

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Newpark Care Centre
<b>Centre ID:</b>	OSV-0000150
<b>Centre address:</b>	Newpark, The Ward, Co. Dublin.
<b>Telephone number:</b>	01 864 3465
<b>Email address:</b>	info@newparkcc.ie
<b>Type of centre:</b>	A Nursing Home as per Health (Nursing Homes) Act 1990
<b>Registered provider:</b>	Newpark Care Centre Limited
<b>Provider Nominee:</b>	Matthew McCormack
<b>Lead inspector:</b>	Deirdre Byrne
<b>Support inspector(s):</b>	Shane Walsh
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	67
<b>Number of vacancies on the date of inspection:</b>	5

## 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.

Please note the definition of the following term used in reports: responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

**Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 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 monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

**The inspection took place over the following dates and times**

From: 10 May 2016 09:00 To: 10 May 2016 17:30

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

<b>Outcome</b>	<b>Our Judgment</b>
Outcome 02: Governance and Management	Substantially Compliant
Outcome 05: Documentation to be kept at a designated centre	Substantially Compliant
Outcome 07: Safeguarding and Safety	Compliant
Outcome 08: Health and Safety and Risk Management	Compliant
Outcome 09: Medication Management	Non Compliant - Moderate
Outcome 10: Notification of Incidents	Compliant
Outcome 11: Health and Social Care Needs	Non Compliant - Moderate
Outcome 18: Suitable Staffing	Non Compliant - Moderate

**Summary of findings from this inspection**

This was an unannounced inspection by the Health Information and Quality Authority (HIQA). The purpose of the inspection was to follow up on matters arising from a registration inspection that was carried out on 17 and 18 February 2016 and to monitor progress on the actions required.

As part of the inspection, the inspectors met with residents' and staff members, observed practices and reviewed documentation such as policies and procedures care plans, medical records and risk management processes.

Inspectors found the provider had made good progress to comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland. There was evidence of progress in many areas by the provider in implementing the required improvements identified at the previous inspection. The provider made some progress to address the nursing staff levels and an additional nurses were being recruited. There were good systems in place to review the quality and safety of care in the centre. Inspectors found effective fire safety procedures and regular drills were completed. The provider was actively implementing the National Policy "Towards A Restraint Free Environment" in the

centre. Inspectors found the healthcare needs of residents' were met to a good standard.

However, there were areas where continued improvement was identified, and these are in relation to outcomes on:

- governance
- documentation
- medication management,
- health and social care needs,
- workforce.

There were 19 actions at the previous inspection that inspectors followed up on. 13 actions were fully addressed, 3 were in progress and 3 were not completed. There were 8 actions required at this inspection. 8 were the responsibility of the provider, and 2 the responsibility of the person in charge.

The Action Plan at the end of this report identifies a number of areas where improvements are required to meet the requirement of the regulations and Standards.

**Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality Standards for Residential Care Settings for Older People in Ireland.**

***Outcome 02: Governance and Management***

***The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.***

**Theme:**

Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**

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

**Findings:**

Inspectors found the provider had made good progress to improve the governance and resources in the centre to ensure the effective delivery of care to residents'. There were revised systems in place to review the quality and safety of care provided to residents in the centre, with an area of improvement identified.

The centre is operated by New Park Care Centre Limited. The clearly defined senior management team includes the person nominated on behalf of the provider (the provider), the person in charge and two other directors of the organisation. Inspectors found the provider had improved the systems in place to ensure effective governance of the centre. The person in charge held weekly meetings with the staff where each resident who had a clinical incident was reviewed. Detailed records of the reviews were read. There was evidence where actions where agreed were followed up by the person in charge. A risk management committee met every month. The minutes of the last meeting read confirmed a range of matters were discussed. The person in charge presented a detailed report at each meeting of all incidents that had occurred in the previous month. For example, falls in the centre were reviewed in detail, and where issues in relation to them had been identified, the action to be taken to address them.

Inspectors found the provider ensured resource allocations were regularly reviewed and in line with the Statement of Purpose. Inspectors found there were sufficient resources to ensure effective delivery of care. Additional nurses had been recruited since the last inspection, with more to commence in the next few months. This is discussed in more detail in Outcome 16 (workforce).

The management systems in place to ensure the service provided is consistently and effectively monitored were reviewed. Following the previous inspection, the provider had implemented a new management audit system. The provider explained that audits were

based on the key operational policies of the service and would be completed by himself and the person in charge. It was planned to complete two audits per month. The results of each audit will be discussed at the risk management meeting. There were audits read by inspectors on restraint and nutrition. Inspectors also reviewed a recent medication audit. While the audits included recommendations to bring about improvements, these had yet to be implemented. This is discussed further in Outcome 9 (medication management).

Since the last inspection the provider had developed an annual report on the overall review of the safety and quality of care of residents' in the centre. The reported included a range of findings and actions to be brought about in the centre. The review had not been completed in consultation with residents' or their families. However, the provider assured inspectors residents' would be included in the next review of the centre.

**Judgment:**  
Substantially Compliant

***Outcome 05: Documentation to be kept at a designated centre***  
***The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 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 2013.***

**Theme:**  
Governance, Leadership and Management

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

**Findings:**  
The actions from the previous inspection in relation to policies and procedures, the directory of residents' and some residents' records had been addressed. However, there were some areas of improvement in relation to other records in the centre.

There were improved practices in the completion of records for residents' as outlined in Schedule 2, 3 and 4 of the regulations however, there inspectors found the completion and documentation of some records required improvement:

1. There was inconsistent evidence on medical records of residents' overall health status on admission to the centre.
2. There were records kept of residents' administered crushed medications without

being individually prescribed.

In addition, the documentation of fire drill records required improvement as outlined in Outcome 8 (health and safety and risk management). For example, the length of time, outcome and actions to bring about improvement were not recorded.

At the time of the inspection there were no residents' who required a record of their dietary intake. The provider introduced pictorial images of portion sizes which staff refer to when recording the meals taken by residents' who will be monitored. This will be reviewed at the next inspection.

Inspectors reviewed the policies on the management of falls, nutrition and hydration, restrictive practices and the prevention of abuse. These policies had been updated since the last inspection and guided staff practice. This is detailed under outcome 7 and 11.

The directory of residents' was reviewed and it contained the information required by the regulations For example, the time and cause of death was recorded.

**Judgment:**  
Substantially Compliant

***Outcome 07: 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. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.***

**Theme:**  
Safe care and support

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

**Findings:**  
Inspectors found the provider had put in reasonable measures to safeguard residents' and protect them from abuse. The use of restraint was used in accordance with national policy. The actions from the previous inspection had been addressed.

A policy on restrictive practices was read by inspectors. It had been updated since the last inspection and now reflected the National Policy "Towards a Restraint Free Environment". It was evident a restraint free environment was being actively promoted in the centre. For example, there was a large reduction in the number of bedrails in use in the centre. The person in charge and records read by inspectors confirmed that three residents required bedrails (on both sides) to be used. The person in charge attributed this to education with regular discussion with residents', and the risk assessment process. In addition, an information letter had been sent to the families of the

residents'.

The use of all physical restrictive practices were reviewed and monitored through regular assessment. The rationale for the use of restraint was documented on residents' files. There were care plans developed for when restrictive practices were in use. There was evidence that consent had been obtained from residents'. Consultation took place with representative where required. There was evidence that the alternatives had been considered. For example, the use of low beds, crash mats or other means were considered in the first instance.

Inspectors reviewed incident reports in relation to residents' who had responsive behaviours, and it was seen that a follow up of each incident was carried out with a risk assessment, and identification of any changes needed to reduce the possibility of it occurring again. There were detailed care plans in place to guide staff that described the behaviours, the triggers to the behaviours and the strategies to mitigate them.

Training for staff in the management of responsive behaviours was taking place. Records seen confirmed the majority of the staff had commenced an online dementia course that included a module on responsive behaviours. There were five staff who had yet to complete the training but these were to commence on the 11 May 2016.

There was a policy on the protection and prevention of abuse in place. It had been reviewed since the last inspection and reflected the Health Service Executive Safeguarding Vulnerable Persons at Risk of Abuse, National Policy & Procedures of 2014. There had been no incidents of suspected abuse in the centre that required notification to HIQA. The person in charge was familiar with the procedures to follow if an investigation was required.

Records of training were read for the protection of vulnerable adults. There were some deficits in the training provided, with three staff yet to complete refresher training. The person in charge informed HIQA these staff had read the policy and the procedures in advance of training being provided. A training date was scheduled for five staff on the 18 May 2016, which would include two new staff recently employed in the centre. Inspectors spoke with staff who knew what action to take if they witnessed, suspected or had abuse disclosed to them. They also explained what they would do if they were concerned about a colleagues behaviour.

There was a visitor's book at reception, which all visitors, staff and work persons were required to sign on arrival and exit from the centre. There was a secure entrance and exit from the centre. A receptionist was based in the centre during the day .

**Judgment:**  
Compliant

***Outcome 08: Health and Safety and Risk Management***  
***The health and safety of residents, visitors and staff is promoted and protected.***



**Theme:**

Safe care and support

**Outstanding requirement(s) from previous inspection(s):**

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

**Findings:**

The provider ensured there were measures in place to protect and promote the health and safety of residents, visitors and staff. The actions from the previous inspection were fully addressed.

Inspectors found that fire drills were now taking place in the centre. The provider had reviewed the fire safety management system since the last inspection. A fire safety consultant had revised the fire evacuation procedures and provided training on their implementation for all of the staff. Inspectors spent time discussing the new procedures with the provider, which he felt would improve the evacuation of residents', in the event of a fire, from the centre. There had been three fire drills to date. The records of these drills were read. However, the length of time, the outcome and issues that arose during the drill were not documented. This is discussed in Outcome 4 (documentation).

Inspectors found staff spoken were knowledgeable of the fire evacuation procedures and described them clearly. Staff informed inspectors there had been drills taking place to practice the new procedures also. There were fire evacuation procedures displayed throughout the centre. Service records showed that the emergency lighting and fire alarm system was serviced regularly and fire equipment was serviced annually. It was noted that the fire panels were in order and fire exits, which had weekly checks, were unobstructed.

Inspectors read the policies that governed risk management. The action from the previous inspection was addressed and the policies met the requirements of the regulations. For example, there was reference in the policy to the procedures in place for the management of the risk of abuse.

There were systems in place to manage adverse events. As reported earlier there was a risk management committee that met every month to review incidents. In addition, the person in charge prepared a detailed quarterly review of all incidents. A review of the number of falls in the centre from March to April 2016 indicated 27 falls had occurred. This was an increase from the previous two months. This was discussed with the person in charge. She had identified a correlation between the reduction in bedrails and the increase in the falls. The majority of falls were one off incidents and had not occurred since. She had introduced falls prevention training for staff and increased observation of the residents'. The person in charge said she will continue to review falls on a monthly basis and complete the roll out of training for staff.

Inspectors saw residents' were encouraged to be actively mobile and were seen being escorted around the centre. There was a physiotherapist who was based full time in the centre, and along with the provider they facilitated movement and handling training. The action from the last inspection was completed regarding training. Records were

read that confirmed all staff had now completed up-to-date training. There had been three training dates in April 2016, and more dates were planned in May 2016.

**Judgment:**

Compliant

***Outcome 09: Medication Management***

***Each resident is protected by the designated centre's policies and procedures for medication management.***

**Theme:**

Safe care and support

**Outstanding requirement(s) from previous inspection(s):**

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

**Findings:**

The inspectors found the residents' were protected by the centre's policies and procedures for medication management. However, the actions from the previous inspection were not fully completed.

The inspectors viewed completed prescription and administration records, there were some improvements in the prescription practices found:

- "as required" (PRN) medications were administered without the maximum dose prescribed,
- medications were administered crushed without being individually prescribed (see outcome 5 (documentation)).

In addition, some residents' received meals fortified with supplements however, there were inconsistent records to confirm if the supplements had been prescribed by a GP.

There was evidence of detailed and regular medication audits available. These took place on a monthly basis, and included a review of six residents' prescription and administration records. The most recent audit report read included detailed findings and recommendations from the audits. The issues identified above had also been identified in the audits. However, they had not been actioned. The person in charge explained the provider was in the process of amending the administration sheet which would address the issues.

There was a medication policy which guided practice and administration practices were observed to be of a good standard. Nursing staff were familiar with the arrangements around accepting delivery and appropriate storage requirements.

Written evidence was available that three-monthly reviews were carried out. This was an action from the previous inspection and fully addressed. The pharmacist was also

involved in medication safety and was available if required in the centre.
<b>Judgment:</b> Non Compliant - Moderate

<b><i>Outcome 10: Notification of Incidents</i></b> <b><i>A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.</i></b>
<b>Theme:</b> Safe care and support
<b>Outstanding requirement(s) from previous inspection(s):</b> The action(s) required from the previous inspection were satisfactorily implemented.
<b>Findings:</b> Inspectors found the provider maintained a record of all incidents occurring in the designated centre and notified where required to the Chief Inspector.  The person in charge ensured that where required incidents were notified to HIQA within three working days. The centre had also submitted quarterly notifications of incidents as required by the regulations. The action regarding the notification of restrictive practices in use in the centre had been fully addressed.
<b>Judgment:</b> Compliant

<b><i>Outcome 11: Health and Social Care Needs</i></b> <b><i>Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.</i></b>
<b>Theme:</b> Effective care and support
<b>Outstanding requirement(s) from previous inspection(s):</b> Some action(s) required from the previous inspection were not satisfactorily implemented.
<b>Findings:</b> Inspectors found nursing staff had a good knowledge of the residents' health-care needs, and there was evidence of good practices in the management of weight loss and

falls, however, some improvement were required in the management of residents' nutritional needs and the documentation of care plans. The actions regarding this matter from the previous inspection was partially addressed however, further progress was required.

There were improved practices in the management of residents' nutritional needs regarding weight loss. However, the use of oral supplements to fortify meals required review. Inspectors found residents at risk of weight loss were given meals fortified with supplements. This was discussed with the nursing and catering staff. There was no evidence that all of the residents receiving the meal had been prescribed the supplement. While the menu had been reviewed by a dietician, it was not evident if the fortified meal had been reviewed.

The policy on the management of nutrition and hydration had been updated since the last inspection. It now contained direction to staff on the care to be delivered. For example, if a resident loses weight, what action to take and when to make a referral to a dietician. Although it did not include information on the fortified meals as discussed above. The policy was implemented in practice in relation to the monitoring of residents' at risk of weight loss. The records were reviewed of four residents' who had lost in excess of 3kg in four months. The residents' had all been reviewed by a dietician. There were fortnightly weights were carried out as per the dieticians recommendations. There were care plans developed that incorporated the recommendations of the dietician and the regular weight monitoring. There was a small area of improvement identified. Some care plans did not indicate that that a resident had lost weight which was why they had been referred to a dietician and required close monitoring. The person in charge assured inspectors that appropriate action would be taken to update the care plans.

Inspectors found suitable practices in the management of falls. The falls policy was updated since the last inspection and provided direction to staff. It included post fall procedures to be followed. Inspectors reviewed the files of two residents' who had recently fallen. An accident/incident form was completed following each fall. There was records of neurological observations completed after the fall completed by staff who were knowledgeable of the procedures. The residents' had been assessed post fall. There were care plans for falls developed for these residents'. However, they were not consistently updated after a fall to include the interventions to be put in place to prevent falls occurring in the future or if residents' mobility needs changed.

Inspectors found each resident was comprehensively assessed on admission to the centre. There were recognised tools used to assess residents' clinical needs. It was evident that the assessments were utilised to re-assess healthcare needs on a four monthly basis. However, the completion of the malnutrition universal score tool (MUST) required improvement. The nursing staff informed inspectors they referred to a guidance document and inputted each resident's score, but there was no record of how the score was calculated. Inspectors found residents' information was documented clearly on a daily basis in their nursing notes or within the vital signs records completed on a monthly basis for example, body mass index, weight, blood pressure, temperature.

The nursing staff were familiar with the residents and spoke knowledgeably of their healthcare needs. There were care plans developed for all residents' where an assessed

healthcare need was identified. However, as outlined above the care plans for some residents' did not consistently guide the care to be delivered. For example, weight loss. Care plans were updated or reviewed four monthly or as their needs changed. However, some had not been updated following a recent fall to guide the post falls care required. This had been an action at the previous inspection and required improvement. There was evidence that the residents' and where appropriate the next of kin had been consulted in relation to the development of care plans.

Inspectors found policies and procedures were in place for the management of wound care. The staff were familiar with wound care procedures. At the time of the inspection there were two residents' with wounds in the centre.

The management of residents' with responsive behaviours is reviewed in Outcome 7.

Residents' healthcare needs were supported by good access to GP services and an out-of-hours GP service was available. The residents' had good access to a range of allied health professionals for example, psychiatry of old age, dietician, chiropody, and speech and language therapist. A full time physiotherapist was employed by the service. Letters of referrals and appointments were seen on residents' files. The recommendations of allied health professionals were incorporated into care plans.

**Judgment:**

Non Compliant - Moderate

***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. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.***

**Theme:**

Workforce

**Outstanding requirement(s) from previous inspection(s):**

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

**Findings:**

Inspectors found the staff skill mix to meet the assessed healthcare needs of residents' in the centre during the day continued to be work in progress.

The staff skill mix in the centre to ensure the assessed healthcare needs of residents' were met continued to require improvement. Following the last inspection the provider

had ceased the admission of residents' to the centre until there was an adequate skill mix of nursing staff during the day. At this inspection, a review of the planned and actual staff rota for six weeks up to the inspection was carried out. Overall, the provider ensured there were three nurses generally rostered on duty from 8am to 8pm. However, in the two weeks leading up to the inspection, the number of nurses on duty from 8am to 8pm had reduced to 2. While the deficits in the staff skill mix had occurred on some dates, there was no evidence of negative outcomes for residents' in relation to their healthcare needs and the management of medication practices. Inspectors spoke to a number of staff who said there were an adequate number of nurses in the centre. However, on the day of the inspection there were 67 residents' in the centre at the time of the inspection. Over 50% of the residents had a high to maximum dependency level, and 80% of all residents had a dementia, cognitive impairment or a psychiatric diagnosis.

The staff skill mix was discussed with the provider and person in charge. The provider explained that due to unexpected staff shortages it had resulted in the reduction in nurses to two during the day. The person in charge was present during the week which meant a third nurse was on duty but on some weekends, this reduced to two nurses. The centre currently has three whole time equivalent nursing grades vacancies. The provider had recently recruited two new nurses and three nurses were due to commence in the centre in July 2016. This was an action at the previous inspection and was still in progress.

There was evidence that staff had access to education and training as there was a training programme in place coordinated by the person in charge. There was evidence that staff had up-to-date training for all staff in the prevention of abuse and movement and handling. Where staff were new or were out-of-date, additional training dates had been scheduled for the staff to attend.

There were systems in place to supervise staff in the centre. The provider had ensured each grade of staff was supervised by their head of department. The staff reported into the senior person within their area. The person in charge had overall responsibility for the supervision of the staff in the centre. There were monthly risk management meetings that the head of department also attended.

**Judgment:**

Non Compliant - Moderate

## Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

### **Acknowledgements**

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

### ***Report Compiled by:***

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

## Health Information and Quality Authority Regulation Directorate

### Action Plan



### Provider's response to inspection report<sup>1</sup>

<b>Centre name:</b>	Newpark Care Centre
<b>Centre ID:</b>	OSV-0000150
<b>Date of inspection:</b>	10/05/2016
<b>Date of response:</b>	20/06/2016

### Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non-compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

### Outcome 02: Governance and Management

#### Theme:

Governance, Leadership and Management

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

The implementation of findings from audits requires improvement.

#### **1. Action Required:**

Under Regulation 23(c) you are required to: Put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

<sup>1</sup> 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 audit system took time to develop and ensure it was fit for purpose .Audits carried out had just been completed. The Medication audit referred to was completed on 4/5/16 with date of May 31st as completion date for recommendations/ actions. This has been achieved. Audits are an on- going process

**Proposed Timescale:** 31/05/2016

**Theme:**

Governance, Leadership and Management

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

The annual report was not completed in consultation with the residents'.

**2. Action Required:**

Under Regulation 23(e) you are required to: Prepare the review referred to in regulation 23(1)(d) in consultation with residents and their families.

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

It is recognised that there is no evidence of consultation with families with regard to annual report. This will be remedied for next report at year end 2016

**Proposed Timescale:** 31/12/2016

**Outcome 05: Documentation to be kept at a designated centre**

**Theme:**

Governance, Leadership and Management

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

Crushed medications were administered without being individually prescribed.

There was unclear information in residents' medical records of their overall health status on admission to the centre.

**3. Action Required:**

Under Regulation 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

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

Residents Kardex have been updated to enable the individual prescribing of medications for residents that require crushed medication. Any resident requiring crushed medication have each medication that can be crushed identified individually on their

medication Kardex.

All residents admitted to Newpark Care Centre have a detailed medical discharge letter and an up to date prescription from the discharging hospital. Those coming from the community are asked to bring a medical update from their own GP and an up to date prescription. This information is filed within their medical file. The GP has oversight for his entries in his medical notes, however I will discuss with the GP areas when the medical files might be improved.

**Proposed Timescale:** 17/06/2016

**Theme:**

Governance, Leadership and Management

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

The completion of fire drill records required improvement for example, the length of time, the outcomes and actions to be taken, were not documented.

**4. Action Required:**

Under Regulation 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

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

When the fire alarm is activated details of the actions and outcomes will be recorded in the fire register. This will include the length of time it took to deal with the alarm and a de-briefing to staff which will identify areas that require improvement.

These actions will be recorded in the Fire Register

**Proposed Timescale:** 31/05/2016

### **Outcome 09: Medication Management**

**Theme:**

Safe care and support

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

PRN medications were administered without the maximum dose in a 24 hours period prescribed.

Residents' were receiving oral supplements without being prescribed.

**5. Action Required:**

Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident

concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.

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

Residents kardex has been updated and this is also to include max dose for PRN medication.

As discussed at inspection and with pharmacist Oral supplements are not described as medication however the GP is happy to use Kardex to prescribe supplements for those identified residents.

Any resident in receipt of Oral supplements will have them prescribed on their medication kardex.

Going forward any resident recommended to receive oral supplements will have them written up on their medication kardex.

**Proposed Timescale: 03/06/2016**

**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:**

Care plans did not consistently guide the care to be delivered to residents'.

**6. Action Required:**

Under Regulation 05(3) you are required to: Prepare a care plan, based on the assessment referred to in Regulation 5(2), for a resident no later than 48 hours after that resident's admission to the designated centre.

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

Each nurse has been allocated a number of residents where they will take responsibility to for their care plans under the guidance of CNM and PIC. Two new staff nurses have attended a work shop on Care Planning incorporating revised National Standards for Residential Care Settings.

**Proposed Timescale: 31/07/2016**

**Theme:**

Effective care and support

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

The management of residents' nutritional needs regarding fortification of meals required improvement.

The completion of the malnutrition universal score tool for each resident requires

improvement.

**7. Action Required:**

Under Regulation 06(1) you are required to: Having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care for a resident, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais.

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

The guidance document used to calculate MUST score includes a document that calculates scores and this score is inputted to system in care plans. We are upgrading Epic system and the migration to new system has taken place 16-6-16 This updated version includes the recording of MUST score for each resident.

Dietician visit from 14th June 2016 indicated that Food first option preferably as per our policy.

The Dietician indicated that meal fortification using neutral flavour supplements was a reasonable approach to management of a resident who could not or would not be able to manage oral supplementation without support. Supplement 'shot' could also be used in food (Calogen) where prescribed. No issues arose from her review of residents.

**Proposed Timescale:** 17/06/2016

**Outcome 18: Suitable Staffing**

**Theme:**

Workforce

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

There was an inadequate staff skill mix on some days of the week to meet the assessed needs of residents'.

**8. Action Required:**

Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

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

As outlined at inspection Newpark Care Centre is experiencing the same recruitment difficulties nationally experienced.

Two new staff nurses were recruited and have taken up employment since April 2016. We have 2 nurses due to complete their adaptation in July and a further one due to complete this exam in August.

We supplement any nursing requirements with agency staff using the same personnel from same agency. In the event that there is an occasion where 2 nurses are on duty the PIC is available to support the remaining 2 staff nurses.

We are currently below capacity (64 Residents) and have commenced a process of room upgrades in the Aisling unit.

Our aim is to have our full nursing compliment restored by Aug 2016 but as already explained to inspectors this is fully dependant on co operation from state agencies over which we have no control.

**Proposed Timescale: 31/08/2016**