Health Information and Quality Authority
Social Services Inspectorate

Registration Inspection report
Designated Centres under Health Act 2007

Centre name:	Glenaulin Nursing Home
Centre ID:	0041
Centre address:	Lucan Rd Chapelizod, Dublin 20
Telephone number:	01 6264677
Fax number:	01 6267196
Email address:	info@glenaulin.com
Type of centre:	☒ **Private** ☐ **Voluntary** ☐ **Public**
Registered provider:	Glenaulin Nursing Home Ltd
Person authorised to act on behalf of the provider:	Veronica McCormack
Person in charge:	Orla Quigg
Date of inspection:	24 and 25 August 2011 and 12 October 2011
Time inspection took place:	**Day-1 Start:** 08:40 hrs **Completion:** 17:30 hrs **Day-2 Start:** 08:40 hrs **Completion:** 15:00 hrs **Day-3 Start:** 11:00 hrs **Completion:** 13:00 hrs
Lead inspector:	Angela Ring
Support inspector:	Fiona Whyte (Day 1 and Day 2) Mary O'Donnell (Day 3)
Type of inspection:	☒ **Registration** ☒ **Announced** ☐ **Unannounced**

About registration

The purpose of regulation is to protect vulnerable people of any age who are receiving residential care services. Regulation gives confidence to the public that people receiving care and support in a designated centre are receiving a good, safe, service. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected.

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.

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.

As part of the registration process, the provider must satisfy the Chief Inspector that s/he is fit to provide the service and that the service is in compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centre for Older People) Regulations 2009 (as amended).

In regulating entry into service provision, the Authority is fulfilling an important duty under section 41 of the Health Act 2007. Part of this regulatory duty is a statutory discretion to refuse registration if the Authority is not satisfied about a provider's fitness to provide services, or the fitness of any other person involved in the management of a centre. The registration process confirms publicly and openly that registered providers are, in the terminology of the law, "fit persons" and are legally permitted to provide that service.

Other elements of the process designed to assess the provider's fitness include, but are not limited to: the information provided in the application to register, the Fit Person self-assessment, the Fit Person interviews, findings from previous inspections and the provider's capacity to implement any actions as a result of inspection.

Following the assessment of these elements, a recommendation will be made by inspectors to the Chief Inspector. Therefore, at the time of writing this report, a decision has not yet been made in relation to the registration of the named service.

The findings of the registration inspection are set out under eighteen outcome statements. These outcomes set out what is expected in designated centres and are based on the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended); the *National Quality Standards for Residential Care Settings for Older People in Ireland*. Resident's comments are found throughout the report.

The registration inspection report is available to residents, relatives, providers and members of the public, and is published on www.hiqa.ie in keeping with the Authority's values of openness and transparency.

About the centre

Location of centre and description of services and premises

Glenaulin Nursing Home is a family run centre providing residential care to 67 older people. The premises comprises of the original period house, built in 1903, and an integrated extension to the rear of the building. The accommodation is over three levels - lower ground floor, ground floor and first floor with lift and stair access.

Building work was ongoing as the provider is currently extending the centre and is intending to increase the total bed numbers to 86 on completion of the works. In addition to increasing bed numbers, this new build will also provide increased communal space and other services within the centre which are described in more detail in Outcome 15. During this registration inspection, the provider has applied for an increase in capacity from 67 to 74. This revised accommodation will result in the provision of 26 single rooms, 11 twin rooms, 5 three-bedded rooms, a six-bedded room and a five-bedded room at this point in time. All of the bedrooms in the new build have an ensuite with a shower.

During the building work, the provider sought permission from the Authority to use two bedrooms in the newly refurbished areas to allow for building work to commence in other areas. The building work has resulted in the centre having capacity for 66 residents on the day of inspection.

On the ground floor the current bedroom accommodation consists of eight single rooms and two twin bedrooms with shower en suite, known as the Liffey wing. There is also one six-bedded room which has a shower and toilet en suite.

The lower ground level has been reconfigured since the previous inspection, there are thirteen single bedrooms with shower and toilet facilities, a six-bedded room with en suite shower, a five-bedded room with en suite shower and two twin bedrooms with shower and toilet facilities. There is a small sitting/dining room on this floor.

The first floor Maple Wing is split-level with a platform lift, has five three-bedded bedrooms and five twin bedrooms none of which are ensuite. There are three showers and toilets on this floor.

On the ground floor to the front, there are two sitting rooms (one large and one small), two dining rooms (one large and one small), a sunroom and an oratory. The building overlooks a landscaped garden, which residents can use in good weather.

Parking is available at the front of the building.

Glenaulin Nursing Home is located on the old Lucan Road in Chapelizod, in West County Dublin. It overlooks the river Liffey and is within a 15 minute drive of Dublin city centre. It is within walking distance of shops and churches. There is also a bus stop nearby.

Date centre was first established:	1 September 1986
Number of residents on the date of inspection:	62 + 2 in hospital
Number of vacancies on the date of inspection:	3

Dependency level of current residents:	Max	High	Medium	Low
Number of residents	23	13	14	12

Gender of residents	Male (✓)	Female (✓)
	✓	✓

Management structure

Glenaulin Nursing Home is a limited company. The person named on behalf of the Provider is Veronica McCormack. Bizet McCormack and Seamus McCormack (family members) are Directors in the company and also work full-time in the centre. Veronica McCormack manages human resources and the day-to-day running of the facility. Bizet McCormack manages the catering, household and laundry departments and Seamus McCormack manages the finances and overall maintenance. Orla Quigg is the Person in Charge, and reports to the Provider. There are three Clinical Nurse Managers (CNMs) who report to the Person in Charge, the staff nurses, care assistants and activity staff also report to the Person in Charge.

Summary of compliance with Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

This report set out the findings of a registration inspection, which took place following an application to the Health Information and Quality Authority for registration under Section 48 of the Health Act, 2007. A brief unannounced inspection was carried in October in order to further assess the suitability of the accommodation arrangements in the two new multi-occupancy rooms.

Inspectors met with residents, relatives, and staff members during the inspection. Inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files. Separate fit person interviews were carried out with the provider and the person in charge, both of whom had completed the fit person self-assessment document in advance of the inspection. This was reviewed by inspectors, along with all the information provided in the registration application form and supporting documentation.

Overall inspectors found that the provider and person in charge met with most of the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland* in the main. There was a robust governance structure in place and there were procedures in place for monitoring the quality of care given to residents.

The provider and the person in charge were committed to promoting the safety of residents. A risk management programme was in place for all areas of the centre. Staff received training and were knowledgeable about the prevention and response to elder abuse. Fire precautions such as fire drills, fire training for staff and procedures for servicing of equipment were in place.

The health and social needs of residents were met. Residents had access to medical services, to a range of other health services and evidence-based nursing care was provided. Care plans were in place and residents were regularly reviewed. The quality of residents' lives was enhanced by the provision of a choice of interesting things for them to do during the day.

However, there were some improvements required in the premises. The provider was in the process of building an extension. Inspectors found that the two multi-occupancy bedrooms in the extension were not suitable to meet residents' needs and would not promote the privacy and dignity of the residents.

Improvements were also required medication management and in maintaining the directory of residents. These areas for improvement are discussed further in the report and are included in the Action Plan at the end of the report.

Section 50 (1) (b) of the Health Act 2007

Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

1. Statement of purpose and quality management

Outcome 1

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.

References:

Regulation 5: Statement of Purpose
Standard 28: Purpose and Function

Inspection findings

Inspectors found that the statement of purpose did not accurately describe the service that was provided in the centre. There was no clear description of the high dependency units including the profile of resident and the staffing arrangements in place to meet these residents' specific needs.

There were a high number of residents with varying degrees of dementia and a small number of residents were under 65 years. Inspectors did not see any evidence to suggest that the service could not meet the diverse care needs of these residents, as stated in the statement of purpose. The statement of purpose was kept under review by the provider and was made available to residents.

Outcome 2

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

References:

Regulation 35: Review of Quality and Safety of Care and Quality of Life
Standard 30: Quality Assurance and Continuous Improvement

Inspection findings

Inspectors were satisfied that the quality of care given to residents was monitored and developed on an ongoing basis.

Inspectors found that the person in charge was at the initial phase of implementing a system of auditing for quality monitoring purposes. Data was being collected on a number of key quality indicators such as accidents/incidents, use of antibiotics, use of psychotropic drugs and wounds but this data had yet to be analysed. However, there were some completed audits on medication management with areas for

improvement identified. Inspectors read the minutes of the staff meetings and saw that there was evidence of staff learning following the medication audits.

The person in charge discussed the clinical governance action plan with inspectors and it was evident that further auditing of practices such as nutrition and wound management were planned. Several aspects of the clinical governance plan was already completed such as developing new policies and procedures and gaining feedback from residents and relatives. The person in charge informed inspectors that she and the newly recruited CNM were attending a training course in clinical audit in the coming weeks and this would equip her with the necessary skills to implement her clinical governance plan.

A residents' committee was also active within the centre and this is discussed in more detail under Outcome 11.

Outcome 3
The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

References:
Regulation 39: Complaints Procedures
Standard 6: Complaints

Inspection findings
Inspectors found evidence of good complaints management. The complaints policy was reviewed and was found to be comprehensive, it complied with the requirements of the Regulations and it was displayed in prominent positions around the centre. The complaints officer was named and the policy included the name of an independent appeals person who could be contacted should the complainant be dissatisfied with the outcome of their complaint. Inspectors found that staff members were fully aware of the complaints procedure.

Residents and relatives told inspectors they felt comfortable raising any concerns with the provider, person in charge or any member of staff.

Inspectors noted that the complaints log was maintained on an electronic software system that was widely used within the centre. Verbal concerns from residents and relatives were recorded and inspectors saw how these had been acted upon and followed up by the person in charge. The provider told inspectors that no written complaints were received by the centre.

2. Safeguarding and safety

Outcome 4
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse.

References:
Regulation 6: General Welfare and Protection
Standard 8: Protection
Standard 9: The Resident's Finances

Inspection findings
Inspectors found that measures were in place to protect residents from being harmed or abused. The person in charge attended a 'Train the Trainer' course for the prevention, detection and response to elder abuse and most staff had received a refresher training course on identifying and responding to elder abuse and there were plans in place to retrain the remainder of the staff. Inspectors found that staff were fully aware of the types of elder abuse and their responsibilities in reporting suspected elder abuse to the management team.

Residents spoken to and those who completed questionnaires confirmed to inspectors that they felt safe in the centre.

A centre-specific policy was available which gave guidance to staff on the assessment, reporting and investigation of any allegation of abuse. During the fit person interviews, the provider and person in charge displayed sufficient knowledge of their responsibilities in responding to and investigating elder abuse.

The provider and person in charge managed small amounts of money for some residents and they had access to their money at all times. The inspector checked the balances which were correct. Deposits and withdrawals were signed and witnessed by two members of staff and there were spot checks completed to ensure that all money was accounted for.

Outcome 5
The health and safety of residents, visitors and staff is promoted and protected.

References:
Regulation 30: Health and Safety
Regulation 31: Risk Management Procedures
Regulation 32: Fire Precautions and Records
Standard 26: Health and Safety
Standard 29: Management Systems

Inspection findings
Inspectors found that practice in relation to the health and safety of residents and the management of risk sufficiently promoted the safety of residents, staff and visitors.

There was a health and safety statement in place. Inspectors read the minutes from regular management meetings and found that health and safety concerns were regularly discussed and addressed.

Inspectors reviewed the risk management policy and found that it did not comply with the Regulations as it did not address self-harm, aggression and violence and assault. However, inspectors found that the person in charge was fully aware of this and had plans in place to update the risk management policy to address these issues.

The procedures for fire detection and prevention were in place. Inspectors reviewed service records which showed that the fire alarm system, emergency lighting and fire equipment were monitored regularly. Inspectors read records which showed that daily inspections of fire exits were carried out and the fire exits were unobstructed. Inspectors read the training records which confirmed that all staff had attended training on fire prevention and response. All staff spoken with were clear about the procedure to follow in the event of a fire.

The environment was kept clean and well maintained and there were measures in place to control and prevent infection, including arrangements in place for the segregation and disposal of waste, including clinical waste. Staff had received training in infection control and staff spoken with were knowledgeable of best practice in infection control. There were adequate supplies of disposable gloves, aprons and alcohol hand gels available for staff and there were no residents with infectious disease on the days of inspection.

Inspectors found that there was a comprehensive emergency plan in place which identified the procedures to follow in the event of fire, flood, loss of power or heat and any other possible emergency. The provider had arranged for alternative accommodation for residents if full evacuation was necessary. There was an emergency pack in the centre and the emergency plan was displayed in a prominent place.

Outcome 6
Each resident is protected by the designated centres' policies and procedures for medication management.

References:
Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines
Standard 14: Medication Management

Inspection findings
Inspectors found evidence of good medication management processes. There was a comprehensive medication management policy which provided guidance to staff. Inspectors observed the nurses on part of their medication rounds and found that medication was administered in accordance with the policy and An Bord Altranais guidelines. Inspectors also noted that all nurses had attended training on best practice in medication management. As already stated in Outcome 2, there were procedures in place for auditing medication practices and there were improved links with the pharmacist as a result of completing these audits. There was also evidence of medication errors or near misses being discussed at the monthly nurses meetings.

Medications that required special control measures were carefully managed and kept in a secure cabinet in keeping with the Misuse of Drugs (Safe Custody) Regulations, 1984. Nurses kept a register of controlled drugs. Two nurses signed and dated the register and the stock balance was checked and signed by two nurses at the change of each shift.

A medication fridge was in place and inspectors noted that it was kept locked and the daily temperatures were recorded. Medications in use were dated on the day they were opened.

Reviews of medication prescriptions, administration records and stock balances were carried out by the nursing staff. There was evidence of medication being reviewed by the residents general practitioner (GP) every three months.

Inspectors noted that small improvements were required in medication management. All medications no longer used were not signed as discontinued by the medical practitioner, the maximum dose in 24 hours of as "required as necessary" medication was not recorded on the prescription and the medication policy did not address the prescription and administration of as required medication.

3. Health and social care needs

Outcome 7
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied healthcare. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

References:
Regulation 6: General Welfare and Protection
Regulation 8: Assessment and Care Plan
Regulation 9: Health Care
Regulation 29: Temporary Absence and Discharge of Residents
Standard 3: Consent
Standard 10: Assessment

Standard 11: The Resident's Care Plan
Standard 12: Health Promotion
Standard 13: Healthcare
Standard 15: Medication Monitoring and Review
Standard 17: Autonomy and Independence
Standard 21: Responding to Behaviour that is Challenging

Inspection findings
There was an emphasis placed on health promotion in the centre and the person in charge had a health promotion strategy in place for the coming months. Inspectors observed residents attending group exercise classes and many were seen walking about during the day. Inspectors noted that some residents were supported to go outside for walks in the garden accompanied by staff or family members.

Residents had access to a range of peripatetic services. There was good access to medical practitioners in the local area and there was evidence of residents being regularly reviewed by their GP. Physiotherapy was available, individual and group exercise sessions were provided, some at additional cost. The services of a speech and language therapist and dietician were available to residents where necessary. While reviewing residents' medical files inspectors noted the input of the various services who recorded their review and treatment plans for each resident.

All of the nursing documentation was stored on an electronic software system. Inspectors reviewed a sample of residents' files and noted that a nursing assessment and additional risk assessments were carried out for all residents. Comprehensive care plans were in place which identified residents' needs and there were three-monthly reviews completed. There were care plans developed for residents' preferred day and night routine to which all staff had access and this allowed them to provide person-centred care. Because the care planning system was electronic, it was difficult for residents to easily access their care plan. However, the person in charge told inspectors that the nurses involved the residents while reviewing their care plan as much as possible.

Inspectors saw evidence of the number of falls being audited and analysed by the provider and person in charge. There were comprehensive assessments completed on falls risk, care plans developed for falls prevention and a post falls analysis recorded for residents who experienced a fall. Inspectors reviewed the care plans of a sample of residents who had fallen and noted that strategies had been implemented including medication review, provision of hip protectors and the use of bed and chair alarms to prevent further falls. Inspectors saw falls prevention checklists displayed around the centre to remind staff of the necessary safety measures to be taken for falls prevention and there was a good awareness of falls prevention strategies among staff. Inspectors noted that all communal areas were supervised by staff and there was evidence of falls being discussed at staff meetings.

Inspectors reviewed the procedures in place for responding to behaviours that challenged. Training had been provided to a number of staff and there was a policy in place which provided guidance to staff. Inspectors reviewed a sample of residents' files and noted that appropriate assessment and care plans were in place which identified the behaviour and the most effective responses to the behaviour. Staff spoken to were aware of the policy and were knowledgeable of the appropriate strategies to use with individual residents. Inspectors saw evidence of a small number of residents displaying behaviours that challenge and the staff responded in an understanding and caring manner.

There were a small number of residents with wounds - inspectors found that there were records for assessment and treatment plans. Staff told inspectors that they accessed the services of specialist nurses in wound care when necessary.

The use of restraint had decreased since the previous inspection. The provider had invested in a number of recliner chairs for dependent residents and there were no lap belts in use. The CNM explained to inspectors that the recliner chairs had integrated tables which were used for activity such as mealtimes and were therefore not used as a form of restraint. However, there were a number of residents using bedrails - there was an assessment completed for the use of the bedrail and there was evidence of alternatives being used such as low beds and bed alarms. There was a restraint register maintained with details of each restraint used which was regularly reviewed by the person in charge. There was a comprehensive restraint policy in place to guide practice and staff were aware of the potential dangers associated with the use of bedrails.

Outcome 8
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.

References:
Regulation 14: End of Life Care
Standard 16: End of Life Care

Inspection findings
There were no residents receiving end of life care on the days of inspection. However, inspectors found that there were adequate procedures in place to ensure that this care could be provided when necessary.

There was a comprehensive centre-specific policy on end-of-life care and some of the staff had attended training sessions on palliative care. In addition, there were guidelines available to staff on caring for bereaved relatives. There was a small oratory available for relatives of a resident who wished to remain with their loved one.

Inspectors noted that end-of-life care plans were developed for a small number of residents who were quite frail which were informed by the residents and family wishes at the time of death. The person in charge explained that they accessed the services of the local palliative care team who provided support and advice when required.

Outcome 9
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.

References:
Regulation 20: Food and Nutrition
Standard 19: Meals and Mealtimes

Inspection findings
Inspectors were satisfied that residents received a nutritious and varied diet that offered choice and mealtimes were unhurried social occasions that provided opportunities for residents to interact with each other and with staff.

There was a large central dining room on the ground floor which retained its period features and residents were seen to enjoy the social dining occasion. Inspectors noted that meals were hot, well presented and tasty. However, inspectors found that improvements were required in the dining experience for residents in the lower ground floor, many of whom had dementia. Although staff assisted residents discreetly and the food was presented in an attractive manner, the tables were not set and there was no sense of anticipation of the meal as the residents remained in the day room for their meal. This issue was discussed with the provider, person in charge and two directors and they agreed to review the dining experience for these residents.

Staff were seen to assist residents discreetly and respectfully if required. Residents confirmed that they enjoyed the food. The main course was served plated, and residents were offered a choice of sauces or gravy separately. Residents told inspectors that they had a choice at mealtimes and menus were displayed in each dining room. Inspectors noted that during the residents' meetings described later under Outcome 11, menu suggestions had been made and acted upon.

Inspectors saw residents being offered drinks throughout the day. Residents told inspectors that they could have tea or coffee and snacks any time they asked for them.

Inspectors spoke with the chef who had a very good knowledge of each resident's dietary needs and preferences. The person in charge told inspectors that there were plans in place to develop a record of each resident's dietary preferences and inspectors saw evidence of this in the clinical governance action plan. Inspectors saw that residents who needed their food served in an altered consistency such as pureed had the same menu options as others and the food was presented in

appetising individual portions. The chef also ensured that the needs of residents on a diabetic diet were met.

Weight records were examined which showed that residents' weights were checked monthly or more regularly if required. Nutritional risk assessments were used to identify residents at risk. Records showed that some residents had been referred for dietetic review. The treatment plan for the residents was recorded in the residents' files. The person in charge told inspectors that she intended to concentrate on nutrition in the coming months to ensure that evidenced based practice was adhered to at all times.

4. Respecting and involving residents

Outcome 10
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.

References:
Regulation 28: Contract for the Provision of Services
Standard 1: Information
Standard 7: Contract/Statement of Terms and Conditions

Inspection findings
Inspectors were satisfied that this outcome was achieved.

Contracts were agreed with and provided to residents. Inspectors read a random sample of completed contracts and noted that they set out the overall care and services provided to the residents and the fees charged, including any additional fees charged.

Outcome 11
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.

References:
Regulation 10: Residents' Rights, Dignity and Consultation
Regulation 11: Communication
Regulation 12: Visits
Standard 2: Consultation and Participation
Standard 4: Privacy and Dignity
Standard 5: Civil, Political, Religious Rights
Standard 17: Autonomy and Independence
Standard 18: Routines and Expectations
Standard 20: Social Contacts

Inspection findings
Residents' privacy and dignity were respected by staff although the use of communal bedrooms made this difficult and this is discussed in more detail under Outcome 15.

Staff were observed knocking on toilet and bedroom doors and waiting for permission to enter. There were signs placed on doors advising people not to enter the room as residents were receiving personal care.

Residents were dressed well and according to their individual choice. Inspectors observed staff interacting with residents in a courteous manner and addressing them by their preferred name.

Residents' civil and religious rights were respected. The person in charge confirmed that residents had been facilitated to vote at the previous election. Mass took place on a weekly basis and the person in charge said that residents from all religious denominations were supported to practice their religious beliefs.

A residents' committee had been established which was chaired by an external residents' advocate. Inspectors read the minutes of some of these meetings and noted that where suggestions were made by residents these had been addressed by the person in charge. For example, the residents had asked for changes to the menus as outlined under Outcome 9 and this had been facilitated.

There was an activity manager and three activity coordinators employed in the centre and residents were provided with an extensive range of things to do during the day. A schedule of activities was available each day and there was evidence of the staff and residents holding an internal competition on upcoming events such as the Rose of Tralee and the presidential campaign. Inspectors noted that some members of staff were also involved in bringing residents to functions in the local area and out shopping in the nearby shopping centre. Some residents told inspectors how much they enjoyed the regular quizzes and newspaper reading. Inspectors observed residents sitting listening to music and others reading newspapers in a relaxed manner.

Inspectors met with the activities manager who was very well informed and enthusiastic. She and the activity staff had implemented several positive initiatives in the centre for residents with dementia which they were seen to enjoy. These included baking, laundry duties and Sonas (a therapeutic communication activity which focuses on sensory stimulation). Staff were in the process of collating life books for all residents with the assistance of the residents' relatives which captured the biography and interests of each residents.

Outcome 12
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.

References:
Regulation 7: Residents' Personal Property and Possessions
Regulation 13: Clothing
Standard 4: Privacy and Dignity
Standard 17: Autonomy and Independence

Inspection findings
Inspectors found that although the laundry facilities were adequate, there were problems with clothes going missing on occasion.

Inspectors reviewed the laundry and the systems in place to ensure that residents' property was appropriately cared for. There was a new laundry in use which was spacious and well equipped. Inspectors spoke to the staff member seen working there and found that she was knowledgeable about infection control and the different processes for different categories of laundry.

However, inspectors found evidence of residents' clothes going missing on several occasions and this was identified in some residents' feedback and in the complaints log. Inspectors found that the provider was well aware of this and had introduced a new tagging system to identify each item of clothing to assist in preventing items going missing.

5. Suitable staffing

Outcome 13
The designated centre is managed by a suitably qualified and experienced nurse with authority, accountability and responsibility for the provision of the service.

References:
Regulation 15: Person in Charge
Standard 27: Operational Management

Inspection findings
The person in charge was a registered general nurse, had the relevant necessary experience and worked full-time at the centre since December 2010. The person in charge initially worked as an assistant director of nursing and was promoted to person in charge in March 2011. Inspectors found that her appointment has resulted in improvements being made in several clinical areas. She continued to keep her skills up-to-date by undertaking on going professional development and was planning to complete a diploma in management and gerontology in the coming two years. She demonstrated a good knowledge of her responsibilities as outlined in the Regulations and demonstrated good leadership and organisational skills.

Inspectors found that she was knowledgeable about residents' needs and their background. She was observed to engage well with residents and relatives throughout the days of inspection. She demonstrated a firm commitment to the provision of good quality care to the residents and welcomed the inspection process to assist in driving forward quality care for residents. She was supported in her role by three clinical nurse managers who deputise in her absence. The provider explained that there were plans in place to appoint an Assistant Director of Nursing to support the person in charge once the building work was complete.

Outcome 14
There are appropriate staff numbers and skill-mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

References:
Regulation 16: Staffing
Regulation 17: Training and Staff Development
Regulation 18: Recruitment
Regulation 34: Volunteers
Standard 22: Recruitment
Standard 23: Staffing Levels and Qualifications
Standard 24: Training and Supervision

Inspection findings
There was a robust written operational recruitment policy in place. Inspectors examined a sample of staff files and found that all files contained the information required by the Regulations.

Inspectors found that staff turnover was very low and most of the staff had worked in the centre for a number of years. They were knowledgeable about residents, had established a good relationship with them and inspectors saw them responding to residents' needs in an informed and kind manner. Staff told inspectors that they enjoyed working in the centre and they felt very well supported by the management team. In particular they spoke about the availability of continuing training and education that was made available to them.

Inspectors found that the provider and person in charge were committed to providing ongoing training to staff. Extensive training had been undertaken in the last 12 months including training on pain management, clinical decision making, wound care, dementia care and the management of behaviour that challenged. Inspectors read the training records and staff spoken with confirmed that they had attended. All staff had attended mandatory training in moving and handling and staff spoken with were knowledgeable in this regard.

Formal induction arrangements for newly employed staff were in place where they were mentored for a short time by a senior member of staff. The person in charge explained to inspectors that she had commenced staff appraisals and inspectors saw evidence to verify this.

Inspectors found that most of the health care assistants had Further Education and Training Awards Council (FETAC) Level 5 training and some were scheduled to commence the course in the coming months. Staff spoken with confirmed how much they had enjoyed doing the training and how it helped them in their work.

There was one volunteer in the centre who had been vetted appropriately and there was a written agreement outlining the person's roles and responsibilities in place as required by the Regulations.

Staff, residents and relatives agreed that there were adequate staffing levels on duty. The person in charge told inspectors that the provider was very supportive and responsive to the need to increase staff numbers when necessary. Inspectors viewed the staff rota and found that the planned staff rota matched the staffing levels on duty. The person in charge or CNM on duty was always supernumerary and available to support and supervise staff. The provider told inspectors that there were plans in place for increasing the staff numbers and skill-mix once the new build was complete and there was documentary evidence of these plans.

There were good communication systems in place to ensure that all staff were kept well informed of issues related to residents and matters arising in the centre. There was a staff handover at the commencement of the morning and night shift and regular management and staff meetings which were recorded and available to staff.

6. Safe and suitable premises

Outcome 15
The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

References:
Regulation 19: Premises
Standard 25: Physical Environment

Inspection findings

The facility was not purpose built and some deficits in the existing building will be addressed when new extension is completed. For example, the extension will provide a larger kitchen, more private space for residents to meet visitors, improved staff facilities, assisted bathrooms, additional sluice rooms and therapy rooms. As already stated in the introduction, the provider is applying to increase their bed numbers from 67 to a total of 86 once the building work is completed. However, inspectors found that the new accommodation consisted of two multi-occupancy rooms which is

not in line with evidenced based practice, particularly for residents with dementia. The new building was also not in compliance with the requirements of the Standards which state that a new build has a minimum of 80% of residents accommodated in single bedrooms.

A multi-occupancy room with six beds was in use on the day of inspection and an additional multi-occupancy room with five beds was completed and due for registration. These rooms were described as "high dependency units". Inspectors found that although most of the residents who occupied the six-bedded room required assistance of two staff for bathing and dressing, these residents were out of bed and sitting in the day room during the day. Inspectors could not find evidence to indicate that the residents' needs in the high dependency unit were different than some of the other residents deemed as high dependency in the centre. Staff could not identify how the needs of these residents differed from the needs of other residents. The sleeping accommodation in the multi-occupancy rooms was confined and these types of rooms are not recommended accommodation for people with dementia.

In addition, the staffing levels did not indicate that the residents in the high dependency unit required high support nursing. For example, the nurse on duty at night time had responsibility for 33 residents who included those in the high dependency unit, in other beds on the ground floor and on the second floor. The care assistant on night duty had responsibility for 21 residents on the ground floor including the high dependency unit. These staffing levels did not indicate that these residents had high support nursing needs and therefore required to be in a high dependency unit.

Inspectors met with residents in the high dependency unit, all of whom were cognitively impaired and found that they were unable to verbally express their wishes and were therefore unable to make a choice as to whether they wished to live in this unit. Inspectors noted that the day room adjacent to the high dependency unit was bright, stimulating and suitable for the residents. However, it was not spacious enough to accommodate a further five additional residents from the second multi-occupancy room. The planned second day room was still under construction.

Inspectors found that there were a number of additional areas for improvement in these multi-occupancy rooms. Although the screening was new, it was inadequate as the curtain had to be pulled over one resident's bed in order for it to be used for the resident in the next bed. This caused disruption to residents. This was due to the provision of an integrated overhead hoist. There was also a lack of adequate storage facilities for residents' clothing and personal effects in the six-bedded room and residents' belongings were stored in another bedroom.

Inspectors found that there was a strong potential for negative outcomes for residents in these multi-occupancy rooms due to their layout and design. Staff told inspectors that one of the residents with behaviour that challenged occasionally disturbed the other residents at night. Inspectors found that the screening between beds made it difficult to ensure complete privacy and dignity for each resident and they did not block out noise or malodours. The layout of the bedrooms with beds facing each other did not allow for residents to create their own sense of space as

other residents had to pass through their space to access their bed. There was very little space at the bedside for residents to personalise their area with their belongings. Inspectors also found that it was difficult for staff to ensure that all residents' preferences and individual needs were met in these rooms as each resident did not have autonomy over television controls or when the lights should be on or off.

Inspectors noted that some areas of the new extension did not have adequate natural lighting. The five-bedded room was overshadowed by an adjoining building and the windows in the L shaped room did not illuminate a considerable part of the room. The level of natural light in the room did not support wellbeing and poor lighting could lead to potential problems for residents with dementia or visual impairment. This was discussed with one of the directors who stated he had plans in place to supplement the natural light and he stated that he had plans to engage the services of a lighting consultant.

Although inspectors did not find negative outcomes for residents in the three-bedded rooms, the provider was aware that some of the three-bedded rooms will not meet the requirements of the Standards and planned to address this within the timeframe.

There were assisted bathrooms on each floor with showers, but there were no assisted bath facilities for residents. However, the provider assured inspectors that two assisted baths would be available to residents once the building work was complete.

There was no secure garden for residents to access independently due to the building work. The provider assured inspectors that this issue would be addressed on completion of the building works and this was verified by reviewing the plans. Some residents were seen sitting outside the front door of the centre greeting visitors and getting fresh air.

Staff were provided with changing and storage facilities in the basement of the centre. Inspectors reviewed one of the new sluice rooms and found that it was adequate with a bedpan washer, a sink and a wash-hand basin.

There was a new call bell facility installed and inspectors saw staff respond promptly. Each resident had access to locked personal storage space.

Although it was quite small, inspectors found that the kitchen was well organised with access to sufficient storage facilities. Inspector observed a plentiful supply of fresh and frozen food.

There was appropriate assistive equipment available such as hoists, pressure relieving mattresses, cushions, wheelchairs and walking frames. Handrails were available to promote independence. Hoists and other equipment had been maintained and service records were up-to-date.

7. Records and documentation to kept at a designated centre

Outcome 16
The records listed in Part 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

References:
Regulation 21: Provision of Information to Residents
Regulation 22: Maintenance of Records
Regulation 23: Directory of Residents
Regulation 24: Staffing Records
Regulation 25: Medical Records
Regulation 26: Insurance Cover
Regulation 27: Operating Policies and Procedures
Standard 1: Information
Standard 29: Management Systems
Standard 32: Register and Residents' Records

Inspection findings
** Where "Improvements required" is indicated, full details of actions required are in the Action Plan at the end of the report.*

Resident's guide

Substantial compliance ☒ Improvements required* ☐

Records in relation to residents (Schedule 3)

Substantial compliance ☒ Improvements required* ☐

General records (Schedule 4)

Substantial compliance ☒ Improvements required* ☐

Operating policies and procedures (Schedule 5)

Substantial compliance ☒ Improvements required* ☐

Directory of residents

Substantial compliance ☐ Improvements required* ☒

There was no overall directory of residents being maintained to record all information specified in the Regulations. The directory was being maintained in two formats, a hard copy and electronic with different information being stored in each and this could lead to potential problems.

Staffing records

Substantial compliance ☒ Improvements required* ☐

Medical records

Substantial compliance ☒ Improvements required* ☐

Insurance cover

Substantial compliance ☒ Improvements required* ☐

Outcome 17
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

References:
Regulation 36: Notification of Incidents
Standard 29: Management Systems
Standard 30: Quality Assurance and Continuous Improvement
Standard 32: Register and Residents' Records

Inspection findings
Practice in relation to notifications of incidents was satisfactory.

The person in charge was aware of the legal requirement to notify the Chief Inspector regarding incidents and accidents. To date all relevant incidents had been notified to the Chief Inspector by the person in charge.

Outcome 18
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.

References:
Regulation 37: Notification of periods when the Person in Charge is absent from a Designated Centre
Regulation 38: Notification of the procedures and arrangements for periods when the person in charge is absent from a Designated Centre
Standard 27: Operational Management

Inspection findings
There were appropriate arrangements in place for the absence of the person in charge.

The CNMs deputised for the person in charge. The person in charge and provider were aware of their responsibilities to notify the Authority but as yet this was not required. Inspectors were informed that there have been no absences of the person in charge for such a length that required notification to the Chief Inspector.

Closing the visit

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

Acknowledgements
The inspectors wish to acknowledge the cooperation and assistance of the residents, relatives, provider and staff during the inspection.

Report compiled by:

Angela Ring

Inspector of Social Services
Social Services Inspectorate
Health Information and Quality Authority

20 October 2011

Health Information and Quality Authority
Social Services Inspectorate

Action Plan

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

Provider's response to inspection report*

Centre:	Glenaulin Nursing home
Centre ID:	0041
Date of inspection:	24 and 25 August 2011 and 12 October 2011
Date of response:	4 November 2011

Requirements

These requirements set out the actions that must be taken to meet the requirements of the Health Act 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care settings for Older People in Ireland.*

Outcome 1: Statement of purpose and quality management

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

The Statement of purpose did not adequately describe the facilities and services which are provided for residents.

Action required:

Compile a Statement of purpose that describes the facilities and services which are provided for residents.

Reference:

Health Act, 2007
Regulation 5: Statement of Purpose
Standard 28: Purpose and Function

* 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 with timescales:	Timescale:
Provider's response: Attached is our amended statement of purpose which describes the facilities and services which are provided for residents.	Completed

Outcome 5: Health and safety and risk management

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

The risk management policy did not cover the precautions in place to control the following specified risks: assault; aggression and violence; and self-harm.

Action required:

Ensure that the risk management policy covers the precautions in place to control the following specified risks; assault; aggression and violence; and self-harm.

Reference:

Health Act, 2007
Regulation 31: Risk Management Procedures
Standard 26: Health and Safety

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: We will review our risk management policy as part of our Clinical Governance Plan to ensure it covers all of the above.	3 months

Outcome 6: Medication Management

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

Residents were not fully protected by procedures for medication management.

- all medications no longer used were not signed as discontinued by the GP
- the maximum dose in 24-hours of as required medication was not recorded in the prescription
- the medication policy did not address the prescription and administration of as required medication.

Action required:

Put in place appropriate and suitable practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents and ensure that staff are familiar with such policies and procedures.

Reference:

Health Act, 2007
Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines
Standard 14: Medication Management

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: We have reviewed our written operational policies relating to the ordering, prescribing, storing and administration of medicines to our residents. We have respectfully requested our GPs to adhere to our policy.	Completed

Outcome 15: Safe and suitable premises

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

Communal bedrooms did not provide the optimal environment for residents with dementia and did not meet the needs of the residents.

The layout and design of communal bedroom did not support staff to uphold the dignity or residents and did meet the individual needs of residents

There was inadequate screening between beds.

There was inadequate storage in the multi occupancy rooms.

There was poor lighting in some areas.

Action required:

Ensure the physical design and layout of the premises meets the needs of each resident, having regard to the number and needs of the residents.

Action required:

Provide suitable storage facilities for the use of each resident.

Action required:

Provide lighting suitable for residents in all parts of the designated centre which are used by residents.

Reference:

Health Act, 2007
Regulation 19: Premises
Standard 25: Physical Environment
Standard 28: Purpose and Function

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: We will review the over head hoists so that they may only be used over one bed as not to disturb other residents and we will provide adequate screening between beds. A reassessment will be carried out on the usage of the overhead hoist in this unit to ensure that there are no negative outcomes for our residents. New screening is currently been researched. We will provide suitable additional storage facilities for the use of each resident. Lighting has been assessed by our lighting consultant and tests are in the process of been analysed. If there are areas deemed necessary for improvement as a result of this process we will comply.	1 month

Outcome 16: Records and documentation to be kept at a designated centre

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

There was no overall directory of residents being maintained to record all information specified in the Regulations.

Action required:

Establish and maintain an up-to-date directory of residents in relation to every resident in the designated centre in an electronic or manual format and make this information available to inspectors as and when requested.

Reference:

Health Act, 2007
Regulation 23: Directory of Residents
Standard 32: Register and Residents' Records

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Inspectors viewed both our electronic and manual directory of residents on the inspection days. It was decided that going forward, we will maintain our electronic format.	Completed

Any comments the provider may wish to make:

Provider's response:

We would like to thank our inspector and her team for their professionalism, courtesy and dignity shown to all of our staff, residents and families during our inspection. The report encapsulates the work ethic and professionalism that exists in Glenaulin as we provide a high level of safe quality care to our much respected residents

The registration process and experience for all staff was new and indeed challenging at times. I would like to thank all our staff for their high levels of commitment, care and dedication that they display on daily basis and we look forward to their continued support and professionalism. We will continue a firm commitment to the provision of high quality care in conjunction with the standards and regulations as laid down by the authority.

A separate letter had been lodged with the authority in relation to our extension and proposed registration.

Provider's name: Veronica McCormack
Date: 7 November 2011