is being procured and will be installed on delivery.

Proposed Timescale: 28/02/2014

Outcome 08: Medication Management

Theme: Safe Care and Support

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

The centre has a medication policy and procedure in place to inform practice however, inspectors found that this documentation was not centre specific as it did not reflect all the medication arrangements and practices in the centre.

Transcribed prescriptions were not signed by the nurse transcribers and by a second person who completed a 'check' procedure to ensure accuracy of the transcribed document against the original prescription as documented by each resident's GP. Inspectors also observed that medications controlled under the Misuse of Drugs Act (1977) legislation which requires documentation by a medical practitioner were transcribed by registered nurses.

Crushing of residents' medications was not consistently prescribed in line with best practice requirements and posed a risk of medication error and injury to residents involved. A list of medications unsuitable for crushing prior to administration was not readily available for reference.

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:

Medication Policy is now centre specific and reflective of all practices within the centre.

Two nurses now sign transcriptions as per policy.

Controlled drug prescriptions on the prescription sheet are now completed by the GP and this will be the practice going forward.

Medication prescribed is listed with crushed or not to be crushed written beside each medication.

There is now a list of drugs which cannot be crushed available and on display as provided by the pharmacist.

Proposed Timescale: 31/12/2013

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

Theme: Effective Care and Support

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

Records of incidents and accidents review, a fire drill audit, an audit of resident falls, review of restraint use and complaints received and the management of medication audit plus a resident satisfaction survey were completed. While there was evidence that quality improvement actions had been taken in response to some of the findings from these audits, there was inconsistent analysis of the data collated with associated development of quality improvement action plans.

Action Required:

Under Regulation 35 (1) (b) you are required to: Establish and maintain a system for improving the quality of care provided at, and the quality of life of residents in, the designated centre.

Please state the actions you have taken or are planning to take:

The system to audit, analyse and act on outcomes is in place, we are currently reviewing the areas of emphasis, with reference to HIQA's publication 'Guidance on developing Key Performance Indicators and Minimum Data Sets to Monitor Healthcare Quality'.

Proposed Timescale: 28/02/2014

Theme: Effective Care and Support

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

This information from audits and satisfaction surveys had not been formulated into a report as required by Regulation 35 to date. However, the provider and person in charge said that it was their plan to complete same.

Action Required:

Under Regulation 35 (2) you are required to: Make a report in respect of any review conducted by the registered provider for the purposes of Regulation 35(1), and make a copy of the report available to residents and, if requested, to the Chief Inspector.

Please state the actions you have taken or are planning to take:

A review of 2013 information and production of an annual report is currently being compiled.

Proposed Timescale: 28/02/2014

Outcome 15: Food and Nutrition

Theme: Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

An option of one main dish was available and displayed on the menu with reference to alternatives being available if desired however, no choice was offered by staff distributing the meals and residents all ate the dish on offer with the exception of one resident who ate potatoes with butter. One resident was expecting chicken and not the dish on offer.

Action Required:

Under Regulation 20 (2) part 1 you are required to: Provide each resident with food and drink in quantities adequate for their needs, which is properly prepared, cooked and served; is wholesome and nutritious; offers choice at each mealtime; is varied and takes account of any special dietary requirements; and is consistent with each residents individual needs.

Please state the actions you have taken or are planning to take:

The Board of Management, with the Catering Manager, are reviewing our process to ensure that each resident choice at mealtime is recorded.

Proposed Timescale: 31/03/2014

Outcome 17: Residents clothing and personal property and possessions

Theme: Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Records of residents own assistive chairs were not included in their personal property list.

Action Required:

Under Regulation 7 (2) you are required to: Maintain an up to date record of each residents personal property that is signed by the resident.

Please state the actions you have taken or are planning to take:

A record of clients own assistive chairs are now included in the property list.

Proposed Timescale: 31/12/2013

Outcome 18: Suitable Staffing

Theme: Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

The duty rotas given to the inspectors for review referenced some staff 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 are recorded on the duty rota for example, the provider, the catering manager, the compliance and support person who were each working in the centre on the day of inspection. The physiotherapist's working hours in the centre were also not recorded in the duty roster.

Action Required:

Under Regulation 16 (3) you are required to: Maintain a planned and actual staff rota, showing staff on duty at any time during the day and night.

Please state the actions you have taken or are planning to take:

The duty rota has been amended to include the, accidentally omitted, surname of the staff member in question.

Members of management will be evidenced on the rota in future.

The physiotherapist, having accepted the appointment, was entered in the Statement of Purpose and Function but had not commenced working in the centre on the day of inspection, her details are now on the duty rota.

Proposed Timescale: 11/11/2013