<table>
<thead>
<tr>
<th><strong>Centre name:</strong></th>
<th>Glebe House Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Centre ID:</strong></td>
<td>OSV-0000039</td>
</tr>
<tr>
<td><strong>Centre address:</strong></td>
<td>Kilternan Care Centre, Glebe Road, Kilternan, Dublin 18.</td>
</tr>
<tr>
<td><strong>Telephone number:</strong></td>
<td>01 4824001</td>
</tr>
<tr>
<td><strong>Email address:</strong></td>
<td><a href="mailto:glebehouse@cowpercare.ie">glebehouse@cowpercare.ie</a></td>
</tr>
<tr>
<td><strong>Type of centre:</strong></td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
</tr>
<tr>
<td><strong>Registered provider:</strong></td>
<td>Cowper Care Centre Limited</td>
</tr>
<tr>
<td><strong>Provider Nominee:</strong></td>
<td>Seamus Shields</td>
</tr>
<tr>
<td><strong>Lead inspector:</strong></td>
<td>Deirdre Byrne</td>
</tr>
<tr>
<td><strong>Support inspector(s):</strong></td>
<td>None</td>
</tr>
<tr>
<td><strong>Type of inspection</strong></td>
<td>Unannounced</td>
</tr>
<tr>
<td><strong>Number of residents on the date of inspection:</strong></td>
<td>46</td>
</tr>
<tr>
<td><strong>Number of vacancies on the date of inspection:</strong></td>
<td>2</td>
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</table>
About monitoring of compliance

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

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

Regulation has two aspects:

▪ Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
▪ Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider’s compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

▪ to monitor compliance with regulations and standards
▪ to carry out thematic inspections in respect of specific outcomes
▪ following a change in circumstances; for example, following a notification to the Health Information and Quality Authority’s Regulation Directorate that a provider has appointed a new person in charge
▪ arising from a number of events including information affecting the safety or wellbeing of residents.

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.
This inspection report sets out the findings of a monitoring inspection, the purpose of which was following receipt of unsolicited information. This monitoring inspection was un-announced and took place over 1 day(s).

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

From: 21 June 2016 10:00  
To: 21 June 2016 19:00

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

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Our Judgment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome 07: Safeguarding and Safety</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 10: Notification of Incidents</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 11: Health and Social Care Needs</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 13: Complaints procedures</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 18: Suitable Staffing</td>
<td>Non Compliant - Moderate</td>
</tr>
</tbody>
</table>

**Summary of findings from this inspection**

The inspector met with residents, relatives and staff members and observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures. This inspection also considered unsolicited information brought to the attention of HIQA and information received in the form of notifications forwarded by the provider. The unsolicited information were found to be unsubstantiated.

This monitoring inspection was unannounced and took place over one day. There were areas of good practice found and some areas of non compliance identified in the inspection.

There were 46 residents accommodated in the centre on the day of inspection. Twenty five of the residents were assessed as having maximum dependency needs, 9 had high dependency needs, 9 assessed as medium dependency and 3 were assessed as having low dependency needs. There were policies and procedures on the management of responsive behaviours and staff had also received training in this area.

There were policies on the use of restrictive practices to assess, monitor and review practice. There were adequate systems in place to safeguard residents from the risk of abuse. There were measures in place to document and investigate complaints. Staff were very familiar with the residents and were observed to interact with the residents in a respectful and patient manner with them.
The inspector identified areas where improvements were required to enhance positive outcomes for residents, and these related to:

- aspects of care plan documentation,
- the staff skill mix at night time,
- provision of refresher fire safety training for staff.

The areas of non compliance and good practice were discussed with the deputy person in charge, the person nominated on behalf of the provider (the provider ) and senior management following the inspection. The action plan at the end of this report identifies 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 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.
Outcome 07: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe care and support

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

Findings:
The inspector found the provider ensured there were systems in place to protect residents from being harmed or suffering abuse. There were measures to ensure a positive approach to manage responsive behaviours. Restrictive practices carried out, were done in accordance with the regulations and national policy, with an area of improvement identified.

There was a detailed policy on the protection of vulnerable adults. It referenced the Health Service Executive (HSE) Safeguarding Vulnerable Persons at Risk of Abuse, National Policy & Procedures of 2014. The policy included information on the types of abuse, the reporting arrangements and the procedures to investigate an allegation of abuse. Records read confirmed all staff had received training in the prevention of abuse. Staff spoken to were knowledgeable of the types of abuse and the reporting arrangements in place.

The deputy person in charge told the inspector that the centre was not managing residents' monies however, where cash had been provided to residents at their request there was a clear system of this being added to their monthly bill. Each resident had a lockable drawer in their bedroom to hold money.

There had been no allegations of abuse notified to HIQA since the last inspection. The deputy person in charge was familiar with the procedures on how to investigate an allegation, suspicion or disclosure of abuse, and the requirement to notify any such allegation to HIQA.

All residents spoken to said that they felt safe and secure in the centre. Residents stated that they attributed this to the staff who they said they were caring and trustworthy.
The inspector read a policy on the management of responsive behaviours which guided staff practice. At the time of inspection a small number of residents presented with responsive behaviours. Nurses spoken with were clear they needed to consider the reasons people’s behaviour changed, and would also consider and review for issues such as infections, constipation, and changes in vital signs. During the inspection, the inspector observed the staff interacting with residents in a positive manner and taking steps to support individuals when they started to communicate distress or anxiety. For example, distracting residents and moving them to another part of the unit if tensions were rising by taking them for a walk round the corridor and chatting to them.

There were regular assessments completed for the residents and care plans were developed to guide the practice to be delivered, with some improvement identified. For example, the triggers to behaviours and the de-escalation measures to mitigate behaviours were not consistently included (see Outcome 11). Staff informed the inspector how they would handle certain situations with residents. They used evidenced based tools to record incidents when required. Where psychiatric or psychological services had been referred to or appointments made, there were records on file of visits from these professionals and their recommendations.

There was evidence that the National Policy "Towards of Restraint Free Environment" was being implemented in the centre. However, this was still work in progress. For example, there were 19 residents using bedrails. There had been a reduction in recent months, which had slightly had increased again. The deputy person in charge said bed rail usage was regularly reviewed and residents were encouraged to remove bedrails. The majority of bedrails were in place to prevent risks to residents and when they were specifically requested by a resident.

A comprehensive centre specific policy on the use restrictive practices was in place. As reported above, the use of restrictive practices was mainly in the form of bedrails. Some residents required bed alarms. There was evidence these were routinely risk assessed, alternatives trialled, and care plans developed to guide care to be delivered. A number of residents were prescribed an "as required" medicine if they became anxious. There had been limited or no administration of these medicines.

**Judgment:**
Non Compliant - Moderate

<table>
<thead>
<tr>
<th>Outcome 10: Notification of Incidents</th>
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<tbody>
<tr>
<td><strong>A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.</strong></td>
</tr>
</tbody>
</table>

| Theme: |
| Safe care and support |

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

| Findings: |
| The inspector was satisfied a record of all incidents occurring in the designated centre |
were maintained and notified where required to HIQA.

There was an electronic database of incident and accident records maintained. The inspector reviewed a sample of the records which were easy to retrieve and up-to-date.

The person in charge ensured that where required incidents where notified to HIQA within three working days. A quarterly notification of incidents was also submitted as required by the regulations.

**Judgment:**
Compliant

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### Outcome 11: Health and Social Care Needs

*Each resident’s wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident’s assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.*

**Theme:**
Effective care and support

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

No actions were required from the previous inspection.

**Findings:**

The inspector found the residents wellbeing and welfare was maintained to a good standard of nursing care. There was good access to general practitioner (GP) and allied health services. There were aspects of care plan documentation that required improvement.

The assessment and care plans for residents were held in hard copy, and they were securely stored in a locked room or a locked press depending on the unit. The nursing staff completed a range of recognised clinical assessments for the residents and care plans for their identified needs, for example, nutrition, continence, activities, communication, nutrition, daily living skills, mobility and pain management. These were completed on a four monthly or more frequent basis. Records showed that where there were known risks related to a residents care, these were clearly were set out in the care planning documentation on admission.

The inspector reviewed three residents care plans. The care plans were seen to cover residents assessed healthcare needs, with information about residents social, emotional and spiritual needs included. However, the documentation of some care plans required improvement as the plans did not consistently reflect the good practices carried out by staff. For example, personal care, responsive behaviours, nutrition and pressure sore prevention. This was discussed with the deputy person in charge who assured the inspector the care plans would be updated.
There was evidence of consultation with residents or their families in their care plan reviews. There were records were on file when residents were updated on any changes made to their care plans. This was confirmed by residents and family members spoken to.

There were policies and procedures in place for the management of falls, nutrition, and wound care. The inspector found good practice in these areas and staff were familiar with the policies which were implemented in practice. There were regular reviews carried out of each area. It was noted there were records of weekly weights for some residents. However, some of the records were not clear. For example, records were not in chronological order and some were not dated. It is acknowledged that the dietician for the service completed a monthly review of all residents' weights and developed a detailed report on each resident that included weight loss, weight gain and the action being taken.

There was good access to internal allied health services of a physiotherapist and dietician. In addition, residents were seen by and referred to other services, for example, speech and language therapy, chiropody, optician and dentist. There was access to geriatrician and psychiatry of older age services in the area also. There was evidence that the allied health professionals recommendations were included in the care plans.

There was access to services of GP, who visited the centre. If the residents preferred they could also retain the services of their own GP. Records showed that where medical treatment was needed it was provided. If residents' refused treatment, this was respected and documented.

There was evidence was during the inspection that residents were closely monitored, and where there was a change in the condition of the resident, action was taken quickly in response. Records showed that residents had been seen by a GP, or in some cases went to hospital for further assessments. Where residents had been admitted to hospital, transfer records were seen that detailed what the residents' needs were, and included any medication they were prescribed.

The inspector found there were meaningful social activities in place. The care staff facilitated activities in the centre. There was an activities programme displayed in the main sitting room. Residents individual social care needs were assessed. A care plan of their likes and interests was completed. A "Key To Me" life story had been developed for some residents' by their families. It provided detailed personal information on the resident such as their background, family, occupation, hobbies and interests. There was a range of interesting things for residents' to take part in if they chose to. During the inspection, activities were taking place with residents' including a skittles/exercise class, music session and chat amongst the residents. There is a separate dementia focused wing that accommodates 16 residents. A separate communal sitting room and a quieter sitting room is provided here for these residents.

**Judgment:**
Substantially Compliant
Outcome 13: Complaints procedures
The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:
Person-centred care and support

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

Findings:
The provider demonstrated a positive attitude towards complaints. There was a complaints procedure displayed in the reception and at the back of the residents' bedroom door. The procedure included an appeals process if complainants were unhappy with the outcome.

All complaints were logged and investigated by the complaints officer (the person in charge). The inspector read a sample and there was evidence of the action taken, outcome, and a record of the complainant's level of satisfaction.

The complaints policy had been recently updated and the inspector found that it was comprehensive. However, there was no person formally nominated and separate from the complaints officer to oversee complaints were recorded and responded to. This was discussed at the feedback meeting and the provider said the general manager for the centre would be nominated to this role.

The residents and relatives told the inspector they could talk to the person in charge if they had any complaints.

Judgment:
Substantially Compliant

Outcome 18: Suitable Staffing
There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

Theme:
Workforce

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

**Findings:**
The inspector found the provider had ensured staff had good access to training, and all staff were regularly appraised. However, an adequate staff skill mix was not in place to meet the assessed needs of residents' in the centre at night-time. There were some deficits in staff having up-to-date fire safety training, and fire safety information for agency staff required improvement.

There was a satisfactory staff skill mix on duty during this inspection. However, the inspector was not satisfied that there was an adequate nursing staff skill mix at night time to meet the assessed needs of residents in The Glebe Nursing Home. From a discussion with the deputy person in charge and clinical director, one nurse was rostered on duty at night time in the centre from 8pm to 8am. While there was no evidence of negative outcomes for residents, of the 46 residents living in the centre at the time of the inspection, 50% of the residents' had a high to maximum dependency level, and approximately 80% of all residents' had a dementia, cognitive impairment or a psychiatric diagnosis.

The provider and the deputy person in charge acknowledged the skill mix was not adequate. The centre was currently down three whole time equivalent nursing staff grades. A recruitment drive was taking place and to date two nurses had accepted placement. As more nurses accepted placement, the staff skill mix would be increased.

An actual and planned staff was roster was read. It was noted agency staff were not indicated when they worked shifts. The deputy person in charge assured the inspector this would be rectified.

The centre used between one and three agency staff per day. The deputy person in charge said they used the same staff to ensure continuity of care was provided to the residents. There was an agency service level agreement in place, which outlined the training and documents in place for these staff.

Residents interviewed were complimentary of the staff team and commented on their caring nature.

There was evidence that staff had access to education and training as there was a training programme in place coordinated by the person in charge. In addition, all staff had completed mandatory training (prevention of abuse training and fire safety training). However, there were some deficits identified:

1. Four staff did not have up-to-date refresher fire safety training,
2. Some staff were unclear of the fire safety arrangements in place,
3. There were no fire safety induction procedures for agency staff.

This was brought to the attention of deputy person in charge, who took immediate action to address the matter. Following the inspection, confirmation of training for the staff was submitted, which confirmed training would take place on the 22 and 27 June 2016. A new fire safety checklist to be signed by all agency staff had been developed.
All new agency staff would be briefed on fire safety precautions on start of duty in the centre.

The inspector reviewed a sample of files and found that nursing staff had up-to-date registration with An Bord Altranais agus Cnámhseachais na hÉireann (Nursing and Midwifery Board of Ireland).

A staff appraisal system was in place. This was completed on an annual basis, and reviewed staff development and training requirements.

Judgment:
Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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

Action Plan

Provider’s response to inspection report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Glebe House Nursing Home</th>
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</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000039</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>21/06/2016</td>
</tr>
<tr>
<td>Date of response:</td>
<td>18/07/2016</td>
</tr>
</tbody>
</table>

Requirements

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

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

Outcome 07: Safeguarding and Safety

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Progress was required in the implementation of the National Policy in terms of the use of bedrails in the centre.

1. Action Required:
Under Regulation 07(3) you are required to: Ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Please state the actions you have taken or are planning to take:
The nursing home management has an aspiration to achieve a goal of a restraint free environment. Where suitable, existing bed rails shall be replaced with easy riser bed rails which are less restrictive compared to standard bed rails. These easy riser bed rails shall also be used for residents who specifically request the use of bed rails as they feel safer if there are bed rails in place to stop them from rolling out of their beds. A full assessment and education shall be carried out prior to use of these bed rails.
As per national policy, we will continue to use restraints as a last resort where all means have been exhausted to ensure the safety of the residents. Comprehensive risk assessments shall be completed before implementing equipment which may be considered a form of physical restraints such as bed rails.

Proposed Timescale: 31/08/2016

Outcome 11: Health and Social Care Needs

Theme:
Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Care plans did not consistently reflect the practices delivered by staff for example, responsive behaviours, nutrition and prevention of pressure sores.

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

Please state the actions you have taken or are planning to take:
The key workers were directed by the Person in Charge to review and update the individual care plans allocated to them to ensure that the contents are reflective of the practices delivered by the staff. The assistant care manager shall audit these care plans to ensure that these are appropriately updated, provides clear direction to staff, and are compliant to the regulations. The audit outcome shall also be validated by the Person in Charge.
The ongoing training of the staff involved in care planning shall continue and shall focus on providing the staff with knowledge and understanding on how to develop and implement person centred care plans.
Regarding care plans for responsive behaviours, we shall continue to monitor triggers for changes in the resident’s behaviours and document effective actions taken by the staff to deescalate behaviours. This information shall be used to inform the resident’s care plan and guide the staff in effectively managing responsive behaviours.
Outcome 13: Complaints procedures

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A person had not been nominated to oversee complaints were responded to and recorded.

3. Action Required:
Under Regulation 34(3) you are required to: Nominate a person, other than the person nominated in Regulation 34 (1)(c), to be available in a designated centre to ensure that all complaints are appropriately responded to and that the person nominated under Regulation 34 (1)(c) maintains the records specified under in Regulation 34 (1)(f).

Please state the actions you have taken or are planning to take:
The complaints procedure has been reviewed and the Centre Business manager has been designated as the person responsible for following the complaints process through from beginning to end. This includes auditing responsibility and verification that complaints are responded to and recorded in a timely manner. The complaints policy has been updated to reflect this change.

Proposed Timescale: 31/08/2016

Outcome 18: Suitable Staffing

Theme:
Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was an inadequate staff skill mix night time to meet the assessed healthcare needs of residents’

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

Please state the actions you have taken or are planning to take:
Cowper Care is committed to increase the number of staff nurses on the night staff complement. The availability of nursing staff is a most serious issue for the organisation at present and is preventing the implementation of this plan. We are currently recruiting in the Philippines, India, Zimbabwe, and across Europe in an effort to fill the nurse vacancies.
We have a number of nurses waiting in their own countries for registration with NMBI. A number of nurses are also scheduled to complete their adaptation and should be
available for employment before the end of the year. This plan shall be implemented following this process.

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<tr>
<th>Proposed Timescale: 31/01/2017</th>
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<tr>
<td><strong>Theme:</strong> Workforce</td>
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**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There were gaps in the provision of refresher fire safety training for some staff.

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

**Please state the actions you have taken or are planning to take:**
All staff are now current with their annual fire training. The Person in Charge has an electronic recording system which lists staff members who are due for training. The staff from the HR department shall be notified to schedule the staff to attend. A monthly review of training is carried out by the Person in Charge to ensure that the mandatory staff training is kept up to date.

<table>
<thead>
<tr>
<th>Proposed Timescale: 18/07/2016</th>
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<tr>
<td><strong>Theme:</strong> Workforce</td>
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**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Not all staff were knowledgeable of fire safety procedures in the centre.

The provision of fire safety information for agency staff required improvement.

6. **Action Required:**
Under Regulation 16(1)(c) you are required to: Ensure that staff are informed of the Act and any regulations made under it.

**Please state the actions you have taken or are planning to take:**
We have added an induction document for agency staff to receive an appropriate introduction to the fire safety procedures of the centre. On completion of the induction, they shall sign a document confirming that they have understood the procedures on what to do in the event of an emergency, The manager on duty or an appointed nurse on duty shall carry out the induction and shall ensure that this procedure is adhered to for all agency staff.

| Proposed Timescale: 18/07/2016 |