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:	Our Lady's Manor Nursing Home
Centre ID:	0081
Centre address:	Dublin Road Edgeworthstown Co. Longford
Telephone number:	043 6671007
Fax number:	043 6671355
Email address:	donolm@newbrooknursing.ie
Type of centre:	☒ **Private** ☐ **Voluntary** ☐ **Public**
Registered providers:	Lady Edgeworth Limited Nursing Home
Person in charge:	Martina Higgins Stacey
Date of inspection:	17 August 2011
Time inspection took place:	**Start:** 10:30 hrs **Completion:** 17:45 hrs
Lead inspector:	Geraldine Jolley
Support inspector:	N/A
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

Our Lady's Manor Nursing Home is operated by Lady Edgeworth Nursing Home Limited. The centre has been in operation since the 1950s, the present owners took over in 2009. It is an old building which was originally a convent and has been converted and modified over the years to improve the facilities available for residents. In 2010 and 2011 a major refurbishment programme commenced and part of this work is now complete. The centre can accommodate 59 residents providing long-term, short-term and convalescent care.

There are 32 single bedrooms of which 13 have en suite facilities, eleven double rooms one of which has an en suite facility and a five-bedded room with a fully accessible en suite facility. Residents are accommodated on each of the three floors. The basement and upper floors can be accessed by stairs or by passenger lift. The building is surrounded by several acres of grounds with gardens that are cultivated with flower beds and shrubs including a walled vegetable garden. There is seating at intervals around the gardens. There is ample car parking available. The main residence for the community of sisters that operated the service previously is also located in the grounds and is linked by tunnel which provides direct access for the sisters to the centre and church.

The communal space comprises a large dining room, three sitting areas, visitors' room, smoking area and a church. There is also space for residents to meet visitors in private. The new bedrooms met the size requirements outlined in the standards and had spacious well designed en suite facilities that contained a toilet, shower and wash-hand basin. There were assistive aids such as handrails and these were in contrast colours to assist residents with visual problems.

Location

The centre is located a short distance from the main street of Edgeworthstown (adjacent to the main Dublin to Sligo N4 roadway). The local church is across the road from the centre and the shops and business facilities of the town are within walking distance.

Date centre was first established:	1 March 1952
Number of residents on the date of inspection:	49
Number of vacancies on the date of inspection:	10

Dependency level of current residents	**Max**	**High**	**Medium**	**Low**
Number of residents	35	7	7	0

Management structure

Our Lady's Manor Nursing Home is owned by Lady Edgeworth Limited Nursing Home. The directors of the company are Sarah Anne and John Noel McGivney. Sarah Anne McGivney is the nominated provider on behalf of the company. The person in charge is Martina Higgins Stacey who reports directly to the providers. She is supported in her role by a team of staff nurses, care staff, a physiotherapist, housekeeping staff and an administrator. There are also a number of garden/maintenance staff who report to the provider.

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	11	3	3	1	2*

* two activity coordinators

Background

This was an unannounced follow up inspection to the registration inspection that took place on 19, 20 and 28 April 2011. This inspection focused on the areas of practice that required improvement as outlined in the action plan of that report. The inspectors had identified 30 areas where improvements were required. Four recommendations were made. The registration inspection was suspended on the second day, the 20 April and an immediate action letter issued requiring the provider to address fire safety failures. The fire escapes were blocked and could not facilitate a safe exit from the building and appropriate checks of fire safety measures were not in place. The inspection continued on 28 April and the inspectors found that the providers had addressed the actions outlined in the immediate action letter. The fire escape layout had been completely revised and made safer and a new fire alert system had been installed.

During the registration inspection, the provider and person in charge were interviewed as part of the fit person assessment for registration. Both demonstrated good knowledge of the *National Quality Standards for Residential Care Settings for Older People in Ireland* and the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended). They were clear about the differences in their roles and responsibilities. There was evidence of some good practice in nursing care. Inspectors found that staff knew residents well and were observed to be engaged and attentive to them. There were good multidisciplinary working arrangements established to ensure that residents had appropriate expertise to identify and address their care needs. However, the inspectors found significant failings in risk management. Aspects of care practice such as the identification of pressure area vulnerability and the management of pressure ulcers required improvements as did monitoring of the quality of life for some residents and some of the required records needed amendments to meet regulatory requirements. The provider and person in charge made a timely response to the inspection report and described how they were addressing the action plan.

Summary of findings from this inspection

The centre was noted to be clean and appropriately warm. Residents were sitting in the varied sitting rooms and many attended morning Mass. Staff were friendly and welcoming and were observed to be available to residents in two sitting areas. Interactions between staff and residents were noted to be positive with staff taking time to talk as they went about their duties. Nurses and other staff answered the inspectors' queries in an informed and professional manner.

The residents' group was now attended by an external advocate and residents' requests and views were being recorded. Matters highlighted for attention were being addressed the inspector was told. Residents had requested a visit to Knock and one resident had asked to have a telephone which had been provided. The visit to Knock was being arranged for interested residents.

Since the last inspection, there had been improvements made to how communication was managed in the centre. A dedicated handover period for staff to communicate between shifts was now in place, the menu boards outside the main dining room and meal choices were outlined in large print and staff were allocated time to spend with the more frail residents in addition to time spent engaged in care duties.

Other improvements included the temporary closure of rooms that were a distance from the main area of activity on the upper floor and where the inspectors had noted during the registration inspection that some residents had to wait for assistance. However, it is not intended that the closure of these rooms was long term. The rooms were scheduled for redecoration and the inspector was told they would be in use again when the fire safety improvements had been completed.

During the follow up inspection, progress on the action plan was reviewed with the provider and person in charge. They had started to address the actions identified. However, progress had been slow with only eight actions fully complete and the remaining 22 actions in progress or introductory work on them just commenced. The person in charge had a significant number of matters to address but it was evident that she did not have adequate time to devote to her responsibilities as person in charge. There are two staff nurses on duty daily but they are fully engaged attending to the needs of the highly dependant resident group and supervising care staff throughout this large diverse building. The timeframes outlined in the response to the action plan for many of the remedial actions was due to expire at the end of August or in September.

Priority actions had not been completed. These included remedial actions to ensure fire safety measures were appropriate, review of staffing levels in the context of dependency levels and the layout of the building, more comprehensive risk management and the introduction of suitable and appropriate procedures for safe medication management.

The Authority's inspectors met with the provider, the person in charge, the Chief Executive and another member of the management team on 26 August 2011 to discuss the persistent failings in areas such as risk management, medication administration and fire safety identified during all inspections since 2009. They emphasised the need to see more evidence of remedial action on these matters before registration of the centre could proceed. The provider and chief executive indicated that they intended to employ more staff to expand the nursing team but had found recruitment difficult. The provider was also requested to review the numbers of beds to be registered as the application to register was for 59 nine residents, but during the inspection the inspector was informed that 65 residents were to be accommodated.. The provider was requested to submit final written information as to the number of residents to be accommodated by September 12 2011.

Issues covered on inspection

1. Staff deployment:

At the last inspection the inspectors had been concerned about staff deployment and there were indicators that there was insufficient staff to provide care to residents during the day and at night. This situation was largely unchanged at this inspection. However, an extra nurse had been made available on Monday mornings to assist with the admission of residents for respite care. An examination of the staff rota indicated that there are normally two nurses on duty with 11 care staff. There is generally one nurse and three carers on duty at night. There are some week end nights when the skill mix is two nurses and two carers.

The maintenance of staffing levels to match residents' care needs taking in to account the design and layout of this large diverse building was an ongoing challenge according to the person in charge. A recruitment drive had been completed and new staff were due to commence their adaptation course prior to commencing duties in the centre. The inspector formed the view that the person in charge could not carry out her role effectively as she had little support as staff nurses were engaged all day addressing the needs of residents and could not undertake additional duties to support the person in charge. This was evidenced by the number of actions that were the responsibility of the person in charge not complete. These included training on mandatory topics such as moving and handling, improvements to care planning systems and resolving medication management problems.

The inspector found the deployment model at night needed review as there was one nurse on duty at night with three care staff to provide care for 50 plus residents. This meant that the nurse had to dispense medication to the fifty residents over three floors and cold not be available to provide guidance to care staff or comfort and support to residents for considerable periods of time. Taking into account that 35 of the 49 residents currently accommodated were maximum dependency and a further seven were high dependency the inspector formed the view that the skill mix during the night needed review.

2. Risk Management:

Training on challenging behaviour had been completed on two dates in July and August and 2 further sessions were planned. This was based on actual scenarios from the centre to maximise staff learning as there are 3 residents who currently present with varied behaviour challenges from time to time. All three residents have improved in recent weeks the inspector was told.

While a risk register for the centre was being compiled and there was a reporting and review system for accidents and incidents, there was a deficit in the identification of risk. The inspector found that the risks posed by staircases that led off the main hallways had not been identified and there was no protection measures

in place. Training on risk management was due to take place according to the person in charge to enable staff to identify risk and plan remedial action as part of the introduction of the new risk register system. Overall, the inspectors have consistently found that the management of risk in the centre was variable and that during a number of inspections significant risks had not been identified such as blocked fire exits or poor signage to fire exits.

3. Medication Management:

All reports have identified that improvements are needed to medication management. A medication administration error was reported and investigated but there was no evidence during inspections that remedial actions to prevent a recurrence had been put in place. There were continued deficiencies in medication prescribing and the person in charge said that her audits continue to highlight shortfalls such as sensitivities not being documented, maximum doses of as required medication not outlined and routes of administration not evident.

4. Accidents, Incidents and Notifications:

The inspector reviewed the accident and incident record and the notifications made to the Authority. In April there had been six falls, in May 11 had been reported and in June and July there had been 17 and 16 respectively. There was some improvement in falls management as a risk assessment form and a falls audit form were now part of the documentation completed. Neurological observations were now completed for all falls that are not witnessed.

A review of falls and incidents was not in place as a regular feature of prevention or learning from incidents but the person in charge had recorded information on falls on a data base with a view to making analysis of the information.

Actions reviewed on inspection:

1. Action required from previous inspection:
Provide adequate means of escape in the event of fire.

Make adequate arrangements for the evacuation, in the event of fire, of all people in the designated centre and the safe placement of residents.

Provide to the Chief Inspector of Social Services, together with the application for registration or renewal of registration, written confirmation from a competent person that all the requirements of the statutory fire authority have been complied with.

Provide suitable training for staff in fire prevention.

This action was in progress but was not complete. This was a concern as fire had been the subject of an immediate action letter during the inspection. An additional fire assembly point had been identified. There were plans to compartmentalise the building but this had not been finalised and the person in charge did not consider it appropriate to do more fire training until the final containment arrangements were in place and could be incorporated into the training.

The location of the new kitchen completed as part of the refurbishment presented some problems during a fire safety inspection and a fire wall has been installed to protect the attic. This work was complete. No residents are currently accommodated on the upper floor over the boiler area. This arrangement will be reviewed when the compartmentalisation is complete the inspector was told.

A fire safety certificate was forwarded to the Authority however a further certificate has been requested as the information supplied did not comply with Article 4 (3) (d) of the Health Act 2007.

2. Action required from previous inspection:

Ensure that the numbers and skill mix of staff are appropriate to the assessed needs of residents, and the size and layout of the designated centre.

Have in place dedicated time within the duty rota to enable staff to communicate effectively between shift changes to ensure that suitable and sufficient care to maintain the residents' welfare and well-being is provided.

This action was partially addressed. At the last inspection inspectors had concerns about the deployment of staff. They concluded that while there was sufficient nursing and care staff to provide care to residents during the morning and afternoon periods, there was an inadequate skill mix provided at night taking into account the design and layout of the building which is organised over three floors. This situation was unchanged at this inspection.

An examination of the staff rota indicated that there was generally one nurse on night duty except for some weekend nights when two nurses were on duty. The inspector also had concerns about the number of nurses available during the day to support the person in charge. There were two nurses scheduled for day duty but taking into account the training needs of staff, the dependency of residents, the layout of the building and the number of actions required to be completed by the person in charge outlined in the last inspection report this was not sufficient to provide high quality care and enable the person in charge to introduce the required changes. The inspector was told that management had considered having a third nurse in mornings but so far this has been confined to Monday mornings to assist with the admission of residents for respite care. The inspector was told that qualified nurses had been recruited from abroad but they have yet to go through adaptation training and will not be available for some months.

The person in charge had made efforts to ensure better communication among staff and had introduced a key worker system and divided staff into “teams” for each floor. She had also introduced a dedicated 15 minute period at the beginning of each shift change to enable staff to convey information more effectively. She was also introducing care staff meetings to enable carers to share their views and one meeting with 5 carers had taken place so far.

3. Action required from previous inspection:

The risk assessment procedure was inadequate and did not identify all the hazards in the centre. The provider was required to put in place a comprehensive written risk management policy and implement this throughout the designated centre.

Ensure that the risk management policy covers, but is not limited to, the identification and assessment of risks throughout the designated centre and the precautions in place to control the risks identified.

Ensure that the risk management policy covers the precautions in place to control the following specified risks: the unexplained absence of a resident; assault; accidental injury to residents or staff; aggression and violence; and self-harm.

Provide training for all staff in risk identification and management.

This action was in progress. The inspector was told that the safety statement had been revised and risk assessments for the environment had been completed. Two fire doors were identified as needing new seals and this work was scheduled. The person in charge is compiling a risk register for the centre and the inspector saw the baseline data that had been recorded so far. Risk assessments and a falls audit form are now completed when a fall occurs. Training on risk assessment had been identified for staff to enable them to assess and manage risk more effectively and proactively however, this training had not yet taken place.

4. Action required from previous inspection:

There was inconsistent recording and management of wound care problems. Wound care practice did not reflect up to date good practice guidance for professionals such as the *National Good Practice and Evidence based Guidelines for Wound Management* Health Service Executive 2009.

The provider was required to have in place suitable and sufficient care to maintain each resident's welfare and wellbeing, having regard to the nature and extent of each resident's dependency and needs.

Provide a high standard of evidence-based nursing practice.

Develop a contemporary evidence-based wound care policy to inform wound management in the centre and include reference to latest good practice guidance to guide professionals- *National Good Practice and Evidence based Guidelines for Wound Management* Health Service Executive 2009.

This action was in progress. The inspectors had found that there was inconsistent recording of wound care problems and that care practice did not reflect up to date standards. The person in charge said that the development of the wound care policy and procedure was in progress and that this included a more comprehensive method for recording wound care problems and pressure ulcers.

There were no pressure sores being treated at this time and a staff nurse reported that there were three small dressings required for superficial skin scratches. Access to a dietician to provide nutritional guidance and support where residents required this service has been arranged from the Health Service Executive. Infection control support was also available through the HSE. The person in charge was arranging for infection control training for staff and had made contact with a trainer to do this. She was awaiting dates to be scheduled.

5. Action required from previous inspection:

Provide training for staff in the moving and handling of residents.
Maintain a complete record of staff training including dates on which training took place so that refresher training can be provided within appropriate timescales.

This action was not complete. The person in charge is the moving and handling instructor for the service. Staff have been identified to attend this training but it had not been possible to organise the training so far due to other commitments and holiday arrangements.

6. Action required from previous inspection:

Implement a centre-specific policy on restraint that reflects up to date practice.
In compliance with contemporary evidence-based practice, ensure that the use of a

restraint measure is only considered as a measure of last resort and is the least restrictive option for the shortest period of time to maintain the care and welfare of the resident.

Where residents lack capacity to give informed consent to the use of the restraint measure, a consensus view should be reached between all healthcare staff involved in the residents care and the residents' next of kin/significant other. This decision should be documented clearly in care records.

This action was in progress. Three staff had attended training on the new restraint policy being introduced nationally and are now able to provide training in the centre. A training schedule is being developed and the restraint policy is in the process of being revised. Restraint use has been reduced. There are two lap belts in use now and these are in place as a safety measure following care reviews and risk assessments the inspector was told. Staff are working on having a consensus judgement for the use of any restraint measure. Bed rails are checked regularly when in use and risks associated with their use are identified in accordance with the new good practice guidance. The inspector was shown the documentation that supports the new procedures.

7. Action required from previous inspection:

Put in place a policy on and procedures for the prevention, detection and response to abuse.

Make all necessary arrangements, by training staff or by other measures, aimed at preventing residents being harmed or suffering abuse or being placed at risk of harm or abuse.

This action was complete. The policy had been reviewed and the reporting system clarified. This information is now available on a flow chart so that staff can access the details they need readily. The name of the new elder abuse officer for the area was known to staff.

8. Action required from previous inspection:

Set out each resident's needs in an individual care plan developed and agreed with the resident.

Complete, and maintain in a safe and accessible place, an adequate nursing record of each resident's health and condition and treatment given, on a daily basis, signed and dated by the nurse on duty in accordance with any relevant professional guidelines.

Facilitate all appropriate health care and support each resident on an individual basis to achieve and enjoy the best possible health.

This action was in progress. A formal schedule for the three month reviews of residents care was in place to ensure reviews took place in a timely manner. The schedule for July to September was available for the inspector. Care staff now work in teams with nurses and undertake the reviews. Residents and relatives are involved. End of life care is scheduled for discussion as part of the review.

Communication folders have been introduced on each floor to keep staff informed of changes. There is also support for residents through the advocacy service that has been made available.

9. Action required from previous inspection:

Provide written operational policies and procedures relating to the making, handling and investigation of complaints from any person about any aspects of service, care and treatment provided in, or on behalf of a designated centre.

Ensure the complaints procedure contains an independent appeals process, the operation of which is included in the designated centre's policies and procedures. Identify an appropriate person to provide the overview of complaints management.

This action was complete. The complaints policy had also been reviewed and the procedure identified on a flow chart to guide staff. There was an independent overview of complaints managements now provided by a member of head office staff.

10. Action required from previous inspection:

Ensure staff personnel files contain all the information outlined in Schedule 2, (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended)

This action was complete. All outstanding information had been procured for staff currently employed.

11.**Action required from previous inspection:**

Ensure the physical design and layout of the premises meets the needs of each resident, having regard to the number and needs of the residents.

Keep all parts of the designated centre clean and suitably decorated.

Provide suitable storage facilities for the use of each resident.

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

Provide appropriate equipment and furniture for use by residents and maintain in good decorative order. Remove the beds that are not fit for purpose.

This action was partially complete. There were some rooms that were not in use at present due to the vacancy factor however it was intended that these rooms would be used if required. Rooms over the boiler area are not in use until the fire safety arrangements and compartmentalisation was complete. Although there are plans for a major refurbishment of the areas in the building that have not yet received attention this work is not scheduled for some time. All rooms that are to be used for residents' accommodation need decoration and appropriate furniture. This includes rooms 321, 325, 215.

All beds in rooms currently in use had been serviced and repaired.

The inspector found that there was still a deficit in accident prevention as all stairs were not protected and residents could walk off the corridor and go up or down steps in some locations. This finding was also highlighted at the registration inspection. The situation presented a falls hazard for residents and the provider and person in charge had not fully addressed the risk presented.

12.Action required from previous inspection:

Provide adequate facilities for each resident to appropriately store, maintain and use his/her own clothes.

Provide a lockable area for residents to keep personal items.

This action was in progress. All residents now have a lockable storage area. Residents who did not have an appropriate facility to store their clothes were being provided with new wardrobes. These had been purchased but were not yet assembled in residents' rooms.

13. Action required from previous inspection:

Ensure that the directory of residents includes the information specified in Schedule 3 paragraph (3) of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 as amended.

This action was complete. An audit of the information recorded in the directory is now completed by the administrator to ensure that the required information is systematically recorded.

14.**Action required from previous inspection:**

Have infection control measures in place that are in keeping with good practice standards including information in care plans to guide and inform the actions of staff.

Provide training for staff on infection control so that they are sufficiently knowledgeable to appropriately protect residents and manage potentially infectious situations.

This action was in progress. Details of infections that present a hazard are now recorded in residents care records.

Training for staff in infection control practice had not been completed but was being organised by the person in charge. She said she had made contact with an infection control nurse who was willing to provide the training but it had not yet been scheduled.

15.Action required from previous inspection:

Ensure that call bells are readily accessible to residents when in their rooms. Call bells were not accessible to residents in rooms 313 and 318.

Make suitable adaptations, and provide such support, equipment and facilities for residents, as may be required.

This action was in progress according to the person in charge. An audit of the call bell response was completed between 29 July and 3 August. There had been a revision to the way staff were deployed as a result of the information established as delays had been evident. Staff are now allocated a small number of residents to care for – usually 5 – and attend to their care needs throughout the shift including answering call bells and other requests for assistance. There is also a more formal system for managing staff breaks to ensure that sufficient staff are available to attend to the needs of residents.

16.Action required from previous inspection:

Compile a Statement of purpose that consists of all matters listed in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

This action was completed on Monday 20 August and a copy was provided to the inspector. All information described in Schedule 2 is now described.

17.**Action required from previous inspection:**

Put insurance cover in place against loss or damage to the property of residents including liability as specified in Regulation 26 (2).

Update documents such as contracts for residents and the residents' guide to reflect the change.

This action was complete. The appropriate insurance is now available and the provider said that this information is included in all new contracts.

18.Action required from previous inspection:

Provide each resident with the freedom to exercise choice to the extent that such freedom does not infringe on the rights of other residents.

Provide and maintain external grounds which are suitable for and safe for use by residents.

This action was not complete but efforts to ensure that all residents had access to the gardens were in progress according to the person in charge. Staff were now dedicating time to ensure that residents who wished to go out were enabled to do so according to their choice.

While there are extensive gardens surrounding the premises there is no safe external area for residents to use independently.

19. Action required from previous inspection:

Set out the roles and responsibilities of volunteers working in the designated centre in a written agreement between the designated centre and the individual.
Provide the staff team with information on the role of volunteers within the centre.

This action was in progress. The roles of the volunteers who regularly visit the centre had been outlined by the person in charge and the document was with head office awaiting approval.

20. Action required from previous inspection:

Provide adequate facilities for each resident to appropriately store, maintain and use his/her own clothes.

Have in place a system for labelling and managing personal clothing that protects residents against loss.

This was in progress.

Additional wardrobes had been purchased for residents use and were awaiting assembly the inspector was told.

The staff team had been advised that clear labelling to prevent loss or damage was a priority and some garments viewed were noted to have clear identification.

21. Action required from previous inspection:

Make suitable adaptations, and provide such support, equipment and facilities for residents, as may be required.

Ensure that residents are assessed for seating requirements to ensure that any specialist needs are met.

This action was in progress. Residents who have specialist seating requirements are now being assessed by an occupational therapist from the Health Service Executive. Eight residents were in the process of being assessed. Some residents have already been provided with specialist cushions and chairs. One resident now has two seating arrangements as she becomes uncomfortable in one chair after a time.

22. Action required from previous inspection:

Put in place a system for reviewing the quality and safety of care provided to and the quality of life of residents.

Utilise data collated to manage risk and improve resident care outcomes.
Make a report in respect of any review conducted by the registered provider for the purposes of Regulation 35(1), and make a copy of the report available to residents and, if requested, to the Chief Inspector.

This action was in progress according to the provider and the person in charge. A weekly report on matters such as accidents, infections, wounds, medication errors, episodes of challenging behaviour, staff turnover and dependency levels is provided to head office by the person in charge. This information is being collated and will form part of the regulation 35 reports which it is intended will be produced annually

for each centre. Information on medication management is being shared between centres as a learning initiative the inspector was told.

23. Action required from previous inspection:

The nutrition needs of residents who needed their nutrition monitored were not effectively met. Food and fluid intake charts were not fully completed and did not give an accurate picture of fluid and dietary intake.

The person in charge was required to implement a comprehensive policy and guidelines for the monitoring and documentation of residents' nutritional intake. Provide each resident with food and drink in quantities adequate for their needs.

Ensure appropriate assistance is given to residents who due to infirmity require such assistance.

Ensure that staff adhere to systems put in place to determine food and fluid intake.

This action was in progress. These topics are now discussed at handover according to the person in charge and residents with specialist nutrition needs are identified and discussed in detail. A record is made in the communication book in the communication book. The management of nutrition in older people is also part of the Further Education and Training Awards Council (FETAC) level five training that care staff are undergoing.

A nutrition policy to guide and inform staff on the management of nutrition was in the process of being completed according to the person in charge.

24.Action required from previous inspection:

Residents with severe physical disability and other residents with cognitive impairment did not have any means of supporting their communication needs.

The person in charge was required to provide opportunities for each resident to participate in activities appropriate to his/her interests and capacities.

Provide training for staff to enable them to provide activities in a competent manner according to residents' needs and wishes.

Provide social opportunities appropriate to the needs of residents with confusion or dementia.

This action was in progress. A formal assessment tool is now in use to identify residents' choices and interests and the activities that most appeal to them. This information is being used to plan a more structured activity programme that has wider appeal. This work had just commenced according to the person in charge. A meeting of the activity staff had also taken place and the person in charge said that a variety of new activities were being explored and residents' views were being

sought on the suggested changes. The chair exercises and coffee before Mass were proving very popular with residents and the inspector saw several residents gather in the sitting area near the church to chat together before the activity commenced.

25.Action required from previous inspection:

Residents' property was recorded on admission but the record was not kept up date when new items were acquired by residents. The person in charge was required to maintain an up to date record of each residents' personal property that is signed by the resident.

This action was complete. A system has been introduced where care staff update the property records and review that they are up to date with new items every 3 months.

26.Action required from previous inspection:

There were areas of medication management that were not in keeping with safe practice and up to date guidance. The person in charge was required to:

- Put in place suitable arrangements and appropriate procedures and written policies in accordance with current regulations, guidelines and legislation for the handling and disposal of unused or out of date medicines and ensure staff are familiar with such procedures and policies
- Maintain, in a safe and accessible place, a medical record in respect of each resident with details of investigations made, diagnoses and treatment given, and a record of all drugs and medicines prescribed, signed and dated by a medical practitioner
- Have in place a meaningful system for the review of residents care and medication.

This action was in progress. The pharmacist, person in charge and nursing staff were in discussion about new medication administration systems and had reviewed a number of options. The person in charge was conducting regular audits of the medication system which had indicated that there were still problems evident. These included sensitivities not recorded, maximum dose of "as required medication" not always indicated and the route for administration not recorded. The inspector spoke with the pharmacist who was in the centre during the inspection. He was aware of the areas of concern and said that the person in charge and staff were working towards having an error free system and he was assisting with this.

27.Action required from previous inspection:

Residents unable to get up daily or only for a very limited periods of time each day did not have a comprehensive plan in place that described how their care needs were being supported and there was no evidence of specialist contributions to enhance their care and comfort.

The person in charge was required to ffacilitate all appropriate health care and support each resident on an individual basis to achieve and enjoy the best possible health.

Set out each resident's needs in an individual care plan developed and agreed with the resident.

Provide appropriate access to healthcare professionals as required.

This action was in progress. Residents who spend long periods in bed were being assessed as part of the overall review of residents social care interests and needs the inspector was told. The allocation of care staff to a small group of residents is designed to assist staff to build better personal relationships with their resident group and the new assessment tool will ensure that staff have evidence based information on residents' social care needs. Training on the new assessment tool was scheduled.

The person in charge said she had not been able to audit care plans for content or assess documentation for descriptions of specialist care needs but said that.

28 . Action required from previous inspection:

Residents with severe physical disability and other residents with cognitive impairment did not have any means of supporting their communication needs.

The person in charge was required to have in place practices that facilitate and encourage each resident to communicate taking into account their specialist needs.

This action was in progress. There were now communication cards in use and staff were exploring the options suitable for residents particular difficulties. Problems with communication was recorded more systematically in care records the inspector was told. Care records were not examined to verify this at this time.

29.Action required from previous inspection:

While a number of residents had dementia care needs there were few references to dementia care in the daily records and no references on how dementia and memory loss impacted on the daily life of residents. There was no information to guide staff as to the levels and extent of confusion and there was an absence of specialist interventions to promote the well being of persons with dementia.

The person in charge was required to outline resident's specialist needs in their care plan and to have in place specialist interventions to ensure that the needs of residents with dementia are appropriately met day to day and maintain an adequate nursing record of each resident's health and condition and treatment given on a daily basis.

This action was not complete. Dementia care had been a topic covered in recent training sessions and this had addressed some of the management problems associated with dementia. The person in charge felt that staff needed more training on how to effectively outline memory problems and cognitive difficulties in care records. She had yet to commence an audit of care plans to assess if they accurately outlined residents' specialist needs.

30.Action required from previous inspection:

Room 313 was a new room and was designed for multiple occupancy use. However, all residents accommodated were not of high dependency and the furniture provided was not adequate for the number of residents accommodated.

The provider was required to review the use of the multiple occupancy room and ensure the facilities adequately meet the needs of residents.

This action was not complete. Additional new furniture had been provided for the residents accommodated in room 313. However, the use of this room for 5 residents needed review particularly in relation to the design and layout. While there is a large accessible well equipped en suite area and a wash hand-basin provided this does not meet the specifications outlined in standard 25 of the *National Quality Standards for Residential Care Settings for Older People in Ireland* where a wash-hand basin for every two residents is outlined as necessary.

In the inspectors view the dependency level of residents accommodated does not meet the specification of standard 25 of the *National Quality Standards for Residential Care Settings for Older People in Ireland* which describes that in newly built residential care settings, new extensions or first time registrations that " a room to accommodate up to six highly dependant residents together is used only where the resident needs 24 hour high support nursing care or is in transition from hospital to nursing home care". The care needs of residents accommodated in this room did not meet this criteria. At the meeting held with the provider and person in charge on 26th August the use of this room was discussed and a request made to review its use in the best interests of residents.

Report compiled by:

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

28 August 2011

Chronology of previous HIQA inspections	
Date of previous inspection:	**Type of inspection:**
19, 20 and 28 April/ 2011	☒ Registration ☐ Scheduled ☐ Follow-up inspection ☒ Announced ☐ Unannounced
10 March 2011	☐ Registration ☐ Scheduled ☒ Follow-up inspection ☐ Announced ☒ Unannounced
02 February 2010	☐ Registration ☐ Scheduled ☒ Follow-up inspection ☐ Announced ☒ Unannounced
17 August 2009	☐ 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:	Our Lady's Manor
Centre ID:	0081
Date of inspection:	19 August 2011
Date of response:	01 November 2012

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:

The fire safety arrangements were not of an adequate standard. Fire escape routes were now clearly marked however the compartmentalisation of the building to ensure the safety of personnel while identified as necessary had not been completed.

Staff training could not proceed until this essential work was completed.

Action required:

Make adequate arrangements for the evacuation, in the event of fire, of all people in the designated centre and the safe placement of residents.

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

Action required:

Provide to the Chief Inspector, together with the application for registration or renewal of registration, written confirmation from a competent person that all the requirements of the statutory fire authority have been complied with.

Action required:

Provide training for staff in fire prevention including training in the new fire safety arrangements.

Reference:

Health Act, 2007
Regulation32: Fire Precautions and Records
Standard 26: Health and Safety

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response:	
Evacuation policy has been updated and rolled out to staff. Temporary accommodation for residents in the case of full evacuation from nursing home have been identified and letters of confirmation have been received	Completed October 2011
All documentation has been submitted to the fire officer in relation to improvements to the facility carried out for his approval. Currently awaiting regularisation of the fire certificate. This will be forwarded to the Chief Inspector when received	Dependant on response from Fire Officer
Fire training has been conducted for all staff.	Completed September 2011

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

The staffing level, skill mix and deployment of nursing and care staff required review in line with the dependency level of residents taking in to account the layout of the building, the commitment to providing respite care and the significant workload of the person in charge to make changes in accordance with requirements in the action plan.

The person in charge had insufficient time allotted to carry out her legal responsibilities. This was evidenced by the number of actions that were outstanding or had preliminary work undertaken.

Action required:

Ensure that the numbers and skill mix of staff are appropriate to the assessed needs of residents, the size and layout of the designated centre and the commitments of the person in charge.

Action required:

Put a system in place to allow the Person in Charge sufficient time to be involved in the operation and governance of the centre to meet her legal responsibilities.

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: Staff Levels have increased to ensure that the needs of all residents are being met, taking into account the size and layout of the building. A CNM post has been created and filled who is in a supernumerary capacity which assists the person in charge to fulfil her legal responsibilities	 Completed 24 October 2011 12 September 2011

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

The risk assessment procedure was inadequate and did not identify all the hazards in the centre.

Action required:

Put in place a comprehensive written risk management policy and implement this throughout the designated centre.

Action required:

Ensure that the risk management policy covers, but is not limited to, the identification and assessment of risks throughout the designated centre and the precautions in place to control the risks identified.

Action required: Ensure that the risk management policy covers the precautions in place to control the following specified risks: the unexplained absence of a resident; assault; accidental injury to residents or staff; aggression and violence; and self-harm.	
Action required: Provide training for all staff in risk identification and management.	
Reference: Health Act, 2007 Regulation 31: Risk Management Procedures Standard 26: Health and Safety	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Risk management policy has been updated and is currently being implemented and rolled out to staff. Environmental risk assessments are conducted at a minimum annually, or as highlighted by inspections/audits/ recommendations by external professionals/auditors and corrective actions will be taken to minimise risks. Resident risk assessments (activities of daily living, waterlow, MUST, Falls, Restraints etc) will be carried out prior to admission, upon admission, where changes in condition occur, depending on resident diagnosis and needs, upon re admission to nursing home, as recommended by specialist providers/external auditors etc and at a minimum of three-monthly. Corrective action plans will be developed and implemented. The risk management policy has been broken down into include the following: ▪ risk management strategy ▪ violence and aggression policy ▪ hazard Identification and risk assessment procedure ▪ self harm management policy ▪ challenging behaviour ▪ falls management policy ▪ use of restraint policy ▪ resident elopement policy Training will be carried out for all staff.	Completed by 31 December 2011 Completed October 2011 Completed September 2011 Completed 31 December 2011

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

There was inconsistent recording and management of wound care problems evidenced during the registration inspection. Wound care practice did not reflect up to date good practice guidance to guide professionals such as t*he National Good Practice and Evidence based Guidelines for Wound Management* Health service Executive 2009. Care plans did not reflect changes in wounds and did not reflect actions taken such as the introduction of position changes.

Action required:

Put in place suitable and sufficient care to maintain each resident's welfare and wellbeing, having regard to the nature and extent of each resident's dependency and needs.

Action required:

Provide a high standard of evidence-based nursing practice.

Action required:

Develop a contemporary evidence-based wound care policy to inform wound management in the centre and include reference to latest good practice guidance to guide professionals- *National Good Practice and Evidence based Guidelines for Wound Management:* Health service Executive 2009.

Reference:

Health Act, 2007
Regulation 6: General Welfare and Protection
Regulation 31: Risk Management Procedures
Standard 13: Healthcare

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Wound care policy has been reviewed and updated to include best practice recommendations. The new policy has been rolled out to all staff – currently awaiting all staff sign off. Residents in need of specialist provider care are referred to the relevant Multidisciplinary teams e.g. Dietician, OT and Tissue Viability where the need is identified based on individual resident assessments. Follow up care and recommendations advised by specialist advisors will be carried out and records of care maintained	04 November 2011

Nursing Care provided and records of care will be maintained in accordance with best practice guidelines. Training will be provided for staff on Wound Management, Pressure Ulcer Classification and Infection Control Training for relevant staff.	Complete October 2011 31 December 2011

5. The provider has failed to comply with a regulatory requirement in the following respect: Mandatory training in moving and handling had not been completed by all staff.	
Action required: Provide training for all staff in safe moving and handling techniques.	
Action required: Maintain a complete record of staff training including dates on which training took place so that refresher training can be provided within appropriate timescales.	
Reference: Health Act, 2007 Regulation 6:General Welfare and Protection Regulation 31: Risk Management Procedures Standard 26: Health and Safety Standard 8: Protection.	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: All staff have received mandatory training on manual handling. Records of training type, date, trainer etc are maintained. A training Matrix will be continuously updated and reviewed to assist in the identification of training needs for staff. Identified training will be provided for staff. Training needs will be discussed and identified also as part of staff appraisal procedures	 Complete September 2011, refresher course to take place. Complete September 2011

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

The use of restraint was not reflective contemporary evidenced-based practice and no evidence was available to confirm that other measures of protection had been considered prior to the use of restraint.

Action required:

Implement a centre-specific policy on restraint that reflects up-to-date practice.

Action required:

In compliance with contemporary evidence based-practice, ensure that the use of a restraint measure is only considered as a measure of last resort and is the least restrictive option for the shortest period of time to maintain the care and welfare of the resident.

Action required:

Where residents lack capacity to give informed consent to the use of the restraint measure, a consensus view should be reached between all healthcare staff involved in the residents care and the residents' next of kin/significant other. This decision should be documented clearly in care records.

Reference:

Health Act, 2007
Regulation 31: Risk Management Procedures
Regulation 6: General Welfare and Protection
Standard 26:Health and Safety
Standard 21: Responding to Behaviour that is Challenging

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Policy has been updated to reflect best practice guidelines which is currently being rolled out to staff – awaiting sign off by staff. 2 and 3: Restraint risk assessments have been conducted on residents. In the case where residents have expressed their wishes to use a restraint as an enabler this has been recorded and the resident has signed off. Where a risk assessment has identified the need for restraint intervention, the least restrictive method has been identified and signed off where possible has been sought from the resident. In the event that a resident lacks capacity to give informed consent to use a restraint, relative input as to the type of restraint identified has been sought and the restraint signed off	10 November 2011 2 and 3 October 2011

through clinical evaluation. Records will be maintained to reflect risk assessments carried out, release times, consent of residents etc.	

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

While evidence-based assessment tools were in use to identify care needs and dependency levels and care plans were in place, the information did not provide a good overview of care needs, how residents were responding to interventions and essential information on infections did not have a strategic response outlined in the care plan.

The daily flow charts did not provide adequate detail on the care provided and did not reflect the goals set out in care plans. Care plans for very frail residents did not convey fully their care needs or how their care needs were to be met.

Action required:

Set out each resident's needs in an individual care plan developed and agreed with the resident.

Action required:

Complete, and maintain in a safe and accessible place, an adequate nursing record of each resident's health and condition and treatment given, on a daily basis, signed and dated by the nurse on duty in accordance with any relevant professional guidelines.

Action required:

Facilitate all appropriate health care and support each resident on an individual basis to achieve and enjoy the best possible health.

Reference:

Health Act, 2007
Regulation 9: Health care
Regulation 25: Medical Records
Standard 13: Healthcare

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Care plans will be developed and recorded for each resident based on their individual needs and in consultation with the resident and/or family. A review of each care plan will be carried out at a	Update Completed 30.11.2011

minimum of every 3 months or as changes in condition occur/or as recommended by service providers/external auditors etc A safe and accessible place to store nursing records on both floors of the nursing home have been identified. Adequate records of care provided will be maintained in accordance with best practice. Care plans will be developed and recorded for each resident based on their individual needs and in consultation with the resident and / or family. Care plans will also be developed, implemented and maintained in association with a multidisciplinary team.	 Complete October 2011 Update completed 30 November 2011

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

There were a range of deficits in parts of the building mainly in areas that had not been upgraded. The provider had design plans for the remedial work. The deficits noted included:

- several areas needed decoration including rooms 305, 318 and 205
- there was inadequate furnishings in room 254 as there was only one armchair in a double room
- the cupboards in room 321 needed repair
- the use of rooms 313 and 215 as shared rooms for five and two residents respectively needed review
- some stairs in the building were not protected and were dangerous for residents with mobility, sensory or dementia care problems. For example, there was ready access through some fire exit doors to flights of stairs.

Action required:

Ensure the physical design and layout of the premises meets the needs of each resident, having regard to the number and needs of the residents.

Action required:

Keep all parts of the designated centre appropriately decorated.

Action required:

Provide suitable storage facilities for the use of each resident.

Action required:

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

Action required:

Provide appropriate equipment and furniture for use by residents and maintain in good decorative order.

Reference:

Health Act, 2007
Regulation 19:Premises
Regulation 31: Risk Management Procedures
Standard 25: Physical Environment.
Standard 26: Health and Safety

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Refurbishment is underway. A snag list is being carried out. Room 205, 305 and 318 have been redecorated. Further redecoration of rooms is ongoing. Furnishings in all rooms, including room 254 have been reviewed and adequate furniture & fittings are in place. Centre is currently being redecorated. A snag list is being carried out and corrective actions being implemented. Going forward a snag list will be carried out annually. Adequate storage facilities have been provided for all residents. Safety gates are in place on the main stairs. All other staircases are protected by doors with coded locks and green emergency break glass units.	 Snag list Complete 10 November 2011 Completed September 2011 Complete Complete Complete

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

There was poor storage space in some rooms for example rooms 321 and 326 had inadequate wardrobe space.

Action required:

Provide adequate facilities for each resident to appropriately store, maintain and use his/her own clothes.

Reference: Health Act, 2007 Regulation 13: Clothing Standard 4: Privacy and Dignity	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Adequate storage facilities have been provided for all residents	Complete

10. The person in charge has failed to comply with a regulatory requirement in the following respect: The procedures and control measures for the management of infection control were not in accordance with good practice guidance or the centre's infection control policy. The management of methicillin resistant staphylococcus aureus (MRSA) was not in line with best practice guidance and did not offer residents appropriate protection. One area used for the storage of bed linen on the lower ground floor was not appropriately clean. Commodes had not been effectively cleaned. The centre's cleaning techniques included in the infection control policy had not been implemented effectively.	
Action required: Have infection control measures in place that are in keeping with good practice standards including information in care plans to guide and inform the actions of staff.	
Action required: Provide training for staff on infection control so that they are sufficiently knowledgeable to appropriately protect residents and manage potentially infectious situations.	
Reference: Health Act, 2007 Regulation 31: Risk Management Procedures Regulation 30: Health and Safety Standard 26 :Health and Safety	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Housekeeping hours have been increased; a new housekeeper has been appointed and started work; cleaning schedules have been updated, cleaning records have been placed on the backs of all doors which housekeeping have responsibility to update. Regular infection control audits will be carried out and findings will	Complete October 2011 Complete

be communicated to staff and acted upon. Training will be provided for all staff in infection control measures.	November 2011

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

Call bells were not always accessible to residents who spent time in their rooms. This was noted in rooms 313 and room 318.

Action required:

Ensure that call bells are readily accessible to residents when in their rooms.

Action required:

Make suitable adaptations, and provide such support, equipment and facilities for residents, as may be required to address their needs expediently.

Reference:

Health Act, 2007
Regulation 19: Premises
Standard 24: Physical Environment

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Extra call bells have been installed to ensure that all residents have access to call bells. Rooms have been renovated, 318 has been decorated and new flooring laid. Room 313 has been reviewed and in view of the clients that occupy the room a decision has been taken to use this room for 3 occupants only. The CNM supervises the breaks and allocation of staff throughout the nursing home. A daily duties allocation is in place and this is rolled out through the daily morning meeting with all heads of units (including external service providers on site on the day e.g. physio, dietician, maintenance person, OT etc.)	 Complete October 2011 Complete October 2011 Complete October 2011

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

The routines of the centre did not facilitate residents' independence and choices. No part of the extensive garden areas was safe and secure to use independently and residents

were unable to use the dining room at breakfast time.	
Action required: Provide each resident with the freedom to exercise choice to the extent that such freedom does not infringe on the rights of other residents.	
Action required: Provide and maintain external grounds which are suitable for and safe for use by residents.	
Reference: Health Act, 2007 Regulation 10: Residents Rights, Dignity and Consultation Regulation 19: Premises Standard 25: Physical Environment Standard 18: Routines and Expectations	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: A person-centered approach to care has been adopted. New resident file is being created and will be implemented and will reflect resident choice in the development of their care plan, activities to be carried out etc. A resident satisfaction (anonymous) questionnaire has been developed and a survey is underway to identify if there are any changes that the residents would like to be made. The findings will be reviewed and an action plan will be developed and implemented in conjunction with residents and staff. An external secure garden is in the process of completion which will incorporate a sensory garden.	31 December 2011 31 January 2011

13. The provider has failed to comply with a regulatory requirement in the following respect: The role of volunteers who regularly visited the centre was not defined in accordance with regulation 34.
Action required: Set out the roles and responsibilities of volunteers working in the designated centre in a written agreement between the designated centre and the individual.

Action required: Provide the staff team with information on the role of volunteers within the centre.	
Reference: Health Act, 2007 Regulation 34: Volunteers Standard 22: Recruitment	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Volunteer policy has been developed. Volunteer policy has been rolled out to staff and awaiting sign off by each member.	Completed October 2011 Complete 10 November 2011

14. The provider has failed to comply with a regulatory requirement in the following respect: Some residents did not have chairs or seating appropriate to their needs.	
Action required: Make suitable adaptations, and provide such support, equipment and facilities for residents, as may be required.	
Action required: Ensure that residents are assessed for seating requirements to ensure that any specialist needs are met.	
Reference: Health Act, 2007 Regulation 19:Premises Regulation 9: Health Care Standard 25: Physical Environment Standard 13: Healthcare	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Referral to service providers e.g. OT (onsite upon request) and Physiotherapist (onsite twice a week) made where individual	Completed October 2011 and ongoing

assessments highlighted the need. Equipment required for residents based on recommendations by service providers will be facilitated. Referral to service providers e.g. OT (onsite upon request) and Physiotherapist (onsite twice a week) made where individual assessments highlight the need.	thereafter

15. The provider has failed to comply with a regulatory requirement in the following respect: The person in charge was collecting data on a range of matters relevant to the quality and safety of care including accidents and incidents, pressure sores and restraint use. Data had not been complied in report format in accordance with regulation 35.	
Action required: Put in place a system for reviewing the quality and safety of care provided to and the quality of life of residents.	
Action required: Utilise data collated from the centre to manage risk and improve resident care outcomes.	
Action required: Make a report in respect of any review conducted by the registered provider for the purposes of Regulation 35(1), and make a copy of the report available to residents and, if requested, to the Chief Inspector.	
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: Weekly statistics are collected and include the amount of falls, restraints in use, accidents/incidents, wounds/pressure ulcers, training carried out, staff turnover, waterlow scores, MUST assessments etc. Findings of the data collected will be assessed and discussed at management and staff meetings. Corrective action plans will be drawn up from findings and acted upon.	Complete October 2011 31 December 2011

A resident satisfaction (anonymous) questionnaire has been developed and a survey is underway to identify if there are any changes that the residents would like to be made. The findings will be reviewed and an action plan will be developed and implemented in conjunction with residents and staff. Weekly statistics are collected and include the amount of falls, restraints in use, accidents/incidents, wounds/pressure ulcers, training carried out, staff turnover, waterlow scores, MUST assessments etc. Findings of the data collected will be assessed and discussed at management and staff meetings. Corrective action plans will be drawn up from findings and acted upon. A report will be developed in line with Regulation 35(1) on a quarterly basis	Complete October 2011 30 November 2011

16. The person in charge has failed to comply with a regulatory requirement in the following respect: The nutrition needs of residents who needed their nutrition monitored were not effectively met. Food and fluid intake charts had not been fully completed and did not give an accurate picture of fluid and dietary intake. There was not an effective procedure in place to inform staff on nutrition management.
Action required: Implement a comprehensive policy and guidelines for the monitoring and documentation of residents' nutritional intake.
Action required: Provide each resident with food and drink in quantities adequate for their needs.
Action required: Ensure appropriate assistance is given to residents who due to infirmity require such assistance. Ensure that staff adheres to systems put in place to determine food and fluid intake.
Reference: Health Act, 2007 Regulation 20: Food and Nutrition. Standard 19: Meals and Mealtimes

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

Provider's response: A comprehensive policy providing guidelines for the monitoring and documentation of resident's nutritional Intake has been adopted and has been rolled out to staff. The policy is awaiting sign off by all staff. MUST assessments are carried out and reviewed weekly. Any residents who are at risk are referred to and reviewed by company dietician and food diary's are maintained. Staff Nurses and Care Assistants are allocated residents to their care. A daily duties allocation is in place and this is rolled out through the daily morning meeting with all heads of teams (including kitchen staff). Dining room supervision has been increased. The Chef and her staff serve residents from a bain-marie which is located in the dining room. Resident's have a choice of meals on the day Staff are supervised and fluid and food charts are maintained to ensure that accurate intake by residents is recorded.	 10 November 2011 Completed October 2011 Complete October 2011 Complete October 2011

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

The activities available were not in accordance with all residents' choices and abilities. There were limited opportunities for residents who were highly dependant or who had confusion.

Action required:

Provide opportunities for each resident to participate in activities appropriate to his/her interests and capacities.

Action required:

Provide training for staff to enable them to provide activities in a competent manner according to residents' needs and wishes.

Action required:

Provide social opportunities appropriate to the needs of residents with confusion or dementia.

Reference: Health Act, 2007 Regulation 10: Rights, Dignity and Consultation Regulation 17: Training and Staff Development Standard 18: Routines and Expectations	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: PAL assessments have been completed for each resident. A resident satisfaction (anonymous) questionnaire has been developed and a survey is underway to identify if there are any changes that the residents would like to be made. The findings will be reviewed and an action plan will be developed and implemented in conjunction with residents and staff. A form has been adopted to document all residents' choice of activities most suitable to them (if necessary with family members). Activities coordinator hours have been increased and activities staff have been employed for weekends. Suitable training is being sourced for staff to enable them to provide activities in a competent manner according to resident's needs and wishes.	31 December 2011 Completed October 2011 31 December 2011

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

There were areas of medication management that were not in keeping with safe practice and up to date guidance. These included:

- all discontinued medications had not been signed by a medical practitioner
- A review of PRN (as required) medication prescription was required, maximum dose in 24 hours was not recorded
- Medication prescriptions were transcribed by the pharmacist and then signed by the resident's GP without on-site review

Action required:

Put in place suitable arrangements and appropriate procedures and written policies in accordance with current regulations, guidelines and legislation for the handling and disposal of unused or out of date medicines and ensure staff are familiar with such procedures and policies.

Action required:

Maintain, in a safe and accessible place, a medical record in respect of each resident with details of investigations made, diagnoses and treatment given, and a record of all drugs and medicines prescribed, signed and dated by a medical practitioner.

Action required:

Have in place a meaningful system for the review of residents care and medication.

Reference:

Health Act, 2007
Regulation 33:Ordering Prescribing, Storing and Administration of Medicines
Standard 15:Medication Monitoring and Review

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Policies and procedures have been updated in accordance with current regulations, guidelines and legislation for the handling and disposal of unused or out of date medicines. Currently awaiting sign off by staff. A safe and accessible place to store nursing records on both floors of the nursing home have been identified. Adequate records of care provided will be maintained in accordance with best practice. Monthly audits are carried out onsite by person in charge, CNM and Pharmacist to review each resident's script, PRN medications and relevancy of current medication. Weekly audits carried out by Person in Charge and CNM to check staff competency and adherence to policies and practices. Staff Nurses carries out weekly audits to ensure correct delivery of medications from Pharmacist.	15 November 2011 Completed October 2011 Complete and in progress

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

Residents unable to get up daily or only for a very limited periods of time each day did not have a comprehensive plan in place that described how their care needs were being supported and there was no evidence of specialist contributions to enhance their care and comfort.

Action required:

Facilitate all appropriate health care and support each resident on an individual basis to achieve and enjoy the best possible health.

Action required:

Set out each resident's needs in an individual care plan developed and agreed with the resident.

Action required:

Provide appropriate access to healthcare professionals as required.

Reference:

Health Act, 2007
Regulation 9: Health Care
Standard13: Healthcare

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Care plans will be developed and recorded for each resident based on their individual needs and in consultation with the resident and / or family. A review of each care plan will be carried out at a minimum of every 3 months or as changes in condition occur / or as recommended by service providers / external auditors etc Referral process in place. A form has been adopted and in use for private service providers e.g. Physio and Dietician. Formal referral process in place through HSE and GP for other service providers	Complete 30 November 2011 Complete October 2011

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

Residents with severe physical disability and other residents with cognitive impairment did not have many options to enable their communication needs.

Action required:

Put in place practices that facilitate and encourage each resident to communicate taking into account their specialist needs.

Reference:

Health Act, 2007
Regulation 11: Communication
Standard 17: Autonomy and Independence

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: Communication aids are now in use and staff are exploring options suitable for residents particular difficulties. This will be reflected in each resident's care plan.	Complete 31 December 2011

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

While a number of residents had dementia care needs there were few references to dementia care in the daily records and no references on how dementia and memory loss impacted on the daily life of residents. There was no information to guide staff as to the levels and extent of confusion and there was an absence of specialist interventions to promote the well being of persons with dementia.

Action required:

Describe resident's specialist needs in their care plan.

Action required:

Have in place specialist interventions to ensure that the needs of residents with dementia are appropriately met day to day and maintain an adequate nursing record of each residents health and condition and treatment given on a daily basis

Reference:

Health Act, 2007
Regulation 9: Health Care
Standard 11: The Residents care Plan

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: Care plans will be developed and recorded for each resident-based on their individual needs and in consultation with the resident and/or family. A review of each care plan will be carried out at a minimum of every 3 months or as changes in condition occur/or as recommended by service providers/external auditors etc	Complete 31 December 2011

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

Room 313 was a new room constructed as part of the refurbishment and was designed for multiple occupancy use for five residents. However, all residents accommodated

were not of high dependency as described in standard 25 of *The National Quality Standards for Residential Care Settings for Older People in Ireland* which states that a high dependency room can accommodate up to six highly dependant residents in need of 24 hour high support nursing care or who are in transition from hospital to nursing home care.

Action required:

Review the use of this multiple occupancy room and ensure that it meets the specific criteria outlined for the use of multiple occupancy rooms.

Reference:

Health Act, 2007
Regulation 19: Premises
Standard 25: Physical Environment

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Occupants of the room have been reviewed and a decision has been made to convert the room into a 3-bedded room.	 Completed October 2011

New requirements

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

A review of falls and incidents was not in place as a regular feature of prevention or learning from incidents of falls .While the person in charge had recorded information on falls on a data base, no analysis of the information collected was conducted to prevent further episodes or as part of comprehensive risk management.

Action required:

Conduct an analysis of the falls data to identify trends and to guide and inform staff as part of an effective risk management procedure.

Action required:

Provide the Authority with a copy of the falls review and actions taken on foot of analysis.

Action required:

Provide a high standard of evidence based practice in relation to falls prevention, reduction and management.

Reference: Health Act, 2007 Regulation 6: General Welfare and Protection Regulation 31: Risk Management Procedures Regulation 9: Health Care Standard 26: Health and safety Standard 29: Management Systems	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: An analysis of falls that have occurred in the nursing home has been conducted, when review is completed will be rolled out to all staff. When review of analysis is completed of the falls review we will be forwarding same to the authority.	Complete 30 November 2011

Any comments the provider may wish to make:

Provider's response:

Provider's name: Sarah Ann McGivney

Date: 1 November 2011