

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Newpark Care Centre
Centre ID:	OSV-0000150
Centre address:	Newpark, The Ward, Co. Dublin.
Telephone number:	01 864 3465
Email address:	info@newparkcc.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Newpark Care Centre Limited
Provider Nominee:	Matthew McCormack
Lead inspector:	Deirdre Byrne
Support inspector(s):	Nuala Rafferty
Type of inspection	Announced
Number of residents on the date of inspection:	69
Number of vacancies on the date of inspection:	3

About monitoring of compliance

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

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

Regulation has two aspects:

- Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of 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 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 inform a registration renewal decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
17 February 2016 09:30	17 February 2016 19:00
18 February 2016 08:00	18 February 2016 15:30

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

Outcome	Our Judgment
Outcome 01: Statement of Purpose	Compliant
Outcome 02: Governance and Management	Non Compliant - Major
Outcome 03: Information for residents	Compliant
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Substantially Compliant
Outcome 06: Absence of the Person in charge	Compliant
Outcome 07: Safeguarding and Safety	Non Compliant - Moderate
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 09: Medication Management	Non Compliant - Moderate
Outcome 10: Notification of Incidents	Non Compliant - Moderate
Outcome 11: Health and Social Care Needs	Non Compliant - Moderate
Outcome 12: Safe and Suitable Premises	Compliant
Outcome 13: Complaints procedures	Compliant
Outcome 14: End of Life Care	Compliant
Outcome 15: Food and Nutrition	Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Compliant
Outcome 17: Residents' clothing and personal property and possessions	Compliant
Outcome 18: Suitable Staffing	Non Compliant - Moderate

Summary of findings from this inspection

This report sets out the findings of a registration inspection, which took place following an application to the Health Information and Quality Authority's (the Authority) to renew registration. As part of the inspection, the inspectors met with residents, relatives, and staff members. Inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and

procedures and staff files. In addition, questionnaires submitted by residents and relatives prior to the inspection were read.

Inspectors found significant improvements were required in order 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. A robust action plan response will need to be submitted before a recommendation for registration renewal can be made.

There was a clearly defined management structure in place however, the governance arrangements were not robust. There was evidence of poor clinical governance and leadership in relation to the staffing skill mix in the centre and practice in the management of residents nutritional needs, the prevention of falls, the use of restrictive practice and care planning. There were deficits in the provision of up-to-date mandatory training in the prevention of abuse and movement and handling of residents. The system of monitoring the quality and safety of care of residents' and aspects of fire safety managements also required improvement.

While the person in charge and person nominated on behalf of provider (the provider) were aware of their statutory obligations, their knowledge of their responsibilities within the Regulations required improvement. This was discussed with the provider and person in charge during the inspection, who assured inspectors appropriate action would be taken to address all issues identified by inspectors. Following the inspection the provider submitted an action plan that would satisfactorily address the deficits identified. The action plan is referenced in the report also.

There were good practices in the interactions and care practices observed by staff, who were knowledgeable of the resident social and health care needs. The centre was pleasantly decorated and furnished and maintained to a good standard of cleanliness and repair. A number of internal courtyards were available to residents to take walks and sit in.

The religious and civil rights of residents were respected, and systems were in place to ensure residents were regularly consulted in the operation of the centre. Inspectors found there was plenty of interesting things to do during the day, and residents could receive visitors at any time in a number of communal and private areas around the centre.

There were safeguarding arrangements in place to ensure residents were protected. There was a range of choice of meals at mealtime, and residents who required support were discreetly supported by staff.

Inspectors found the two actions from the thematic nutrition and end-of-life inspection in August 2014 had been addressed.

The actions required from this inspection are detailed in the report and included in the Action Plan at the end of the report.

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 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:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

Inspectors were satisfied there was a statement of purpose that met the requirements of schedule 1 and regulation 3 of the Regulations. It accurately described the services and facilities, the management structure, staffing levels and the way in which care was to be provided to residents.

Judgment:

Compliant

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):

No actions were required from the previous inspection.

Findings:

Inspectors found there was a clearly defined management structure however, there was insufficient governance and resources to ensure the effective delivery of care to residents in the centre. Furthermore, systems in place to review the quality and safety of care provided to residents in the centre required improvement.

The centre is operated by New Park Care Centre Limited. There was a clearly defined senior management team which included the provider, the person in charge and two other directors of the organisation. The person in charge reported to the provider who was also based full time in the centre. There were risk management meetings held that provider and person in charge attended. However, inspectors found that the governance and management in place did not provide an adequate level of supervision of care and practice in order for the centre to be in compliance with the Regulations as supported in findings of this inspection in Outcomes 7 (health and safety), 9 (medication management), 11 (health and social care needs) and 18 (workforce). As reported earlier, the provider submitted an action plan after the inspection that outlined the improvements they would bring about to come into compliance.

There were some systems in place to ensure the service provided to residents were effectively monitored however, these required improvement. Inspectors read audits on end-of-life survey, a pharmacy medication audit, dietician review, a quarterly analysis of incidents. However, the audits did not include any actions or recommendations, improvements or learning, and some were not dated. In addition, apart from the quarterly incident audit, no other clinical audits were completed of care practices in the centre, therefore it could not be ascertained if any improvements or learning were required in these areas.

The provider had not developed an annual report on the overall review of the safety and quality of care of residents as required by the Regulations.

Judgment:
Non Compliant - Major

Outcome 03: Information for residents
A guide in respect of the centre is available to residents. 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:
Governance, Leadership and Management

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

Findings:
A guide to the centre was available to residents and a contract of care was agreed with each resident on their admission to the centre.

There was evidence a written contract of care was agreed with residents' on their admission to the centre. A sample of contracts was reviewed and they set out the services to be provided and the fees to be charged. Where services incurred an additional fee, these charges were included in the contract.

The residents guide to the centre was reviewed and met the requirements of the Regulations. It was provided to each resident and a copy was also available in each residents' bedroom.

Judgment:
Compliant

Outcome 04: Suitable Person in Charge

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

Theme:
Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

Inspectors were satisfied that the centre was managed full time by a registered nurse with experience in care of the elderly. Overall, this outcome is compliant however, where improvements were identified, they are actioned under the outcomes referred to below.

The centre is managed by a suitably qualified and experienced manager. Inspectors found there were some gaps in the manager's knowledge of the relevant legislation and her responsibilities therein, as evidenced and reported on in the following areas: restrictive practices (as discussed in outcome 7), aspects of health care needs (outcome 11), staff training and provision of an adequate staff skill mix (outcome 18). These matters were discussed with the person in charge and the provider during and following the inspection, who acknowledged this and assured inspectors improvements would be carried out.

The person in charge was knowledgeable of the residents and their health and social care needs. It was evident she very familiar with the residents, and was observed stopping to spend time and talk with residents. The person in charge had a gerontology qualification. She continued her own professional development, through attendance at various training days, seminars and talks.

She was supported in her role by a clinical nurse manager (CNM), who deputised in her absence. This person was met and interviewed during the inspection also. Although relatively new to the role, the CNM was familiar with the residents and their health and social care needs.

Judgment:
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):

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

Findings:

Inspectors found most of the documents required to be maintained in the centre as outlined in Schedules 2, 3 and 4 of the Regulations were maintained in a manner to ensure completeness, accuracy and ease of retrieval. However, improvements were required in relation to policies, medical records and the directory of residents.

An area of improvement was identified in the completion of some records for residents as per Schedule 3 of the Regulations:

- there was no indication of the overall health status of residents on residents on their admission in their medical records.

In addition, there were gaps in other records required to be maintained as per Schedule 4 of the Regulations:

- the documentation of residents dietary intake was inadequate and would not guide care.

There were policies and procedures in place as required by Schedule 5 of the Regulations. Inspectors found most policies were up-to-date. However, the policies on the management of falls, nutrition and hydration, restrictive practices and the prevention of abuse were not comprehensive enough to guide practice. This is detailed under outcome 7 and 11.

There was a hard copy directory of residents seen by inspectors. However, not all information required by the Regulations was maintained. For example, the time and cause of death of residents were not recorded. Inspectors discussed this with management, who assured them they were recorded elsewhere, and in future all residents' information would be captured in the directory.

Judgment:

Substantially Compliant

Outcome 06: 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:
Governance, Leadership and Management

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

Findings:
Inspectors were satisfied the provider had adequate arrangements in place should the person in charge take leave requiring notification to the Chief Inspector.

There were formal measures in place in the event of any such absence. The CNM deputised for the person in charge in her absence.

Judgment:
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 systems were in place to promote the safeguarding of residents and protect them from the risk of abuse required improvement. Furthermore, additional improvements were required around the use of restrictive procedures and the management of behaviours that challenge.

Inspectors found the management of restrictive practices in the centre required improvement. The provider had not notified the Authority of restrictive practices in use in the centre as required by the Regulations. This is further discussed in Outcome 9 (notifications). A policy was in place however, it was not comprehensive enough to guide staff practice. For example, it did not make reference or incorporate the principals

of the National Policy "Towards a Restraint Free Environment".

Some restrictive practices were not in line with the national policy. Inspectors found the use of restrictive practices included bedrails, tilted chairs and access to personal monies. There were records of bedrails assessments however, there was inconsistent evidence of the alternatives considered. In addition, there was unclear assessments, review or evidence of consultation with a resident who had restrictions on access to their personal monies. The determination of capacity for residents was also unclear. For example, one resident was documented as having capacity to have bedrails in use, but other records read for the same resident stated they had no capacity to make financial decisions. The resident was last reviewed by a geriatrician in June 2015 and the last documented MMSE (mini mental state examination) was in May 2015. These matters were discussed in detail with the provider and the person in charge.

Although inspectors saw staff dealing with all residents' in a calm and dignified manner, where there were incidents of responsive behaviours read, gaps were noted in the documentation. For example, inspectors reviewed a sample of care plans and saw that specific triggers or possible suitable interventions were not identified (see outcome 11 for more details). There was evidence of specialist input when required.

There was an elder abuse policy in place dated 2013. However, it did not include reference to the Health Service Executive Safeguarding Vulnerable Persons at Risk of Abuse, National Policy & Procedures of 2014. Inspectors spoke with staff who knew what action to take if they witnessed, suspected or had abuse disclosed to them. They also clearly explained what they would do if they were concerned about a colleagues behaviour. However, one staff member was not so clear, upon discussing this with the person in charge, she assured inspectors that appropriate action was would be taken.

Records that were reviewed confirmed that staff had received training on recognising and responding to elder abuse. However, records read indicated some staff had not completed training since 2012, and there was no record of training for three staff. The person in charge facilitated the training in the centre. These matters were brought to the attention of the person in charge during the inspection, who advised inspectors that additional training dates would be scheduled.

There had been no suspicions or allegations of abuse in the centre since the last inspection. The person in charge was aware of the requirement to complete an investigation and was familiar with the procedures to be followed.

Judgment:

Non Compliant - Moderate

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):

No actions were required from the previous inspection.

Findings:

Although there were measures in place to protect and promote the health and safety of residents, visitors and staff, there was no completion of fire drills in the centre, and an aspect of risk management required review.

Inspectors were concerned that fire drills had not been carried out in the centre. Therefore, there was no system to regularly practice the fire evacuation procedure and make any improvements if required. This matter was discussed with the provider. He assured inspectors that the matter would be addressed. Inspectors were also informed that a full review of fire procedures was to take place by a fire safety consultant on the 24 February 2016. The provider assured inspectors that fire drills would be incorporated into the review of the procedures.

Fire procedures were 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 training records which confirmed that all staff had attended training within the last year. Staff spoken with were knowledgeable of the procedure to follow in the event of a fire.

Inspectors read policies that governed risk management and found they met the requirements of the Regulations, with an area of improvement. For example, there was no reference in the policy to the procedures in place for the management of the risk of abuse. A risk register was read and it contained risk assessments for a range of hazards identified along with control measures to manage them.

There were systems in place to manage adverse events. A risk management committee met monthly, and minutes of meetings were read. A range of issues including incidents and falls were discussed. A detailed quarterly review of all incidents was carried out by the person in charge. A high number of un-witnessed falls had been identified. Between 15 and 19 of these incidents involved residents falling in their bedroom. However, as reported in Outcome 2 (governance) the review did not include what actions were to be taken to bring about reductions in this number.

Inspectors saw residents were encouraged to be actively mobile and were seen being escorted around the centre. A physiotherapist was based full time in the centre. The provider and physiotherapist were movement and handling instructors. Records were read and confirmed most staff had completed up-to-date training, with some gaps were identified. For example, three staff had not completed training since 2012. The provider confirmed two training sessions were to be scheduled this year. There was safe floor covering and handrails throughout the centre which was over one floor.

An emergency plan that guided practice was in place, which identified what to do in the event of fire, flood, loss of power or heat and any other possible emergency.

Inspectors found measures and policies were in place to control and prevent infection. Staff appeared to follow best practice. There was access to supplies of gloves and disposable aprons and staff were observed using the alcohol hand gels which were available throughout the centre.

Judgment:

Non Compliant - Moderate

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):

No actions were required from the previous inspection.

Findings:

Each resident was not protected by the designated centre's policies and procedures for medication management.

Inspectors reviewed the prescription sheets for a sample of residents with a nurse. There were some improvements required:

- some residents who required medication on an as and when required (PRN) basis-the maximum dose to be given in 24 hours was not consistently recorded.

- there were a number of errors noted in relation to medications not administered in accordance with residents prescriptions for example: diuretic medication, eye gel and anti inflammatory gel. These had not been identified by staff. This was brought to the attention of the nurse and person in charge.

-a number of residents required their medication to be crushed. In some cases the medication was not individually prescribed as requiring crushing. See outcome 5 (documentation).

There were records that some residents' medications were reviewed regularly on three monthly basis. A multi-disciplinary team consisting of the general practitioner and pharmacist had also completed a review of residents' medications in May 2015. However, there was no documented evidence the residents medications had been reviewed since.

There was a system in place for monitoring safe medication practices. Inspectors read

audits carried out by the pharmacy. The audit included recommendations and evidence of action taken. However, issues identified above were not picked up in the audit process.

Medications that required strict control measures (MDAs) were carefully managed and kept in a secure cabinet in keeping with professional guidelines. Nurses kept a register of MDAs. The stock balance was checked and signed by two nurses at the change of each shift. Inspectors checked a sample of balances and found them to be correct

A secure fridge was provided for medications that required specific temperature control. Inspectors noted that the temperatures were within acceptable limits at the time of inspection. There were appropriate procedures for the handling and disposal of unused and out-of-date medicines.

Judgment:

Non Compliant - Moderate

Outcome 10: 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

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

No actions were required from the previous inspection.

Findings:

The provider maintained a record of all incidents occurring in the designated centre and made notifications within three days to the Authority of incidents set out in Schedule 4 of the Regulations, with an area of improvement identified.

As reported in Outcome 7 (safeguarding), there are restrictive practices in use in the centre. However, these practices had not been notified to the Authority on a quarterly basis as required by the Regulations. This was discussed with the person in charge and the provider during the inspection.

Judgment:

Non Compliant - Moderate

Outcome 11: Health and Social Care Needs

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.

Theme:

Effective care and support

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

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

Findings:

Inspectors found improvements were required to ensure residents health care needs was maintained by a high standard of nursing care, with improvements also required in relation to access to allied health professionals and the care planning process.

Inspectors found weight loss in the centre was not appropriately monitored and addressed. There was a policy on the management of nutrition however; it did not fully guide staff practice. For example, when to refer residents at risk of malnutrition or weight loss to allied health professionals such as dietician services. Inspectors reviewed the files of four residents who had experienced between 5 and 10% weight loss in a six month period. While the residents had been seen by the GP, they were not referred to a dietician. Furthermore, the monitoring of the residents nutritional intake was inadequate. Records read were unclear and did not demonstrate how much food the residents consumed during the day. This is also discussed under Outcome 5 (documentation).

Following the inspection the person in charge submitted an action plan that provided assurances that each resident had been referred to the dietician. The dietician review was confirmed for the 1 March 2016.

Inspectors found the management of falls required improvement. Inspectors found where residents fell, they were assessed by a physiotherapist and a falls assessments carried out. The majority of falls in the centre were un-witnessed. However, neurological observation was not completed or rationale not to complete was not reported. The care plan for resident's were not consistently updated post fall and did not contain detailed information on how to prevent similar falls recurring. There was a policy in place. However, it did not fully guide practice in the post falls procedures to be followed by staff. This was discussed with the person in charge who undertook to address the matter the day of the inspection. The policy on the management of falls will need to be submitted to the Authority on its completion.

An electronic system of care planning was used and a sample of residents' files was reviewed. The residents clinical needs were assessed using recognised tools. There was evidence of consultation with residents or their loved ones. However, assessments and care plans were not reviewed on a four monthly basis as required by the Regulations. For example, some care plans had only been reviewed twice in 2015. Where reviews took place they were not consistently meaningful for example, some included a one line update.

Some of the care plans reviewed did not consistently guide practice, for example, the management of diabetes, weight loss, behaviours that challenge and the prevention of

falls. Some care plans were not updated after a change in condition, for example, after a fall. There was no system of auditing or reviewing the care plan process to identify what gaps existed in the care planning process. These matters were brought to the attention of the person in charge. An update submitted after the inspection indicated all care plans would be reviewed and monthly thereafter.

There was good access to a GP involved with residents at the centre, and residents could choose to retain their own GP on admission. Residents were seen by a GP on their admission to the centre. However, there was no indication of the overall health status of residents on their admission in their medical records. This is actioned under Outcome 5 (documentation) and was discussed at feedback during the inspection.

Inspectors found there were meaningful social activities in place on a group and individual basis. Two activities coordinators were present in the centre on the inspection day. A new activities coordinator had recently been recruited also. There was an activities programme in place and this was discussed with the activities coordinator in one unit. Residents individual social care needs were assessed. A Key To Me which (a document on the residents personal life, family, history and likes) was completed. There was a good range of interesting things for residents to take part in if they chose to. In addition, there was one to one time with resident's who preferred not to take part in group activities.

Judgment:

Non Compliant - Moderate

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. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:

Effective care and support

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

No actions were required from the previous inspection.

Findings:

The design and layout of the centre was suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way.

The centre was a purpose-built one storey facility with a good standard of private and communal space and facilities. Throughout the centre, inspectors observed it to be well maintained with a high degree of cleanliness throughout. The décor in the centre was bright, and it was pleasantly furnished. Residents and relatives reported that the centre

offered a homely comfortable environment and were happy with the standards maintained.

The centre is divided into three areas: Mayfield, Aisling and Papillon (a dementia specific unit). They all are interconnected and accessible via the main entrance. There were a number of communal areas for residents to sit, with a sitting room provided in each unit. There were two smaller sitting rooms also, and a number of sitting areas close to the reception area and around the centre. Residents were observed to sit and watch activities or receive visitors. The areas had pleasant furnishings and comfortable seating.

Inspectors found best practice principals in dementia care were used in the design and layout of the Papillion dementia unit, and around the whole centre. Contrasting colours and appropriate signage all created an environment which balanced sensory stimulation for residents and promoted freedom of movement. The area was secure but residents had the freedom to move around the unit independently, and access to a secure outdoor area.

Residents' bedrooms were made up of 69 single and one three-bedded room. The bedrooms all had en-suite facilities, with toilet, hand wash basin and shower. The rooms were spacious and some were observed to be personalised. The three bedded room was provided with screens for privacy and there was sufficient space to access both side of the beds, and provide a locker, chair and personal possessions.

There were a number of internal patios and key coded secure courtyards that residents had access to throughout the day.

There was appropriate equipment for use by residents or staff which was maintained in good working order.

There were areas where residents could meet visitors in private and tea/coffee making facilities were available.

A staff room and staff toilet facilities were also provided.

Judgment:
Compliant

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

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

Findings:

Practice in relation to complaints management met the requirements of the Regulations.

The procedure for complaints was displayed for residents and it clearly identified the complaints officer. Complainants who were not satisfied with the initial response to their complaint were directed to an independent appeals process. There was a centre-specific policy in place which provided clear guidance to staff.

The complaints records read contained details of whether or not the complainant was satisfied with the outcome of a complaint investigation. There was evidence of feedback to complainants also.

Judgment:

Compliant

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

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

No actions were required from the previous inspection.

Findings:

Inspectors were satisfied that end-of-life policies and procedures were in place. There were systems in place to record resident's wishes and preferences.

An end-of-life policy reviewed provided guidance to staff. Inspectors were informed that no residents were approaching end-of-life care on the day of inspection. However, there was evidence of regular review of resident's end-of-life wishes, and care plans were developed where required.

Families informed inspectors that the person in charge discussed end-of-life wishes with their loved one when the time required it.

There was access to the local palliative care team who provided support and advice when required. There was evidence that staff had completed training in end-of-life care.

There were a number of private areas and meeting rooms available for relatives and friends for privacy if required. An oratory was available if families wished to use it. A universal sign was used to gently inform residents, staff and visitors of a resident approaching end-of-life in the centre.

Staff and residents were discreetly informed of any residents passing. There were procedures in place to document all residents personal belongings returned to their families after their death.

Judgment:
Compliant

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

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

No actions were required from the previous inspection.

Findings:

Inspectors found each resident was provided with food and drinks at times and in quantities adequate for his/her needs.

Food was properly prepared, cooked and served, and looked wholesome and nutritious. Inspectors spent time in the main dining room during the lunch time meal, and the dementia unit during the evening meal. It was a calm, sociable time for residents. Where required, residents were discreetly and patiently assisted by staff. The menu was displayed on the wall and on each table. A nurse was present to oversee the mealtime and the provision of modified consistency diets for residents. The dining experience was pleasant. Tables were nicely laid and meals were appetisingly presented. Residents told inspectors they enjoyed the meal and there was a range of choice available.

Inspectors visited the kitchen and noticed that it was well organised and had a plentiful supply of fresh and frozen food which was stored appropriately. The chef on duty discussed the special dietary requirements of individual residents and information on residents' dietary needs and preferences. He told inspectors that he met with residents to discuss their preferences and also got information from the staff.

Where dietary recommendations had been made by specialist services in the past, these were documented and found to be followed by the staff.

Judgment:
Compliant

Outcome 16: Residents' Rights, Dignity and Consultation

Residents are consulted with and participate in the organisation of the centre. Each resident's 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. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

Inspectors were satisfied that staff treated residents with privacy and dignity, their civil and religious rights were respected and they were consulted with in the operation of the centre.

Staff were observed knocking on bedroom, toilet and bathroom doors and waiting for a response to enter and this was confirmed by residents. Inspectors observed staff interacting with residents in a friendly and courteous manner.

There was an open visiting policy and contact with family members was encouraged. There were facilities available should a resident or relative wish to make tea/coffee and inspectors observed this to be in use during the inspection.

A residents' committee continued to meet, this was provided for residents to give them the opportunity to express any concerns they may have and for it to be discussed with the person in charge if they wished. The minutes showed that issues identified were responded to by the provider and person in charge. Issues regarding residents wandering into bedrooms were addressed.

Relatives said if they had any query it is addressed immediately. Relatives said they were kept up to date on their family status and any changes. It was reported in some questionnaires read that consultation with relatives on residents was not adequate. Inspectors did not see evidence of this at this inspection.

Some residents went out various outings from the centre during the day which they said they enjoyed. Some reported they would like to go out more and that outings had reduced. This was discussed with the provider and person in charge who outlined the list of events that had taken place and that residents were accommodated in accordance with their assessed needs and the staffing levels available.

Inspectors found that most residents said they had flexibility in their daily routines, for example, residents could decide whether to participate in activities available to them. They chose when to go to for example, bed and the time they got up.

Inspectors observed staff working from a person centered approach, for example, there were examples of appropriate positive engagement from staff for example, non verbal residents were spoken to in an age appropriate respectful manner.

Residents civil rights were respected in the centre. This was discussed with the person in charge. The local county council set up a polling booth at each election in the centre. The person in charge reported she had encountered a lot of difficulty to obtain this for the upcoming election, and hoped in the future there would be no obstacles.

Inspectors noted that televisions and telephone phone had been provided in residents' bedrooms.

Judgment:
Compliant

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

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

Findings:
Residents' rooms were personalised with photographs, paintings, furniture and their own personal belongings brought into the centre. Residents were provided with adequate storage space for clothing and personal possessions.

The laundry services were outsourced, and minimal laundry was undertaken in the existing laundry room. Arrangements were in place for collection and return of resident laundry.

Since the laundry had been outsourced, no complaint of missing clothing had been made. Residents and relatives spoke to were happy with how their clothes were managed.

Judgment:
Compliant

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)

Theme:
Workforce

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

No actions were required from the previous inspection.

Findings:

Inspectors were not satisfied there was an adequate staff skill mix to meet the assessed needs of residents in the centre during the day.

There was a satisfactory staff skill mix on duty during this inspection. However, a review of the planned and actual staff rota found two nurses were generally rostered on duty from 8am to 8pm. Inspectors were not satisfied the nursing skill mix meets the assessed needs of residents in Newpark Care Centre. There were 69 residents in the centre at the time of the inspection. 50% of the residents had a high to maximum dependency level, and 80% of all residents have a dementia, cognitive impairment or a psychiatric diagnosis. There was evidence of negative outcomes for residents due to the inadequate level of nursing staff, as outlined in outcome 7 (safeguarding) and 11 (health care needs).

The centre currently was down three whole time equivalent nursing grades. An additional nurse was due to commence work at the end of February 2016, and with another two nurses in process. Following the inspection the provider confirmed as an interim arrangement, admissions to the centre were to cease for one month, with a monthly review of staffing levels thereafter.

Although there were staff rosters that specified the roles of persons and the shift times, the staff location per shift was not stated. The roster for the duty hours of the person in charge was not clear, as shift times were not consistently stated. See outcome 5 (documentation).

Residents interviewed were complimentary of the staff team and commented on their caring nature. In addition questionnaires submitted were reviewed as part of the inspection process. While the vast majority were satisfied with the level of care provided to their loved one, some reported their dissatisfaction with staffing levels at certain times in the centre and waiting for staff to attend to their needs.

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. However, there were deficits in the provision of up-to-date training for all staff. For example, prevention of abuse and movement and handling.

Inspectors reviewed a sample of personnel files for nurses and care assistants in the centre and found them to contain the documentation required by Schedule 2 of the Regulations.

A staff appraisal system was in place. This was completed on an annual basis. However, there was no system of staff supervision, as required by the Regulations.

A number of volunteers visited the centre, and all have An Garda Síochána vetting in place.

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 report¹

Centre name:	Newpark Care Centre
Centre ID:	OSV-0000150
Date of inspection:	17/02/2016
Date of response:	06/04/2016

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 overall system of auditing the service provided to residents in the centre required 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

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

monitored.

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

We are developing a Management System Audit whereby clinical risks will be identified with outcomes and actions if required. This will commence with Falls, Nutrition, Hydration and Supporting a Risk Free Environment and will develop over a period of 3 months.

We will have a comprehensive Management System Audit tool in place, clinical Audits will be conducted by PIC and CNM's using this tool on those issues initially highlighted during the inspection.

There will be a systematic review of all our policies conducted by the registered provider and parallel with this process there will be a random selection of 3-4 residents and they will be audited against the policies by the CNM/Staff Nurses to ensure that our policies are fit for purpose.

Any actions highlighted will be brought to Risk management meeting for further review.

We are also introducing weekly MDT meetings which will be attended by Physiotherapist, CNM, Nurse, 2 Healthcare Assistants and Management.

The purpose of this meeting is to review any residents whose condition has changed or those who might have had an incident recorded. This will form the basis of the meetings, action plans will be implemented and documented for those residents who have been identified.

Outcomes from these meeting's will again be reviewed at monthly risk management to ascertain if the action plans from MDT meetings were effective or require further action and this will inform care planning going forward.

This information will be disseminated to all staff via email and by hard copy.

Our organisational and clinical audit results will be reviewed every 3 months and this will inform learning and improvement of our services. This information will also form the basis of our annual review.

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:

There was no annual review of the safety and quality of care provided to the residents in the centre.

2. Action Required:

Under Regulation 23(d) you are required to: Ensure there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.

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

We are currently developing a template for our annual review and will submit our Annual Review for 2015 to the Authority when it is completed.

Proposed Timescale: 30/04/2016

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:

The policies on the prevention of abuse, management of falls and nutrition and hydration did not fully guide staff practice.

3. Action Required:

Under Regulation 04(3) you are required to: Review the policies and procedures referred to in regulation 4(1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.

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

The policies on Safeguarding Vulnerable Adults, Management of Falls, Nutrition and Hydration have been updated to reflect best practice. Staff will be issued with these reviewed policies via email and they will be required to sign as having read and understood these policies.

Training will be undertaken by PIC and Physiotherapist on the management of falls and an external facilitator is currently being sourced to carrying out training on Safeguarding Vulnerable Adults. In the meantime the PIC is updating the 3 three staff who required training on our updated policy.

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 time and cause of death of residents was not recorded in the directory of residents.

4. Action Required:

Under Regulation 19(3) you are required to: Ensure the directory includes the information specified in paragraph (3) of Schedule 3.

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

A review of the directory of residents has taken place from Jan 2016 and is now being audited every 2 months to ensure that the information specified in Paragraph 3 of schedule 3 complies with regulations. The time and cause of death of residents has also been updated since Jan 2016.

Proposed Timescale: 07/04/2016

Theme:

Governance, Leadership and Management

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

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

Crushed medications were administered without being individually prescribed.

There were unclear food records maintained for some residents who lost significant weight.

5. 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:

Each Resident has a pre admission assessment which is incorporated into their Medical Files. Residents admitted from hospital have a comprehensive discharge summary and those admitted from the community will have a CSAR assessment and sometimes previous GP records.

Our pharmacy is currently re-structuring our Kardex system so it will include the facility to individually prescribe crushed medication if required.

We have introduced pictures of the portion sizes that are normally given out to residents at meal times. These pictures are at each nurse's station so staff can clearly identify the size and type of meal each resident receives at meal times and upload this information onto our epic care system. We have also introduced a facility on our epic care system to select snacks and drinks such as hot drinks, fortified snack's, milk, fruit, tea and toast. We have also introduced icons on epic which reflects our lunch/dinner such as soup and dessert, soup only, dessert only and if families bring in meals for residents this is reflected in own meal.

This will ensure that staff clearly record resident's nutritional intake.

Proposed Timescale: 30/04/2016

Outcome 07: Safeguarding and Safety

Theme:

Safe care and support

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

Practices in the management of restraint were not in line with the National Policy

There was inconsistent evidence that all forms of restrictive practices were regularly assessed, reviewed and alternatives considered.

There was lack of consultation with all residents in the use of restrictive practices.

6. Action Required:

Under Regulation 07(3) you are required to: Ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.

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

Residents were consulted on the use of bedrails within Newpark and over a 3 night period from the 24th-26th February 2016 and all bedrails were taken down during this time. Alternatives were used such as extra pillows, bed alarms and lo lo beds. The result is that 3 residents have requested the use of bedrails and have consented to their use and this is documented in their care plans. These care plans will be reviewed and discussed every 3 months with those residents who have given their consent for the use of bedrails.

Going forward if a resident requires the use of tilting chairs they will be fully assessed by our Physiotherapist or an Occupational therapist if required. This will be documented in their care plans.

The resident highlighted in relation to access to personal monies has been spoken to by the social worker regarding her monies and this is documented in her notes. This resident has accessed the account on the 3rd March 2016 and has been advised of the remaining balance and that monies can be accessed when required. This residents situation will be reviewed every 6 months in association with the social worker.

Our policy in supporting a restraint free environment has been developed by our MDT and this guides best practice and promotes a restraint free environment that reflects the national policy on restraint. PIC will meet staff to discuss the updated restraint free environment policy

All staff and resident's families have been issued with our new protocols on restraint and staff training will take place around our new policy and protocols.

Proposed Timescale: 31/05/2016

Theme:

Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement

in the following respect:

The staff had not received training in the management of responsive behaviours

7. Action Required:

Under Regulation 07(1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.

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

All Staff are currently undertaking online Dementia training from Olive Media which includes a module on dealing with responsive behaviours. This training has been fully accredited by the NMBI.

18 of our Care Assistants have completed a 6 month Dementia course accredited by the University of Stirling which also includes a module on management of responsive behaviours. In addition 10 further staff have also attended a seminar on behaviours that challenge in April 2014 which was conducted by the Crisis Prevention Institute.

Proposed Timescale: 30/04/2016

Theme:

Safe care and support

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

There was no record of three staff having completed training in the prevention of abuse.

8. Action Required:

Under Regulation 08(2) you are required to: Ensure staff are trained in the detection and prevention of and responses to abuse.

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

The PIC will meet and discuss our updated policy with the three Staff identified as having not received training in the prevention and responding to abuse and an external facilitator is being sourced to carry out ongoing staff training.

A new computerised system for managing staff training records has been implemented and this will ensure that all staff training records will be kept up to date.

Proposed Timescale: 31/05/2016

Outcome 08: 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:

The risk management policy did not include the measures and actions in place to control the risk of abuse.

9. Action Required:

Under Regulation 26(1)(c)(i) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control abuse.

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

Our policy on safeguarding vulnerable adults has been updated and now forms part of our Risk Management Policy. All staff will be advised of the changes to the risk management policy.

Proposed Timescale: 30/04/2016

Theme:

Safe care and support

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

No fire drills were taking place in the centre to review staff practice.

10. Action Required:

Under Regulation 28(1)(e) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and residents are aware of the procedure to be followed in the case of fire.

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

A comprehensive review of fire procedures to include Fire Drills is currently taking place. We have received an updated fire safety plan from our Fire Safety Instructor and this is currently under review. A Fire Drill took place on the 15th March with results entered in the Fire Register. All staff are currently doing on line fire training and will receive practical fire training based on our updated fire safety plan. This training is scheduled to begin on the 12th and 14th of April and will include a system for regular fire drills.

Fire training will be conducted on an annual basis and Fire wardens will conduct fire drills both day and night to replicate the sequence of events that would be expected to occur in a real fire situation.

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:

Medications were not consistently administered in accordance with residents prescriptions.

11. 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:

Our pharmacy is currently re-structuring our Kardex system so it will include the facility to individually prescribe crushed medication if required. A 3 monthly medication review has been completed for 43 residents on the 24th February 2016 and the next review is due on the 6th April 2016 whereby the remaining residents will be reviewed by the GP.

Proposed Timescale: 07/04/2016

Outcome 10: Notification of Incidents

Theme:

Safe care and support

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

Restrictive practices had not been notified to the Authority on a quarterly basis.

12. Action Required:

Under Regulation 31(3) you are required to: Provide a written report to the Chief Inspector at the end of each quarter in relation to the occurrence of any incident set out in paragraphs 7(2) (k) to (n) of Schedule 4.

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

Any use of restrictive devices will be recorded and notified to the Chief Inspector on a quarterly basis as required by Regulation.

Proposed Timescale: 30/04/2016

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:

Residents care plans were not consistently reviewed on a four monthly basis.

13. Action Required:

Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.

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

Our CNM is currently reviewing and auditing our care plans and is working with our nurses to ensure that care plans are updated and patient centred. Resident's whose care plans were identified during inspection have now been reviewed with either the resident or the family. All Care plans will be reviewed on a three monthly basis going forward or earlier if necessary.

Proposed Timescale: 31/05/2016

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.

14. 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:

All care plans are currently being reviewed and updated under the supervision our CNM. This will ensure that the care plans are person centred and reflect the care delivered to the residents.

Proposed Timescale: 31/05/2016

Theme:

Effective care and support

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

The management of residents healthcare in relation to their nutritional needs and the prevention of falls required improvement.

15. 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:

Our Nutrition and Hydration policy has been updated and 15 residents have been seen by a dietician on 1st March 2016 and 11 by SALT on the 7th March and their care plans have been updated to reflect any recommendations.

All resident's weights are reviewed every 3 months to monitor any resident who might have unintentional weight loss within that period.

A staff nurse has been assigned to audit weights over a 3 month period and any resident who has unintentional weight loss will be referred to a dietician or salt for review.

Our Falls policy has been updated to include guidance on un witnessed falls. Our incident/accident record book has been adapted to record neurological observations and all falls are discussed at our monthly risk management meetings and our weekly MDT meeting.

There will be a systematic review of all our policies conducted by the registered provider and parallel with this process there will be a random selection of 3-4 residents and they will be audited against the policies by the CNM/Staff Nurses to ensure that our policies are fit for purpose.

Any actions highlighted will be brought to Risk management meeting for further review

Proposed Timescale: 30/04/2016

Theme:

Effective care and support

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

Access to dietician and speech and language therapy services was not provided for residents where a need was identified.

16. Action Required:

Under Regulation 06(2)(c) you are required to: Provide access to treatment for a resident where the care referred to in Regulation 6(1) or other health care service requires additional professional expertise.

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

15 residents were seen by dietician on the 1st March 2015

11 residents were seen by SALT in the 7th March 2015

All resident's weights are reviewed every 3 months to monitor any resident who might have unintentional weight loss within that period.

A staff nurse has been assigned to audit weights over a 3 month period and any resident who has unintentional weight loss will be referred to a dietician or salt for review.

Proposed Timescale: 30/04/2016

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 in terms of nursing care to meet the assessed needs of residents.

17. 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:

The difficulty in the recruitment of Nursing Staff is nationwide problem.

The authority were advised by us of the change to our Nursing levels in August 2015 and our purpose and function was changed and submitted to the authority to reflect this.

We currently have 2 new nurses that have completed their RCSI adaptation and 1 received her pin on the 22nd March 2016, the second nurse is awaiting her pin from NMBI.

An additional third nurse is awaiting her decision letter from NMBI and is provisionally booked to complete her RCSI training in May 2016.

Our second CNM who was on long term sick leave since Aug 2015 returned to work on the 14th March 2016.

We aim to have 3 nurses on every day shift with 2 on night duty. Our accepted minimum of nurses is 2 during day duty and 2 during night duty.

Proposed Timescale: 31/05/2016

Theme:
Workforce

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

There was no system of staff supervision in the centre.

18. Action Required:

Under Regulation 16(1)(b) you are required to: Ensure that staff are appropriately supervised.

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

All staff receives comprehensive induction within the first week of employment and is

supervised by their appropriate manager thereafter.
The registered provider works at the centre between 5 and 6 days per week and has overall responsibility for the supervision of staff within in the centre
Our PIC works 5 days per week and ensures that staff are appropriately supervised within the centre
We have two CNM's who are responsible for the supervision of nurses and all care staff in the centre and when required they will also cover the PIC when on annual leave.
We have two lead carers who are responsible for the supervision of all carers on a daily basis ensuring that carers have the necessary training and experience to carry out their duties
Our head chef has the responsibility for supervision of all kitchen staff and ensures that all staff have the necessary training
Lead Activity co-Ordinator and Head of household all ensure that their staffs are appropriately supervised and have the necessary training.
There will be management meetings every 2 weeks and monthly meetings with the managers of each department to discuss matters arising from each area and actions to be taken.

Proposed Timescale: 31/05/2016

Theme:
Workforce

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

Not all staff had up-to-date training in the prevention of abuse and movement and handling.

19. Action Required:

Under Regulation 16(1)(a) you are required to: Ensure that staff have access to appropriate training.

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

Staff identified has having not received training in the prevention and responding to abuse and moving and handling are in the process of completing this training.

A new computerised system for staff training has been implemented and this will ensure that all staff training records will be kept up to date.

Proposed Timescale: 31/05/2016