<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Mill Brook Manor Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000763</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Slade Road, Coolmines, Saggart, Co. Dublin.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>087 777 3271</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:millbrookmanor@yahoo.ie">millbrookmanor@yahoo.ie</a></td>
</tr>
<tr>
<td>Type of centre:</td>
<td>Health Act 2004 Section 38 Arrangement</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>Coolmine Healthcare Limited</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Gerry Gallen</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Deirdre Byrne</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>Shane Walsh</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Unannounced</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>58</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>5</td>
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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 to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From: To:
08 August 2016 20:00 08 August 2016 22:30
09 August 2016 09:30 09 August 2016 20:00

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

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Our Judgment</th>
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<tbody>
<tr>
<td>Outcome 01: Statement of Purpose</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 02: Governance and Management</td>
<td>Non Compliant - Moderate</td>
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<tr>
<td>Outcome 04: Suitable Person in Charge</td>
<td>Compliant</td>
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<tr>
<td>Outcome 05: Documentation to be kept at a designated centre</td>
<td>Non Compliant - Moderate</td>
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<tr>
<td>Outcome 07: Safeguarding and Safety</td>
<td>Non Compliant - Moderate</td>
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<tr>
<td>Outcome 08: Health and Safety and Risk Management</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 09: Medication Management</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 11: Health and Social Care Needs</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 12: Safe and Suitable Premises</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 13: Complaints procedures</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 14: End of Life Care</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 18: Suitable Staffing</td>
<td>Substantially Compliant</td>
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Summary of findings from this inspection

This was an unannounced monitoring inspection by the Health Information and Quality Authority (HIQA). The purpose of the inspection was to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and the National Standards for Residential Care Settings for Older People in Ireland. This inspection also considered information received by HIQA relating to end of life care and health and social care needs.

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

The centre is located in a suburban part of Dublin. At the time of the inspection,
there were 58 residents accommodated in the centre. The premises met the requirements of the regulations. They were clean and well maintained.

Inspectors identified an area of risk regarding staff knowledge of the centre's fire evacuation procedures. This required immediate action. In addition, staff knowledge of the policy on safeguarding vulnerable adults was inadequate. The provider took appropriate action during the inspection to address these issues.

The monitoring and care of residents with unintended weight loss and those at risk of pressure related skin ulcers required improvement. The procedures for the recruitment and vetting of staff were not fully implemented.

Staff were observed to be responsive to residents' health and social care needs, and appeared to be respectful of their privacy. There was an adequate number and skill of staff. Residents spoken with expressed satisfaction with the care and supports available to them. There were good practices in the provision of end-of-life care.

A total of 12 outcomes were inspected and four outcomes were found in full compliance. There was substantial compliance in relation to three outcomes: premises, complaints and workforce.

There were moderate non compliances identified relating to five outcomes: governance, documentation, safeguarding and safety, health and safety, health and social care needs.

The seven actions from the previous inspection were followed up. Six actions had been completed. One action was not fully addressed, as outlined under Outcome 8.

The action plan at the end of this report identifies the actions where improvements must be made to meet the requirements of the regulations and the national standards.
Outcome 01: Statement of Purpose
There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:
Governance, Leadership and Management

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

Findings:
The action from the previous inspection regarding the statement of purpose was followed up.

The provider nominee had revised the statement of purpose since the last inspection. It had been updated to reflect the needs of the residents for whom the centre provides care for, including the arrangements for admissions. It stated the number of beds registered in the centre was now 63.

Since the last inspection, the provider had considered the deficits regarding lack of private space to meet visitors in private and the limited communal space available to residents. A visitor's room was now provided, and there was more use of space throughout the centre to incorporate communal seating space for residents. This is discussed in outcome 12 (premises).

Judgment:
Compliant

Outcome 02: Governance and Management
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.

Theme:
Governance, Leadership and Management

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

**Findings:**
Inspectors found there was a clearly defined management structure in the centre. However, improvements were identified in the governance of the centre to ensure the effective delivery of care to residents. Furthermore, the systems in place to monitor the quality of the service and support continuous quality improvements were not sufficiently robust.

There was a clearly defined senior management team that included the representative of the provider entity (the provider), the person in charge and a clinical standards officer. There were arrangements in place for senior management to meet and clear lines of authority and accountability of their roles were in place. The provider was based in the centre two to three days per week and met the person in charge on site. In addition, there were formal meetings held every two months with the provider and the person in charge. A sample of recent meetings minutes was read and they contained detailed reports of the operation of the centre. However, the governance and management arrangements at local level required improvement. They did not provide an adequate level of supervision of care and practice in order for the centre to be in compliance with the regulations. This is supported in the findings on this inspection as described in Outcomes 7 (safeguarding and safety), 8 (health and safety), 11 (health and social care needs) and 18 (workforce).

There were systems in place to monitor the service provided to residents. However, these required improvement. There were weekly reports generated by the person in charge on key performance indicators (KPIs). Where clinical risks were identified the person in charge said these were discussed and escalated if required, there was no evidence of the discussions or a plan developed of the follow up action to be taken.

The person in charge completed a range of audits on a monthly and three monthly audits basis. A sample were read on areas such as end of life, restraint, weight loss, medicines, fire safety and staff documentation. The audits were discussed at the bi-monthly management meetings between the provider nominee and the person in charge. However, there was no action plan developed to address findings from the audits to bring about improvement. Furthermore, the audit process had not picked up on issues regarding weight-loss, pressure sore prevention, fire safety and staff files which were identified by inspectors as outlined in the body of the report.

The provider had developed an annual report for 2015 on the overall review of the safety and quality of care of residents as required by the regulations.

**Judgment:**
Non Compliant - Moderate

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**Outcome 04: Suitable Person in Charge**
The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.
Theme:
Governance, Leadership and Management

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

Findings:
Inspectors were satisfied that the centre was managed full time by a registered nurse with experience in the care of older people.

The centre is managed by a suitably qualified and experienced person in charge. The person in charge id full time in her role since the centre opened in November 2015. She had been interviewed at the previous inspection. Inspectors found she was familiar with the residents and their health and social care needs.

Residents told inspectors they were familiar with the person in charge. She ensured all documentation required for review during the inspection was promptly provided and made fully accessible to inspectors.

The person in charge had a post graduate management qualification in care of older people and in management. She also continued her own professional development and was completing a course in management and leadership. She had attended infection control and restraint training, and had completed all mandatory training areas.

She was supported in her role by a clinical nurse manager (CNM), who deputised in her absence.

Judgment:
Compliant

Outcome 05: Documentation to be kept at a designated centre
The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:
Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):
The action(s) required from the previous inspection were satisfactorily implemented.
Findings:
Inspectors found documentation was secure, easy to retrieve and accessible. However, a number of improvements were identified in relation to the centre's key operational policies and procedures.

The three actions from the previous inspection were followed up. The actions were:

1. The admissions policy had included a plan on admitting the initial intake of residents (when the centre first opened in 2015).
2. The centre did not have a record of the number, type and maintenance record of fire fighting equipment.
3. The centre did not have a copy of the certificate of insurance.

The three actions had been addressed. The admissions policy had been updated since the last inspection, to indicate the number of residents to be admitted once the centre opened. There were now 58 residents living in the centre.

The fire safety records included the record of the number, type and maintenance record of fire fighting equipment as required.

A certificate of insurance was read that confirmed there was cover in the event of injury to residents and loss of property.

At this inspection, a sample of policies and procedures as required by schedule 5 of the regulations were read. There were some improvements identified:

The policy on the management of nutrition and hydration required review. For example, it did not outline the criteria to refer residents who had experienced significant weight loss or gain to a dietician.

The recruitment and vetting policy was not fully implemented in practice. For example, one staff references had not been verified, and some were verified after staff had commenced work in the centre.

Inspectors reviewed four staff files, and found most of the information required as per Schedule 2 of the regulations was in place. However, one file had no reference from their previous employer and two files had no explanation for gaps in the person’s employment history.

Judgment:
Non Compliant - Moderate

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 provider had measures were in place to protect residents from abuse however, improvements were identified in relation to staff knowledge of safeguarding.

Inspectors found improvements were required to ensure staff were knowledgeable of the policies and procedures on the prevention, detection and response to abuse. Inspectors spoke to some staff who were not fully informed about abuse and were not sufficiently familiar with the policies and procedures. For example, the types of abuse that exist and the indicators of abuse. This was discussed with the person in charge who was requested to take appropriate action. She assured inspectors that action would be taken. Training was scheduled to take place on the 11 August 2016. It would be facilitated by the person in charge. Following the training, the person in charge submitted the staff sign in sheets to HIQA, confirming all staff had completed the elder abuse training.

The training records also read indicated up to 24 staff had yet to attend safeguarding training. It is acknowledged that the centre opened in late 2015, as a result a high number of new staff had been recruited recently as more residents were accommodated in the centre. All staff received an overview of the policy during their induction until they attended formal training. To capture all staff who had yet to complete the course there had been regular training days and a schedule of future training dates was drafted.

There was a policy on the prevention, detection and response to abuse which guided staff practice. While the policy did not reference the Health Service Executive (HSE) policy and procedures "Safeguarding Vulnerable Persons at Risk of Abuse" 2014, the provider was aware of the policy and had a copy of same. The inspector was shown an updated policy at the end of inspection that included reference to the procedures.

The person in charge was familiar with the procedures on how to investigate an allegation, suspicion or disclosure of abuse. There had been no allegations of abuse in the centre that required notification prior to the inspection.

A visitor’s book was maintained and all visitors to the centre were required to sign in and out of the centre. There was a staff member assigned to the main reception until 10pm each day. The entrance was secure and required a key pad code to open the doors. Inspectors spoke to some residents who said that they felt safe and secure in the centre.
There was a policy on the management of responsive behaviours. It guided staff practice. At the time of inspection there were a small number of residents who presented with responsive behaviours. Care plans were developed to ensure a consistent approach when working with these residents. Staff informed inspectors how they would handle certain situations with residents. They used evidence based tools to record incidents and then determine a plan of care. There was access to psychiatric or psychological services if required.

The national policy Towards of Restraint Free Environment in Nursing Homes (2011) was implemented in the centre. The most up-to-date records from July 2016 confirmed five residents used bedrails. The person in charge said bed rails after an assessment and the alternatives were considered. For example, six residents used shorter bedrails which were not full length and enabled each resident pull themselves up in their bed.

There was a policy on the use restrictive practices. As reported above, the use of restrictive practices was mainly in the form of bedrails. There was evidence these were routinely risk assessed, alternatives trialled, and care plans developed to guide care to be delivered. Residents' consent was clearly documented on their file. There was very little use of "as required" (PRN) medicines to manage residents' behaviours. In the last month there had been one instance of this type of medicine administered.

Judgment:
Non Compliant - Moderate

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

Theme:
Safe care and support

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

Findings:
Inspectors found there were procedures in place to prevent the spread of fire. However, improvements were required in staff knowledge of the procedures.

The systems in place to ensure staff working in the centre were familiar with the fire evacuation procedures required improvement. Inspectors found some staff were not aware of the procedures to follow in the event of the fire alarm. For example, some staff spoken with knew what to do if the fire alarm was activated and were unfamiliar with the fire evacuation procedures. This was brought to the attention of the person in charge and the provider. Immediate action was taken before the end of the inspection, as follows:

- revised fire safety procedures were developed for display at each nurse's station,
- pictorial fire procedures were also developed to be displayed throughout the centre for residents to see,
- staff were scheduled to attend fire safety training on the 11 August 2016.

The staff sign in sheets were submitted to HIQA following the training which confirmed the staff had completed the training.

The fire safety training records were read by the inspectors. While there was evidence of regular fire safety training happening in the centre every few months, up to 24 new staff had yet to complete fire safety training. An additional date for fire safety training was scheduled for of the 19 August 2016 to capture all staff. As reported earlier, there had been a large number of staff recently recruited since the centre opened. All new staff were given an overview of fire safety procedures by the general manager as part of their induction.

Inspectors met the centre manager who outlined his role in fire prevention. He said fire drills take place every two to three months in the centre. However, drills had not picked up on staff lack of knowledge as outlined above.

Service records read confirmed that the emergency lighting and fire alarm system were serviced regularly and the fire extinguisher equipment had been serviced in September 2015. It was noted that the fire panels were in order and fire exits, were checked on a weekly basis, and were unobstructed.

An up-to-date safety statement was in place. There were risk management policies read the met the requirements of the regulations. There was a risk registers developed for the centre. Where a risk was identified, they were evaluated and controls were in place for mitigation. However, one area of risk had not been assessed and required improvement. For example, the smoking room had not been risk assessed for potential hazards such as fire risk. While there was regular half hour checks carried out when residents were in the room, it was not provided with fire safety equipment within it or close by. This was an action at the previous inspection and was not addressed. This was brought to the provider’s attention.

Inspectors observed many residents were actively mobile, and were seen to walk around the centre. Where residents required support they were seen being escorted around the centre. There was training provided for staff in the movement and handling of residents. There was safe floor covering and handrails throughout the centre. A passenger lift accessed the centre’s two floors.

There was a policy in place for the prevention and control of infection. Some staff had received training in infection control and hand hygiene. However, some members of staff had not yet completed the training. To date there had been no outbreak of an infection in the centre, and there was access to supplies of gloves and staff were observed using the alcohol hand gels which were available throughout the centre.

**Judgment:**
Non Compliant - Moderate
Outcome 09: Medication Management
Each resident is protected by the designated centre's policies and procedures for medication management.

Theme:
Safe care and support

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

Findings:
Inspectors found the provider ensured residents were protected by the centre's policies and procedures for medication management.

A medicine management policy was read and it provided detailed guidance to staff. A nurse was accompanied by one of the inspectors on a medicine administration round and was observed to administer the prescribed medicines for each resident in line with professional guidelines.

All medicines were securely stored in the centre, inside a locked room only accessible to nursing staff and within a locked trolley during medicine administration rounds. The medicines that required temperature controls were stored in a designated refrigerator. There were daily temperature checks recorded and these were found to be within the minimum standard required.

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

There were procedures in place to investigate medicine near misses and errors. Inspectors were informed there had been no medicine near misses or errors in the centre.

There were audits of the medicine and prescription sheets along with staff practices. The reports of a sample of audits were read by inspectors and they contained detailed action plans and recommendations.

Staff nurses were trained in medicine management practices by the pharmacy service. The service had recently provided training on the 4 August 2016. The nursing staff completed an online medicine course on an annual basis.

Judgment:
Compliant

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:
Inspectors found improvements were required in relation to unintended weight loss and monitoring residents at risk of developing pressure sores.

Weight loss:
Inspectors found that residents were not consistently monitored for unintended weight loss and consequently the interventions and specialist services were not consistently provided. There was a policy on the management of nutrition however, it did not fully guide staff practice. For example, the policy did not include the procedures for when to refer residents at risk of malnutrition or weight loss to allied health professionals, such as the dietician services. Inspectors reviewed the files of one resident who had experienced weight loss of 5kg in one month period. However, they had yet to be referred to a dietician. Inspectors requested that action be taken and to provide an update to HIQA. Before the end of the inspection the resident had been reviewed by a dietician and a general practitioner (GP).

A second resident’s weight records indicated large gaps in monitoring and responding to their weight loss. For example, in January 2016 the resident’s weight was documented but there was no weight recorded for six months until June 2016, which indicated a weight loss of 9kg. The resident’s weight was then measured two days later indicating a gain of 18kg. While the resident was seen by a dietician in relation to their weight loss following this, there was no further monitoring of their weight to ascertain whether the information was correct and what further action was required. A nutritional care plan was read. However, it did not reference the resident's risk of weight loss and gain over the past year, and the advice of the dietician in relation to their diet. This was brought to the attention of the person in charge during the inspection.

There was monthly data collection of residents' weight data and a review was carried out. Improvements were identified as outlined in Outcome 2.

Wound Care:
There were systems in place to prevent the risk of residents developing pressure sores. However, the monitoring of residents required improvement. Residents’ skin integrity was regularly assessed and where a risk of developing pressure sores was identified a care plan was developed. However, one resident’s care plan was not implemented in
practice. For example, the care plan stated the resident was to be turned every few hours. But this was not happening in practice. A small number of residents spent long periods of time in bed during the day and required support to mobilise. Three of these residents’ files read by inspectors. There were limited or no documented evidence to indicate if these residents had been re-positioned in bed on a regular basis. In addition, the pressure relief mattress settings for two residents were incorrect. There were weekly checks of the pressure relief mattresses by staff but these issues had not been picked up on. These matters were also brought the attention of the person in charge during the inspection.

Assessment and care planning:
Inspectors reviewed a sample of residents’ files. The clinical needs of residents were assessed using recognised tools. There were care plans in place for residents where required. However, some care plans did not guide the care to be delivered. For example, significant weight loss, prevention of pressure sores and end of life care plans. Some care plans were not consistently updated to reflect the residents changing condition. There was evidence of consultation with residents or their loved ones where required.

There was good access to the services of medical professionals, with some improvement identified. There was evidence that residents had access to general practitioner services. If residents wished they may retain the services of their own GP. There was evidence of referrals and follow up appointments with chiropody, speech and language therapy and dietician services, apart from the dietician referral above. One resident wished to have an appointment to see a physiotherapist. However, to date, no referral had been made on the resident's behalf, and there was no rational for why the referral was not made. This was discussed with the person in charge and she said action would be taken. A physiotherapist had just been recruited to work part time in the centre.

Judgment:
Non Compliant - Moderate

Outcome 12: Safe and Suitable Premises
The location, design and layout of the centre is suitable for its stated purpose and meets residents’ individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:
Effective care and support

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

Findings:
The location, design and layout of the centre was suitable for its stated purpose. It met
residents’ individual and collective needs in a comfortable and homely way. The premises were in line with Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. Further exploration in best practice in the design and layout of the environment for residents with a dementia is recommended.

There were 23 residents with a diagnosis of dementia living in the centre at the time of the inspection. It was noted that the design and layout of the centre could be improved to enhance the functioning and overall experience of these residents. For example:

1. the creation of specific areas of interest along and throughout the corridors used by residents,
2. the use of contrasting colours in en-suite and communal bathrooms to enable those with dementia to remain independent when using their bathroom,
3. the use of directional signage at eye level which would enable residents living with a dementia to orientate their way around the centre.

The centre was clean, well lit and well heated. Bedrooms contained all the furniture residents required including adequate storage facilities. Residents were encouraged to personalise their bedrooms and inspectors saw that most residents did so. Bedrooms were en-suite. There were several communal areas and all were decorated in a homely manner.

The corridors were wide and had handrails in place. There were seating areas along the corridors which gave residents a place to rest when walking. Inspectors noted that there were a number of communal areas on the ground floor, along with a large sitting room. A large conservatory and reception area provided communal seating areas also.

There was a dining room cum sitting room on the first floor. An activities room and meeting rooms were provided. There was a visitor’s room located in the centre if residents preferred to meet in private.

Residents could access the enclosed garden via double doors leading from some communal rooms. It was safe, secure and contained a circular walking path and seating for residents. There was a large garden around the perimeter of the centre also.

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 complaints procedure was displayed at the main entrance to the centre and it clearly described how to make a complaint. The written policy on complaints management was in line with legislative requirements.

A record of complaints was maintained. Since the centre opened 13 complaints had been received and investigated. Inspectors read a document which gave an overview of each complaint, a summary of the investigation carried out and the action taken. However, the complainants satisfaction with the outcome and if details of the appeals process had been provided were not documented. This was discussed with the person in charge.

The complaints policy listed details of the nominated complaints officer within the centre and an independent person was available for appeals.

The person in charge stated that verbal complaints would be brought to her direct attention also.

Judgment:
Substantially Compliant

Outcome 14: End of Life Care
Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.

Theme:
Person-centred care and support

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

Findings:
The provider had developed policies and procedures to ensure each resident’s end-of-life care needs were met.

There was an end-of-life care plan was developed for each resident. There was one resident approaching end of life during the inspection. There was detailed guidance on the care to be provided to support the resident in their plan. It included information on the resident's spiritual, emotional and psychological needs. There was information on the resident's preferences and family involvement in their end-of-life care. It was noted that the physical care needs to be provided for the resident was not clearly outlined, see Outcome 11 (healthcare needs).

The person in charge and provider informed the inspector that a local palliative care
team provided support and advice when required. There was evidence of their visits on the resident's file also.

There was access to religious services where necessary. An oratory was also available in the centre.

Judgment:
Compliant

Outcome 18: Suitable Staffing
There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) 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:
Inspectors found there was an adequate staff skill mix and number to meet the current residents' assessed needs. An area of improvement was identified in the recruitment practices and the provision of training for staff.

There was a recruitment and vetting policy in place. Inspectors reviewed four staff files, there were some gaps were identified. Furthermore, the system of verifying references was not in line with the centre's own policy. See Outcome 5 (documentation) for more information on both.

Inspectors found that nursing staff had up to date registration with An Bord Altranais agus Cnáimhseachais na hÉireann (Nursing and Midwifery Board of Ireland) for 2016.

There were a number of external service providers providing a valuable service in the centre. While there was evidence of An Garda Siochana vetting for these persons, their roles and responsibilities were not set out in writing.

Training records read confirmed that mandatory training was provided to all staff. There was a system to identify those who had received any training and any deficit.

There was evidence of other training provided to staff in order to meet residents' assessed needs. For example, infection control, restrictive practices, medicines
management and movement and handling of residents'. However, training for staff in the prevention of pressure sores and nutrition was required. Also, some staff had not yet completed the infection control training.

At the time of the inspection there were 58 residents accommodated in the centre. Nine residents' were assessed as maximum dependency, 18 assessed as high dependency and 24 were medium dependency. There were three residents assessed as low dependency and a further three assessed as independent. Inspectors found there was adequate number and skill mix of staff working in the centre to meet the assessed needs of the residents. An actual and planned roster was maintained. A review of the roster showed there was a minimum of three nursing staff on duty over a 24 hour period. There was a regular pattern of rostered care staff.

The person in charge told the inspector that she was satisfied with the staff skill mix. She said she regularly reviewed the staffing number and skill mix as per the dependency levels of the residents. Residents and staff spoken with felt there was adequate levels of staff on duty.

A bank of relief staff was available if staff went on unexpected leave. There were teams of ancillary staff directly employed in the centre, e.g. a receptionist, housekeeping staff, laundry staff and catering staff.

Judgment:
Substantially Compliant

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>Mill Brook Manor Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000763</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>08/08/2016</td>
</tr>
<tr>
<td>Date of response:</td>
<td>20/09/2016</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 02: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The systems in place to monitor the quality of the service and support continuous quality improvements were not sufficiently robust. There was no action plan developed to address findings from the audits to bring about improvement. The audit process had not picked up on issues regarding weight-loss, pressure sore prevention, fire safety and staff files.

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
The governance and management arrangements at local level required improvement as they did not provide an adequate level of supervision of care and practice in order for the centre to be in compliance with the regulations.

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

**Please state the actions you have taken or are planning to take:**
An updated auditing plan has now been put in place which includes clearly identified action plans in order bring about improvement. The action plans will address findings & will be documented on audit reports. This is allowing us to address any deficits in the service and take follow up action. The clinical areas audited are as follows:
- Fire safety
- Contracts of care
- Medication Management
- Care plans
- Cleaning
- Falls/Health & Safety
- Personnel-staff files
- End of Life
- Complaints
- Care delivery audits
- Restraint
- Catering/HACCP
- Call Bell
- Weights/Nutrition
- Wounds
This list is non exhaustive. There are other audits that are carried out as identified and required learning outcomes identified showing improvement in practice.
Results of all action plans to be circulated and discussed with relevant staff to ensure review and quality improvement.
All audits to be discussed at monthly management meetings.
A weekly report on weight monitoring to be actioned and evaluated by PIC.
Regular meetings with all disciplines to evaluate audits and ensure learning outcomes.
Having reviewed care practices a robust training plan has been submitted to ensure that all staff have mandatory training completed within 2 months of commencing employment.
Induction process has been reviewed to enhance staff knowledge in fire safety & protection of the vulnerable adult.

**Proposed Timescale:** 10/09/2016

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

**Theme:**
Governance, Leadership and Management
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The policy on the monitoring of residents' nutritional needs did not fully guide practice in relation to referral to dietician services.

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

Please state the actions you have taken or are planning to take:
The policy on monitoring of residents nutritional needs has been reviewed and updated in order to fully guide practice. This has been disseminated to all staff 25/8/2016. Further nutrition training has been organised and MUST training for all Staff Nurses is on 4/10/2016.
The policy includes procedures for when to refer residents who are at risk of nutritional imbalance to allied professionals such as the dietician or GP services. Our policy gives clear guidance in relation to any resident who has a nutritional imbalance.

Proposed Timescale: Completed

Proposed Timescale: 20/09/2016
Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The policy on the recruitment and vetting of staff was not fully implemented in practice.

3. Action Required:
Under Regulation 04(1) you are required to: Prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.

Please state the actions you have taken or are planning to take:
Monthly meetings recommenced with administration staff to ensure quality improvements around recruitment and vetting process. New processes in place from 30/8/2016.
Clear evidence of verification of references to be documented on all files prior to an employee commencing work in the centre.
All new employees are required to have a reference request sent to previous employer.
All new personnel files are checked and signed off by PIC before being filed. Effective from 10/08/2016.
Clarify & document on all gaps on CV’s to be completed by 9/09/2016.
Monthly audit to ensure completion of all individual files to meet the standards and followed up by PIC.
Proposed Timescale: 09/09/2016

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors reviewed four staff files, and found most of the information required as per Schedule 2 of the regulations was in place. However, one file had no reference from their previous employer and two files had no explanation for gaps in the person’s employment history.

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

Please state the actions you have taken or are planning to take:
Reference from previous employer obtained.
PIC has identified gaps in employment history and same documented & completed by 9/09/2016.
All new processes ensure best practices in place.

Proposed Timescale: 09/09/2016

Outcome 07: Safeguarding and Safety

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provision of training for staff in the centre requires review.

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

Please state the actions you have taken or are planning to take:
A comprehensive schedule of future training dates has been submitted. This is a proactive plan that captures all staff in a timely manner. Extra training is being identified by appraisal process.
All staff employed currently have completed mandatory training.
All mandatory training for new employees to be completed within 2 months of commencing employment. However induction process will ensure that staff are knowledgeable around emergency fire, detection and prevention & care of the
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider had not ensured effective measures were in place to protect residents from abuse as some staff were not familiar with centres policy on this area.

6. Action Required:
Under Regulation 08(1) you are required to: Take all reasonable measures to protect residents from abuse.

Please state the actions you have taken or are planning to take:
All staff issued with questionnaire to establish baseline knowledge on 11/08/2016. Policy re-issued to all staff on 11/08/2016. Every member of staff presently employed in centre has completed training. All new employees to complete training within 2 months of commencing employment. There is a monthly scheduled training date for ‘Care of the vulnerable adult’ and all new staff will attend. It will also be discussed at handover each morning to ensure staff have adequate knowledge. The induction process ensures that all new staff are confident in their knowledge of care of their vulnerable adult and fire safety before they attend formal training.

Outcome 08: Health and Safety and Risk Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The smoking room had not been risk assessed to manage all potential hazards.

7. Action Required:
Under Regulation 26(1)(a) you are required to: Ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.

Please state the actions you have taken or are planning to take:
The existing Individual risk assessments on all residents who smoke are supplemented by the smoking room risk assessment. Smoking room risk assessment completed. The installation of a fire blanket and fire extinguisher has been completed and our fire register has been updated. All staff have received supplementary information about management of fire hazards and incident management within the smoking room area. The smoking room checklist has been updated to include checking of the installed fire prevention management measures. Staff knowledge of steps to be taken is being checked on a shift by shift basis to ensure all staff have the required competencies to ensure the safety of our clients at all times. Fire training includes these actions.

**Proposed Timescale:** 10/08/2016

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Some staff were not knowledgeable of the fire safety procedures in the centre.

The fire drills carried out in the centre had not picked up on staff lack of knowledge and require review.

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

**Please state the actions you have taken or are planning to take:**
Increased number of Fire drills to be carried out to ensure staff are fully aware of practical element of fire drill and evacuation.
Fire Training completed on 23/08/2016.
Night time fire drill and compartmental evacuation completed on 23/08/2016 with subsequent action plan & learning evaluation. Further fire drill completed on 1/09/2016. Emergency fire procedure discussed at handover each morning to ensure staff have adequate knowledge around fire safety.
The induction process ensures that all new staff are informed of their role in relation to fire safety and they then attend the next scheduled fire training date.

Proposed Timescale: Completed

**Proposed Timescale:** 20/09/2016

**Outcome 11: Health and Social Care Needs**

**Theme:**
Effective care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The management of nutritional needs in terms of weight loss required improvement.
The practices in the prevention of pressure sores required improvement.

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

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

**Weight Loss:**
All staff Nurses have been re-issued with the updated nutritional policy in order to guide and support their response to nutritional imbalance i.e. weight loss/weight gain.
All residents are weighed monthly. This is verified and analysed by the PIC. Results in MUST score and BMI are recorded in care plan. Any deficits are reported immediately.
Immediate referral to specialist services where deemed appropriate i.e. GP, dietician, SALT.
Weekly monitoring of residents weights for unintended weight loss is identified to PIC and actioned immediately.
Following initial assessment there is an 8 week follow up by dietician on all referrals.
3 day Food diary continues on all new admissions to establish baseline. Food diary kept on all residents with unintended weight loss.
The updated nutritional policy clearly guides staff on what to do with regards to MUST score.
Nutritional training has been arranged for 4/10/2016.

**Wound Care:**
Continuous evaluation throughout the 24 hour period on pressure relieving mattresses & documented system to indicate appropriate setting to each resident. Spot checks to be completed by PIC and House Manager. All relevant staff have been in formed to check mattresses each time they provide care to a resident. This was discussed at general staff meeting on 24/08/2016.
Resident’s skin integrity is checked daily or when a change in a residents condition and any changes are reported immediately to the Nurse. Waterlow assessment is updated immediately. Care plan updated.
Where the care plan identifies a requirement for repositioning, the times and position of the resident are recorded as per best practice guidelines.
Care plans are updated on a monthly basis or depending on their changing needs.
In house training sessions to improve all staffs knowledge around pressure sore prevention and mattress settings.

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

**Theme:**
Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A timely referral had not been made to a allied health professional such as a dietician.
A referral to a physiotherapist was not made when specifically requested by a resident.

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

Please state the actions you have taken or are planning to take:
All residents with nutritional imbalance are referred to dietician. Verbal advice can be sought immediately. The nutritional policy guides staff in exactly when a resident must be reviewed.

Referral to community physiotherapist completed. In house physiotherapist appointed and commencing week beginning the 5/08/2016.

Proposed Timescale: Completed

Proposed Timescale: 20/09/2016

Outcome 12: Safe and Suitable Premises

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Aspects of the layout of the centre required improvement to enhance the experience of residents with dementia.

11. Action Required:
Under Regulation 17(1) you are required to: Ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.

Please state the actions you have taken or are planning to take:
A calendar have placed in every resident’s room which is person specific with photo. Clocks to be placed in all communal areas.
Sonas programme has been in place and a further 2 staff have been identified to be trained in same.
Mobile shop has been introduced to optimise the resident’s independence to purchase incidentals on a daily basis. Ongoing training by in house dementia specialist to both
Staff and families. These sessions commenced prior to inspection and will continue.

Proposed Timescale: 01/09/2016

### 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:
The complainants satisfaction with the outcome of a complaint was not recorded.

12. **Action Required:**
Under Regulation 34(1)(f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.

Please state the actions you have taken or are planning to take:
Complaints form has been adjusted to fully capture all interventions taken to manage and evaluate the complaint pathway in order to incorporate complainant’s satisfaction with outcome.
All complaints are reviewed, actioned and complainants satisfaction recorded.

Proposed Timescale: 10/09/2016

**Theme:**
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Complainants were not provided with details of the appeals process.

13. **Action Required:**
Under Regulation 34(1)(g) you are required to: Inform the complainant promptly of the outcome of their complaint and details of the appeals process.

Please state the actions you have taken or are planning to take:
All complainants are now offered the independent appeals process.

Proposed Timescale: 10/09/2016

### Outcome 18: Suitable Staffing

**Theme:**
Workforce
The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff required training to meet the assessed needs of residents, for example, nutrition and prevention of pressure sores.

Some staff had not completed infection control training.

14. **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 have completed online training in basic nutrition, dysphagia. Further nutrition training arranged for September. 2 x Infection control training sessions for all staff will be completed on 9/09/16 & 27/09/2016.

**Proposed Timescale:** 30/09/2016

**Theme:**
Workforce

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The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The roles and responsibilities of external service providers was not set out in writing.

15. **Action Required:**
Under Regulation 30(a) you are required to: Set out in writing the roles and responsibilities of people involved on a voluntary basis with the designated centre.

**Please state the actions you have taken or are planning to take:**
Each external provider has an outline of their role and responsibility documented in their personnel file and processes are in place for any new service provider going forward.

**Proposed Timescale:** 30/09/2016