**Health Information and Quality Authority**
**Regulation Directorate**

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

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

| | |
|---|---|
| **Centre name:** | Brentwood Manor |
| **Centre ID:** | OSV-0000322 |
| **Centre address:** | Letterkenny Road,<br>Convoy,<br>Donegal. |
| **Telephone number:** | 074 914 7700 |
| **Email address:** | brentwoodmanor@brindleyhealthcare.ie |
| **Type of centre:** | A Nursing Home as per Health (Nursing Homes) Act 1990 |
| **Registered provider:** | The Brindley Manor Federation of Nursing Homes |
| **Provider Nominee:** | Amanda Torrens |
| **Lead inspector:** | Geraldine Jolley |
| **Support inspector(s):** | PJ Wynne |
| **Type of inspection** | Unannounced |
| **Number of residents on the date of inspection:** | 45 |
| **Number of vacancies on the date of inspection:** | 3 |

## 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.

**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 Quality 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 monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

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

| From: | To: |
|---|---|
| 25 January 2016 10:30 | 25 January 2016 18:00 |

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

| Outcome | Our Judgment |
|---|---|
| Outcome 01: Statement of Purpose | Compliant |
| Outcome 02: Governance and Management | Non Compliant - Moderate |
| Outcome 04: Suitable Person in Charge | Non Compliant - Moderate |
| Outcome 05: Documentation to be kept at a designated centre | Non Compliant - Moderate |
| Outcome 07: Safeguarding and Safety | Compliant |
| Outcome 08: Health and Safety and Risk Management | Non Compliant - Moderate |
| Outcome 09: Medication Management | Non Compliant - Moderate |
| Outcome 11: Health and Social Care Needs | Non Compliant - Moderate |
| Outcome 12: Safe and Suitable Premises | Non Compliant - Moderate |
| Outcome 13: Complaints procedures | Compliant |
| Outcome 15: Food and Nutrition | Non Compliant - Moderate |
| Outcome 18: Suitable Staffing | Non Compliant - Moderate |

**Summary of findings from this inspection**

This was an unannounced inspection undertaken by the Authority to monitor compliance with the regulations and standards that govern the operation of designated centres. The inspectors observed the delivery of care and reviewed documentation such as care plans, medical records, accident/incident reports, policies and procedures and the arrangements for social care. The inspectors talked to residents about their experience of living in the centre where this was possible and also talked to staff about their training and specific roles.

The centre is designed to reflect dementia friendly design features. It is divided into self contained units that accommodate 12 residents. Each unit has a small kitchen, a dining area and sitting room. This enables residents identify with a small scale space and become familiar with other residents and staff. The building was comfortably warm, visible clean and in good decorative repair. The person in charge had introduced features of interest such as wall murals that depicted activities and

country side scenes that could be used to introduce topics of conversation for residents or to prompt their interest as they walked along hallways.

The centre is dedicated to the care of people who have dementia and dementia related illnesses. The majority of residents were older people. The inspectors noted that there was good access to local medical services including mental health services and that residents had good support from allied health professionals. Care, nursing and ancillary staff were well informed and conveyed positive attitudes about the care of older people and displayed a good understanding of individual residents' needs, wishes and preferences. They described how they addressed memory problems and disorientation and said that talking to residents and being aware of the preferences, choices and daily patterns reduced distress and helped residents' orientation. The inspectors found that the assessment of residents at the time of admission and at subsequent intervals which was the subject of an action plan in the last report had improved. Residents were regularly reviewed to assess their potential for rehabilitation and varied options were explored to ensure they could achieve maximum capacity.

The last inspection of the centre was an unannounced monitoring inspection conducted on 6 June 2014. There were improvements required to the system for assessing dependency levels and to pre admission assessments and to risk management. These actions were largely addressed but there were improvements still required in the area of fire safety. Not all staff on duty had participated in fire safety training and some checks of fire safety arrangements were not consistently maintained. The inspectors again identified that qualified staff deployment required review as there were days when only one staff nurse was on duty to meet the needs of forty five residents and some days when two nurses were on duty, one was the person in charge who was engaged with his management responsibilities. The supervision of staff also required improvement as carers did not support residents in a manner that protected their dignity during meal times and some records were not fully and accurately completed. There were management systems and resources in place in most areas to ensure the delivery of care met appropriate standards of quality and safety. However, as described in outcome 18- Suitable staffing, the current arrangement where the person in charge was covering a shortfall in another of the organisation's centres compromised capacity to supervise staff in a centre where residents had a range of complex conditions such as dementia and problems associated with brain injury and the only staff nurse on duty had qualified two months ago.

The areas for improvement are further discussed in the body of the report .The Action Plan at the end of this report identifies mandatory improvements required to come into compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

**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 Quality 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):**
No actions were required from the previous inspection.

**Findings:**
The statement of purpose for the centre had been updated for 2016. The arrangements for the provision of services described in the statement of purpose were unchanged. The centre continues to provide a day care service once a week on Wednesdays for up to four residents. A separate staff allocation is provided for this service.

**Judgment:**
Compliant

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

**Theme:**
Governance, Leadership and Management

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

**Findings:**
There is a clearly defined management structure that identifies the lines of authority and accountability. The person in charge is supported by staff nurses and carers. The organisation also had a number of senior staff who had a role to monitor compliance, quality of service and other aspects of governance. There was evidence of ongoing

improvements to the service. The provider and person in charge had introduced a number of features that reflected good practice for dementia design and this had enhanced the environment for residents and provided focal points for reminiscence and discussion.

However, there were substantial staffing availability and resource issues identified on inspection that demonstrate that a revision of management approach and resources is required. The practice of deploying the person in charge to cover qualified nurse and person in charge shortfalls in another centre compromised their responsibility for this centre. An examination of the staff nurse allocation for the week of the inspection conveyed that there were two days when two nurses were on duty for the twelve hour shift and three days when there were two nurses on duty for half of the shift. On two of these days the second nurse was the person in charge who said he used this time to address his management responsibilities. This non compliance is actioned under outcome 18, Staffing.

**Judgment:**
Non Compliant - Moderate

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

**Theme:**
Governance, Leadership and Management

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

**Findings:**
The person in charge was a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service and he had a full time role as required by legislation however he was being deployed to cover a short fall in qualified staff and the absence of the person in charge in another centre when this inspection took place. He demonstrated good clinical knowledge and understanding of his legal responsibilities as required by the regulations and standards.

He had a good level of knowledge of dementia care and had introduced a number of changes that were of benefit to residents such as a sensory space, wall murals that provided topics of interest for residents as well as being decorative and had improved standards of assessments at the time of admission and had also improved nursing care records. The efficacy of his role was however compromised by his deployment to another centre and staffing allocations. This issue is described for action under outcome 18-Staffing

**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:**
There was evidence that the administration systems and documentation were well established. Records were accessible and easy to read. Many are maintained on the computer system and include care , complaints and training records. The registration certificate was on display. The last report required that adequate daily records were maintained by nurses and the inspectors found that this had been addressed. In the sample of records viewed described health care needs, responses to interventions and residents emotional health.

The following records however, were found to need attention at this inspection: Records of nutrition such as fluid and food records were not always completed in a timely way when liquids or food was consumed. This compromised the use of the records as care staff said some were completed later based on memory of what residents had eaten or taken in liquids. Some records were noted to be fully complete and gave a good overview of diet and nutrition over the day and night however improvement was required to ensure all records were accurate. Records of fire safety checks such as daily checks of fire exits and the alarm panel were not completed at times such as weekends. A directory of residents was maintained but was not fully complete as the address of residents and next of kin details were not recorded for some residents.

**Judgment:**
Non Compliant - Moderate

***Outcome 07: Safeguarding and Safety***
***Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a***

***positive approach to behaviour that challenges. A restraint-free environment is promoted.***

**Theme:**
Safe care and support

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

**Findings:**
There were measures to protect residents being harmed or suffering abuse in place and staff knew what constituted abuse and knew what to do in the event of an allegation, suspicion or disclosure of abuse, including how incidents were to be reported. A policy and associated procedures for the prevention, detection and response to allegations of abuse was in place. Staff had received training and information on adult protection to ensure they could safeguard residents appropriately and protect them from harm and abuse.

There were no active incidents, allegations, or suspicions of abuse under investigation. A notification in relation to adult protection advised to the Authority during 2015 was investigated promptly and appropriate action was taken by the provider. The appropriate notifications were provided to the Authority and to the designated case worker in the Health Service Executive. The investigation and subsequent actions taken conveyed that staff had a good awareness of how vulnerable people should be protected and raised concerns promptly.

There was a visitors' record located in the reception area at the main entrance. This enabled staff to monitor the movement of persons in and out of the building to ensure the safety and security of residents. This was noted to be signed by visitors entering and leaving the building.

The centre had a policy on the use of restraint to ensure residents were protected from potential harm. The use of any measures that could be considered as restraints such as bed rails was underpinned by an assessment and information was recorded in care records that showed that other methods such as low to floor beds and supervision was put in place to protect residents from falls before bed rails were introduced.

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

**Findings:**
There were systems in place to promote and protect the safety of residents, staff and visitors to the centre. There was a risk management policy that included the areas described in regulation 26(1) in place. There was information on general hazard identification that included moving and handling, the management of accidents and incidents, kitchen safety and fire safety. There were assessments for clinical risks outlined by nurses in care records and the areas identified included falls, skin vulnerability and compromised nutrition status. The information provided a good overview of the risks presented and the control measures in place.

An emergency plan revised in June 2015 was in place to guide staff on to how to respond to serious untoward incidents and emergency situations. This procedure provided staff with information on senior managers contact details and advised evacuation to the nearby centre owned by the organisation, Brindley Manor should this be necessary.

There were systems in place to ensure an appropriate standard of infection control management. There were hand sanitising solutions and hand gels available throughout the centre. These were noted to be used frequently by staff as they moved from area to area and from one activity to another. Hand washing and hand drying facilities were located in all toilet areas. There were supplies of personal protective equipment available.

Measures were in place to prevent accidents in the centre and grounds. The building was generally clutter free and there were grab rails on each side of hallways and in bathrooms and toilets. Manual handling assessments were available for residents, were up to date, reflected resident's dependency and included details of the equipment to be used for manoeuvres and the number of staff required to assist. All staff had been trained in moving and handling of residents and on the prevention of accidents.

Accidents and incidents were recorded and were reviewed to determine any circumstances that could have contributed to the incident and to establish prevention measures as part of a learning culture from serious incidents/adverse events involving residents. The inspectors saw that assessments included exercises to maintain and improve mobility as part of falls prevention. Equipment was observed to be stored safely and did not present a trip hazard.

The fire safety arrangements were reviewed. The inspectors noted that the majority of staff were trained in what to do in the event of a fire however the staff nurse on duty said he had not had training since he commenced employment in December. He was familiar with the fire procedure and evacuation arrangements and could describe these to the inspector who talked to him about fire safety. Fire training records confirmed that 39 staff completed fire safety training in November 2015. Staff the inspectors talked to were aware of the fire safety measures and how to evacuate through each set of fire doors.

There was a weekly fire test report which described the check of the fire alarm panel, the response of staff and any action required. The inspectors concluded that these exercises needed to be expanded to include activities such as mock rehearsals of a fire situation to ensure staff could revise the learning from formal fire training. The fire alarm was serviced on a quarterly basis and emergency lights, fire extinguishers and the nurse call system were serviced in November 2015 according to records provided to inspectors. A list of fire fighting equipment was available. There was adequate means of escape and fire exits were noted to be unobstructed and were clearly identified. There were some improvements to the fire safety measures identified and these included:
• There was a check to ensure that they were unobstructed however the record available indicated that this completed Monday to Friday and was not completed over weekends. The record viewed indicated no check was completed on 16/17 January or 23/24 January. One fire exit was noted to be blocked by an armchair.
• The fire procedure was displayed but there were some obsolete fire notices on display which could cause confusion in a fire situation.
• One fire door (in Elm/Birch unit) that formed part of a fire control zone had a damaged fire seal.

The centre had a smoking area however the nurse call point did not have a cord or mechanism to call staff and the extractor fan needed cleaning as an accumulation of dust was evident.

The centre had a missing person procedure and there were safety measures in place to ensure that residents did not leave the building unnoticed as each unit was secure however a door by the kitchen and in close proximity to the visitors room was in constant use during the day and presented a risk as residents meeting with visitors could leave unnoticed. An action plan in relation to this is described under the outcome on premises.

There were some residents with fluctuating behaviour patterns that required intensive staff input at times. The inspectors saw that these behaviours were recorded, that a range of interventions were put in place such as increased staff input and distraction to ensure residents well being and to minimise disruption to other residents. There was a policy that provided staff with guidance on how to manage behaviours that challenge and staff had training in dementia care and challenging behaviour that provided them with additional skills to manage such behaviour effectively and in a manner that protected the dignity of residents. There was specialist input from the community mental health team and other disability service teams that ensured that residents were appropriately assessed and referred for psychological or neurological assessment. There were residents where behaviour presented particular concerns as critical aspects of care such as ensuring adequate nutrition was a problem and high levels of supervision and expert staff input was required to ensure safety. While the situation was being managed well and records confirmed that a range of specialist reviews and assessments had been undertaken the inspectors found that the absence of the person in charge to cover a short fall in another centre and the availability of one nurse to supervise and deliver care for 45 residents with fluctuating behaviour patterns and a range of medical needs presented a potential risk to staff and other residents. An action in relation to this is outlined under outcome 18-Suitable Staffing.

**Judgment:**
Non Compliant - Moderate

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

**Theme:**
Safe care and support

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

**Findings:**
The inspectors found that the systems in place for the management of medication was safe in most aspects but some medication required by residents such as sedatives and antibiotics had not been appropriately signed. There was a clinical room for the secure storage of medication including medication that required special control measures. This area was noted to be clean and well organised.

The nurse on duty was well informed about the medication in use and residents' medication regimes. The inspectors found that each resident's medication was reviewed every three months by doctors, specialist services and nursing staff. There was emphasis on ensuring that medication no longer required by residents was discontinued. Residents who had conditions that could fluctuate were monitored regularly by mental health and disability services. The inspectors noted that where nurses transcribed medication that there were two signatures available to indicate the prescription had been checked. There were several instances were prescribed medication had not been signed. This included antibiotics on 17 January 2016 and 8 December and 30 October 2015. A resident who had returned from hospital the week prior to the inspection did not have her updated medication regime signed. There were alos block signatures on some medication records.

Medications that required special control measures were carefully managed and kept in a secure cabinet in keeping with professional guidelines. Nurses maintained a register of controlled drugs. Two nurses signed and dated the register and the stock balance was checked and signed by two nurses at the change of each shift.

**Judgment:**
Non Compliant - Moderate

***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:**
There were 45 residents in the centre during the inspection including one resident who was on a short break at home. There were 26 residents assessed as having maximum or high level care needs, 16 residents had medium level needs and the remaining three residents were assessed as having low care needs or were independent. The majority of residents were noted to have complex healthcare issues in addition to their primary diagnosis of dementia or brain injury and were being treated for more than one medical condition.

The arrangements to meet residents' assessed needs were set out in individual care plans which were maintained on a computer programme. Recognised assessment tools were used to evaluate residents' progress and to assess levels of risk for deterioration, for example vulnerability to falls, dependency levels, nutritional care, risk of developing pressure area problems and moving and handling requirements. The inspectors' review of care plans focused on the assessment and management of dementia and the management of areas such as nutrition, fluctuating behaviour patterns, wound care problems and complex conditions.

The assessments completed were suitably linked to care plans and there were appropriate interventions outlined to meet the needs and risks identified. For example there was evidence of frequent multidisciplinary involvement where residents had brain injury problems and behaviours that altered frequently. Plans for more intensive interventions had been discussed and transfer to specialist units for further rehabilitation was planned based on residents needs. There was input from professionals such as neuropsychologist and professional advice outlined in relation to risk factors and appropriate interventions were recorded, known to staff and adhered to so that the well-being of residents and staff was promoted.

Overall care plans provided a reasonable overview of residents' care needs and how care was to be delivered. They were updated at the required intervals or in a timely manner in response to a change in a resident's health condition. Some records related to care such as nutrition records were found to need improvement as they were not updated at times when fluids and food was given and some the inspectors viewed did not convey fully the full diet that had been given on that day. Staff had completed some records but could not explain the procedure for ensuring that all records were fully complete and there was no review system in place to ensure that staff completed a contemporaneous accurate record. Records that described dementia care needs also required improvement.

Residents had access to general practitioner (GP) services and an out-of-hours cover was also readily available. Nurses told the inspectors they were satisfied with the current healthcare arrangements and service provision and said that they had formed good relationships with the primary care team and allied health professionals.

A review of residents' medical notes showed that GP's visited the centre to review medications and to respond to changes in health care. Access to allied health professionals such as speech and language therapists, dieticians and community mental health nurses was available. There was evidence that residents and relatives were involved in care plans and the inspectors saw that their views and contributions to their relatives care were recorded and included in care plans.

The majority of residents had cognitive assessments and while many of these were noted to convey a accurate picture of residents ability to communicate and specific memory problems there were some where it was difficult to establish the level of impairment or what residual ability or capacity residents retained. For example assessments completed indicated varied levels of impairment however there was a lack of information on what residents could still do, orientation to surroundings or who they recognised which was essential to determine what activities would be suitable for them and to enable staff to engage with them in a meaningful way.

There were processes 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 shared between providers and services.

Residents had opportunities to participate in activities and there were staff specifically allocated to social care interventions. However the inspectors noted that residents spent long periods between getting up and having breakfast to the time when activity staff came on duty at 12 noon without any structured activity. The inspectors saw that carers chatted and engaged well with residents when they were not engaged in personal care however many residents who could only respond on a one to one basis spent long periods without engagement throughout the morning except when offered mid morning drinks.

There were no residents with pressure ulcers on the days of inspection. Two minor wound care problems were in receipt of attention. Records indicated that there were regular assessments of the condition of the wound and progress towards healing. Reviews by the GP were recorded for three dates in January in one case and in the other a dry dressing had resolved the problem.

**Judgment:**
Non Compliant - Moderate

***Outcome 12: Safe and Suitable Premises***
***The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents,***

***conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.***

**Theme:**
Effective care and support

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

**Findings:**
The actions described in the last inspection report in relation to the level of light at entrances to units and odour in a unit were addressed in a timely way according to the action plan response and the inspectors found both actions were fully addressed. Some units had been redecorated in lighter colours and wall murals of varied country side scenes had been added to provide interest for residents.

Brentwood Manor is a modern purpose-built, single-storey nursing home that provides care to dependent persons who have problems associated with dementia or brain injury. It can accommodate 48 residents and the layout is divided into four units named Oak, Ash, Elm and Birch. The layout reflected a number of good dementia design features that enable residents to identify with a smaller scale of space and assists them to become orientated to their surroundings. Each unit has a kitchen/dining area and a communal room large enough to facilitate all residents to sit together. Residents' bedroom accommodation is mainly provided in single rooms. There are 34 single and 6 double rooms for residents use. The entrance opens into the reception area that has seating for residents and visitors and a designated visitors' area where residents can meet their visitors away from their unit units and in private. The units were warm, visibly clean and furnished to suit residents needs. The person in charge had created a sensory room which was appropriately equipped, provided residents with a comfortable area for relaxation and was noted to be used well throughout the day.

The majority of residents were accommodated in the centre on a long-term basis. Residents' rooms viewed were personalised with photographs and ornaments however some rooms lacked these touches which staff said reflected residents' choices. There was also a sensory room that was well equipped, a clinical space for staff, a staff changing area, a catering kitchen and sluice facilities. The building was comfortably warm, clean and odour free. Hot water temperatures were tested regularly to ensure that hot water was dispensed at a safe temperature and did not present a burns risk. There were good colour contrasts between walls and handrails to enable residents to recognise them easily.

There was appropriate equipment for use by residents and staff which was maintained in good working order. Equipment, aids and appliances such as hoists, call bells, hand rails were in place to support and promote the independence of residents. Service records were available to demonstrate equipment was maintained in good working order. Staff were trained to use all equipment. The inspectors noted the following areas that required attention:

The call bells in the smoking area and in some toilets needed to be identified clearly to indicate their function and some required a fitting /cord to ensure that residents could recognise the bells and access them readily when required.
The fire exit door by the kitchen was easily opened, was used throughout the day by staff and others and was not alarmed. This presented a hazard for residents out of their units to see visitors and day care clients as people could leave the building unnoticed and there was no system to alert staff. The provision of additional hand rails in some toilets would benefit residents as there was evidence that many residents needed assistance from staff when using toilet areas and also to support residents who used these facilities independently.

**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):**
No actions were required from the previous inspection.

**Findings:**
Residents that the inspectors talked to said that they would approach any member of staff or the person in charge if they had any issues that concerned them or wished to make a complaint. The person in charge addresses complaints and tries to resolve the issue the inspectors were told. A record of all complaints is maintained on the computer system. During 2015 there had been no complaints recorded. The complaints procedure included an appeals process and there was an identified additional person from the company to oversee that complaints were addressed according to the established procedures.

**Judgment:**
Compliant

***Outcome 15: Food and Nutrition***
***Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.***

**Theme:**

Person-centred care and support

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

**Findings:**
The inspectors found that the menus available conveyed that residents had a varied and balanced diet that met their nutritional needs and preferences. There were systems in place for assessing, reviewing and monitoring residents' nutritional intake and residents that were at risk of nutrition shortfalls were identified and monitored closely. However as described in outcome 11-Healthcare, some nutrition records were not maintained consistently which compromised how staff could judge that dietary intake was satisfactory.

There was a planned menu that provided cooked meals at midday and in the evening. Snack options were available to ensure sufficient and adequate calorie intake particularly where residents were on fortified diets or had active behaviour patterns. The inspectors saw that mid morning snacks included soup or fruit and during the afternoon a variety of cakes were served. Snacks, beverages and cold drinks were available throughout the day and staff were observed to remind residents to have a drink and to provide drinks where residents could not assist themselves.

There were some improvements required in the way meals were served to residents who needed assistance. The inspectors observed that while some staff were noted to assist residents in a way that protected their dignity by engaging them in conversation during meal times and describing what was being served the practice of other staff did not maintain residents dignity or contribute to ensuring the meal was a pleasant experience. One member of staff was observed to stand while assisting a resident to eat and another offered food to two residents and did not engage with residents during the meal.

**Judgment:**
Non Compliant - Moderate

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

**Findings:**
An action plan in the last report required that the numbers and skill mix of staff and the allocation of nursing staff were appropriate to meet the needs of residents particularly as a new client group-people with brain injury and associated cognitive and behaviour problems had been introduced. This action is repeated in this report. The person in charge was competent, familiar with residents and their specific needs and had made a number of changes that had a positive impact for residents. However, on the day of inspection, he was allocated to be in charge of another of the organisation's centres to cover an unexpected absence. The duty rota for the week of the inspection indicated that he was scheduled to do three shifts of twelve hours including a night duty in the other centre. He was scheduled to do two six hour shifts on Saturday and Sunday in his own role as person in charge. A review of the staff rotas for the previous week indicated that this was a more prolonged situation as he was allocated to complete three twelve hour shifts and one eight hour shift in the other centre and to undertake just one shift in this centre.

The staff nurse on duty when the inspectors arrived was competent and capable and was busy with requests from care staff and undertaking medication administration duties for the 44 residents in the centre. He had qualified as a mental health nurse in November 2015 and had started work in the centre in December 2015. He was supported by eight carers, including one who was a nurse awaiting registration. An examination of the staff nurse allocation for the week of the inspection conveyed that there were two days when two nurses were on duty for the twelve hour shift and three days when there were two nurses on duty for half of the shift. On two of these days the second nurse was the person in charge who said he used this time to address his management responsibilities.

The inspectors found that the arrangements required review to ensure a suitably qualified and experienced nurse was on duty when the person in charge when absent from the centre. The practice of deploying the person in charge to cover qualified nurse and person in charge shortfalls in another centre compromised their responsibility for this centre. The inspectors noted from staff reports and residents care records that there were fluctuations in residents' care needs and changes in behaviour patterns which necessitated greater levels of supervision and that qualified nurse staffing levels and the role and duty hours of the person in charge required review to ensure the safety and health care needs of residents were met effectively and to ensure the person in charge could meet their governance responsibilities. The requirement to enhance qualified nurse availability was described in previous reports for this centre and included the reports of the inspections conducted on 18 July and 8 August 2013 and 6 June 2014. There were indicators described in this report that demonstrated that staff required additional supervision to ensure the safety and well being of residents. This included meal times and when moving residents as dignity and safety was compromised as observed by the inspectors. There were also a number of health and safety matters that had not been identified by staff.

The inspectors were provided with details of the training that had been provided to staff during 2015. Training had been provided on a range of topics and included the statutory topics of elder abuse and the protection of vulnerable people, fire safety and moving and handling. The majority of staff had up to date training except for fire safety where a nurse had not received this training. Training on behaviour management had been completed by eighteen staff. The inspectors found that staff were familiar with factors that triggered changes in residents behaviour and were generally able to divert them so that behaviours did not become too problematic to themselves or others.

Residents and staff were observed to have good relationships and residents were comfortable and relaxed when staff approached them. Staff said they knew residents daily patterns and adhered to them as this contributed to their quality of life and ensured their choices were respected.

**Judgment:**
Non Compliant - Moderate

## Closing the Visit

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

**Acknowledgements**

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

***Report Compiled by:***

Geraldine Jolley
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**[1]

| | |
|---|---|
| **Centre name:** | Brentwood Manor |
| **Centre ID:** | OSV-0000322 |
| **Date of inspection:** | 25/01/2016 |
| **Date of response:** | 30/03/2016 |

## Requirements

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

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

## Outcome 02: Governance and Management

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There were substantial staffing availability and resource issues identified on inspection that demonstrate that a revision of management approach and resourcing is required.

**1. Action Required:**
Under Regulation 23(a) you are required to: Ensure the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of

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

purpose.

**Please state the actions you have taken or are planning to take:**
Since inspection, a new PIC has been employed in full time management of the centre, as advised to the authority

**Proposed Timescale:** 15/02/2016

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

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The details of residents' addresses and of next of kin addresses were not always recorded.

**2. Action Required:**
Under Regulation 19(3) you are required to: Ensure the directory includes the information specified in paragraph (3) of Schedule 3.

**Please state the actions you have taken or are planning to take:**
The resident register has been updated to reflect all required information and will be monitored on an ongoing basis by the PIC

**Proposed Timescale:** 15/03/2016

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Some records of food and nutrition provided for residents were not fully maintained and did not provide a complete record of dietary intake.
Records of fire safety checks such as checks of the fire exits and alarm panel were not maintained at some times particularly weekends.

**3. 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:**
The importance of maintaining food and nutrition records has been reiterated to all staff and will be closely monitored going forward

Records of fire safety checks are being completed daily and adherence will be monitored going forward

**Proposed Timescale:** 15/03/2016

**Outcome 08: Health and Safety and Risk Management**

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Fire safety training had not been provided for all staff on duty.

**4. Action Required:**
Under Regulation 28(1)(d) you are required to: Make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.

**Please state the actions you have taken or are planning to take:**
Fire safety training is delivered to all staff at induction and fire warden training delivered annually, this will be monitored going forward

**Proposed Timescale:** 15/03/2016

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There was a mix of fire procedures on display which could cause confusion in a fire situation.

**5. Action Required:**
Under Regulation 28(3) you are required to: Display the procedures to be followed in the event of fire in a prominent place in the designated centre.

**Please state the actions you have taken or are planning to take:**
Fire signage is being reviewed to ensure consistency

**Proposed Timescale:** 30/03/2016

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was a check to ensure that they were unobstructed however the record available indicated that this completed Monday to Friday and was not completed over weekends. The record viewed indicated no check was completed on 16/17 January or 23/24 January.

One fire door (in Elm/Birch unit) that formed part of a fire control zone had a damaged fire seal.

One fire exit was not accessible as it was blocked by a chair.

**6. 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:**
As stated under action 3: Records of fire safety checks are being completed daily and adherence will be monitored going forward

Damaged fire seal is scheduled for replacement

All staff have been reminded of the importance of maintaining clear egress through fire doors

**Proposed Timescale:** 30/03/2016

**Outcome 09: Medication Management**

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There were several instances where medication being administered had not been appropriately signed including when antibiotics or sedatives were prescribed and when revised medication regimes following a hospital admission were put in place.

**7. Action Required:**
Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.

**Please state the actions you have taken or are planning to take:**
In the event of a telephone order by a doctor, or a hospital prescription accompanying a resident on transfer, we will continue to urge the resident's GP to sign the prescription

kardex in a timely manner, this will be monitored going forward

**Proposed Timescale:** 15/03/2016

## Outcome 11: Health and Social Care Needs

**Theme:**
Effective care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Some care assessments and care plans did not describe information such as levels of cognitive impairment, who residents recognised and what abilities they retained which would inform care practice and provide indicators of what activity would be beneficial and suit their needs most appropriately.

**8. Action Required:**
Under Regulation 05(1) you are required to: Arrange to meet the needs of each resident when these have been assessed in accordance with Regulation 5(2).

**Please state the actions you have taken or are planning to take:**
Assessments and care plans will be reviewed as part of ongoing family & MDT meetings, to better inform care practice.

**Proposed Timescale:** 30/04/2016

## Outcome 12: Safe and Suitable Premises

**Theme:**
Effective care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The call bells in the smoking area and in some toilets needed to be identified clearly to indicate their function and some required a fitting /cord to ensure that residents could recognise the bells and access them readily when required.

The fire exit door by the kitchen was easily opened, was used throughout the day by staff and others and was not alarmed.

The provision of additional hand rails in some toilets would benefit residents as there was evidence that many residents needed assistance from staff when using toilet areas and also to support residents who used these facilities independently.

**9. 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:**
Call bells are recognised by residents with cognitive capacity, residents without such capacity are accompanied to the toilet and smoking area.

The fire exit door by the kitchen is not accessible to residents within the home. Residents or day care attendees within this area are under constant supervision.

The occupational therapist, employed in the centre, assess all residents for equipment needs within the home and will continue to do so

**Proposed Timescale:** 15/03/2016

**Outcome 15: Food and Nutrition**

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

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Some staff did not maintain residents dignity or contribute to ensuring the meal was a pleasant experience. One member of staff was observed to stand while assisting a resident to eat and another offered food to two residents and did not engage with residents during the meal.

**10. Action Required:**
Under Regulation 18(3) you are required to: Ensure that an adequate number of staff are available to assist residents at meals and when other refreshments are served.

**Please state the actions you have taken or are planning to take:**
All staff have been reminded of the need to encourage a positive dining experience whilst promoting the dignity of each individual resident. The dining experience will continue to be monitored by the PIC.

**Proposed Timescale:** 15/03/2016

**Outcome 18: Suitable Staffing**

**Theme:**
Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Qualified nurse staffing levels and the role and duty hours of the person in charge required review to ensure the safety and health care needs of residents were met effectively and to ensure that the person in charge was engaged in the governance and

management of the service in accordance with regulation 14-Persons in Charge.

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

**Please state the actions you have taken or are planning to take:**
Since inspection, a new PIC has been employed in full time management of the centre, as advised to the authority. Staff rotas have been reorganised to ensure that the number and skill mix of staff is appropriate to the assessed needs of the residents, in accordance with regulation

**Proposed Timescale:** 15/03/2016