<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Earlsbrook House</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000033</td>
</tr>
<tr>
<td>Centre address:</td>
<td>41 Meath Road,</td>
</tr>
<tr>
<td></td>
<td>Bray, Wicklow.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>01 276 1601</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:earlsbrook@firstcare.ie">earlsbrook@firstcare.ie</a></td>
</tr>
<tr>
<td>Type of centre:</td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>FirstCare Ireland (Earlsbrook) Limited</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Leone Ewings</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>Niall Whelton; Nuala Rafferty</td>
</tr>
<tr>
<td>Type of inspection:</td>
<td>Announced</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>57</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>7</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.

Please note the definition of the following term used in reports:
responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).
Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration renewal decision. This monitoring inspection was announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 07 December 2017 09:30
To: 07 December 2017 19:30

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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</thead>
<tbody>
<tr>
<td>Outcome 01: Statement of Purpose</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 02: Governance and Management</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 05: Documentation to be kept at a designated centre</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 07: Safeguarding and Safety</td>
<td>Compliant</td>
</tr>
<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>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 12: Safe and Suitable Premises</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 13: Complaints procedures</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 18: Suitable Staffing</td>
<td>Compliant</td>
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Summary of findings from this inspection

This was the ninth inspection of this centre by HIQA, and the third this year. During the course of the inspection, the inspectors met with residents, relatives and staff. The views of all were listened to, staff practices were observed and documentation maintained was also reviewed. Feedback reviewed also included questionnaires completed by residents and/or their relatives. As part of this inspection all notifications and unsolicited information received were also reviewed. Information received included matters relating to the governance and management of the centre, staffing, hygiene and care practices.

Overall, there was positive feedback received which was complimentary of care practices and the admissions process.

A major non-compliance relating to fire safety evacuation procedures was identified by inspectors at the time of the last inspection. Following the last inspection which took place on 20 June 2017, a provider meeting was held to discuss regulatory non-compliances and actions taken to address these. Actions taken by the provider were reviewed on this inspection by the fire and estates inspector. The findings of this inspection were that some improvements had taken place since the last inspection,
including staff training and ensuring suitable personal evacuation plans were in place for residents. However, a further risk was identified with the evacuation strategy in place for one zone on the ground floor. All other actions required following the last inspection had been satisfactorily addressed.

The governance and management of the centre has improved and the management team had shown effective changes had taken place. The layout of the premises and the environment had changed since the time of the last inspection. The plans of the premises and the statement of purpose provided as part of the registration process were not fully reflective of the changes made to the premises by the provider.

Improvements were required to meet the requirements of 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 included improvements relating to governance and management, statement of purpose, health and safety and risk management, health and social care needs and record-keeping.
Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

**Outcome 01: Statement of Purpose**

There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

**Theme:**
Governance, Leadership and Management

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

**Findings:**
A statement of purpose dated was received as part of the registration application on 18 October 2017. This contained detailed information in terms of aims and objectives of the service. Although kept under review by the provider, a version dated October 2017 was submitted, some improvements were required to meet the requirements of the regulations:

- the management structure on page 8 does not include details of the provider
- conditions of registration did not reflect those as stated in the current certificate of registration
- the environment and layout and in particular details of residents who may be accommodated in areas of the centre with a single means of escape was not clearly outlined
- the complaints summary not fully reflective of the policy as outlined to inspectors

Changes and measures taken by the provider to re-configure and increase the number of bedrooms on the ground floor were not clearly outlined in the statement of purpose. The layout and occupancy had changed substantially since the time of the last inspection with additional day space on the first floor and some bedroom layouts changed and amended in the absence of any application to vary conditions of registration.

A further version dated November 2017 was shown to inspectors on the day of the inspection, and did not meet the above requirements.

**Judgment:**
Substantially 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):**
Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**
Structured governance and management systems were found to be in place. The entity responsible for operating the centre was FirstCare Ireland (Earlsbrook) Limited and is part of a group of nursing homes. The provider has delegated responsibility to the provider representative who reports directly to the provider. Both the provider representative and the person in charge were key in terms of the management team responsible for the governance, operational management and administration of services and resources. The person in charge was had not changed since the time of the last registration renewal. She demonstrated that she had the required skills knowledge and experience in this role. She is a registered nurse with post-graduate management qualifications and she works full-time in the centre, and is aware of her regulatory responsibilities. She reports to and is supported by the quality and compliance manager, and a clinical nurse manager. A further clinical nurse manager participating in management of the centre was on planned leave since the last inspection, and this absence was noted on the staffing complement.

Fortnightly weekly management team meetings were confirmed as taking place. The provider representative attends this meeting with the person in charge and the quality and compliance manager and minutes were maintained. Areas reviewed during the meetings included progress in terms of building works, staffing, admissions, notifications, incidents and complaints. However, all works by the provider to the premises to address all fire safety measures were not yet fully implemented.

A group operations manager role for the person in charge to report to was vacant, as notified since May 2017. The provider confirmed he was actively recruiting into this role. In the interim the quality and compliance manager was undertaking responsibilities commensurate with this role.

The group bed manager was named as a key manager but not present at the time of the inspection. Her role included managing the admissions process and undertaking pre-admissions assessments of prior to any admission of a resident. The findings of this inspection were that this staff member did not participate in the overall running of this centre, but had a particular role within the admissions policy with the person in charge.

The management oversight of complaints required further review as outlined in Outcome 13 of the report where the provider representative as nominated person for
complaints oversees the complaints, the record of any regular reviews completed was not clearly recorded within the complaints records or elsewhere.

The findings of this inspection were that some measures had been taken by the management team to address the actions from the last inspection, and evidence of some improvements was found. However, the management team responsible for the governance, operational management and administration of services and resources had not yet fully demonstrated the ability to meet all regulatory requirements, as outlined in terms of health and safety and risk management as outlined in Outcome 8 of this report. The provider gave assurances that all outstanding fire safety measures would be completed, and had requested a fire safety risk assessment completed by a fire safety consultant. However, this had not been completed at the time of this inspection. The fire safety risks identified on this inspection were clearly communicated to the provider on the day.

Plans of the premises submitted by the provider as part of the registration process did not reflect the works completed on the day of the inspection. The layout of the premises had changed substantially since the time of the last inspection, and the plans and statement of purpose as provided were not found by inspectors to be fully reflective of all changes. Full and satisfactory information including accurate plans which reflected any changes in the layout of the premises were requested from the provider to fulfil the requirements of the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015.

Judgment:
Non Compliant - Moderate

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:
Overall, the standards of record-keeping had shown some improvement particularly relating to Schedule 4 fire safety records.

The records as listed in Part 6 of the Regulations were maintained in a manner so as to ensure completeness and accuracy. Records requested were accessible with some
records held electronically. Staff nurses were now signing for medicines on the administration sheet in line with Schedule 3 requirements. However, as outlined in Outcome 9 records of faxed transcribed medications were not consistently managed and recorded in line with the written policy; in terms of ensuring the prescriber completes the records within 72 hours on a sample of three examples reviewed.

Some Schedule 3 records required improvement, for example how records of food and fluids were maintained to ensure care practices and policies were fully implemented.

The centre was adequately insured against accidents or injury to residents', staff and visitors, as well as loss or damage to a residents' property.

A directory of residents was maintained which contained all of the matters as set out under regulation 19.

A sample of staff files were reviewed, and contained all the requirements of schedule 2 of the regulations, including Garda vetting disclosures.

The designated centre had now reviewed all of the written operational policies as required by schedule 5 of the regulations. Overall the policies in place were up to date, evidence-based and guided staff practices.

**Judgment:**
Substantially Compliant

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**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 inspectors found that systems were in place to protect residents being harmed or suffering abuse. There was a policy to guide staff and they received appropriate training and refresher training. Residents were supported to maintain their independence, although some residents told inspectors that aspects of the environment mitigated against the accessibility of some areas.

The centre was guided by policies on the protection of vulnerable adults in place and policies read were updated to reflect best practice and guide staff. This policy had been reviewed and updated in 2017. The inspectors spoke to a number of residents who said that they felt safe and secure in the centre.
There was regular staff training in the protection of vulnerable adults. Staff spoken to were knowledgeable of the types of abuse and the reporting arrangements in place. The person in charge was aware of the requirement to notify any allegation of abuse to HIQA. Two reports had been made since the last inspection and all the actions taken to safeguard all residents living at the centre were reviewed. The inspectors found the responses were timely by the person in charge, and all safeguarding measures had been implemented in line with policy.

A policy on the management of challenging behaviours that guided practice was in place. A small number of residents presented with behaviours associated with dementia and cognitive difficulties. Overall, the residents were well supported and positive behavioural plans were in place. The inspectors found that evidenced-based tools were utilised to monitor behaviours where required. Staff were familiar with the residents and understood their behaviours, what triggered them and the least restrictive interventions to follow. There was a good awareness by staff of the symptoms associated with dementia, and any changes in behaviours due to infections or acute illness. Training was in place to support staff working with residents with challenging behaviours. Established links were in place to obtain specialist advise and referral to psychiatry for any mental health difficulties.

There was a separate policy on the use of restraint which reflected the national policy "Towards of Restraint Free Environment". The person in charge confirmed that staff were working towards a restraint-free environment. There were a small number of residents with bedrails in use at the time of this inspection. A system was in place that ensured that a detailed risk assessment took place, with alternatives trialled prior to the use of bed rails or any restrictive practice was in place. Following a review of records the inspectors noted that a resident using a lap belt did not have a release record in place. The person in charge undertook to address this on the day of the inspection.

The inspectors were informed that the provider was not involved with managing pensions or supporting residents with pensions or finances.

**Judgment:**
Compliant

**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):**
Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**
During the previous inspection, inspectors found that adequate means of escape was
not provided for some residents with limited mobility in areas of the centre provided only with single means of escape. Inspectors found that this issue had been addressed. The person in charge was conducting regular drills and carrying out assessments of the needs of residents prior to admission to determine suitable areas to accommodate those residents in the building.

Inspectors found that the needs of residents in the event of a fire were assessed by way of Personal Emergency Evacuation Plans (PEEPs). These were available on the inside of each resident’s wardrobe with pertinent details for the evacuation of the resident. Subsequent to the inspection, HIQA requested information regarding the mobility status of residents. Documentation submitted included a summary sheet which contained the room number, mobility status and mode of evacuation for each resident. Upon review of this document, inspectors were not assured that the provider had sufficient oversight of methods of evacuation identified in this document. This was immediately brought to the attention of the provider and assurance was sought in this regard.

Inspectors found that a number of layout changes to the building had occurred since the previous inspection, with further work to be completed in January 2018.

The alterations to the building included a new homestead room at upper floor level, relocation of stairs 5, provision of four bedrooms at the ground floor and increasing a single bedroom to a twin bedroom. The remaining outstanding work includes the provision of lobbies enclosed in fire rated construction to the stairs in Oaklands. This would provide a safer means of escape from the upper floors of this area.

In the main, inspectors noted and acknowledged that there were significant improvements with regard to the level of fire safety in the centre. Some examples include;
- Alteration of layout including new homestead at upper level, which provides alternative means of escape to two areas of the upper floor
- Relocation of one stairway to provide improved means of escape
- Improvements to the fire detection and alarm system
- Additional emergency lighting was provided to external escape routes
- Improvements to evacuation drills
- Provision of a fire suppression system in the kitchen to reduce the risk of hot oil fires

Owing to the findings at the previous inspection, the provider was requested to commission a fire safety risk assessment of the building by a suitably qualified and competent person with relevant experience in fire safety. This was to include an assessment to identify and evaluate risks relating to fire safety in the building, together with recommended remedial actions to mitigate those risks. This was requested in August 2017 and had not been completed at the time of inspection. The findings detailed in this outcome highlight again the requirement for such an assessment to be carried out. Subsequent to the inspection, the provider confirmed that an inspection would be carried out on 21 December 2017 to inform the fire safety risk assessment with the report to follow in January 2018.

The building was reviewed in the presence of the person in charge. A lift motor room was located within an area accessible to residents and visitors and was found to be
unlocked with the key in the door. Inspectors noted equipment with warning labels indicating the risk of electric shock, within the lift motor room. This was brought to the attention of the person in charge and the room was subsequently securely locked on the day of the inspection.

A door to a bedroom was found to be propped open with a chair, even though an acoustically operated hold open device was in place. The person in charge indicated that this was an isolated incident and confirmed that staff were aware of the requirement not to hold fire doors open.

Inspectors noted two armchairs located within the entrance corridor causing an obstruction to the means of escape. This was brought to the attention of the person in charge and they were removed. Otherwise, all escape routes were well maintained and clear of obstruction. There were records available to demonstrate that exits were checked daily.

Oxygen cylinders were observed in three locations along escape routes. Inspectors were not assured that the location of the oxygen cylinders were appropriate. The positioning of oxygen cylinders would benefit from review by a competent person as part of the fire safety risk assessment for the building to determine the suitability of the placement of oxygen cylinders. Checks of these cylinders were recorded; however the last check was dated 24 October 2017.

Since the last inspection, the oratory had been relocated from a room to an area within an escape stairway. It was not separated in fire rated construction from the stairway. Inspectors noted candles within the oratory, however there was no evidence that they had been lit. There were drapes screening the oratory from the stairs, which did not have a label confirming they were not flammable.

As a result of the material alterations within the building, the means of escape for residents had improved. The provision of the new homestead room at upper floor level had provided an alternative means of escape for two areas of the building. The relocated stairway 5, provided additional protection from the effects of fire for rooms 80, 81, 82 and 84.

The external escape route through the herb garden led to a gate providing egress onto the adjoining public laneway. This route was well maintained and clear. However, there was not a sign on the gate indicating that it was an escape route, to prevent cars parking directly in front of the gate.

The centre was provided throughout with emergency lighting, fire fighting equipment and a fire detection and alarm system. Records showed that they were being serviced periodically as required.

However, there was no certificate available for the annual inspection and testing of the emergency lighting system. The most recent quarterly inspection report from 15 November 2017 highlighted issues with the system that required remedial work. It is noted that additional emergency lighting had been provided to external escape routes as required.
At the previous inspection, one zone of the fire alarm system was spread across two separate areas with single means of escape. The panel previously was capable of identifying the zone only and not the exact location of the activation. Through upgrade of the alarm system and the alterations to the layout, this issue had been rectified. The compliance manager confirmed that the system was fully addressable and capable of identifying the location of activation.

Fire drills were carried out frequently at the centre and the person in charge demonstrated good knowledge of the procedures to be followed. The drill records reflected varying scenarios to ensure the procedures were fit for purpose. Of the staff spoken to, they were found to be knowledgeable and aware of the procedures to be followed and confirmed that fire safety awareness was prevalent in the centre.

At the previous inspection, containment issues were identified. The provider arranged for an audit of all fire doors in the centre to identify and remedy deficiencies with the fire doors. However, on this inspection fire doors were noted where gaps were evident, fastenings prevented doors self-closing and smoke seals which had been painted over. Some fire doors were noted to be fitted within frames which were not fit for purpose and would not perform as required to contain a fire.

The wall separating a dayroom from the adjoining escape stairway enclosure contained a window which was not appropriately fire rated. This would not contain a fire should one start in the living room presenting a risk to the resident in an adjacent bedroom. The escape route from this bedroom required circulating past the non-fire rated window. This was brought to the attention of the person in charge and the provider. Information submitted to HIQA subsequent to the inspection confirmed that window had been replaced with appropriate fire rated construction.

The lift motor is a room of special fire risk and was not provided with construction that would adequately contain a fire. The frame of the door was not fit for purpose. This was brought to the attention of the provider and the person in charge.

Inspectors observed examples of store rooms which were not adequately enclosed in fire resisting construction, some of which contained large quantities of combustible material within. Store rooms are required to be enclosed in fire resisting construction to prevent the spread of fire and smoke should a fire start in the store room.

Inspectors noted a number of instances where the line of fire resistance was breached. For example, a door frame between a stairs and bedroom corridor contained a hole for pipe work which required fire stopping to prevent the spread of fire and smoke.

There was a comprehensive emergency plan in place in the centre. Progressive horizontal evacuation was the procedure adopted. This included evacuation procedures for each zone of the centre. While these were comprehensive, inspectors found that they would benefit from being aligned to the compartments associated with horizontal evacuation, rather than the fire alarm zones. Some fire alarm zones were spread over multiple compartments which may cause confusion during an evacuation.
Infection control precautions within the centre were satisfactory. Household staff were able to describe the infection-control procedures in place. However, the space available for the safe storage of soiled lined was inadequate on the day of the inspection and the inspectors saw seven large bags of soiled linen on top of full trolleys, this included red alginate bags. The external location of two large clinical waste bins needed review. The person in charge addressed this matter on the day of the inspection.

**Judgment:**
Non Compliant - Moderate

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

**Findings:**
There were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents. All policies had been updated in June 2017 to inform and guide staff in best practice. All staff had received medicines management training and all practices were subject to audit and review by the person in charge. The signing of medicines administered and procedures around handling controlled drugs had improved since the last inspection. As outlined in Outcome 5 one area for improvement related to a review of the policy on using faxed prescriptions which was not fully outlined in the medicines management policy.

The processes in place for the handling of medicines, including controlled drugs, were safe and in accordance with current guidelines and legislation. Systems were in place for ordering, supply and dispensing methods. There were appropriate procedures for the handling, checking, reporting errors, return and disposal of medicines. Inspectors saw that controlled drugs were stored safely in a double locked cupboard. Stock levels were recorded at the beginning and end of each shift in a register in keeping with legislative requirements.

Nursing staff demonstrated safe practices in medicine administration and management. The inspectors observed the staff nurse consulting with residents during the administration of medicines, and performing good hand hygiene. A gentle unhurried approach was consistently demonstrated which helped residents feel relaxed taking their medicines.

A system was in place for reviewing, reconciliation and monitoring of medicine management practices was in place. The use of psychotropic and sedative medicines on a PRN basis was subject to close audit and reviews. The records showed evidence of reducing levels used or administered.
Arrangements for the review of prescribed medicines by the General Practitioner (GP) were in place, and records were available to demonstrate this arrangement was implemented in practice, and in response to changing needs.

The pharmacist was available to residents if required and involved in the management and delivery of prescribed medicines to residents in the centre. Staff and residents were found to be satisfied with the pharmacy service provided. None of the residents were self-medicating but this option was available subject to guidance outlined in the policy and could be considered on each admission.

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

**Findings:**
Arrangements were in place to ensure each resident’s wellbeing and welfare was maintained by an adequate standard of nursing care and appropriate medical care and allied healthcare was provided.

From a review of a sample of residents' care plans, and discussions with residents and staff, as outlined in Outcome 5 some improvements were required with adequately documenting residents' oral food and fluid intake.

Overall there had been improvements in short-term admission procedures and there were no adequate care plans in place to support all assessed care needs. Safe processes were also in place to ensure that when residents were admitted, transferred or discharged to and from the centre, relevant and appropriate information about their care and treatment was available and maintained, and shared between providers and services. A selection of care records and plans were reviewed. A pre-assessment prior to resident admission formed part of the centre’s admission policy and practice, and each resident’s care was reviewed following any acute admission to hospital. Some examples reviewed included full nursing review on return from hospital admissions. However, one example viewed noted that a resident was not weighed for over two weeks following return from hospital and had sustained weight loss and was identified as at risk. Gaps were noted by inspectors where food and fluids records did not include sufficient detail of food and fluid intake and snacks taken between meals for those assessed at being at
risk of weight loss or having difficulty maintaining their weight. The person in charge audited and monitored weight loss and found that 28 residents were noted to be losing weight and 26 residents had increased their weights in the records over the last six months. Most of the people with identified weight-loss were found to have lost between 5% and 10% of their body weight. A policy on the management of hydration and fluid balance guided staff in how to provide sufficient fluid intake. Residents confirmed their satisfaction with meals provided and residents had appropriate referral for dietetic assessments for supplements and suitable modified meals provided where required. However, the implementation of the nutritional policies in place required further review and clinical oversight. For example, to ensure individual residents’ records fully reflected meals and drinks taken and offered to residents throughout the day. Some practices observed by inspectors related to staff ensuring that accurate documentation of food and fluids intake for residents took place. This area was identified to the person in charge as being a risk, as the records reviewed on the day of the inspection were not fully completed with some gaps identified in resident intakes. Observation of staff practices at the centre ensured residents had appropriate assistance at mealtimes. However, inspectors noted that closer oversight of the implementation of the nutritional policy was required, to ensure that all residents at risk in terms of their nutritional intake were monitored safely.

There was a documented assessment of all activities of living, including communication, personal hygiene, continence, eating and drinking, mobility, spirituality and sleep. Social and recreational plans were also completed in a sample reviewed. There was evidence of a range of assessment tools being used to monitor areas such as the risk of falls and malnutrition, mobility status and skin integrity. The development and review of care plans was done by an allocated staff nurse in consultation with residents or their representatives. Each resident’s care plan was subject to a formal review at least every four months.

The assessment of resident’s views and wishes for the end of life were recorded and outlined in a related care plan and subject to regular reviews. A care plan to include details and information known by staff regarding religious, spiritual and cultural practices or named persons to assist residents in decisions to be made was noted in the records reviewed. The inspectors reviewed the management of clinical issues such as wound care and falls management and found that overall they were well managed and guided by policies. Physiotherapy and occupational therapy (OT) services were available on a referral basis. Residents had suitable mobility aids and modified chairs following seating assessments by an occupational therapist or a physiotherapist. Hand rails on corridors and grab rails were seen in facilities used by residents, which promoted independence. The new bedrooms did not have suitable handrails in place, but this was addressed on the day of the inspection.

**Judgment:**
Substantially Compliant

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**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 premises were extensively reviewed at the time of the last registration renewal inspection. General maintenance and décor was homely and some re-decoration had taken place. Generally residents were satisfied with the works completed by the provider.

Two lifts were in place to access the first floors, the centre has an original period house frontage with newer building works completed to extend, it is now separated into four areas known as households- Oaklands, Avoca, The Garden and Ceann Bhree.

As outlined in outcomes 1 and 2 of this report some aspects of the plans and statement of purpose were not fully representative of the layout and recent changes made to the premises. A number of refurbishments, building works and changes had taken place over the last number of months this included:

- building of four single en-suite new bedrooms on the ground floor from existing communal day space
- re-configuring a single room to include the adjacent oratory space to a twin en-suite bedroom
- removal of room 98 on first floor and additional changes to the layout included the reduction of size of room 96 and laundry, and creation of a new day space in this area
- new doctors office space and creation of an open plan oratory in old nurses station
- new laundry on ground floor
- change of use of room 26 twin room on first floor to a staff room

All the new bedrooms had been suitably furnished to accommodate residents on the ground floor. All but one of the rooms were now being used by residents at the centre. The changes made by the provider as outlined in Outcome 8 had taken place to accommodate more dependent residents on the ground floor. A discussion was held at feedback with the provider who is also the director of estates. He outlined that any works completed had been done so as to address risks and action plans following the last inspection.

Also, outlined in Outcome 8 suitable storage space for soiled laundry was not in place in terms of storage of laundry for collection. The laundry room on the ground floor was to undertake some in-house laundry. However, inspectors noted that it was also used as an office area with files stored in this area.

The call bell system was not functioning correctly on the day of the inspection and a
service call had been placed by the person in charge.

Judgment:
Non Compliant - Moderate

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

Findings:
The complaints policy was displayed in the reception area. The inspectors noted that it meets the requirements of the Regulations. Arrangements outlined to inspectors that the quality and compliance manager was the complaints person, and the person in charge oversaw the complaints process. Details of the appeals process to the managing director should a complainant be dissatisfied with the outcome were clear. However, as outlined in Outcome 2 there was no clear written evidence of where the managing director was overseeing complaints in terms of management oversight. The right to access the services of the Ombudsman, should a complainant remain dissatisfied was clearly outlined within the policy.

The provider has also ensured that the complaints policy was also provided to each resident within their written residents guide. Residents, relatives and staff spoken with were aware of the procedure and who to speak with if they wished to make a complaint.

Complaints and feedback from residents were viewed positively by the provider and the person in charge and used to inform service improvements. The inspectors read the complaints records relating to any complaints which were logged since the time of the last inspection, and found that records maintained had improved.

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

**Findings:**  
Inspectors reviewed the actual and planned rosters for staff rosters, and records of agency staff use. They found that overall following the last inspection the staffing skill-mix available had improved. Recruitment procedures in place were effective and in line with regulations. The management team confirmed that there was some staff turnover, but this was improving. Staff vacancies and the ongoing requirement to use temporary internal or agency care staff was being sufficiently monitored by the provider and person in charge.

On the day of the inspection staffing levels and skill-mix was sufficient to meet the needs of residents. The person in charge reviewed of resident dependency, and staffing levels were monitored monthly to inform staffing levels and skill-mix. Staff spoken to confirm that they had sufficient time to carry out their duties and responsibilities, and nursing staff explained the systems in place to supervise staff. Clinical supervision was in place with a clinical nurse manager to support the person in charge, with designated management hours to support staff nurses and care staff with their duties. The centre had a process of staff appraisals in place, and the records of staff mandatory training was up to date.

Staff interactions observed with residents by inspectors were respectful and pleasant. Some residents spoken with, praised staff for their helpful manner. Inspectors were told staff were quick to respond to requests for help and assistance. Residents spoken to, said they were happy with the level of care delivered and had no complaints. Nonetheless some feedback received by inspectors related to reports that residents were waiting some time for their call bells to be answered. The observations on the day of the inspection were that care delivery was timely and this information was relayed to the provider and person in charge at the conclusion of the inspection in order to monitor this aspect of care delivery. The use of temporary staff from other centres or agency staff over the previous week to cover some staffing vacancies was reviewed. The week before the inspection at least one agency care staff was employed to cover staff vacancies. There was evidence that some of the agency staff engaged were regular workers at this centre.

Evidence of current professional registration for all registered nurses working in the centre was seen by inspectors. Training records showed that all aspects of mandatory training had been undertaken and staff spoken with confirmed this. This included in house training on safeguarding and safety, patient moving and handling, fire safety and infection control. All staff nurses had additional training such as medication management and cardio-pulmonary resuscitation. The training matrix records were completed for all staff training. Recruitment and induction procedures were found to be in place. All documents as required by Schedule 2 of the regulations for staff were maintained, and staff did not commence in employment until their Garda Vetting disclosures were
available. Staff were observed to have a gentle approach and knew residents and their care needs well. All staff had attended mandatory the training programme which included dementia care and responding to challenging behaviours.

There were no volunteers working at the centre.

Judgment:
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:

Leone Ewings
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider’s response to inspection report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Earlsbrook House</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000033</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>07/12/2017</td>
</tr>
<tr>
<td>Date of response:</td>
<td>22/02/2018</td>
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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 01: Statement of Purpose

Theme: Governance, Leadership and Management

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

Improvements were required to meet the requirements of the regulations in the November 2017 document:

- the management structure on page 8 does not include details of the provider
- conditions of registration did not reflect those as stated in the current certificate of registration

1 The Authority reserves the right to edit responses received for reasons including: clarity, completeness; and, compliance with legal norms.
the environment and layout and in particular details of residents who may be accommodated in areas of the centre with a single means of escape was not clearly outlined
- the complaints summary not fully reflective of the policy as outlined to inspectors
- the revised layout and new bedrooms were not fully reflected

1. Action Required:
Under Regulation 03(1) you are required to: Prepare a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Please state the actions you have taken or are planning to take:
The Statement of Purpose has been reviewed and updated to reflect the issues raised, noted, and discussed at the time of Inspection. A copy of the updated Statement of Purpose accompanies this action plan.

Proposed Timescale: 22/02/2018

Outcome 02: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Floor plans and statement of purpose as submitted for registration purposes were not compliant.

2. Action Required:
Under Regulation 4 of the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 you are required to: Provide all documentation prescribed under Regulation 4 of the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015.

Please state the actions you have taken or are planning to take:
As communicated on many occasions to HIQA the Provider planned with the Senior Management Team and experienced contractors, commencing in October 2016, an approximately 16-month staggered investment and enhancement works programme in Earlsbrook House.

Linked to that programme the home has undergone significant upgrades and improvements since the previous inspection. In addition, as HIQA were aware, due to the timing of the 3 years re-registration inspection there are a number of further improvements that were planned for completion post the inspection.

The plans submitted were reflective of all these changes, including those intended improvements. Following on from the inspection the architect attended the home to review and update the plans. A copy of the amended plans are submitted with this
The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
A management vacancy for operations manager to oversee management of centre remained vacant.

3. Action Required:
Under Regulation 23(b) you are required to: Put in place a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

Please state the actions you have taken or are planning to take:
The Role of Operations Manager has been advertised with interviews planned over the next two months, with a view to having the position filled by the end of April 2018.

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Inspectors were not assured that the provider had sufficient management systems in place to ensure sufficient oversight of methods of evacuation for all residents in the centre.
Where the provider representative as nominated person for complaints oversees the complaints, the record of any review was not clearly recorded.

4. 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:
There is a comprehensive management system in Earlsbrook House assisted by relevant professionals in relation to the evacuation of the centre. The Provider does not accept that Earlsbrook House does not have sufficient management systems in place to ensure sufficient oversight of methods of evacuation for all residents in the centre.

The Provider has made significant investments and enhancements in the centre, including issues relating to evacuation.
As discussed at the time of inspection, the Provider remains fully aware of their role and function in terms of providing adequate management systems to ensure sufficient oversight in relation to the evacuation of all residents from the centre and has had in place a comprehensive schedule of works which has been executed within Earlsbrook House to ensure its compliance and his commitment to the Nursing Home.

While the review of complaints, took place these reviews had not been recorded in the minutes of the fortnightly Governance and Management Meetings, but will be recorded in the minutes going forward. These overviews include a detailed audit of the Complaints/Concerns/Complements within Earlsbrook House. The audit identifies any significant trends, required refresher training for staff, and/or learning lessons for improvement of the quality of services provided to our residents.

**Proposed Timescale:** 22/02/2018

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

**Theme:**
Governance, Leadership and Management

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
The policy on transcribing medicines requires review and did not fully inform and guide staff in managing faxed prescriptions.

**5. 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:**
This policy has been reviewed. A copy of the policy has been submitted with this action plan to reflect the updated guidelines in respect of handling faxed prescriptions.

**Proposed Timescale:** 22/02/2018

**Theme:**
Governance, Leadership and Management

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
Records of faxed transcribed medications were not consistently managed and recorded in line with the written policy; in terms of ensuring the prescriber completes the records within 72 hours on three examples reviewed.

Records of residents’ food and fluid intake was not fully maintained to ensure care
practices and policies were implemented.

6. **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:**
Earlsbrook House has in place policies to guide and support staff in the management of medication. At the time of inspection Earlsbrook was transitioning to our new computerised medication management system and policies were under review to reflect this change. The policy on faxed transcribed medications has been subsequently updated and reviewed. This has been shared with all nursing staff both at a group and 1:1 level by the Compliance Manager and Clinical Nurse Managers. Auditing of all medications takes place on a formal basis monthly, an is undertaken by the CNM’s, and the transcribing process now forms part of that audit.

Earlsbrook House also has in place a comprehensive set of policies relating to the clinical care of all residents. All Staff within the Nursing Home have been reminded of the importance of documenting food and fluid intake of each resident. There is a reminder to all staff on a daily basis at both handovers, and additionally fluid and food intake are totalled nightly by the day nurses at the end of their shift for the previous 24 hours. Where shortfalls are noted this is discussed with the Health Care Assistants attending to that resident.

The Home Manager has regular daily meetings with all staff in the Nursing Home. In addition to this supervision of all staff on the floors is supported by the CNM’s and newly appointed Team Leaders. One of the roles of the Team Leaders is to ensure that all Health Care Assistants working on a daily basis are maintaining appropriate records on all aspects of care, including but not limited to food and fluid intake.

**Proposed Timescale:** 22/02/2018

<table>
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<tr>
<th>Outcome 08: Health and Safety and Risk Management</th>
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<tr>
<td><strong>Theme:</strong> Safe care and support</td>
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**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
A lift motor room was located within an area accessible to residents and visitors and was found to be unlocked with the key in the door. Inspectors noted equipment with warning labels indicating the risk of electric shock, within the lift motor room.

7. **Action Required:**
Under Regulation 26(1)(c)(iii) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control accidental injury to residents, visitors or staff.
Please state the actions you have taken or are planning to take:
All risks are managed within Earlsbrook House by the Home Manager and supporting staff. In this instance the key had been sought by an external contractor on the previous day for preventative maintenance and was not returned. A new process has been implemented on the signing in and out of keys on a daily basis to mitigate any risks associated with accessibility to locked areas for residents, visitors and families. When an external contractor is signing out of the building at reception the administrator will ensure that all keys have been returned. Each evening the administrator will ensure that all keys signed out during the day have been returned prior to her shift ending.

The Home Manager and Maintenance Team have also reassessed all other risks within the home, to ensure all measures have taken place to minimise, reduce or mitigate risks of any accidental injury to residents, staff and visitors.

Proposed Timescale: 22/02/2018

Theme:
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Storage of soiled linen was inadequate on the day of the inspection.

8. Action Required:
Under Regulation 27 you are required to: Ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.

Please state the actions you have taken or are planning to take:
The observations noted on the day of inspection referred to the storage of flat linen products (bedding, towels etc) which was awaiting collection from the service provider. The linen in question is placed externally in the service yard whilst awaiting collection. The issue relating to linen has been discussed with the service provider, with a change in collection times and increase in collection days proposed. The new daily collection would decrease the number of laundry bins for collection. Separately the laundry service in Earlsbrook House is under review to identify opportunities for improved efficiencies.

Proposed Timescale: 28/02/2018

Theme:
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The provider failed to commission a fire safety risk assessment of the building by a
suitably qualified and competent person with relevant experience in fire safety. This was to include an assessment to identify and evaluate risks relating to fire safety in the building, together with recommended remedial actions to mitigate those risks. This was requested in August 2017.

Oxygen cylinders were observed in three locations along escape routes. Inspectors were not assured that the location of the oxygen cylinders were appropriate. The positioning of oxygen cylinders would benefit from review by a competent person as part of the fire safety risk assessment for the building to determine the suitability of the placement of oxygen cylinders. Checks of these cylinders were recorded; however the last check was dated 24 October 2017.

9. **Action Required:**
Under Regulation 28(1)(a) you are required to: Take adequate precautions against the risk of fire, and provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.

**Please state the actions you have taken or are planning to take:**
The Provider commenced in October 2016 a 16-month comprehensive upgrade works programme in Earlsbrook House which included some fire safety related enhancements. The Provider communicated regularly during this period with HIQA regarding all aspects of the works. HIQA requested a Fire Safety Risk Assessment Report to be completed and a report was forwarded to HIQA on the 14/02/2018. It set out all the remaining works to be carried out in relation to fire safety improvements and mitigate any risks as part of the ongoing project.

For Health and Safety reasons Earlsbrook House use small compressed wall mounted oxygen cylinders. Oxygen cylinders in locations along escape routes have been removed as they were surplus to requirement. Earlsbrook House Nursing Home maintains sufficient stock in a secured external area should additional oxygen be required.

Night staff have been reminded of the importance of recording nightly cylinder checks. The Home Manager and Clinical Nurse Managers have audited these checks to ensure they are taking place.

**Proposed Timescale:** 22/02/2018

**Theme:**
Safe care and support

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
There was no certificate available for the annual inspection and testing of the emergency lighting system. The most recent quarterly inspection report from 15 November 2017 highlighted issues with the system that required remedial work.

The exit gate onto the public laneway did not have a sign indicating it was an escape
route to prevent cars parking directly in front of the gate.

10. **Action Required:**
Under Regulation 28(1)(c)(i) you are required to: Make adequate arrangements for maintaining all fire equipment, means of escape, building fabric and building services.

**Please state the actions you have taken or are planning to take:**
The action plan submitted by the provider was partially acceptable by the Authority.

Signage has been put in place for the exit gate as an emergency exit.

**Proposed Timescale:** 22/02/2018

**Theme:**
Safe care and support

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
Fire doors were noted where gaps were evident, fastenings prevented doors self-closing and smoke seals which had been painted over. Some fire doors were noted to be fitted within frames which were not fit for purpose and would not perform as required to contain a fire.

The wall separating a dayroom from the adjoining escape stairway enclosure contained a window which was not appropriately fire rated.

The lift motor is a room of special fire risk and was not provided with construction that would adequately contain a fire.

There were examples of store rooms which were not adequately enclosed in fire resisting construction to contain a fire.

Inspectors noted a number of instances where the line of fire resistance was breached. For example, a door frame between a stairs and bedroom corridor contained a hole for pipe work which required fire stopping to prevent the spread of fire and smoke.

11. **Action Required:**
Under Regulation 28(2)(i) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

**Please state the actions you have taken or are planning to take:**
The 16-month investment and upgrade programme in Earlsbrook House is now entering its last phase. All works in relation to fire doors throughout the home have now being fully completed.

See below a breakdown of the works completed:

• All doors in the home have had a complete review by a reputable company and
repairs have been completed to ensure that all gaps have been removed in and around door surrounds.

- All door seals are clear of paint debris, allowing the door seal to activate if in the event of a fire.
- A fire rated construction/wall has replaced the glass in the hall at zone 11, allowing complete safety in this compartment if in the event of a fire.
- The lift motor room has been renovated and the issues noted at inspection have been rectified to ensure that this area has in place the resources required to adequately detect, contain, and mitigate any risks attached to the area as a result of its use.
- All storage rooms within the home have been reviewed and assessed following the inspection. Any remedial works required to ensure fire safety have been completed.
- The issues relating to the pipe in the storage room have been addressed.
- Following a reassessment of the areas noted as breaches during the inspection, additional works took place to ensure those noted and observed following the assessment were attended to.

**Proposed Timescale:** 22/02/2018

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### Outcome 11: Health and Social Care Needs

**Theme:**

Effective care and support

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

The clinical oversight and evaluation of the documentation of residents' oral nutritional intake was not sufficient in terms of guiding staff in evidence-based nursing care.

#### 12. 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 Gnáimhseachais.

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

FirstCare have very clear guidelines and policies in place to ensure staff are fully aware of their role in the provision of nutritional care to all residents. These polices were reiterated to all clinical staff at handover and during clinical meetings.

It is the responsibility of the departing day nurse to ensure that all food and fluid charts are completed and totalled, prior to end of the shift, for the previous 24 hours.

The newly appointed Team Leaders are responsible for ensuring that all Health Care Assistants are contemporaneously entering all data appropriately in relation to food and fluid intake. The Clinical Nurse Managers, Team Leaders, and Home Manager, audit these entries daily to ensure compliance with the policy. Audits are conducted after each meal and staff are reminded to complete entries immediately after same. Any shortfalls noted are rectified immediately. Oral nutrition is also discussed with the...
Audits of entries on the charts and feedback from staff throughout the day allows the nurse on duty to ensure that all residents are receiving appropriate oral intake. Where concerns arise, these are escalated to the CNM and/or Home Manager and appropriate action is taken. Ongoing issues with oral intake are discussed with the GP and where necessary referrals are made to the dietician and/or SALT. The Home Manager completes regular reviews on MUST scores and manages communication with a Dietician and or SALT, if and when required.

Proposed Timescale: 22/02/2018

Outcome 12: Safe and Suitable Premises

Theme: Effective care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The call bell system was not functioning correctly on the day of the inspection. Suitable storage space for soiled laundry was not in place in terms of storage of laundry for collection by external provider. The laundry on the ground floor was also used as an office area with files and records stored.

13. Action Required:
Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

Please state the actions you have taken or are planning to take:
On the day of inspection, the call bell system experienced a minor issue which in no way compromised its operation or resident's ability to call for assistance. The issue was logged and reported with the company in question and was rectified the following morning. There have been no issues noted since the day of inspection. Earlsbrook House has a long-standing relationship with the call bell service company and any issues are rectified in a timely manner with nil disruption to residents and staff.

The issue relating to linen has been discussed with a change in collection times and days proposed. This is currently being negotiated with our linen provider. A daily collection would decrease the number of externally placed laundry bins ready for collection. The Housekeeper no longer maintains her files and folders in the laundry area, which was a temporary arrangement during the improvement works in Earlsbrook House.

Proposed Timescale: 28/02/2018