Health Information and Quality Authority
Social Services Inspectorate

Inspection report
Designated centres for older people

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

Centre name:	Brymore House Nursing Home
Centre ID:	0120
Centre address:	Thormanby Road
	Howth
	Co Dublin
Telephone number:	01 8326244
Fax number:	01 8391497
Email address:	brymorehouse@gmail.com
Type of centre:	☒ **Private** ☐ **Voluntary** ☐ **Public**
Registered provider:	Brymore House Nursing Home Ltd
Person in charge:	Cynthia Gosker
Date of inspection:	15 and 16 February 2010
Time inspection took place:	**Day 1 Start:** 12:15 hrs **Completion:** 16:15 hrs **Day 2 Start:** 08:45 hrs **Completion:** 16:00 hrs
Lead inspector:	Leone Ewings
Support inspector(s):	Nuala Rafferty
Type of inspection:	☐ **Registration** ☒ **Scheduled** ☐ **Announced** ☒ **Unannounced**

About inspection

The purpose of inspection is to gather evidence on which to make judgments about the fitness of the registered provider and to report on the quality of the service. This is to ensure that providers are complying with the requirements and conditions of their registration and meet the standards; that they have systems in place to both safeguard the welfare of service users and to provide information and evidence of good and poor practice.

In assessing the overall quality of the service provided, inspectors examine how well the provider has met the requirements of the Health Act 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 and the *National Quality Standards for Residential Care Settings for Older People in Ireland* under the following topics:

1. Governance and leadership: how well the centre is organised.
2. The quality of the service.
3. How well the healthcare needs of residents are met.
4. Premises and equipment: appropriateness and adequacy.
5. Communication: information provided to residents, relatives and staff.
6. Staffing: the recruitment, supervision and competence of staff.

This report summarises the findings of the inspection under some or all of these topics, highlighting areas of good practice as well as areas where improvements were required as follows:

Evidence of good practice – this means that an acceptable standard was reached and the provider demonstrated a culture of review and improvement and aimed to drive forward best practice.

Some improvements required – this means that practice was generally satisfactory but there were areas that need attention.

Significant improvements required – this means that unacceptable practice was found.

The report also identifies minor issues, where applicable, to which the provider should give consideration to enhance the quality of the service.

The report is available to residents, relatives, providers of services and members of the public, and is published on our website www.hiqa.ie.

Acknowledgements

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

About the centre

Description of services and premises

Brymore House is a 40 bedded three-storey residential unit for people over the age of 65 years. During the course of this inspection the provider reduced beds by one to 39 in total. Care is provided on a long and short term basis including respite and convalescence. Care was also provided to three residents with a diagnosis of dementia.

The centre is built into a steep hill and divided over three floors with a small passenger lift and a wide staircase connecting the three floors. Access is via the reception area on the top floor entering from Thormanby Road.

There are 23 single bedrooms, ten of which have an en suite shower and toilet, six twin rooms and one three-bedded room, with a further room annexed from this room.

There are two sitting rooms, one on the top floor, and a second one near the nurses' station on the middle floor. The dining room / conservatory area is located adjacent to the kitchen on the bottom floor.

The top two floors contain residents' bedrooms, two shower rooms, toilets and day space. There are nine single and two twin rooms on the top floor. There are eight single rooms, two twin and one three bedded area, with a single annexed room, on the middle floor.

The bottom floor contains the kitchen, dining area, laundry, six single and two twin bedrooms a shower room and a bath room.

Ample space is provided for car parking.

Location

The centre is located on Thormanby Road on the approach to Howth Hill from Howth, in County Dublin. Shops and all other amenities are located nearby.

Date centre was first established:	1990
Number of residents on the date of inspection	35

Dependency level of current residents	Max	High	Medium	Low
Number of residents	0	19	8	8

Management structure

Brymore House is owned and operated by Brymore House Nursing Home Ltd. Nicola Taylor is the Managing Director and Provider. The Person in Charge is Cynthia Gosker. A team of nurses and care assistants report to the Person in Charge. Catering, domestic and laundry staff all report to the Person in Charge.

Staff designation	**Person in Charge**	**Nurses**	**Care staff**	**Catering staff**	**Cleaning and laundry staff**	**Admin staff**	**Other staff**
Number of staff on duty on day of inspection	Day two only	3	6	3	3	0	0

Summary of findings from this inspection

This was the first inspection of Brymore House by the Health Information and Quality Authority (the Authority). This inspection was unannounced and carried out over two days.

There was some evidence of good practice in that all staff had been trained in and demonstrated a good understanding of detection and avoidance of abuse. Residents received good and regular medical care.

Overall inspectors found that the standard of care required significant improvement. The Action Plan at the end of this report identifies areas where improvements are required to meet 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,* and these include;

- the standard of organisational management
- means of escape blocked from one day room
- maintenance and refurbishment of the premises
- hazards and safety awareness of staff
- cleaning and hygiene of the premises
- the use of unsafe moving and handling techniques
- a lack of storage facilities and space for essential equipment
- inadequate infection control and sluicing facilities
- residents' privacy and dignity was not maintained in shared rooms, toilets, shower and bathrooms.

Residents' and relatives' comments

Inspectors spoke to a number of residents in general and interviewed six residents about their experiences of living at Brymore.

One resident told inspectors he was very satisfied with his care and that the food was particularly good. He reported getting his daily newspaper, and having weekly outings. He had recently attended for a medical appointment at the hospital.

Residents were complimentary about the staff and knew many by name. However, one resident told inspectors there was sometimes a long delay in having her call bell answered in the evening time when everyone was going to bed.

One resident reported they knew the staff well, and enjoyed the music with exercise, which they always attended as it was a good opportunity to take exercise. Some residents reported that they don't have a say in the centre. However, one resident said that suggestions can be made to the staff and "if it's a good idea they will put it into practice".

One resident commented to an inspector that after she had eaten her soup the main meal was not very hot as all courses were served at the same time on a tray in her room.

Some residents reported feeling bored, one resident would like to go to the day room and read. However, he had to stay in his room all the time, as he had limited interest in the group activities and preferred his own company.

One resident discussed with an inspector that the centre was often "very noisy at night" and some residents with dementia came into her room uninvited in the evenings.

Two residents informed inspectors that they had reported problems with leaking taps, and issues with heating to the staff, which had not been fully addressed.

Overall findings

1. Governance: how well the centre is organised

Outcome: The centre is well organised and managed and complies with the requirements of the Health Act 2007, the regulations and standards.

Good governance involves the effective and efficient deployment of resources in accordance with the stated purpose and function of the centre. Governance includes setting clear direction for the service, a commitment to continual improvement and having a system in place to effectively assess and manage risk.

Evidence of good practice

The person in charge had worked at the centre since it opened in 1990. She had recently completed a train the trainer course, in prevention and detection of elder abuse in older people. She had also attended a Further Education and Training Award Certificate (Level 6) in gerontology. Following this training the person in charge reported some changes had taken place, particularly around documentation of care. Inspectors observed that a new system of documentation had been implemented with approximately one quarter of residents' records now stored on this comprehensive system.

The provider was involved with the day to day running of the centre.

Current insurance was in place, and the provider is currently not involved with managing residents' finances.

The provider and the person in charge were involved with writing the policies and procedures available. Policies reviewed were centre specific, easily understood and evidence based.

Some improvements required

When the person in charge is off duty, there was no appropriately qualified key senior manager who takes charge in her absence.

The individual roles of the provider and the person in charge in relation to recruitment, staff appraisal and clinical management were not clearly outlined in the policies and procedures.

The person in charge had recently completed a number of staff appraisals for nursing staff. However, documentation and discussion with staff indicated that not all staff had received their appraisal.

A complaints policy was visible in the reception area. However, the information was out of date and it did not meet the requirements of the legislation in full. This policy had been updated in the statement of purpose but an updated copy had not been placed on display in the reception area

Significant improvements required

The statement of purpose and function did not meet the legislative requirements relating to description of the premises, range of residents accommodated and additional fees for laundry and private peripatetic services were not detailed in this guide. The statement of purpose stated that the provider catered for residents needing "mild dementia care". However, a small number of residents identified to inspectors had severe cognitive impairment.

The provider had an ethos of care outlined in the Residents' Guide. However, inspectors found little evidence that the contents of this guide were adhered to on a consistent basis. None of the residents or relatives spoken with had seen a Residents' Guide.

There were no systems in place for obtaining feedback or monitoring satisfaction with the service delivered. Feedback to the provider was found to be limited, and came from senior staff only.

A safety statement written by the provider was in place. However, this was not centre specific. The safety statement lacked detail in the risk assessments documented, and failed to identify and risk assess a number of hazards observed by inspectors. The controls in place did not adequately address the hazards associated with moving and handling, and staff training records were not up to date. The observations made by inspectors regarding the physical environment and moving and handling hazards to staff did not support the information provided in the safety statement. Training records indicated that a number of care and nursing staff had not attended manual handling training and had not received an update in the last three years.

2. Quality of the service

Outcome: Residents receive a good standard of service, appropriate treatment and are treated with courtesy and respect.

A quality service is one where residents are protected from harm or abuse, where practice is person-centred, where rights are protected, where residents are enabled to play an active part in the centre and where management, staff and residents work together towards continuous improvement.

Evidence of good practice

Residents had access to information through daily newspapers and television and they have access to a private telephone. Some residents had their own mobile telephones.

The person in charge has undertaken training with all staff in the prevention and detection of elder abuse in older people. Staff displayed a good understanding of the theory and how to put this into practice.

The person in charge maintains strong links with residents and relatives. One resident had experienced difficulties with wandering at night and had a fall last year. The person in charge had documented a series of meetings with the resident and her relatives to review progress. A bed alarm has now been put in place connected to the call bell system to alert staff immediately when the resident gets out of bed.

Inspectors reviewed how staff were allocated to their duties. Care staff provided most of the daily care and reported any issues to the staff nurse who completes the medication round.

Residents were seen to be well dressed and cared for. Staff spoken with were knowledgeable about the residents in their care.

Inspectors observed that hot and cold drinks and snacks were available to residents throughout the day.

Some improvements required

The provider informed inspectors that the senior nurse was good at organising activities for residents, and inspectors observed her leading an exercise session with some residents in the top floor sitting room. The nurse was interviewed and described the activities available to residents which included art, crafts, hand massage and exercises classes twice weekly. Residents also had access to a herb garden in the grounds. Documentation confirmed that the senior nurse had undertaken activities training. However, meaningful activity and opportunities to

participate was limited. A number of residents were found to be sitting in the day room for long periods, or in their own rooms, with little to do. Residents had little input into the day to day activities on offer, and some looked forward to twice weekly "exercise sessions".

The person in charge told inspectors that there was no organised residents' committee in place. External access to the local community was limited, apart from one resident, who goes out weekly with a relative. Residents were unable to tell inspectors about any organised outside excursions which had taken place, which the statement of purpose references. One resident expressed a wish to attend mass in order to fulfil her religious needs by attending a service at the local church, as no service took place at the centre.

Moving and handling practices observed were found not to be consistent with best practice. A handling sling, now considered obsolete, was found in place in a resident's room. A staff nurse confirmed it was used for one resident. Four under arm lifts were observed by inspectors.

The menu was displayed on a blackboard in the dining room. However, some of the food provided was lukewarm when it reached the resident. This was found to be the case for breakfast, and when inspectors joined residents for lunch.

The records reviewed indicated a choice of food was available each day. However, inspectors found that only one main course was provided, and residents were unaware of their choices for lunch. Residents told inspectors that they did not know what was for lunch until it came out to them.

3. Healthcare needs

Outcome: Residents' healthcare needs are met.

Healthcare is integral to meeting individual's needs. It requires that residents' health, personal and social care needs are assessed and reviewed on an on-going basis, within a care planning process, that is person centred. Emphasis is firmly placed on health promotion, independence and meaningful activity.

Evidence of good practice

The general practitioner (GP) visits the centre regularly. Residents can maintain their own GP if they stay within their area, otherwise a change is necessary.

Chiropody is provided free of charge by the Health Services Executive (HSE) for eligible residents. Residents who have a medical card can receive up to three visits per year by the chiropodist. A named private physiotherapist is available to residents. However, this is extra to the fee.

Dietetic advice is obtained via the local dietetic department at the acute hospital, and also by a dietician employed by a private food supplement company. Dietary needs were catered for by the staff in the kitchen, including modified and diabetic diets. The person in charge liaised with the chef to ensure any modified diets are catered for appropriately.

The person in charge told inspectors that three residents with a diagnosis of dementia live at the centre. Links are in place with psychiatry of old age and medical records seen by inspectors confirmed that one resident had recently been reviewed.

Some improvements required

Residents who spoke with inspectors were unaware of their individual assessments and care plans. There was no evidence of meaningful reviews of residents' care plans, despite the recent changes made to the residents' records and other documentation reviewed by inspectors.

The residents records reviewed were disorganised and not easily understood. A new system of documentation which involved nursing staff completing one central document had commenced. There was a lack of support or guidance for staff tasked with completion of the documentation. There was no obvious involvement of residents in this record, nor did the document lend itself to this. "Older" style residents' records reviewed were not specific to the residents needs and the daily nursing notes do not reflect content of the care plans in place. Care plans in place for one resident described deficits with "cognitive impairment". However, the care plan was not person centred, or specific to what deficits affected this individual resident.

Relatives and residents told inspectors that they had no involvement with care plans, in place for their care. The records do not record any consultation with the resident or their representative.

Significant improvements required

A local pharmacy provides and delivers medication to a small locked pharmacy room on the top floor. A staff nurse is designated to do the medication ordering and returns to the pharmacy every week. This member of staff works one day a week. However, there is no evidence of the person in charge completing any medication administration audit. Inspectors reviewed drug administration records and found one resident who had been administered a prescribed microlax enema on the first day of the inspection, which had not been signed for by the staff nurse.

General housekeeping in the locked pharmacy room was found to be poor. The room was small and lacked any organisation.

4. Premises and equipment: appropriateness and adequacy

Outcome: The residential care setting provides premises and equipment that are safe, secure and suitable.

A good physical environment is one that enhances the quality of life for residents and is a pleasant place to live. It meets residents' individual and collective needs in a comfortable and homely way, and is accessible, safe, clean and well-maintained. Equipment is provided in response to the assessed needs of each of the residents and maintained appropriately.

Evidence of good practice

The shower room with a toilet on the top floor had been refurbished to a high standard. A level shower / wet room was now in place.

The day room on the top floor is bright and used for activities during the day.

The communal sitting room on the middle floor was used by more dependent residents.

Some improvements required

Three shower / bath rooms required upgrading. Inspectors were informed by the provider that these are planned for.

Hand washing and drying facilities are available for staff in shower rooms / bathrooms. However, tablet soap was found in some bathrooms, and communal toiletries were found in a number of shower rooms.

The visitors' room was bright and has comfortable seating provided. However, this room was also used for storage of walking frames and a hydraulic hoist. This arrangement afforded no privacy to residents and their visitors when staff needed to access equipment.

Equipment used for activities was stored in small corridor cupboards. Inspectors observed that storage cupboards were in a disorganised state.

The room the cleaners used as a cleaning store was also used to store continence supplies. Inspectors also observed nine boxes of former residents' records in this locked store room. The cleaners' room did not contain hand washing facilities, stainless steel sluice sink or lockable safe storage for cleaning chemicals. The laundry room on the bottom floor was also seen to be used to store items including pressure relieving mattresses and pumps, which may pose a cross infection risk.

Inspectors found ten large bags of laundry awaiting collection at the front door. Staff informed inspectors that normally this was collected in the early morning by the external laundry company, but this was not the case on the day of the inspection. The laundry was located on the bottom floor. Inspectors were informed that the laundry company collecting requested it be available at the front door of the premises every week for collection. The person in charge said she would look into an alternative arrangement.

The visitors' toilet did not have a handrail and was not wheelchair accessible. There were sufficient shower / bathrooms available for the number of residents. However, shower rooms and the bathroom at the centre did not have accessible privacy locks in place. All of the toilet / shower rooms had three doors, two doors (not in use) from bedrooms either side and one from the corridor. The provider agreed to put in place a temporary measure to prevent residents accessing from either bedroom and to ensure privacy and dignity for residents.

The layout and design of twin rooms did not allow for adequate levels of privacy. One wash hand basin was in front of the door to the room. There was no screening available in the twin rooms to ensure sufficient privacy.

Residents did not have access to a lockable storage space for personal items in their rooms.

Inspectors did not observe any member of staff using the hydraulic hoist which was located in the middle day room during the course of the two day inspection. The service records inspected for the hydraulic hoists maintenance last service record dated 9 October 2009 stated "hoist is getting very worn looking". The provider informed inspectors she would contact the maintenance provider as soon as possible to address this.

Significant improvements required

The maintenance of the premises was poor. In a number of rooms the décor was tired and dated. Doors and paintwork was scuffed and damaged.

Inspectors observed three rooms where the taps were leaking and pouring water into the sink continuously. One resident informed inspectors that this had been a problem and it had been reported to the provider and the staff nurse on duty. A plumber was organised by the provider and visited on 15 February, and fixed / replaced leading taps. A maintenance log kept at the nurses' station noted problems with a radiator in one room which had been signed off as repaired. However, when inspectors met with the resident in this room, a free-standing electric heater was in place, and a relative reported the radiator was still leaking. There were a number of general maintenance issues that the person in charge was not aware of and had not followed up on with the residents affected.

A power cut took place in the kitchen area, and this area was dark and without lights and power for a short period of time.

The fire extinguishers had been serviced. A number of staff have attended a fire warden course, and were able to describe how an evacuation would be organised in case of fire. However, inspectors also noted that none of the residents' beds at the centre had evacuation sheets in place. Inspectors noted that 19 residents were identified by the person in charge as "high dependency".

Inspectors identified a high risk to resident's safety in respect to evacuation in the event of fire or other emergency.

A tall chest of drawers, curtains and a metal bed blocked the nearest level means of escape / fire escape door from the middle day room. The primary means of escape was being used as part of a larger multiple occupancy residents' bedroom (room 22). There was a double glass panel door from the day room on one side and a resident who required maximum assistance and was bed bound occupied a space on another side of the room.

This room was inadequate with regard to the privacy and safety of the resident occupying this area, the other dependent occupants and residents using the middle day room.

The push bar door of the fire exit was insecure and draughty (a gap in the metal frame allowed cold air to enter the room). The directional emergency lighting and fire door from the residents' day room was not visible behind a full length curtain.

These issues were brought to the attention of the person in charge who consulted the resident's family regarding moving to an alternative bedroom. She reported that they were satisfied with this course of action and the resident was allocated alternative accommodation.

The furniture was removed and the person in charge moved her office equipment to one corner of the room, leaving a clear means of escape from the day room.

The sluicing facilities on the bottom floor were inadequate, and did not meet the legislative requirements or best practice in infection prevention and control. Staff stored commodes on all three floors in the shower rooms. Inspectors found commodes that had not been cleaned stored in shower rooms. No facilities were found to be available for disposal and disinfection of commodes and urinals on each floor. Personal protective equipment was not found to be available to staff in the shower rooms.

Laundry staff told inspectors how they used the low sink in the sluice room to sluice any heavily soiled linen and moved it to the adjacent laundry. This sink was found to be very low to the ground and not suitable for this purpose, presenting a manual handling hazard to the workers.

In one shared room, inspectors found an empty bed which had not been adequately cleaned following the discharge of the last resident. Food residue was found on the metal frame of the bed and the paintwork of the wall. This part of the room had not been cleaned. However, clean linen had been placed on the bed. Plasterwork on the wall was damaged. The floor under the bed was dusty and unhygienic.

A portable hydraulic hoist with a rusty base found stored in room 25, was labelled as not in working order. The provider told an inspector it belonged to a residents' family, and was awaiting collection.

The driveway to the car park was not accessible to all residents and visitors.

The dining room was draughty and cold. Residents confirmed that there is always a draught in the dining room.

A number of residents ate their meals in their bedrooms. The meals were brought up in the lift by care assistants. Inspectors found the dining room dark and cool. The dining room was of insufficient size and layout to meet the needs of all residents.

5. Communication: information provided to residents, relatives and staff

Outcome: Information is relevant, clear and up to date for residents.

Information is accessible, accurate, and appropriate to residents' and staff needs. Feedback is actively sought from residents and relatives and this informs future planning and service provision. Information is recorded and maintained in accordance with legal requirements and best practice and is communicated to staff on a need to know basis to ensure residents' privacy is respected.

Evidence of good practice

Residents confirmed they were aware of whom to address a comment or complaint to.

Inspectors observed a satisfactory level of supervision in the sitting room on the middle floor where most residents are based.

Staff engaged with residents during the day. A volunteer was also observed spending time with residents in this room during the morning.

Some improvements required

Staff were helpful throughout the inspection. However, not all staff demonstrated an awareness or knowledge of the regulations or standards for designated centres for older people.

One resident with a history of falls had a detailed record of consultation with her family regarding her ongoing care needs. The person in charge had kept a record of all family meetings and telephone calls. As part of her care plan the resident had started using an alarm system on her bed should she attempt to get out of bed alone and the use of bed rails on her bed had been discontinued. However, inspectors observed that the bedrails on her bed had not been removed and the person in charge was unaware that the bedrails remained on her bed.

Significant improvements required

There was no residents' forum in place. There was no evidence of any detailed consultation process with residents, their relatives or representatives, regarding the likes, dislikes and day to day preferences of the residents. Staff were observed by inspectors discussing their work, and referring to some residents as having been "done" during the morning. The work of the carers was not seen as person-centred.

A new assessment documentation system had recently been introduced. This system had been introduced to staff without any training to support this change in practice.

Inspectors were informed that they were considering changing to an electronic based information system.

Inspectors noted the paper system recently adopted appeared to relate to the acute setting, and the generic care plans used were not found to be centre specific. A small number of residents' records had been transferred to the new documentation system. The older system was being maintained, and was also reviewed by inspectors. The sample of residents' records reviewed were clear and documented liaison with visiting professionals, and communication with family members.

Minor issues to be addressed

Only one member of staff wore a name badge.

A visitors' book was not available for to maintain a record of visitors to the centre.

6. Staff: the recruitment, supervision and competence of staff

Outcome: Staff are competent and recruited in sufficient numbers to meet residents' needs

Staff numbers and skill-mix are determined by the size and complexity of the service and there should be sufficient competent staff on duty, both day and night, to meet the needs of residents. Robust recruitment and selection procedures ensure the appointment of suitably qualified and experienced staff. Staff are supported in their work by ongoing training and supervision.

Evidence of good practice

Staff had received training in detection and prevention of elder abuse. Care assistants were able to tell inspectors what to do if they witnessed any abuse at any time. Staff spoken with by inspectors were enthusiastic about their roles; many staff had worked there for a long time and were familiar with how the centre runs.

Staff were observed to be respectful when working directly with residents at all times.

The person in charge and one other staff nurse have completed a FETAC level 6 gerontology award.

Some improvements required

Contrary to the statement of purpose / information provided for residents, inspectors found there was no key worker system in place.

Staff rosters did not indicate the hours worked and did not contain the full names of staff working at the centre. One staff member working on the first day of the inspection informed inspectors she was on her day off, and came in voluntarily to complete some nursing documentation. This staff member was found to be rostered for the remainder of the week on five 12 hour shifts and one 6 hour shift. This individual staff member told inspectors that she had no personal objections to being rostered.

The person in charge is rostered to work Monday to Thursday. However, the senior nurse identified to inspectors was found not to be rostered to cover the person in charges' days off Friday to Sunday. Staffing rosters were not designed or reviewed by the person in charge, using a nationally validated tool.

Care staff were seen entering and leaving the kitchen area, and the kitchen assistant was not seen to be dressed appropriately for her role in catering for residents.

Only two care assistants had completed Further Education and Training Award Certification (FETAC) Level 5.

Significant improvements required

A sample of seven staff files were reviewed from the 32 made available to inspectors, and found them not to be in compliance with legislative requirements. Staff files were maintained at the provider's office / administration at a nearby centre. None of the files reviewed had evidence of professional references or medical fitness. In many cases no certificates or details of qualifications, or evidence of Garda Siochana vetting were found on file.

No staff lockers are in place and facilities for staff changing facilities were inadequate.

REPORT COMPILED BY

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

11 May 2010

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:	Brymore House Nursing Home
Centre ID:	0120
Date of inspection:	15 February 2010
Date of response:	24 May 2010

Requirements

These requirements set out what the registered provider must do to meet the Health Act 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 and the *National Quality Standards for Residential Care settings for Older People in Ireland*.

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

Prescribed medication was administered to a resident without a staff nurse signing for this medication. There was no evidence of any audit of medication administration practices or adherence to the medication management policy available for review at the centre.

Action required:

The person in charge to undertake a review of medication administration at the centre, and ensure all staff nurses administering medicines are doing so in line with An Bord Altranais Guidance to Nurses and Midwives on Medication Management (July 2007) and all other regulatory requirements.

Reference:

Health Act, 2007
Regulation 25: Medical Records
Standard 14: Medication Management

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: All staff have attended a medication management course in 2009. An audit of medication administration practices has been conducted and our policy on medication management updated.	Immediate

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

The means of escape and fire exit from the middle day room through room 22 was not kept clear.

Action required:

Maintain clear means of escape from middle day room in line with legislative requirements outlined below.

Reference:

Health Act, 2007
Regulation 32: Fire Precautions and Records
Standard 26: Health and Safety

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: The day room has been extended and a clear escape route maintained.	Complete

3. The provider has failed to comply with a regulatory requirement in the following respect:

The centre had inadequate sluicing facilities in place, with an increased infection control risk; this does not meet the legislative requirement.

Action required:

Review and provide adequate sluicing facilities.

Reference:

Health Act, 2007
Regulation 19: Premises
Standard 25: Physical Environment

Please state the actions you have taken or are planning to take following the inspection with timescales:	Timescale:
Provider's response: We are currently building a purpose built sluice room on the ground floor containing all the necessary requisites including a bedpan washer, stainless steel hand basin and sink, sluice toilet and storage for bedpans / urinals.	 Mid June 2010

4. The provider has failed to comply with a regulatory requirement in the following respect:

The registered provider has not system in place for reviewing the quality and safety of care provided at the centre.

Action required:

Establish a system to review the quality and safety of care provided at the centre and provide for consultation with residents and their representatives. Provide a copy of the report to the Chief Inspector.

Reference:

Health Act, 2007
Regulation 35: Review of Quality and Safety of Care and Quality of Life
Standard 17: Autonomy and Independence
Standard 18: Routines and Expectations

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response:	
Annual surveys regarding the quality and satisfaction have always been sent to residents and / or relatives and any suggestions acted upon. These comprise of postal, telephone & verbal communications	Complete
Risk assessments are audited 3 monthly or more frequently as required.	Ongoing
Accident audits are audited monthly.	
Care plans are reviewed at minimum 3 monthly and will now include more detailed consultation with residents and when appropriate their representatives	Ongoing
We have reinstated a comment box in the reception.	Complete

5. The provider is failing to comply with a regulatory requirement in the following respect: Moving and handling equipment maintenance equipment required replacement or repair	
Action required: The Registered Provider shall ensure equipment provided at the premises is in full working order at all times, and maintained as per legislative requirements.	
Reference: Health Act, 2007 Regulation 19: Premises Standard 26: Health and Safety Standard 25: Physical Environment	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Last service on all equipment was in October 2009 and March 2010. Two new hoists have been purchased.	Complete

6. The provider is failing to comply with a regulatory requirement in the following respect: The safety statement in place was not centre specific, and did not adequately address the potential hazards identified in the original risk assessments.	
Action required: Revise the safety statement, review risk assessments documented and review the adequacy of the control measures in place at the centre.	
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 are currently reviewing our safety statement and risk assessments to identify areas of potential hazards and will update as necessary.	End of June 2010

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

The Residents' Guide and the Statement of Purpose were found to be in one document. This document does not accurately reflect the range of residents accommodated and details of laundry charges and charges and names of peripatetic service providers.

Action required:

Review both documents and provide a Residents Guide and a Statement of Purpose that meet the regulatory requirements, and accurately reflect the centre.

Reference:

Health Act, 2007
Regulation 5: Statement of Purpose
Regulation 21: Provision of Information to Residents
Standard 1: Information
Standard 28: Purpose and Function

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response:	
Our Residents' Guide has been revised and now includes details of laundry charges and names and charges of peripatetic services	Complete
Our statement of purpose is currently being reviewed in order to become more centre specific to Brymore, as are our home objectives.	Mid June
We will consult with our resident / relative / staff committee members in order to seek improvements and meet regulatory requirements.	Ongoing

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

Residents records were not person centred, two separate systems were in use. The new system adopted for use by the person in charge and the Registered Provider has been commenced without adequate training and support for nursing staff.

Action required:

Review and audit this system, obtain appropriate training and support for the system adopted on an ongoing basis. Ensure the resident record system used has involvement of each resident, on an ongoing basis.

Reference:

Health Act, 2007
Regulation 22: Maintenance of Records
Regulation 25: Medical Records
Standard 32: Register and Residents' Records

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: This new documentation was a minimum data set tool (Standard 10.5 & appendix A). This was on a trial basis on 5 residents in order for us to evaluate, and if implemented, full training will be given to all staff. We have now introduced a new resident record system. These records are very person centred with emphasis on a holistic approach & involvement with all residents and / or their representatives.	 Ongoing Complete

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

Staff lockers were not available, and staff changing facilities found to be inadequate for the numbers of staff working at the centre.

Action required:

Provision of facilities for staff changing and storage facilities for staff.

Reference:

Health Act, 2007
Regulation 19: Premises
Standard 26: Health and Safety

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: An area has been identified for a staff locker area. This area has been refurbished and includes staff lockers. A new staff shower room has been completed.	 Completed Completed

10. The provider is failing to comply with a regulatory requirement in the following respect: 24 staff working at the centre do not have up to date manual handling training/certification.	
Action required: The Registered Provider to source and provide training to all staff involved with moving and handling at the centre, in line with legislative requirements.	
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: All staff have completed manual handling training and this will be updated in line with legislative requirements.	Completed

11. The provider is failing to comply with a regulatory requirement in the following respect: The activities available at the centre were not person centred, and the programme did not offer choice and variety to all residents.	
Action required: The person in charge to review current provision of activities at the centre and undertake a review with input from individual residents to any amendments to the programme.	
Reference: Health Act, 2007 Regulation 10: Residents' Rights, Dignity and Consultation Standard 18: Routines and Expectations	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Here is a list of all activities we offer, many have been chosen by our residents. The activities programme will be audited frequently and attendance records maintained.	Ongoing

Exercise to music Holistic massage Art – classes & exhibitions Craft Peta dog therapy Memory enhancement games / sessions Reflexology Theatre group Board games Karaoke Gardening Film club Bingo Mobile & in-house library Irish dancing Concerts & choir Sports parties i.e. betting on Grand National, supporting teams in the World Cup Cheese & wine evenings Clothes parties Charity auctions BBQ's & garden parties Memory book / box collaboration	

12. The provider is failing to comply with a regulatory requirement in the following respect: Staff files were not in compliance with legislative requirements. Files were not kept on the premises.	
Action required: The Registered Provider shall review staff files and ensure they contain full information that will ensure compliance with the legislative requirements outlined below.	
Reference: Health Act, 2007 Regulation 16: Staffing Regulation 24: Staffing Records Standard 23: Staffing Standard 23: Staffing Levels and Qualifications	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**

Provider's response:	
All files are now stored on the premises.	Complete
We are still collecting some of the required documents for some of our long-standing staff members, as many of them have worked in Brymore for over 15 years.	Ongoing
All Garda clearance has been applied for in 2009. These records are being returned to us slowly in batches.	
Any member of staff employed since 1 July 2009 have a complete file with all documents required.	

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

Storage space was limited and equipment was stored inappropriately. Records of former residents were stored in a room also accessed by domestic staff.

Action required:

Review storage requirements, for equipment and records and ensure suitable and secure provision is made for storage at the centre. Update the policy for retention and destruction of records in line with the Standards.

Reference:

Health Act, 2007
Regulation 19: Premises
Standard 25: Physical Environment
Standard 32: Register and Residents' Records

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response:	
We have rearranged our storage areas to ensure all equipment is properly stored.	Complete
All former residents' files have been removed and are securely stored.	Complete
We are updating our policy on the retention & destruction of records.	Mid June

14. The provider is failing to comply with a regulatory requirement in the following respect: The menu does not offer choice at each mealtime; food was served lukewarm at lunch time.	
Action required: Review menu choices in consultation with residents, and ensure that each resident is provided with food which is properly prepared, cooked and served, and offers choice at each mealtime. Provide a written menu to each resident to communicate choices available.	
Reference: Health Act, 2007 Regulation 20: Food and Nutrition Standard 19: Meals and Mealtimes	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: We have reviewed our dining room and tray delivery system. Residents are now given the opportunity to be more independent in the dining room and the tray delivery system is now on a course-by-course basis, with only two trays being delivered at a time. We have in the past provided written menus, but following feedback from the residents these were discontinued, as the residents prefer the system we currently have in operation. All lunchtime choices are written clearly on a blackboard, which is displayed in the dining room. We will review this arrangement with our residents on a regular basis.	 Complete Ongoing

15. The provider has failed to comply with a regulatory requirement in the following respect: The complaints policy and procedure displayed at the centre was out of date.
Action required: Review policy and procedures for complaints management and provide residents and relatives with details on the arrangements for dealing with complaints at the centre.

Reference:	
Health Act, 2007 Regulation 39: Complaints Procedures Standard 6: Complaints	
Please state the actions you have taken or are planning to take following the inspection with timescales:	**Timescale:**
Provider's response: As stated on page 17 - all residents knew who to address a complaint to and all our residents and representatives were sent a copy of our complaints procedure in December 2009. This clearly explains the arrangements for dealing with any issues. We have never in 20 years of operation had a complaint or concern raised that was not dealt with in-house, in a timely manner to everybody's satisfaction. We have a very open relationship with all our residents and relatives and will continue to build upon this relationship. The complaints policy on display in the reception hall has been amended to include the Authorities' details. A copy of our complaints policy & procedure is now included in our admission pack.	 Complete Complete

16. The provider has failed to comply with a regulatory requirement in the following respect:	
One room at the centre accommodated five residents; this was not in compliance with criteria outlined in the Standards for existing centres.	
Action required: Review accommodation in line with the standards and plan how to meet that no more than two residents per room will be achieved within six years of implementation of these Standards.	
Reference: Health Act, 2007 Regulation 19: Premises Standard 25: Physical Environment	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: This is not a 5-bedded room. Up until February 15 2010 it was a 3-bedded room with a 2-bedded balcony annex. This has now been reduced to a 1-bedded annex with a separate exit door.	 Ongoing

This 3-bedded area is only used to nurse highly dependant residents or those residents who choose this room. We shall review this current arrangement of accommodation and include its review in our building plan going forward.	

17. The provider is failing to comply with a regulatory requirement in the following respect: There was no identified member of staff on the roster, suitably qualified, who in the absence of the person in charge took charge.
Action required: Identify a key senior manager who will take charge in the absence of the person in charge.
Reference: Health Act, 2007 Regulation 16: Staffing Standard 27: Governance and Management

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: We have now included in our management structure a nurse manager who will take charge when the Nursing Director or Assistant Director is absent. We have also identified key members of staff who now have specified roles and take full accountability for these roles.	 Complete Complete

18. The provider is failing to comply with a regulatory requirement in the following respect: Staff were unfamiliar with the provisions of Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) (Amendment) Regulations 2010.
Action required: The person in charge shall ensure a copy of the Act and any regulations and rules made thereunder are made available to all staff at the designated centre.

Action required: The person in charge shall ensure that all staff members are made aware of the provisions of the Act and all regulations and rules commensurate with their role.	
Reference: Health Act, 2007 Regulation 17: Training and Staff Development Standard 29: Management Systems	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: There have always been copies of the Health Act available along with many other publications. We will now run educational sessions to ensure all staff are familiar with its contents.	 Complete Ongoing

19. The provider has failed to comply with a regulatory requirement in the following respect: An up to date record of any occasion on which restraint was used was not kept, and changes communicated to all staff working at the centre.	
Action required: An up to date record is kept of any occasion on which restraint is used, the nature of the restraint and its duration. Any restraint is for the shortest possible duration.	
Reference: Health Act, 2007 Regulation 25: Medical Records Standard 21: Responding to Behaviour that is Challenging	
Please state the actions you have taken or are planning to take following the inspection with timescales:	**Timescale:**
Provider's response: We have extremely comprehensive records available on restraint going back many years and these records are available for inspection at any time.	 Complete

20. The provider has failed to comply with a regulatory requirement in the following respect: The dining room was found to be cold and draughty.	
Action required: Review the temperature in the dining room. Investigate the cause of the draught and repair if necessary. Provision of adequate and safe heating to the dining room.	
Reference: Health Act, 2007 Regulation 19: Premises Standard 25: Physical Environment	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: We have a full wall length radiator in the dining room and are now monitoring the temperature of this room to ensure that an ambient temperature of above 21 degrees C is maintained. We have conducted a personal and telephone survey in March 2010 regarding heating and noise levels from all residents and representatives and did not receive any negative feedback. We have investigated the cause of the draught and have had all window seals checked in the dining area.	 Ongoing Complete

Recommendations

These recommendations are taken from the best practice described in *the National Quality Standards for Residential Care settings for Older People in Ireland* and the registered provider should consider them as a way of improving the service.

Standard	Best practice recommendations
Standard 17: Autonomy and Independence	The residents' religious needs including attendance at religious services, are identified and facilitated by the provider. **Provider's response:** All religious needs of our residents are met in-house and we will facilitate the wishes of those who would like to attend external services as best we can.
Standard 25: Physical Environment	Adequate levels of screening is provided and used in rooms with more than one occupant. **Provider's response:** Fixed screening is now provided in all shared rooms.
Standard 22: Staffing	Review volunteers visiting the centre and ensure their roles and responsibilities are set out in a written agreement, and they are vetted appropriately. **Provider's response:** We are currently reviewing our volunteer policy. The person in charge is satisfied that all new staff are competent to communicate effectively with residents, including those with communication difficulties, in particular in relation to speaking, listening, reading and writing. **Provider's response:** All new staff are monitored during a probationary period and encouraged to fully avail of our educational sessions.
Standard 29: Management Systems	Review the management structure and ensure there is clearly defined management structure that defines the lines of authority and accountability, specifies roles and details responsibilities for all areas including support services and maintenance. **Provider's response:** We are reviewing the Management Structure and now have clear lines of responsibility and accountability.

Standard 19: Meals and Mealtimes	Care assistants to limit their access to the main kitchen and wear appropriate protective clothing. Review provision of dining space and ensure the dining room caters for all residents. Staff receive training in safe food handling as appropriate to their role and are compliant with safe food handling. **Provider's response**: Care assistants have limited their access to the kitchen. A full review of the dining space has taken place to ensure that all residents can be catered for. All kitchen staff are fully qualified in food safety and handling. This training shall now be offered to any staff member who requires it.
Standard 25: Physical Environment	Review the policy and procedure for maintenance and repairs at the centre. **Provider's response:** We have reviewed our maintenance procedure and have implemented an annual repair / replacement plan.
Standard 29: Management Systems	The person in charge to consider undertaking a qualification in management as part of her professional development. **Provider's response:** This will be considered and included in our 2011 educational planner.

Any comments the provider may wish to make:

Provider's response:

We would like to thank the inspectors for the manner in which they conducted their inspection and we look forward to working with them in the future to improve further the service we provide.

Provider's name: Nicola Taylor
Date: 31 May 2010