

**Health Information and Quality Authority  
Regulation Directorate**

**Compliance Monitoring Inspection report  
Designated Centres under Health Act 2007,  
as amended**



<b>Centre name:</b>	Millbrae Lodge Nursing Home Limited
<b>Centre ID:</b>	OSV-0000419
<b>Centre address:</b>	Newport, Tipperary.
<b>Telephone number:</b>	061 378 933
<b>Email address:</b>	info@millbrae.ie
<b>Type of centre:</b>	A Nursing Home as per Health (Nursing Homes) Act 1990
<b>Registered provider:</b>	Millbrae Lodge Nursing Home Limited
<b>Lead inspector:</b>	Mary Costelloe
<b>Support inspector(s):</b>	None
<b>Type of inspection</b>	Announced Dementia Care Thematic Inspections
<b>Number of residents on the date of inspection:</b>	70
<b>Number of vacancies on the date of inspection:</b>	10

## **About Dementia Care Thematic Inspections**

The purpose of regulation in relation to residential care of dependent Older Persons is to safeguard and ensure that the health, wellbeing and quality of life of residents is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer and more fulfilling lives. This provides assurances to the public, relatives and residents that a service meets the requirements of quality standards which are underpinned by regulations.

Thematic inspections were developed to drive quality improvement and focus on a specific aspect of care. The dementia care thematic inspection focuses on the quality of life of people with dementia and monitors the level of compliance with the regulations and standards in relation to residents with dementia. The aim of these inspections is to understand the lived experiences of people with dementia in designated centres and to promote best practice in relation to residents receiving meaningful, individualised, person centred care.

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 2 day(s).

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

From:	To:
27 March 2019 09:30	27 March 2019 17:30
28 March 2019 09:30	28 March 2019 18:30

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

<b>Outcome</b>	<b>Provider's self assessment</b>	<b>Our Judgment</b>
Outcome 01: Health and Social Care Needs		Non Compliant - Moderate
Outcome 02: Safeguarding and Safety		Substantially Compliant
Outcome 03: Residents' Rights, Dignity and Consultation		Compliant
Outcome 04: Complaints procedures		Compliant
Outcome 05: Suitable Staffing		Substantially Compliant
Outcome 06: Safe and Suitable Premises		Compliant
Outcome 07: Health and Safety and Risk Management		Substantially Compliant
Outcome 08: Governance and Management		Substantially Compliant
Outcome 09: Statement of Purpose		Substantially Compliant

**Summary of findings from this inspection**

This inspection report sets out the findings of a monitoring inspection which focused on specific outcomes relevant to dementia care.

During this inspection the inspector focused on the care of residents with a dementia who lived in the dementia special care unit. The inspector met with residents, relatives, and staff members during the inspection. The inspector tracked the journey of a number of residents with dementia within the service, observed care practices and interactions between staff and residents who had dementia using a validated observation tool. The inspector also reviewed documentation such as care plans,

medical records, staff files, and relevant policies.

The inspector also followed up on issues identified during the last inspection. Issues relating to risk management, medication management and safeguarding were found to be addressed.

Overall, the inspector found that the management team, person in charge and staff were committed to improving the quality of service for residents including residents with dementia.

The centre was well maintained and nicely decorated. It was warm, clean and odour free throughout. The building was secure and residents had access to enclosed garden areas which was easily accessible. Signs and pictures had been used to support residents to be orientated and find their way around the centre.

The inspector found that residents' overall healthcare needs were met and they had access to appropriate medical and allied healthcare services and each resident had opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

Staff continued to strive to improve the type and variety of activities to ensure that meaningful and interesting activities were provided for all residents. Detailed life histories had been documented for all residents and staff were observed to use this information when conversing with residents.

Residents were observed to be relaxed and comfortable in the company of staff. Staff had paid particular attention to residents dress and appearance. The inspector noted that staff assisting residents with a diagnosis of dementia were particularly caring and sensitive.

The overall atmosphere was homely, comfortable and in keeping with the overall assessed needs of the residents who lived there. The inspector found the residents were enabled to move around as they wished.

The collective feedback from residents and relatives was one of satisfaction with the service and care provided.

Some improvements were required to governance and management, nursing and care planning documentation and risk management. These improvements are discussed further in the report and in the action plan at the end of the report.

**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: Health and Social Care Needs***

**Theme:**

Safe care and support

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

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

**Findings:**

The inspector found that residents' overall healthcare needs were met and they had access to appropriate medical and allied healthcare services and each resident had opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. However, improvements were required to the nursing and care planning documentation.

There were 70 residents accommodated on the days of the inspection, one resident was in hospital and 15 of the residents were accommodated in the special care dementia unit. 25 residents were assessed as having maximum dependency needs; 15 had high dependency needs, 21 had medium dependency needs, eight had low dependency needs and one resident was assessed as being independent.

Residents had access to general practitioner (GP) services of their choice and could retain their own GP if they so wished. There was an out-of-hours GP service available. The inspector reviewed a sample of files and found that GPs reviewed residents on a regular basis.

There was a range of other services available including speech and language therapy (SALT), occupational therapy (OT), dietetic services, tissue viability, physiotherapy and psychiatry of later life. Chiropody, optical and audiology services were also provided. The inspector reviewed residents' records and found that many residents had been referred to these services and results of appointments were written up in the residents' notes.

There was a policy in place that set out how resident's needs would be assessed prior to admission, on admission, and then reviewed at regular intervals. A review of the records showed that this was happening in practice. All residents had a care plan that was developed on admission, and reviewed at regular intervals.

The person in charge advised the inspector that the pre-admission assessment would consider if the centre would be able to meet their needs. The inspector observed that

pre admission assessments were completed by the person in charge for all residents prior to admission.

The assessment process involved the use of validated tools to assess each resident's risk of falls, malnutrition, manual handling requirements and skin integrity. The inspector noted that a range of risk assessments were completed, regularly reviewed and updated.

While care plans were in place for all identified issues and some were found to be informative and person centered, many inconsistencies were noted in the care planning and nursing documentation. For example:

- Some care plans did not provide adequate information to guide care of the resident.
- Some care plans did not reflect the individual preferences of residents.
- Some care plans had not been updated and therefore did not reflect the changing needs of residents, for example, post fall or post hospital admission.
- Some FEDS 'feeding, eating and swallowing guidelines' were inaccurate and not reflective of guidance from allied health professionals such as (Speech and Language therapy) SALT.
- A wound assessment was not up to date and the current status of the wound was not recorded.
- There were inconsistencies in the recording of consultation with GPs regarding the resuscitation status of some residents.
- Resident and relatives involvement in the development and review of care plans was not consistently recorded.

The person in charge had completed a recent review of care plans and had identified areas for improvement. A clinical nurse manager had recently been appointed with responsibility for overseeing care planning and clinical documentation. The person in charge advised that the reviewing and updating of care plans of residents had commenced and the updating of all care plans was being prioritised.

Nursing documentation was completed on a computerised nurse documentation system which facilitated the generation of a hospital transfer letter when a resident was transferred to hospital. The transfer letter allowed for information regarding the health needs, medications and residents specific needs. Nursing staff confirmed that residents with a dementia were always accompanied by either family or a staff member when needing transfer to hospital.

The inspector was satisfied that residents' weight changes were closely monitored. All residents were nutritionally assessed using a validated assessment tool. All residents were weighed regularly. Nursing staff told the inspector that if there was a change in a resident's weight, nursing staff would reassess the resident, inform the GP and referrals would be made to the dietician and speech and language therapy (SALT). Files reviewed by the inspector confirmed this to be the case. While nutrition care plans were in place, inconsistencies were noted in that some care plans were not informative or personalised and others were not reflective of the recommendations of SALT. Nutritional supplements were administered as prescribed. All staff were aware of residents who required specialised diets or modified diets and were knowledgeable regarding the

recommendations of the dietician and SALT. Further training for staff on nutrition and dysphasia was scheduled for April 2019.

Meals were served to residents in three dining areas, two dining areas in the main centre and one in the dementia special care unit. While there were large written menu boards in the dining rooms in the main centre which clearly displayed what food choices and dishes were available for each meal, there was no menu displayed in the dining room of the special care unit on day one of the inspection. There were colourful pictorial menu cards available in the dementia special care unit but staff did not use these on day one of the inspection, however, staff did offer choice of meals and drinks to residents. Staff were observed to engage positively with residents during meal times, offering choice and appropriate encouragement while other staff sat with residents who required assistance with their meal. A variety of assistive plates and cutlery were provided for some residents so that they could eat their meals independently. The inspector noted that staff assisting residents with advanced dementia were caring and sensitive. Nursing staff supervised the mealtimes.

A variety of hot and cold drinks, as well as snacks and fruit were offered and encouraged throughout the day. Residents told the inspector that they could have something to eat or drink at any time including night time.

There was a reported low incidence of wound development and the inspector saw that the risk of same was assessed regularly and appropriate preventative interventions including pressure relieving equipment was in use. While there were wound assessments and wound care plans in place, the inspector noted that a wound care assessment had not been updated and therefore, it was difficult to track the progress of the wound or establish the current status of the wound. Staff had access to support from the tissue viability nurse as required. Nutrition and wound care training was planned for staff.

The inspector reviewed the file of a resident who had recently fallen and noted that while the falls risk assessments had been updated post falls, the corresponding care plan had not been updated to reflect the changing needs of the resident. The person in charge reviewed falls on a regular basis and completed a falls analysis to ensure learning and improvement to practice. Low-low beds and crash mats were in use for some residents. The inspector noted that the communal day areas were supervised by staff at all times.

The inspector was satisfied that caring for a resident at end of life was regarded as an integral part of the care service provided in centre. Staff provided end of life care to residents with the support of their GP and the homecare palliative team. The inspector reviewed a number of 'end of life' care plans that outlined the individual wishes of residents and their families including residents' preferences regarding their preferred setting for delivery of care. Religious sacraments were available to all residents as desired. Some staff members had completed 'What matters to me' end-of-life training, and the person in charge had completed a European certificate in palliative care. The centre had received a 'Journey of change' award from the Irish Hospice following the completion of an end-of-life project. Facilities were available for relatives who wished to stay overnight.

Staff continued to provide meaningful and interesting activities for residents. Each resident had individualised life story and activities plan documented. There was an activities coordinator employed five days a week as well as external facilitators and volunteers. Care staff were also involved in facilitating a variety of activities for residents. The activities coordinator had completed training in Sonas (therapeutic programme specifically for residents with Alzheimer's disease) and 'Fit for life' an exercise programme in which residents perform a variety of movements, stretches and some strengthening exercises to help improve function, reduce the effects of inactivity and help alleviate isolation). Residents had opportunities to partake in weekly education classes on a range of appropriate topics.

The programme of activities supported residents in developing and maintaining links with the community. There were regular visits from local musicians, school students, artist and volunteers. A group of Irish dancers had recently visited to celebrate St. Patrick's day. Other recent events included a visit from a magician and mobile clothing shop. Fundraising events took place throughout the year to which families and friends were invited to, a Daffodil fund raising day was held recently.

**Judgment:**

Non Compliant - Moderate

***Outcome 02: Safeguarding and Safety***

**Theme:**

Safe care and support

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

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

**Findings:**

The provider had taken measures to safeguard residents from being harmed and from suffering abuse.

There were comprehensive policies on responding to allegations of abuse. Staff spoken with and training records viewed confirmed that staff had received ongoing education in safeguarding and elder abuse.

The inspector reviewed the policies on meeting the needs of residents presenting with challenging behaviour and psychological symptoms of dementia and restraint use. The policy on behaviours that challenged outlined guidance and directions to staff as to how they should respond and strategies for dealing with behaviours that challenged. The policy on restraint was based on the national policy and included clear directions on the use of restrictive procedures including risk assessment and ensuring that the least restrictive intervention was used for the shortest period possible. Staff continued to promote a restraint free environment, there were six residents assessed as requiring bedrails at the time of inspection and the inspector saw that alternatives such as low low



beds and crash mats were in use for some residents. Residents in the special care dementia unit did not have bed rails in place.

There was a positive approach to the management of behavioural, psychological symptoms and signs of dementia. Most staff had completed training in dementia care and management of responsive behaviour. Staff spoken with were knowledgeable about and could outline person-centred strategies for dealing with individual residents' responsive behaviours. The inspector observed care staff using a variety of distraction techniques in response to some residents who were anxious and wanting to go home with good effect. Care staff knew the residents well and were observed to use life history and family information when conversing with residents. The inspector reviewed a sample of responsive behaviour care plans and noted inconsistencies in the care planning documentation. Some care plans were found to be comprehensive while others lacked person centered information and clear guidance for staff. There was evidence of regular review by the General Practitioner (GP) as well as regular reviews of medications.

A number of residents were prescribed psychotropic medicines on a 'PRN' as required basis and these were administered occasionally. Staff spoken with informed the inspector that these were always administered as a last resort only when other strategies had been trialled and possible underlying causes had been eliminated. However, records to indicate the rationale for administration of these medications, what other interventions had been tried to manage the behaviour and the effect and outcome for the resident following the administration of the medicine were not consistently recorded.

The inspector observed that residents appeared relaxed, calm and content during the inspection. Staff spoke of the importance of maintaining a calm, noise free environment and allowing residents choice of daily routines. Nursing staff spoken with were clear they needed to consider the reasons people's behaviour changed, and would also consider and review for issues such as infections, constipation, and changes in vital signs.

The inspector was satisfied that robust systems were in place for the management of residents finances. The provider acted as pension agent for a small number of residents and all money was paid into an interest bearing resident account. Residents were invoiced and charges were clearly set out on a monthly basis. Bank balancing statements were available. Small amounts of money were kept for safekeeping on behalf of some residents. The inspector was satisfied they were managed in a clear and transparent manner. All money was securely stored. Individual balance sheets were maintained for each resident and all transactions were clearly recorded and signed by two signatories. There were regular reviews of accounts carried out by the administrator. All residents had access to a secure lockable locker in their bedrooms should they wish to securely store any personal items.

The inspector reviewed a sample of staff files and noted that safeguarding measures such as Garda vetting were in place. The person in charge confirmed that Garda vetting was in place for all staff and persons who provided services in the centre.

The inspector observed staff interacting with residents in a respectful and friendly manner. Residents were observed to be relaxed and happy in the company of staff. Some residents spoken with stated that they felt safe and secure living in the centre.

**Judgment:**

Substantially Compliant

***Outcome 03: Residents' Rights, Dignity and Consultation***

**Theme:**

Person-centred care and support

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

No actions were required from the previous inspection.

**Findings:**

The inspector was satisfied that residents were consulted in the organisation of the centre and that their privacy and dignity was respected.

Residents' committee meetings were held on a regular monthly basis and were facilitated by the resident advocate. Notice of upcoming meetings were displayed on the notice board and included in the monthly newsletter. Minutes of meetings were recorded, issues discussed at recent meetings included activities, requests for large jigsaws, upcoming events including Daffodil fund raising day and visit from mobile clothing shop, upcoming computer classes and visit from SAGE (advocacy group) representative. An annual residents survey was completed, the results of which indicated positive feedback with the quality of care in the centre. A monthly newsletter was produced which included information for residents on upcoming social events and activities, upcoming feast days, residents birthdays and sympathy notes for recently deceased residents.

The inspector noted that the privacy and dignity of residents was respected. All residents had single or twin bedrooms with en suite toilet and shower facilities. Bedroom and bathroom doors were closed when personal care was being delivered. Staff were observed to knock and wait before entering bedrooms. Adequate screening curtains were provided in shared bedrooms.

There were CCTV cameras in use in the day and dining areas of the centre, residents had been informed through the residents guide, signage was erected indicating the use of CCTV and there was a policy in place outlining the rationale for its use, as well as controls in place to protect personal data.

Residents were treated with respect. The inspector heard staff addressing residents by their preferred names and speaking in a clear, respectful and courteous manner. Staff paid particular attention to residents' appearance, dress and personal hygiene and were observed to be caring towards the residents. Residents choose what they liked to wear. The hairdresser visited three times a week and many residents availed of the service.

Residents' religious and political rights were facilitated. Mass was celebrated in the centre every second week. The Eucharistic minister visited weekly and held a prayer service on Sundays and on other holy days. A group of residents continued to recite the rosary each evening. A small oratory was located on the ground floor and residents could spend quiet reflective time there if they wished. Residents of varying religious beliefs were facilitated as required. The person in charge told the inspector that residents were facilitated to vote and explained that residents had been facilitated to vote in-house during the recent elections.

The inspector found the management style of the centre maximised residents' capacity to exercise personal autonomy and choice. The inspector observed that residents were free to join in an activity or to spend quiet time in their room and being encouraged and supported to follow their own routines. Residents were seen going to and from their bedrooms, bathrooms, dining room and enclosed garden areas.

There was an open visiting policy in place. Residents could meet with family and friends in any of the communal day spaces in the centre. There was no designated private visiting space available, however, the person in charge advised that residents could use the activities room if not in use or her office to meet with visitors in private if they wished.

Residents had access to information and news, daily and weekly local newspapers, notice boards, radio, television and Wi-Fi were available. A selection of daily newspapers were delivered each morning and many residents told the inspectors how they enjoyed reading. Some residents had their own mobile telephones and computers. Residents were supported to attend weekly education classes in house.

As part of the inspection, the inspector spent periods of time observing staff interactions with residents. The inspector used a validated observational tool (the quality of interactions schedule, or QUIS) to rate and record at five minute intervals the quality of interactions between staff and residents in the communal areas. The scores for the quality of interactions are +2(positive connective care), +1 (task orientated care, 0 (neutral care), -1 (protective and controlling), -2 (institutional, controlling care). The observations took place for a total of one hour during of the inspection days. An overview of the observations is provided below:

The inspector found that for 85% of the observation period (total observation period of 60 minutes) the quality of interaction score was +2 (positive connective care). Staff knew the residents well they connected with each resident on a personal level, chatting and engaging well with residents. Staff made eye contact and greeted residents individually by their preferred names, staff offered choice such as choice of preferred drinks and meal option, choice of preferred place to sit, choice of preferred reading material and staff reassured a resident who was anxious and unsettled. Residents were observed to be relaxed and enjoyed the company of staff. Staff sat beside residents and were observed offering assistance in a respectful and dignified manner to residents who required assistance with eating.

<b>Judgment:</b> Compliant
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***Outcome 04: Complaints procedures***

<b>Theme:</b> Person-centred care and support
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<b>Outstanding requirement(s) from previous inspection(s):</b> No actions were required from the previous inspection.
<b>Findings:</b> The inspector was satisfied that complaints were managed in line with the centre complaints policy.  There was a comprehensive complaints policy in place which clearly outlined the duties and responsibilities of staff. The complaints procedure was clearly displayed and contained all information as required by the Regulations including the name of the complaints officer, details of the appeals process and contact information for the Office of the Ombudsman.  The inspector reviewed the complaints log, all complaints to date had been investigated and responded to and included complainants' satisfaction or not with the outcome.

<b>Judgment:</b> Compliant
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***Outcome 05: Suitable Staffing***

<b>Theme:</b> Workforce
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<b>Outstanding requirement(s) from previous inspection(s):</b> No actions were required from the previous inspection.
<b>Findings:</b> The inspector found that staff delivered care in a respectful manner. During the inspection, staffing levels and skill-mix were sufficient to meet the assessed needs of residents. A review of staffing rosters showed there was a nurse on duty at all times, with a regular pattern of rostered care staff. The inspector observed that residents and staff knew each other well.  There were normally three nurses and 12 care staff on duty in the morning time. There

were three nurses and eight care staff on duty in the afternoon and three nurses and 11 care staff on duty in the evening time until 20.00hours. There were two nurses and six care staff on duty until 22.00 hours and 2 nurses and five care staff on duty at night time. The clinical nurse manager was also on duty from 8.00 to 20.00 hours. The person in charge normally worked during the day time Monday to Friday. There was a full time activities coordinator who worked five days an week. The staffing complement included catering, activities coordinator, housekeeping, administration and maintenance staff. There was an on call system in place for out of hours and at weekends. The inspector reviewed the staff roster which reflected the staffing arrangements in place. The centre did not use agency staff as it had sufficient numbers of staff to provide cover.

There was a varied programme of training for staff. Staff spoken with and records reviewed indicated that all staff had completed mandatory training in areas such as safeguarding and prevention of abuse, fire safety, manual handling and infection control.

The staff also had access to a range of education, including training in specific dementia care training courses, restraint management, dealing with behaviours that challenge, cardiac pulmonary resuscitation, nutrition and dysphasia, food safety and medication management. Further training was scheduled in infection control, nutrition, dysphasia and wound management.

There were robust recruitment procedures in place. The inspector reviewed a sample of five staff files including the files of recently recruited staff. Staff files reviewed were found to contain all the required documentation as required by the Regulations. Garda Síochána vetting was in place for all staff. Nursing registration numbers were available for all staff nurses. Details of induction and orientation received, training certificates and appraisals were noted on staff files.

**Judgment:**

Substantially Compliant

***Outcome 06: Safe and Suitable Premises***

**Theme:**

Effective care and support

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

No actions were required from the previous inspection.

**Findings:**

The design of the building was suitable for its purpose. It was two storey and purpose built. The building was clean, well-maintained and decorated in a pleasant, comfortable and home-like style.

Overall, the premises promoted dignity and wellbeing. The premises was suitable in size

and layout for the number and needs of the residents. There was a lift provided which allowed residents to independently access both floors. There was adequate lighting and ventilation and an appropriate heating system in place in the centre.

Access to and from the dementia focused care unit was secure. The physical environment was designed in a way that was consistent with the design principles of dementia-specific care units. A conservatory was also provided. Most residents had their own bedroom, which were individually decorated and attractive. Residents had direct access to a secure pleasant outdoor space. Appropriate signage was provided to assist residents find their way around the centre and coloured pictorial signage was provided to help residents with dementia orientate better.

Safe floor covering was provided to corridors which were wide, bright and allowed for freedom of movement. There were pictures positioned on the corridors at eye level for residents to engage with. Corridors had grab rails, and were seen to be clear of any obstructions. Residents were seen to be moving as they chose within the centre.

Bedroom accommodation met residents' needs for comfort and privacy. All bedrooms had en suite toilet and shower facilities. Residents were encouraged to personalise their rooms and many had photographs and other personal belongings in their bedrooms. Bedrooms were adequate in size and ample personal storage space was provided. Call bells were accessible in all bedrooms and bathrooms. The rooms also had enough space for equipment such as hoists to be used.

There was a variety of communal day spaces on each floor, including spacious sitting rooms, dining rooms, recreation room, smoking rooms, oratory, conservatory, and hairdressing room.

There was a range of equipment in the centre to aid mobility. Training records showed that staff had completed manual handling training in relation to the equipment available in the centre. Records were available on equipment such as the lift, hoists, slings, beds and specialised chairs being routinely serviced.

**Judgment:**  
Compliant

### ***Outcome 07: Health and Safety and Risk 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:**  
The provider had systems in place to protect the health and safety of residents, staff

and visitors, however, some improvements were required to putting measures in place to address specific risks identified during the inspection. Issues identified during the last inspection had been addressed.

There was an up to date health and safety statement available. The inspector reviewed the risk register which had been recently reviewed and updated, all risks specified in the regulations were included. However, the inspector noted unattended, unsecured and unlabelled cleaning agents on the cleaner's trolley which posed a risk to residents, staff and visitors.

Systems were in place for the regular review of risk which included discussion and review at the monthly management meetings. Training records reviewed indicated that staff members had received up-to-date training in moving and handling. The person in charge had qualified as a people handling instructor and completed training with staff in-house. Staff spoken with confirmed that they had received training. The inspector observed an instance of poor people handling practice whereby staff had not used a transfer belt in accordance with best practice and in line with the resident's manual handling assessment. This issue of concern was raised with the person in charge and an action is included under outcome 5: Staffing.

The inspector reviewed the fire policies and procedures. Records indicated that all fire fighting equipment had been serviced in April 2018 and the fire alarm was serviced on a quarterly basis. The fire alarm was last serviced in March 2019. Daily, weekly and monthly fire safety checks were carried out and these checks were recorded. Fire safety training took place regularly and included evacuation procedures and use of fire equipment. All staff spoken to told the inspector that they had received recent fire safety training and had been involved in fire drills simulating evacuation of residents. Training records reviewed indicated that all staff had received up-to-date fire safety training. Regular fire drills had taken place to ensure that all staff and in so far as was reasonably practicable, residents, were aware of the procedure to be followed in the case of fire. Details of fire drills completed were documented to include the scenario, time taken to evacuate residents and outcome. Staff had completed fire drills simulating night time staffing levels.

There were comprehensive policies on infection prevention and control in place which guided practice. Hand sanitising dispensing units were located at the front entrance and throughout the building. Staff were observed to be vigilant in their use. The inspector spoke with housekeeping staff regarding cleaning procedures. Staff were knowledgeable regarding infection prevention and control procedures including colour coding and use of appropriate cleaning chemicals. The building was found to be clean and odour free. Staff spoken with and training records reviewed indicated that most staff had attended infection control training and further training was scheduled.

**Judgment:**

Substantially Compliant

## ***Outcome 08: Governance and Management***

### **Theme:**

Governance, Leadership and Management

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

No actions were required from the previous inspection.

### **Findings:**

~~While the governance arrangements in place generally worked well to oversee the quality of care, further oversight was required in relation to nursing and care planning documentation, people handling practice, storage and labelling of cleaning chemicals.~~

There was a clear management structure in place that was accountable for the delivery of the service. There were clear lines of accountability and all staff members were aware of their responsibilities and who they were accountable to. The management team included the two directors of Millbrae Lodge Nursing Home Ltd, who both worked in the centre and were involved in the day-to-day running of the centre. The person in charge was the person nominated to represent the provider and she worked full-time in the centre. The operations manager was also a director of the company and visited daily. The person in charge was supported in her role by a clinical nurse manager and the administrator. Further supports were provided by a health and safety consultancy team.

The management team worked full time in the centre. The clinical nurse manager had recently been appointed as assistant director of nursing and deputised in the absence of the person in charge. There was an on call out-of-hours system in place. The management team met each other, residents and staff on a daily basis.

Systems were in place to review the safety and quality of care. The provider had employed a consultancy team to assist them to improve their quality management system. There was a monthly audit schedule in place. Regular audits and reviews were carried out in relation to incidents, falls, medication management, restraint, complaints, health and safety, care planning, privacy and dignity, pressure ulcers, infection control, access to information, residents rights and access to advocacy. Staff confirmed that results of audits were discussed with them to ensure learning and improvement to practice. The annual review on the quality and safety of care in the centre had been completed for 2018 and a quality improvement plan put in place for 2019.

Feedback from residents' committee meetings and resident satisfaction surveys were also used to inform the review of the safety and quality of care delivered to residents to ensure that they could improve the provision of services and achieve better outcomes for residents.

The management team was aware of the legal requirement to notify the office of Chief Inspector regarding incidents and accidents. To date all relevant incidents had been notified as required by the regulations and had all been responded to and managed appropriately.



**Judgment:**

Substantially Compliant

**Outcome 09: Statement of Purpose****Theme:**

Governance, Leadership and Management

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

No actions were required from the previous inspection.

**Findings:**

The inspector reviewed the statement of purpose submitted with the application to renew registration. It required further updating to clearly describe all rooms in the centre including their size and primary function.

**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:**

Mary Costelloe  
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<sup>1</sup>

<b>Centre name:</b>	Millbrae Lodge Nursing Home Limited
<b>Centre ID:</b>	OSV-0000419
<b>Date of inspection:</b>	27/03/2019
<b>Date of response:</b>	29/04/2019

### 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: Health and Social Care Needs

#### Theme:

Safe care and support

#### **The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Many inconsistencies were noted in the care planning and nursing documentation.

- Some care plans did not provide adequate information to guide care of the resident.
- Some care plans did not reflect the individual preferences of residents.
- Some care plans had not been updated and therefore did not reflect the changing needs of residents, for example, post fall or post hospital admission.

<sup>1</sup> The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.

- Some FEDS 'feeding, eating and swallowing guidelines' were inaccurate and not reflective of advice from allied health professionals such as SALT.
- A wound assessment was not up to date and the current status of the wound was not recorded.
- There were inconsistencies in the recording of consultation with GPs regarding the resuscitation status of some residents.
- Resident and relatives involvement in the development and review of care plans was not consistently recorded.

**1. Action Required:**

Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.

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

CNM has carried out review of care plans and assessments including wound and FEDs assessments.

CNM has updated care plans the goal being to ensure they provide current and adequate information to guide care.

The care plans reflect individual care and there is clear documentation of resident and relative involvement in the development and review of these care plans

Where documentation was not complete in relation to resuscitation status; a review was completed by the CNM and/or Pic in consultation with the GP, resident and (where appropriate) relatives. The goal of this action is, to provide clear and comprehensive documentation to guide staff in relation to resuscitation. April 2019

A senior Staff Nurse has commenced 1:1 training on documentation, primality focus being on care planning; with newer staff nurses. The goal is, to constantly provide a high standard of care planning to direct person centred care for our residents June 2019

Quarterly Audits and reviews of documentation will be carried out by the PiC focusing on care planning and assessments. The goal being to monitor and ensure a good standard of care planning based on recognised assessments and individual needs December 2019

**Proposed Timescale:** 30/06/2019

**Outcome 02: Safeguarding and Safety**

**Theme:**

Safe care and support

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

The rationale for administration of psychotropic medications on a prn basis, what other interventions had been tried to manage the behaviour and the effect and outcome for the resident following the administration of the medicine were not consistently recorded.

**2. Action Required:**

Under Regulation 07(3) you are required to: Ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.

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

This has been a subject of audit with improvement observed but similarly evidence of further progress required. The PiC has met with staff highlighted in the audit as failing to consistently provide good documentation around management of challenging behaviour and psychotropic medications and she will continue to review and audit this area. The goal is to ensure there is clear documentary evidence of the non-pharmacological measures undertaken to manage behaviour which is challenging, prior to the administration of psychotropic medications. April 2019

Majority of staff have completed dementia training which included management of behaviour which is challenging. Training was repeated on 10th April 2019 with a plan to hold further training later in the year. The goal is for all staff to have up to date evidence based training to ensure a high standard of care for residents suffering from dementia and specially behaviour that is challenging. April 2019

**Proposed Timescale:** 30/04/2019

**Outcome 05: Suitable Staffing**

**Theme:**

Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

The inspector observed an instance of poor people handling practice whereby staff had not used a transfer belt in accordance with best practice and in line with the residents manual handling assessment which posed a risk to the resident.

**3. Action Required:**

Under Regulation 16(1)(b) you are required to: Ensure that staff are appropriately supervised.

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

The two staff involved have meet with the Pic to ascertain a) the reason why they did not work as trained b) if changes were required on the resident care plan, c)ensure they understand the fundamentals of correct people handling

The PiC has also met with the staff nurse who was providing direct supervision to those staff members. The goal being to ensure the staff nurse understands her role in

providing direct supervision, her role in the management of staff and obligation of informing the Pic. April 2019

**Proposed Timescale:** 30/04/2019

### **Outcome 07: Health and Safety and Risk Management**

**Theme:**

Safe care and support

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

Cleaning agents some of which were unlabelled were left unattended and unsecured on the cleaner's trolley which posed a risk to residents, staff and visitors.

**4. Action Required:**

Under Regulation 26(1)(b) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the risks identified.

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

The current risk management policy outlines risks involved with the handling and storage of cleaning chemicals; specifically in relation to chemicals on/in the cleaners trolley; which is fitted with a lock box specifically for such items. A meeting has been held with the housekeeper involved regarding his failure to follow the actions outlined in the risk register, along with his training, in relation to the labelling of chemicals. Additional supervision has been carried out by the PiC. The goal is to ensure compliance with training along with the actions set out in the Risk Registered and Health and Safety Statement thus reducing risk of injury from chemical to our residents, staff and visitors. April 2019

**Proposed Timescale:** 30/04/2019

### **Outcome 08: Governance and Management**

**Theme:**

Governance, Leadership and Management

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

While the governance arrangements in place generally worked well to oversee the quality of care, further oversight was required in relation to nursing and care planning documentation, people handling practice, storage and labelling of cleaning chemicals.

**5. 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:**

Please refer to action plans above. In addition a new CNM was employed on March 1st 2019 to provide support to the PiC in achieving higher levels of supervision and support to staff. Completed April 2019 and ongoing

**Proposed Timescale:** 30/04/2019

**Outcome 09: Statement of Purpose**

**Theme:**

Governance, Leadership and Management

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

The statement of purpose required further updating to clearly describe all rooms in the centre including their size and primary function.

**6. 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:**

Statement of Purpose has been updated to include a description of each individual room, including dimensions; and forwarded to HIQA. April 2019

**Proposed Timescale:** 30/04/2019