Health Information and Quality Authority
Social Services Inspectorate

Inspection report
Designated centres for older people

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

Centre name:	New Lodge Nursing Home
Centre ID:	0073
Centre address:	C/O Bloomfield Care Centre Stocking Lane Rathfarnham
Telephone number:	01 4950021
Fax number:	01 4951006
Email address:	ceo@bloomfield.ie
Type of centre:	☐ **Private** ☒ **Voluntary** ☐ **Public**
Registered providers:	Bloomfield Care Centre
Person in charge:	Sharon Hennessy
Date of inspection:	30 June 2011
Time inspection took place:	**Start:** 09:50 hrs **Completion:** 19:15 hrs
Lead inspector:	Linda Moore
Support inspector:	Marian Delaney Hynes
Type of inspection:	☐ Announced ☒ Unannounced
Purpose of this inspection visit:	☐ Application to vary registration conditions ☐ Notification of a significant incident or event ☐ Notification of a change in circumstance ☐ Information received in relation to a complaint or concern ☒ Follow-up inspection

About the inspection

The purpose of inspection is to gather evidence on which to make judgments about the fitness of the registered provider and to report on the quality of the service. This is to ensure that providers are complying with the requirements and conditions of their registration and meet the Standards, that they have systems in place to both safeguard the welfare of service users and to provide information and evidence of good and poor practice.

In assessing the overall quality of the service provided, inspectors examine how well the provider has met the requirements of the Health Act 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

Additional inspections take place under the following circumstances:

- to follow up matters arising from a previous inspection to ensure that actions required of the provider have been taken
- following a notification to the Health Information and Quality Authority's Social Services Inspectorate of a change in circumstance for example, that a provider has appointed a new person in charge
- arising from a number of events including information received in relation to a concern/complaint or notification to the SSI of a significant event affecting the safety or wellbeing of residents
- to randomly "spot check" the service.

All inspections can be announced or unannounced, depending on the reason for the inspection and may take place at any time of day or night.

All inspection reports produced by the Health Information and Quality Authority will be published. However, in cases where legal or enforcement activity may arise from the findings of an inspection, the publication of a report will be delayed until that activity is resolved. The reason for this is that the publication of a report may prejudice any proceedings by putting evidence into the public domain.

About the centre

Description of services and premises

New Lodge Nursing Home, a designated centre, is located on the ground floor of the Bloomfield Care Centre. The centre has 116 places and 36 of these forms New Lodge Nursing Home. Bloomfield Care Centre is itself a separate mental health facility which is inspected by the Mental Health Commission. The Health Information and Quality Authority (the Authority) registers and inspects designated centres, which in this case is the 36 places in New Lodge Nursing Home.

New Lodge Nursing Home provides care to older people some of whom have dementia. There was one resident under 65 years with an intellectual disability.

There is a nurses' station in the centre of the unit and three corridors lead from it. Bedroom accommodation consists of 32 single and two twin bedrooms, all of which have en suite toilet and shower.

Other facilities include two sitting room-cum-dining rooms, a kitchenette, a clinical room, and two assisted bathrooms, hairdresser's salon and a sluice room. Bloomfield Care Centre has a central laundry, which provides laundry services to both New Lodge Nursing Home and the remainder of the centre. There is access to a smoking room on the first floor.

At the entrance to Bloomfield Care Centre, there is a bright spacious dining room and canteen which is used by the more independent residents, visitors and staff of both New Lodge Nursing Home and the Bloomfield Care Centre.

There is an enclosed garden which can be accessed from the sitting room.

Location

New Lodge Nursing Home is located on the Bloomfield Care Centre site on Stocking Lane, approximately two miles from Rathfarnham Village in South County Dublin.

Date centre was first established:	9 September 2005
Number of residents on the date of inspection:	34
Number of vacancies on the date of inspection:	2

Dependency level of current residents	**Max**	**High**	**Medium**	**Low**
Number of residents	17	3	5	9

Management structure

The provider is Bloomfield Care Centre and Robert Haughton is the Chairperson of the Board. Sile McManus, the Chief Executive Officer (CEO), is the person named as the representative of the Provider for New Lodge Nursing Home. She is referred to as the provider throughout the report. She is the person responsible for the day-to-day running of the entire centre and reports directly to the board. The Person in Charge, Sharon Hennessy is the Director of Nursing and reports to the CEO. She is supported by Nicola McConnell who is the Clinical Nurse Manager (CNM) and staff nurses report to the Person in Charge. The care assistants report to the staff nurses on duty on a day-to-day basis.

Staff designation	Person in Charge	Nurses	Care staff	Catering staff	Cleaning and laundry staff	Admin staff	Other staff
Number of staff on duty on day of inspection	1	2	5	2	1 cleaner	3	2*

*Provider and Clinical Nurse Manager

The CNM was on leave on the day of the inspection. However, she came to work for the afternoon of the inspection. There is one activity assistant in the day room from 8.00 am to 7.00 pm.

Background

This was a follow up inspection and the fifth inspection carried out by the Authority. There have been two previous inspections in 2011, a follow up inspection and a registration inspection in March 2011. Inspectors noted that there has been a considerable commitment by the staff in New Lodge Nursing Home to addressing issues identified in the previous two reports.

Summary of findings from this inspection

Inspectors found the staff had worked well as a team to address some of the areas identified at the previous inspection, including providing meaningful engagement for residents with a cognitive impairment. The person in charge facilitated the delivery of training to staff on the prevention, detection and responding to elder abuse, fire safety and manual handling. Although, some staff members had not completed training in these areas, the person in charge had identified the dates for further training sessions.

The inspectors noted there was a cultural change since the previous inspections from a task-orientated service provision to one of more person-centred care.

Inspectors found that nine actions were completed, nine actions were partly completed and four actions were not addressed.

There were some areas of concern that required immediate attention. These included management of weight loss and nutrition, management of residents with swallowing difficulties (dysphagia). The numbers and skill-mix of staff on duty were not sufficient to meet the assessed needs of residents.

A number of improvements were still required to comply with the requirements of the Regulations and the Standards and these are discussed throughout the body of the report. The area of restraint and care planning required particular attention.

Actions reviewed on inspection:

1. Action required from previous inspection:

Review and update the emergency plan for responding to emergencies.

This action was partly addressed.

An emergency plan had been developed since the previous inspection, which identified what to do in the event of fire, flood, loss of power or heat and other possible emergencies. Alternative accommodation for residents was available if evacuation was necessary. However, it was still in draft format and did not include the emergency procedure to guide staff in the total evacuation from the building should that be necessary and the process to re-enter the building following evacuation.

2. Action required from previous inspection:

Make arrangements to ensure that all persons working at the designated centre are aware of the procedures to be followed in the case of fire.

This action was partly addressed and was ongoing.

The training records showed that the majority of staff had attended mandatory fire training and there were only two staff who had not undertaken fire training since 17 June 2010. The person in charge told inspectors that these staff members would be included on the next fire training in July 2011. Staff were knowledgeable on the procedures to be followed in the case of a fire.

3. Action required from previous inspection:

Ensure staff are trained in the moving and handling of residents

Take all measures to prevent accidents to any person in the designated centre.

This action was partly addressed and was ongoing.

While the inspectors noted some good practice in manual handling, they also observed some poor practice. Despite staff being provided with moving and handling training, two staff members were observed using inappropriate techniques to transfer a resident from a wheelchair to a chair. There was potential to cause injury to the resident. The training records showed that 19 of the 23 staff members in the unit had attended training on manual handling in the past three years. The person in charge told inspectors that further manual handling training sessions were booked for July 2011 to bring all staff up-to-date.

4. Action required from previous inspection:

Agree and roll out the operational policies relating to the ordering, prescribing, storing and administration of medicines to residents and ensure that staff are familiar with such policies and procedures.

This was addressed. Inspectors noted significant improvements in this area.

Inspectors found evidence of good medication management processes. There were comprehensive medication management policies which were recently signed off at the clinical governance meeting, which provided guidance to staff. Inspectors observed the nurses on part of their medication rounds and found that medication was administered in accordance with professional guidelines. Medications that required special control measures were carefully managed and kept in a secure cabinet in keeping with the Misuse of Drugs (Safe Custody) Regulations, 1982. These medications were counted at the time of administration and at the change of each shift. Nurses kept 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. Inspectors checked the balances and found them to be correct.

There were appropriate procedures for the handling and disposal of unused and out-of-date medicines.

Inspectors also noted that there was regular input from the pharmacy - reviews of medication prescriptions, administration records and stock balances were carried out. The clinical nurse manager carried out monthly medication management audits, the results of which are discussed at the clinical governance meetings.

5. Action required from previous inspection:

Notify the Authority of serious injuries as per the Regulations.

This was addressed since the previous inspection.

Inspectors noted the practice in relation to notifications of incidents was satisfactory. The person in charge was aware of the legal requirement to notify the Chief Inspector regarding incidents and accidents. Since the previous inspection, all relevant incidents had been notified to the Chief Inspector by the person in charge.

6. Action required from previous inspection:

Develop and roll out the policy on and procedures for the prevention, detection and response to abuse.

This action was partly addressed.

There was a policy to guide staff for the prevention, detection and response to abuse but this could not be located. The person in charge printed a copy of the policy for the inspectors. As a hard or soft copy of the policy was not readily available to staff should they require this, there was potential that care might not be delivered as per the policy.

7. Action required from previous inspection:

Make all necessary arrangements by training staff or other measure in place aimed at preventing residents being harmed or suffering abuse

This action was partly addressed.

Staff members interviewed were able to define their responsibilities should they suspect an allegation of abuse and they were able to tell inspectors what they would do if an allegation of abuse was made to them. Training records showed that the majority of staff had attended elder abuse training in March and May 2011 and training was planned for 8 July 2011 to bring the remaining three staff up-to-date in this training.

8. Action required from previous inspection:

Put in place and implement all polices as required by schedule 5 of the Regulations.

This action had commenced and was ongoing.

Inspectors noted that that some work had been undertaken since the previous inspection to develop the medication management policy and the restraint policy - both of these had recently become available for staff to read. All other polices required by the Regulations were being systematically updated by the person in charge with a timeframe for completion of this project of December 2011. The person in charge said that all policies would be unit-specific, guide practice and meet the requirements of the Regulations.

9. Action required from previous inspection:

Provide appropriate assistance to residents, dependant on their abilities at meal times.

This action was partly addressed.

Inspectors were satisfied that residents received a nutritious and varied diet which included choices. Mealtimes were unhurried social occasions that provided opportunities for residents to interact with each other and staff. This had improved considerably since the previous inspection in February 2011.

However, inspectors were concerned about the management of residents with swallowing difficulties (dysphagia). Inspectors observed that staff were not up-to-date in evidenced based nursing care in the management of residents with dysphagia. Staff told inspectors they were not trained to meet these residents' needs. Residents with dysphagia did not have care plans to guide the care required or delivered. The provider was required to address the deficit in the management of residents with dysphagia in an Immediate Action Plan. The person in charge's response committed that "all staff would receive training in dysphagia on 27 and 28 July. A staff nurse would supervise all meals until the training is delivered. Staff received information on the management of residents with dysphagia".

Inspectors also had concerns about those at risk of weight loss and nutrition (See other issues below).

10. Action required from previous inspection:

Facilitate residents' dietary restrictions based on their religious grounds to a good standard.

This action was addressed and considerable work had been undertaken in this area since the last inspection.

On the day of the inspection, the kosher kitchen was open and a chef was working in the kitchen providing freshly cooked meals to the residents. Residents said they were delighted with this food and they thoroughly enjoyed the meals. The CEO and person in charge were aware of the issues regarding the kosher meals and were actively trying to find a permanent alternative to the provision of Kosher pre-packed food.

11. Action required from previous inspection:

Include residents and or relatives in the development and review of their care plan. Set out each resident's needs in an individual care plan developed and agreed with the resident. Provide suitable and sufficient care to residents as set out in their care plan.

This action was not addressed.

Inspectors read a number of care plans, talked to staff and noted that some work had commenced in this area of care planning since the inspection in February 2011, with the introduction of new care planning documentation. However, there was still considerable amount of work outstanding in this area and the quality of care plans posed a risk that residents might not receive evidenced-based care.

The inspectors noted that the current care plans still did not guide the care to be delivered and were not always updated as the resident's condition changed. For example, one resident who had fallen and had a fractured hip, had a care plan for mobilisation which stated "resident (name) be encouraged to mobilise initially 2-3

steps". The physiotherapist attending this gentleman stated he could not mobilise at this stage. One residents' care plan for pressure sore referred to the dressing care plan - this plan was not a plan but a wound dressing treatment form and did not outline the care of the wound.

The poor quality of care plans continued to pose a risk that the residents may not receive evidenced based care.

There was no evidence that residents and relatives were involved in the development of care plans.

12. Action required from previous inspection:

Maintain, in a safe and accessible place, a record of any occasion on which restraint is used, the nature of the restraint and its duration, in respect of each resident.

Maintain, in a safe and accessible place, a record of any occasion on which restraint is used, the nature of the restraint and its duration, in respect of each resident.

This action was not satisfactorily addressed.

The inspectors acknowledged the work in this area since February, 2011 such as implementing the policy on restraint. The clinical nurse manager had also completed the 'Train the Trainer' course in restraint management and had provided this training to some staff members. However, 25 out of 36 residents had bedrails in place and inspectors considered this to be a high rate of use. The records showed only two staff members had read the policy.

The majority of residents who required a restraint had an assessment in place but this was not always the case and some residents did not have a care plan. The deadline for the roll out of assessments and care plans was 31 May 2011 and this had not been met. The CNM and senior occupational therapist (OT) acknowledged the deficits and were planning to pilot the assessment and care plan process in the coming weeks with four residents and then implement it for all residents.

13. Action required from previous inspection:

Monitor the implementation of the risk management procedures with particular regard to the security arrangements for out of hours.

Take all reasonable measures to prevent accidents to any person in the designated centre by developing a risk assessment for the resident left unsupervised when smoking.

This action was addressed.

The staff were made aware of the security arrangements in place and were adhering to these, supervised by the person in charge.

There were no residents who smoked in the centre on the day of the inspection. The provider had erected a covered area outside in the garden which could be used by residents who smoked and they could be supervised if needed.

14. Action required from previous inspection:

Ensure a record is maintained when a resident refuses treatment, records should be maintained in a manner so as to ensure completeness and accuracy.

This action was complete.

Inspectors reviewed records and noted that they were maintained in a manner so as to ensure completeness and accuracy

15. Action required from previous inspection:

Keep the directory of residents up-to-date.

This action was complete.

The directory of residents was up-to-date and reflected the requirements of the Regulations.

16. Action required from previous inspection:

Provide opportunities for residents to participate in development of activities appropriate to his her interest and capacities.

This action was addressed and inspectors noted the considerable amount of work which was undertaken in this area since the inspection.

Opportunities for residents with a cognitive impairment to participate in meaningful and purposeful occupation and leisure activities had been developed. The senior OT told the inspectors that she had commenced the introduction of the activity assessments and a meaningful activities care plan was also formulated for some residents which guided the care to be delivered. These were read by inspectors. Two OT assistants had been recruited and they provided activation and stimulation for residents in the day room and in particular those with dementia. This meant that there was an OT assistant on duty from 8.00 am to 7.00 pm every day of the week.

The senior OT also guided both structured and unstructured activities and set up individual session time with the assistant OT for each resident with dementia based on their meaningful activities care plan.

17. Action required from previous inspection:

Continue to develop a system for reviewing the quality and safety of care provided.

This action was partly complete.

Inspectors noted there were systems for reviewing the quality and safety of care provided, including the audit of medication management. Data was collated by the CNM in relation to complaints, weigh loss and incidences of falls. The results of these were discussed at the monthly clinical governance meetings, the minutes of which were read by inspectors. Inspectors noted that while there was a system for reviewing the quality and safety of care provided, this was not entirely effective as this system failed to identify one resident who had a considerable weight loss in a two month period which was identified by inspectors.

18. Action required from previous inspection:

Provide suitable storage facilities for the use of each resident.

Provide suitable storage.

This action was addressed.

Storage had been provided since the previous inspection, in that one of the bathrooms was converted into a store room. All store rooms were locked when not in use. Residents had access to storage, personal locked storage space was provided in each bedroom.

19. Action required from previous inspection:

Maintain records in a safe and secure place.

This action was completed.

Inspectors observed that all residents' information was observed to be stored safely and securely.

20. Action required from previous inspection:

Introduce a system of supervision of staff on an appropriate basis pertinent to their role.

This action was not addressed.

There was no still no supervision of staff pertinent to their role, particularly for agency staff. The person in charge said they were currently developing a model of performance management for all staff. The timeframe for completion was June 2011.

21. Action required from previous inspection:

Obtain the information and documentation for each staff member as specified in Schedule 2 of the Regulations.

This action was not addressed.

There were robust written operational recruitment policies. All new staff had all the required documentation as per the Regulations prior to starting work. However, some files for the existing staff were not in line with the Regulations. The administrator was continuing to collect the three references for the existing staff members. The time frame for completion of this action was 30 June 2011 and this date had been exceeded.

22. Action required from previous inspection:

Update the statement of purpose to include all aspects of the Regulations.

This action was complete.

Inspectors were satisfied that the statement of purpose accurately described the service provided in the centre and met requirements of Schedule 1 of the Regulations.

Inspectors observed that the centre's capacity to meet the diverse needs of residents, as stated in the statement of purpose, was reflected in practice. In particular inspectors noted the inclusive, respectful and reassuring manner in which staff interacted with residents. There was relevant staff training and development programmes, and the design and layout of the centre was fit for purpose.

The statement of purpose is kept under review by the provider and made available to residents on admission.

Other issues

Weight Loss and Nutritional Management

Inspectors were concerned about the management of weight loss. This was identified as an issue at the inspection in February 2011. While the CNM had implemented systems to identify and respond to residents at risk of weight loss, these systems were not being consistently monitored to capture all residents at risk.

Inspectors reviewed the clinical governance meeting minutes and a sample of residents' care plans and found that residents previously identified as at risk of weight loss were being well managed. However, one resident had a total weight loss of 11 kgs in two months and appropriate measures were not put in place to manage this risk.

The provider was required to address this issue in an Immediate Action Plan and to ensure appropriate measures were taken to ensure all residents' care and wellbeing were being maintained in relation to their nutritional status. The person in charge informed inspectors that an algorithm was developed which outlined the process to be followed should a resident present with weight loss.

Staffing Levels

Inspectors had concerns that there were insufficient staff on duty to supervise the care delivered to residents at lunch time. The CNM, who was usually supernumery on the unit was on annual leave for one week and was not replaced. The person in charge said she would visit the unit from time to time or staff would call her if needed her. Inspectors observed that a staff nurse was administering medication and another nurse was in the main dining room assisting residents and neither were available should the need arise. The provider was required to address this issue in the Immediate Action Plan. The provider sent details of the revised supervision arrangements to the Authority on the 1 July 2011 and they were satisfactory.

Report compiled by:

Linda Moore

Inspector of Social Services
Social Services Inspectorate
Health Information and Quality Authority

1 July 2011

Chronology of previous HIQA inspections	
Date of previous inspection:	**Type of inspection:**
23 September 2010	☐ Registration ☒ Scheduled ☐ Follow-up inspection ☒ Announced ☐ Unannounced
4 May 2010	☐ Registration ☐ Scheduled ☒ Follow-up inspection ☒ Announced ☐ Unannounced
1, 2 and 3 February 2011	☐ Registration ☒ Scheduled ☒ Follow-up inspection ☒ Announced ☐ Unannounced
22 and 23 March 2011	☒ Registration ☐ Scheduled ☐ Follow-up inspection ☐ Announced ☒ Unannounced

Health Information and Quality Authority
Social Services Inspectorate

Action Plan

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

Provider's response to inspection report *

Centre:	New Lodge Nursing Home
Centre ID:	0073
Date of inspection:	30 June 2011
Date of response:	12 August 2011

Requirements

These requirements set out what the registered provider must do to meet the Health Act, 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

1. The provider has failed to comply with a regulatory requirement in the following respect:

Suitable and sufficient care was not provided to a resident who had significant weight loss.

Action required:

Provide suitable and sufficient care to maintain residents' welfare and well being as set out in the residents care plan.

Reference:

Health Act, 2007
Regulation 6: General Welfare and Protection
Standard 13: Healthcare

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

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: This resident had been obese on previous assessments. Following weight loss he was within the normal BMI range. However, staff did not take into account that this weight loss had been unintentional. Weights and BMI scores are now trended on an ongoing basis, to ensure that unintentional weight loss is not overlooked, even in obese residents.	Complete

2. The person in charge has failed to comply with a regulatory requirement in the following respect:

Inspectors found the staff on duty did not have access to education and training to provide care to residents with dysphagia in accordance with contemporary evidence based practice.

Action required:

Provide staff members with access to education and training to enable them to provide care in accordance with contemporary evidence based practice.

Reference:

Health Act, 2007
Regulation 17: Training and Staff Development
Standard 24: Training and Supervision

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: Staff were given immediate access to an online learning resource. Training was carried out (Category 1 approved) on 27 and 28 July 2011. Another session will be arranged for those who missed those dates due to annual leave.	Complete by 15/09/2011

3. The person in charge has failed to comply with a regulatory requirement in the following respect:

Inspectors had concerns that there was no nurse available on the unit at lunch time should the need arise as one staff nurse was off the unit supervising meals and the other was administering medications.

Action required: Ensure the numbers and skill-mix of staff are appropriate to the assessed needs of residents, and the size and layout of the designated centre.	
Reference: Health Act, 2007 Regulation 16: Staffing Standard 23: Staffing Levels and Qualifications	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Nursing staff are now available at meal times as the cover arrangements for times of absence for the CNM have been improved. The CNM/acting CNM are available at meal times to assist and supervise.	Complete

4. The person in charge has failed to comply with a regulatory requirement in the following respect: There was no evidence of resident or relative involvement in the development or review of their care plans. The care plans did not set out the residents' needs.	
Action required: Include residents and or relatives in the development and review of their care plan.	
Action required: Set out each resident's needs in an individual care plan developed and agreed with the resident.	
Reference: Health Act, 2007 Regulation 8: Assessment and Care Plan Standard 10: Assessment Standard 11: The Resident's Care Plan	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**

Provider's response: Group workshops in completing individual care plans were carried out with staff nurses. The importance of resident or relative involvement was emphasised. Staff nurses have been instructed to ensure care plans always reflect the actual up-to-date needs of our residents. A consultancy service for assessments and care planning processes was appointed on 9 August 2011 and work is expected to commence before the end August.	Complete Complete Complete by 31/10/2011

5. The person in charge has failed to comply with a regulatory requirement in the following respect: The emergency procedure did not include the emergency procedure to guide staff in the total evacuation from the building should that be necessary and the process to re-enter the building following evacuation.
Action required: Review and update the emergency plan for responding to emergencies.
Reference: Health Act, 2007 Regulation 31: Risk management Standard 26: Health and Safety

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: A twelve-step evacuation guide has been added to the emergency plan in case total evacuation from the building is required.	Complete

6. The provider has failed to comply with a regulatory requirement in the following respect: The system for reviewing the quality and safety of care provided was not effective.
Action required: Continue to develop a system for reviewing the quality and safety of care provided.

Reference: Health Act, 2007 Regulation 35: Review of Quality and Safety of Care and Quality of life Standard 30: Quality Assurance and Continuous Improvement	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The clinical governance committee continues to meet on a monthly basis. The system of reporting and the quality of information reported to the clinical governance committee is being reviewed. The committee membership is being extended to widen the expertise available.	Complete by 30/09/2011 And ongoing

7. The provide has failed to comply with a regulatory requirement in the following respect: There was no system of supervision of staff pertinent to their role.	
Action required: Introduce a system of supervision of staff on an appropriate basis pertinent to their role.	
Reference: Health Act, 2007 Regulation 16: Training and Staff Development Standard 24: Training and Supervision	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: A senior staff nurse has been appointed to act up as a supernumerary supervisor in the absence of the clinical nurse manager. The implementation of a staff performance appraisal system was delayed due to the complexities involved in developing one for all services in the Centre. An appraisal system specific to New Lodge Nursing Home staff will be adopted and implemented.	Complete Complete by 30/09/2011

8. The person in charge has failed to comply with a regulatory requirement in the following respect: A number of staff files still did not meet the requirements of the Regulations. The administrator was actively seeking this information.	
Action required: Obtain the information and documentation for each staff member as specified in Schedule 2 of the Regulations.	
Reference: Health Act, 2007 Regulation 18: Recruitment Standard 22: Recruitment	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The outstanding documents are those sent to the Garda Síochána Vetting Office for processing and a couple of external references for existing staff. In the interim we have on file a self declaration from the employee that they do not have any convictions.	Complete by 30/09/2011

Any comments the provider may wish to make:

Provider's response:

The staff and management continue to work hard to improve the quality of the service we provide to our residents. Improvements already implemented are yielding benefits for our residents and increasing job satisfaction for the staff. A culture of continuous improvement is developing among the staff and change is welcomed by all. This inspection process has set in motion a continuous process of questioning how our performance benefits our residents. We would like to thank the inspectors for the positive attitude in which they carry out their role.

Provider's name: Bloomfield Care Centre
Date: 12 August 2011