Health Information and Quality Authority
Regulation Directorate

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

Centre name:	St. Mary's Centre Nursing Home
Centre ID:	0104
Centre address:	St Mary's Centre (Telford)
	185 - 201 Merrion Road
	Dublin 4
Telephone number:	01 2693411
Email address:	br@stmarysblind.ie
Type of centre:	☐ **Private** ☒ **Voluntary** ☐ **Public**
Registered provider:	St. Mary's Centre (Telford) Limited
Person authorised to act on behalf of the provider:	Maura Masterson
Person in charge:	Orla Aver
Date of inspection:	26 March 2013
Time inspection took place:	**Start:** 08:30 hrs **Completion:** 18:50 hrs
Lead inspector:	Linda Moore
Type of inspection	☐ **announced** ☒ **unannounced**
Number of residents on the date of inspection:	57
Number of vacancies on the date of inspection:	1

About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by Regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

- Registration: under section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of their registration.

Monitoring inspections take place to assess continuing compliance with the Regulations and Standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or wellbeing of residents.

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.

Summary of compliance with 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*.

This inspection report sets out the findings of a monitoring inspection, in which 12 of the 18 outcomes were inspected against. The purpose of the inspection was:

- ☐ to inform a registration decision
- ☐ to inform a registration renewal decision
- ☒ to monitor ongoing compliance with Regulations and Standards
- ☐ following an application to vary registration conditions
- ☐ following a notification of a significant incident or event
- ☐ following a notification of a change in person in charge
- ☐ following information received in relation to a concern/complaint

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

Outcome	Inspected
Outcome 1: Statement of Purpose	☐
Outcome 2: Contract for the Provision of Services	☐
Outcome 3: Suitable Person in Charge	☒
Outcome 4: Records and documentation to be kept at a designated centres	☐
Outcome 5: Absence of the person in charge	☐
Outcome 6: Safeguarding and Safety	☒
Outcome 7: Health and Safety and Risk Management	☒
Outcome 8: Medication Management	☒
Outcome 9: Notification of Incidents	☒
Outcome 10: Reviewing and improving the quality and safety of care	☒
Outcome 11: Health and Social Care Needs	☒
Outcome 12: Safe and Suitable Premises	☒
Outcome 13: Complaints procedures	☒
Outcome 14: End of Life Care	☐
Outcome 15: Food and Nutrition	☒
Outcome 16: Residents' Rights, Dignity and Consultation	☒
Outcome 17: Residents' clothing and personal property and possessions	☐
Outcome 18: Suitable Staffing	☒

This monitoring inspection was unannounced and took place over one day. As part of the monitoring inspection the inspector met with residents, relatives, and staff members. The inspector observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files.

At this inspection, the inspector followed up on the two actions for improvement which were identified at the follow up inspection of 24 April 2012. These actions included premises issues and the review of the quality of care and experience of residents. The inspector found that the provider and the person in charge had

implemented a system of review of the care delivered and this was ongoing. The premises issues were not addressed.

The healthcare needs of residents were met to a high standard. Residents had access to general practitioner (GP) services and to a range of other health services.

Residents were treated with respect and dignity by staff. Residents were actively involved in the day-to-day running of the centre.

The provider ensured that suitable recreational opportunities were available to residents and had put measures in place to develop the activities programme to suit all residents' capabilities.

Residents were consulted about the operation of the centre and there were active residents' committees in both units. Systems were in place to audit and review care and inspectors found that information gathered was used to develop the quality and safety of the service. The collective feedback from residents was one of satisfaction with the service and care provided.

There was a commitment to developing staff to ensure that they were competent to meet the changing needs of the residents.

Areas for improvement identified included:

- aspects of the premises
- risk management issues
- policies
- care plan documentation
- assistance at meal times
- fire records.

Section 41(1)(c) of the Health Act 2007

Compliance with 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*.

Theme: Leadership, Governance and Management

Effective governance, leadership and management, in keeping with the size and complexity of the service, are fundamental prerequisites for the sustainable delivery of safe, effective person-centred care and support.

Outcome 3

The designated centre is managed by a suitably qualified and experienced nurse with authority, accountability and responsibility for the provision of the service.

References:

Regulation 15: Person in Charge
Standard 27: Operational Management

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

The person in charge was a registered nurse and she worked full-time in the centre. She was on duty for the duration of the inspection and was supported by two clinical nurse managers. She maintained her professional development and had recently attended courses and study days in:

- safety management and implementation
- team building
- restraint management
- dementia
- behaviours that challenge
- Inspection protocol.

The person in charge had a good knowledge of 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.*

She demonstrated strong leadership and good communication with her team. She frequently met with residents and staff.

The person in charge had deputising and on call arrangements in place to ensure adequate management of the centre during her absence.

Theme: Safe care and support

Safe care and support recognises that the safety of service users is paramount. A service focused on safe care and support is continually looking for ways to be more reliable and to improve the quality and safety of the service it delivers.

In a safe service, a focus on quality and safety improvement becomes part of a service-wide culture and is embedded in the service's daily practices and processes rather than being viewed or undertaken as a separate activity.

To achieve a culture of quality and safety everyone in the service has a responsibility to identify and manage risk and use evidence-based decision-making to maximise the safety outcomes for service users.

Outcome 6

Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse.

References:
Regulation 6: General Welfare and Protection
Standard 8: Protection
Standard 9: The Resident's Finances

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

The provider and person in charge had taken appropriate measures to protect residents from being harmed and from suffering abuse. Some improvements were required to the arrangements for safeguarding residents' finances.

The inspector found that all of the staff spoken to during the inspection were aware of the types of elder abuse and their responsibilities in reporting suspected elder abuse to the line manager or person in charge. Residents spoken to commented that they felt safe and secure in the centre.

There were records to indicate that staff had received training on identifying and responding to elder abuse.

The inspector found that the centre's policy on the prevention, detection and response to elder abuse was in the process of being updated. It was not available at the time of the inspection.

The person in charge and provider also displayed sufficient knowledge and outlined to the inspector their responsibilities.

The inspector found that the provider had not established strong safeguarding measures to manage residents' finances. Small amounts of money were kept for safe keeping on behalf of residents. The balances could not be reviewed due to the poor maintenance of the records. Also, transactions were not being signed by two persons including the resident/relative and staff member and there was no policy to guide the practice.

Outcome 7
The health and safety of residents, visitors and staff is promoted and protected.

References:
Regulation 30: Health and Safety
Regulation 31: Risk Management Procedures
Regulation 32: Fire Precautions and Records
Standard 26: Health and Safety
Standard 29: Management Systems

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

There was a health and safety statement in place and it related to the health and safety of residents, staff and visitors. Some measures were in place to prevent accidents and facilitate residents' mobility, including non-slip floor covering in bathrooms and toilets. However, there were areas for improvement and these included the risks associated with residents who smoked and fire safety.

There was a risk management policy, which met the requirements of the Regulations. It included precautions in place to control the specific risks required in the Regulations such as assault, aggression and violence and self-harm. However, the processes to identify, assess, and manage clinical and non-clinical risks throughout the centre were not outlined in the policy and this policy did not guide practice.

While there were formal systems to identify and manage non clinical risks in the units, risks associated with the open stairwell, residents who smoked and the open kitchenette had not been considered.

The person in charge detailed how the quality and safety committee discussed and managed risk. The inspector reviewed the minutes of these meetings and noted that clinical and non clinical risks were discussed.

Staff were not fully aware of the risks associated with a resident who smoked and supervision of this resident was not robust. The inspector noted that there were no smoking risk assessments or care plan in place for this resident.

The inspector reviewed the emergency plan and found that it was sufficient to guide staff on the procedures to follow in the event of an emergency.

The provider and person in charge had adequate control measures in place to monitor all visitors to the building. A visitors' book was maintained and completed daily. There was full-time receptionist on duty.

The inspector viewed the fire training records and found that all staff had received up-to-date mandatory fire safety training and this was confirmed by staff. All staff spoken to knew what to do in the event of a fire, however there was no evidence that regular fire drills were carried out by staff at suitable intervals as required by the Regulations.

The inspector viewed the fire records and found that they were not maintained appropriately. There were records to show that the fire equipment was serviced in February 2013 and the emergency lighting had been serviced quarterly. However, there was no record that the fire alarm system had been regularly serviced. This

evidence was submitted to the Authority following the inspection. The inspector found that all fire exits were clear and unobstructed during the inspection. Staff said that they checked fire exits twice daily and this was documented.

Outcome 8
Each resident is protected by the designated centres' policies and procedures for medication management.

References:
Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines
Standard 14: Medication Management

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

Overall, the inspector found evidence of good medication management practices.

There was a comprehensive medication management policy in place which provided guidance to staff. Staff received training in medication management annually. The inspector observed a nurse administering medications and found that overall medication was administered in accordance with the centre's policy and professional guidelines.

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

Outcome 9
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

References:
Regulation 36: Notification of Incidents
Standard 29: Management Systems
Standard 30: Quality Assurance and Continuous Improvement
Standard 32: Register and Residents' Records

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

Practice in relation to notifications of incidents was satisfactory.

The provider and person in charge were aware of the legal requirement to notify the Chief Inspector regarding incidents and accidents. To date all relevant notifications had been submitted to the Chief Inspector by the person in charge.

Detailed records were maintained of all accidents and incidents. Each resident was reviewed by the GP, physiotherapist and the nursing staff and a detailed plan was provided to staff to minimise the risk of future falls. Physiotherapists visited the centre twice per week.

Theme: Effective care and support
The fundamental principle of effective care and support is that it consistently delivers the best achievable outcomes for people using a service within the context of that service and resources available to it. This is achieved by using best available national and international evidence and ongoing evaluation of service-user outcomes to determine the effectiveness of the design and delivery of care and support. How this care and support is designed and delivered should meet service users' assessed needs in a timely manner, while balancing the needs of other service users.

Outcome 10
The quality of care and experience of the residents are monitored and developed on an ongoing basis.

References:
Regulation 35: Review of Quality and Safety of Care and Quality of Life
Standard 30: Quality Assurance and Continuous Improvement

Action(s) required from previous inspection:

The action required from the previous inspection was satisfactorily implemented.

Inspection findings

Overall, the inspector found that there were systems in place to audit and monitor the quality of care provided to residents. The person in charge told the inspector that she was aware that the areas identified for improvement identified in the audits had not been implemented and said she was actively addressing this.

Clinical data was collected and reviewed by the person in charge with the staff every five weeks at the multidisciplinary meetings. This included clinical information on falls management, restraints, infections, wounds, weight loss and this information was used to improve the care for the residents. There were no wounds in the centre. The person in charge had identified that the improvements from the audits were in the process of being implemented.

A consultancy company had undertaken audits on governance, infection control, care planning, health and social care needs and the environment. A medication audit had been conducted in each unit in September 2012.

Outcome 11
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

References:
Regulation 6: General Welfare and Protection
Regulation 8: Assessment and Care Plan
Regulation 9: Health Care
Regulation 29: Temporary Absence and Discharge of Residents
Standard 3: Consent
Standard 10: Assessment
Standard 11: The Resident's Care Plan
Standard 12: Health Promotion
Standard 13: Healthcare
Standard 15: Medication Monitoring and Review
Standard 17: Autonomy and Independence
Standard 21: Responding to Behaviour that is Challenging

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

The inspector found that the residents had diverse needs - some were highly dependent and required full assistance while other residents were quite mobile and independent. The inspector found a good standard of evidence-based nursing care and residents had access to appropriate medical and allied healthcare.

There were 57 residents in the centre, the person in charge informed inspectors that the dependencies were as follows.

Dependency level of current residents as provided by the centre	Max	High	Medium	Low
Number of Residents	9	22	11	15

Residents had access to speech and language therapy, dietician, physiotherapy and chiropody services. The inspector reviewed care plans and they contained details of referrals and appointments with the various allied health services. Staff promoted the residents' health by encouraging them to stay active.

The inspector reviewed a sample of residents' care plans and noted that nursing assessments and clinical risk assessments were carried out for all residents. There was a record of the residents' health condition and any treatment given, completed on a daily basis by the nurse on duty.

Care plans were in place which identified residents' needs and three-monthly reviews were being completed but these the care plans were not being consistently kept up to date to reflect residents' care needs. The inspector found that while the delivery of care and progress notes were routinely updated, changes were not consistently reflected in the residents' care plans. For example, one resident had a pressure sore that had healed but the care plan had not been updated with the status or care of the wound. Another resident who displayed behaviours that challenge had a care plan but it did not reflect the care being provided by staff for the resident. The inspector noted that there was evidence that residents and relatives were involved in the development and review of their care plans.

Overall, there was good practice in the management of restraint but there were areas for improvement. There was no policy available to staff to guide the management of restraint. There had been a reduction in the use of bedrails since 2012. Consent forms were in place for the use of bedrails but not for recliner chairs. The inspector found that assessments had been carried out but these were not consistently implemented for residents who required a recliner chair as a form of restraint.

The inspector reviewed a sample of care plans for residents who used restraint and found that overall they needed to be more specific to guide the care delivered. For example, the restraint records included alternative strategies that had been tried prior to the use of bedrails. However, these were not specific for each resident. For example, reminiscence was recorded as an alternative to bedrails, but it was not clear how this therapeutic approach was an appropriate intervention for each resident or how it had been used to reduce the need for bedrails for each resident. The care plan of another resident noted that the resident should be observed frequently but did not state how frequently. All risks associated with the use of the bedrail had been considered and documented. There were robust records on the duration and release of the restraint.

There were no residents with pressure ulcers in the centre. There was a wound management policy which guided the staff in the prevention and management of wounds. The inspector reviewed the file of one resident who had a wound and found that the documentation was not accurate. The wound assessment was incomplete and it stated that the wound was to be dressed daily, when the dressing was changed every two days. Some residents' required pressure relieving devises to maintain their skin condition and for the prevention of pressure ulcers. One resident's mattress was incorrectly set based on the weight of the resident and the staff were

not familiar with how to set another resident's mattress. There was no system to monitor the use of pressure relieving devises.

Records showed that falls were well managed but there was an area for improvement. Nursing staff did not have access to the required resources to monitor residents with suspected head injuries i.e. a comprehensive neurological chart and a pen torch. This could have very serious consequences for residents. However, strategies had been put in place for those residents who were at risk of falling. Residents were assessed post fall by the physiotherapist, nursing staff and GP and the care plans were being updated to reflect the care that residents had received following a fall. The inspector noted that risk assessments and associated manual handling charts had been completed for residents and were retained in residents' files. Inspectors found that during the inspection staff used safe moving and handling practices when assisting residents to mobilise.

The centre had a policy on nutrition and hydration but it had not been adapted to guide the practice in the centre. However, the inspector found evidence of good practice in the centre. Nursing staff monitored the nutritional status of residents. Residents' weights were recorded monthly. All residents at risk were referred to the GP and dietician if required and there were treatment plans in place. Nutritional risk assessments were used to identify residents at risk and while care plans were in place, they were not updated to reflect the treatment prescribed by the dietician.

Outcome 12
The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

References:
Regulation 19: Premises
Standard 25: Physical Environment

Action(s) required from previous inspection:

There were still some rooms with occupancy of more than two on St. Oliver's Unit.

Inspection findings

The inspector reviewed the action from the previous inspection and found that there was no change from the previous inspection. There were still some multi-occupancy bedrooms on St. Oliver's Unit. The inspector found multi occupancy bedrooms did not have sufficient space to meet the needs of residents.

In addition, staff said that the space was tight in the multi occupancy rooms and they had to move beds around to provide space when tending to the care needs of residents.

Theme: Person-centred care and support
Person-centred care and support has service users at the centre of all that the service does. It does this by advocating for the needs of service users, protecting their rights, respecting their values, preferences and diversity and actively involving them in the provision of care. Person-centred care and support promotes kindness, consideration and respect for service users' dignity, privacy and autonomy.

Outcome 13
The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

References:
Regulation 39: Complaints Procedures
Standard 6: Complaints

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

The inspector found that while there was a policy in place on the management of complaints, this was not being followed in practice. Overall complaints management required improvement.

The complaints policy was reviewed and was found to be comprehensive and displayed in prominent positions in the centre. It complied with the requirements of the Regulations.

The inspector reviewed the complaints log in one of the units and saw that complaints from residents and relatives were documented, however, there was no evidence that complaints were appropriately responded to by the clinical nurse manager or person in charge.

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

References:
Regulation 20: Food and Nutrition
Standard 19: Meals and Mealtimes

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

The inspector was satisfied that residents received a nutritious and varied diet that offered choice and mealtimes were unhurried social occasions that provided opportunities for residents to interact with each other and staff.

However, inspectors were not satisfied with the systems to ensure that residents received their modified consistency diets as prescribed. The inspector also observed that appropriate assistance was not provided to one resident with eating and drinking. This may have placed this resident at risk.

The inspector discussed the special dietary requirements of individual residents and saw that information on residents' dietary needs and preferences was maintained in kitchenette on the unit. However, this was not being adhered to and residents were not receiving the correct modified consistency diets as recommended by the speech and language therapist.

Generally, staff were seen to assist residents discreetly and respectfully if required but one resident with complex needs was not appropriately assisted by staff with her meal in one of the units. This resident was in a reclined position eating a meal and there was no care plan to guide care of the resident and manage the risk of choking during the meal.

These issues were discussed with the person in charge who said she would update the Authority by Friday 29 March 2013 with the actions taken to address this. The provider submitted evidence to the Authority on 28 March 2013 that these issues were addressed.

There was a central dining room and dining rooms on each unit which was decorated to a high standard. Most residents choose to have their meals in the dining room on their units. The inspector observed that meals were well presented in appetising individual portions.

Residents told inspectors that they could have tea or coffee and snacks at any time.

Outcome 16
Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence.

References:
Regulation 10: Residents' Rights, Dignity and Consultation
Regulation 11: Communication
Regulation 12: Visits
Standard 2: Consultation and Participation
Standard 4: Privacy and Dignity
Standard 5: Civil, Political, Religious Rights
Standard 17: Autonomy and Independence

Standard 18: Routines and Expectations
Standard 20: Social Contacts

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

Inspectors found that residents' privacy and dignity was respected by staff.

The inspector observed that bedroom doors were closed when personal care was being delivered. The inspector observed staff interacting with residents in a courteous manner and addressing them by their preferred names. The inspector observed good interactions between staff and residents who chatted with each other in a comfortable way. There was an open visiting policy and contact with family members was encouraged.

Resident's religious rights were supported. There was a chapel in the centre which residents and relatives could use for prayer and reflection. Mass took place daily.

Residents' independence was promoted by staff. The inspector saw staff members assisting residents to walk to the dining room at a leisurely pace. Residents were encouraged to eat their meals independently and were given plenty time to enjoy their food.

The inspector found that residents had flexibility in their daily routines, for example, residents could decide whether to participate in activities available to them.

Resident committee meetings were in place on each unit and the meetings were held on a three-monthly basis. The feedback from residents who attended these meetings were very positive.

Theme: Workforce
The workforce providing a health and social care and support service consists of all the people who work in, for, or with the service provider and they are all integral to the delivery of a high quality, person-centred and safe service. Service providers must be able to assure the public, service users and their workforce that everyone working in the service is contributing to a high quality safe service.

Outcome 18
There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

References: Regulation 16: Staffing Regulation 17: Training and Staff Development Regulation 18: Recruitment Regulation 34: Volunteers Standard 22: Recruitment Standard 23: Staffing Levels and Qualifications Standard 24: Training and Supervision
Action(s) required from previous inspection: No actions were required from the previous inspection.

Inspection findings

The inspector found that overall staffing levels and skill mix in the centre were sufficient to meet needs of the residents, however, two care staff were on unplanned leave on the day of the inspection on the Loyola Unit and only one was not replaced. This was not a regular occurrence and was being managed by the person in charge.

The provider had put in place adequate recruitment procedures and had ensured that staff were appropriately selected and vetted in accordance with the Regulations and Standards. The inspector found that there were good induction arrangements for newly employed staff members and staff appraisals were used to monitor performance and support staff.

The inspector examined the files of four staff found that the files contained all of the information required by the Regulations.

There was a robust system to manage volunteers in the centre. A review of two of the files confirmed this. All volunteers had a written agreement in place. The files contained evidence of Garda Síochána vetting, three references and drivers licence.

The inspector carried out interviews with staff members and found that they were knowledgeable about the residents' individual needs, fire procedures and the procedures for reporting alleged elder abuse. The inspector saw them responding to residents' needs in a respectful manner. Staff told the inspector that they were supported by the provider and person in charge.

The inspector saw evidence that systems of communication were appropriate to support staff to provide safe and appropriate care. In addition to daily handover meetings, inspectors reviewed minutes of the multi disciplinary meeting and found that resident's needs were discussed regularly with staff.

The inspector reviewed information with regard to the professional registration status of nursing staff and found that all had up-to-date registration with their professional body for 2013.

The inspector reviewed the training records and found that there was an extensive programme of training in place since the previous inspection. All staff had completed mandatory training including moving and handling and fire safety training. Since January 2012 various members of staff had completed training in:

- elder abuse
- medication management
- dementia
- falls prevention
- manual handling
- palliative care
- behaviours that challenge
- continence promotion
- Sonas programme
- restraint management.

A draft training plan for 2013 was shown to inspectors. This included manual handling, healthy eating in the elderly and CPR (cardio pulmonary resuscitation).

Closing the visit

At the close of the inspection visit a feedback meeting was held with the provider, person in charge and one of the nurse managers to report on the inspectors' findings, which highlighted both good practice and where improvements were needed.

Acknowledgements

The inspector wished to acknowledge the cooperation and assistance of the residents, relatives, provider and staff during the inspection.

Report compiled by:

Linda Moore

Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

28 March 2013

Health Information and Quality Authority
Regulation Directorate

Action Plan

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

Provider's response to inspection report *

Centre Name:	St. Mary's Centre Nursing Home
Centre ID:	0104
Date of inspection:	26 March 2013
Date of response:	29 April 2013

Requirements

These requirements set out the actions that must be taken to meet the requirements of the Health Act 2007 as amended, 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*.

Theme: Governance, Leadership and Management

Outcome 4: Records and documentation to be kept at a designated centre

The provider is failing to comply with a regulatory requirement in the following respect:

Many of the operational policies were in the process of being reviewed and were not available in the centre to guide the practice. This included the policy on falls, behaviours that challenge and restraint.

Action required:

Put in place all of the written and operational policies listed in Schedule 5 of the Regulations.

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

Reference:

Health Act, 2007
Regulation 27: Operating Policies and Procedures
Standard 29: Management Systems

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response:	
The Centre's Policies & Procedures Database is now installed on all Department Managers' PC's. This facilitates the immediate circulation of Policies & Procedures directly to each Department in both draft and active form.	30 March 2013
All operational Policies listed in Schedule 5 of the Regulations are now in place Active on the Q-Pulse Database.	2 May 2013
All operational Policies listed in Schedule 5 of the Regulations will also available in hardcopy format.	10 May 2013
The Provider is in the process of acquiring three additional computers to be installed in appropriate locations throughout the Centre for staff to have individual access to policies. Electrical Engineers have been engaged to install the required network cabling.	30 June 2013

Theme: Safe care and support

Outcome 6: Safeguarding and safety

The provider is failing to comply with a regulatory requirement in the following respect:

The provider had not established strong safeguarding measures. For example, transactions were not being signed by two persons including the resident/relative and staff member and there was no policy to guide the practice.

Action required:

Maintain the records listed under Schedule 3 (records in relation to residents) and Schedule 4 (general records) in a manner so to ensure completeness, accuracy and ease of retrieval.

Reference:

Health Act, 2007
Regulation 6: General Welfare and Protection
Standard 9: The Resident's Finances

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: Resident's Income & Expenditure Record Books have been amended to include two signatures for all transactions. All resident's accounts have been reconciled and balanced to expenditure receipts with an opening balance. Each transaction is accounted for as it occurs and signed off and witnessed by two staff. The Security of Residents' Accounts and Personal Property Policy is Active and available on the Department Managers' PC's This policy will also be available on the Units in hardcopy format.	 23 April 2013 30 March 2013 10 May 2013

The provider is failing to comply with a regulatory requirement in the following respect:

The centre's policy on the prevention, detection and response to elder abuse was not available in the centre to staff.

Action required:

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

Reference:

Health Act, 2007
Regulation 6: General Welfare and Protection
Standard 8: Protection

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: The Centre's Policies: Protection of the Resident from Abuse and Responding to Allegations of Abuse have been reviewed and updated. These Policies are Active and available on the Department Managers' PC's This policy will also be available on the Units in hardcopy format.	 30 April 2013 10 May 2013

Outcome 7: Health and safety and risk management

The provider is failing to comply with a regulatory requirement in the following respect: The processes to identify, assess, and manage clinical and non clinical risks throughout the centre were not outlined in the risk management policy and this policy did not guide practice. Risks which had not been considered included: ▪ residents who smoked ▪ the open kitchenette ▪ the open stairwells in the Loyola Unit.	
Action required: Put in place a comprehensive written risk management policy and implement this throughout the designated centre.	
Action required: Take all reasonable measures to prevent accidents to any person in the designated centre and in the grounds of the designated centre.	
Reference: Health Act, 2007 Regulation 31: Risk Management Procedures 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: Actions: A review of the current Risk Management Policy and Risk Register is scheduled to take place in May 2013 and shall be facilitated by an external support organisation. The Policy will be revised to incorporate all of the risks in St. Mary's Centre (Telford) Limited including but not limited to: - Residents who smoke - The open kitchenette in St. Oliver's Unit - The open stairwells in Loyola Unit Upon completion of the review all staff will be required to read the Risk Management Policy and Risk Register to become familiar with the risks associated with their work areas. Additionally the Risk Register will be discussed at monthly meetings.	May 2013 and Ongoing

Since the inspection the Clinical Services Manager with the Unit Clinical Nurse Managers carried out risk assessments on: - The resident who smokes - The open kitchenette in St. Oliver's Unit - The open stairwells In Loyola House Unit These risk assessments have been placed on the Care Plans of the residents who are at risk. Measures have been put in place to safeguard these residents from the risk.	27 March 2013
We have engaged our Electrical Contractors to install keypads and release buttons to the stairwell doors. These locking systems will be directly linked into the Centre's fire alarm system ensuring the doors will open in the event of a fire or a fire alarm activation.	7 May 2013

The provider is failing to comply with a regulatory requirement in the following respect:

There was no evidence that regular fire drills were carried out by staff at suitable intervals as defined by the Regulations.

Action required:

Ensure, by means of fire drills and fire practices at suitable intervals, that the staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire, including the procedure for saving life.

Reference:

Health Act, 2007
Regulation 32: 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:	
An evacuation of both Units in St. Mary's was carried out on Thursday 28th March 2013.	28 March 2013
A further two evacuations are scheduled to take place in July 2013	9 July 2013
Records of all fire drills and fire training carried out at St. Mary's up to 28 March 2013 which were not available on the day of inspection were submitted to the Inspector by e-mail.	28 March 2013

Theme: Effective care and support

Outcome 11: Health and social care needs

The person in charge is failing to comply with a regulatory requirement in the following respect:

The care plans did not consistently reflect the up to date, assessed needs of all residents, including in the areas of:

- behaviour that challenges
- restraint
- nutrition.

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
Standard 13: Healthcare

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response:	
Behaviour that challenges: The Care Plans for Residents with challenging behaviour have been re-written to reflect the individual needs of these residents.	27 March 2013
A written list of tips that work for each resident with challenging behaviour is available on the resident's Care Plan and in a discreet place in their bedroom in order to guide staff while caring for the resident. All staff have been made aware of these changes.	27 March 2013
Restraint: An Occupational Therapist has been engaged to reassess all residents that are seated in reclining chairs. The reclining chairs are not used as a measure of restraint but are used for the residents' comfort to enable them to be out of bed and enjoy social interaction with other residents. The Care Plans have been updated to reflect the individual needs of the resident and the reasoning for the use of these specialised chairs.	27 March 2013 and Ongoing
These residents are documented in the Restraint Register	1 May 2013

Nutrition: On Wednesday 27th March 2013 Orla Aver, CSM and Doris Demecillo, CNMII met with the Catering Manager and Chefs to discuss the prescribed diets. The outcome of this meeting is that the meals for residents on prescribed diets are now plated in the main kitchen by the Chefs. Each plate is labelled with the residents name and the texture type of diet. Care plans have been updated for residents on prescribed diets. Nursing and Care Staff have been instructed to make themselves aware of the updates with regard to these residents' care plans. On 15th April 2013 Nursing and Care Staff received further education from the Centre's Dietician. We are in the process of arranging training in Dysphagia from a Speech & Language Therapist.	27 March 2013 and Ongoing
The Centre's Dietician met with the Catering Staff on April 15th 2013 to provide up to date education on diets and nutrition. The Dietician and Catering Manager devised a new tea menu for the special diets. A separate page for the residents with special diets has also been added to the Unit's Menu Book to ensure each resident receives their choice of meal.	19 April 2013

Outcome 11: Health and social care needs

The provider has failed to comply with a regulatory requirement in the following respect: Nursing staff did not have access to the required resources to ensure a high standard of evidence based nursing for residents with suspected head injuries as a result of a fall i.e. a comprehensive neurological chart and a pen torch.	
Action required: Provide a high standard of evidence-based nursing practice.	
Reference: Health Act, 2007 Regulation 6: General Welfare and Protection Standard 13: Healthcare Standard 18: Routines and Expectations	
Please state the actions you have taken or are planning to take with timescales:	**Timescale**
Provider's response: Pen torches were purchased for each Nursing and Care Unit. The Glasgow Coma Chart together with Guidelines for its use was distributed to all Units. Nurses were instructed that these	28 March 2013

observations had to be completed for all residents with suspected head injuries as a result a fall.	

Outcome 12: Safe and suitable premises

The provider is failing to comply with a regulatory requirement in the following respect:

The multi-occupancy bedrooms did not have sufficient space to meet the needs of residents.

Action required:

Ensure the size and layout of rooms occupied or used by residents are suitable for their needs.

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: St. Mary's Centre is a charitable non profit organisation which is funded by the HSE under Section 39 of the Health Act. The Centre has encountered difficulty in raising capital toward meeting the requirement to provide single or two bed occupancy rooms. Plans for an extension have been drawn up and approved by the Centre's Board. These plans were submitted to HIQA by e-mail on 27th October 2011. In March 2013 the Board of Directors agreed to appoint a consultant to carry out a feasibility study in relation to this project. This commenced on Monday 29 April 2013	Ongoing

Theme: Person-centred care and support

Outcome 13: Complaints procedures

The provider is failing to comply with a regulatory requirement in the following respect:

There was no evidence that complaints were appropriately responded to by the clinical nurse manager or person in charge.

Action required:

Investigate all complaints promptly.

Action required:

Maintain a record of all complaints detailing the investigation and outcome of the complaint and whether or not the resident was satisfied.

Action required:

Inform complainants promptly of the outcome of their complaints and details of the appeals process.

Action required:

Record all complaints and the results of any investigations into the matters complained about. Ensure these records are in addition to and distinct from a resident's individual care plan.

Reference:

Health Act, 2007
Regulation 39: Complaints Procedures
Standard 6: Complaints

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The Complaints Books which are maintained on each of the Nursing and Care Units have been reviewed and now contain a comprehensive record to be completed with regard: - Type of Complaint - How Complaint is Dealt With - Timeframe - Initial Actions by Staff Who receive the Complaint - Further Actions by Line Manager - Outcome - If Client is Satisfied - If Client Not Satisfied - Further Actions. A sample page from a Complaint Book will be submitted with this Action Plan. The Centre's Incident Report Forms were also reviewed in relation to the Complaints being included as an occurrence on these forms. A separate Resident Complaint Report Form was drafted for the reporting of more serious complaints. Any complaint recorded on these Complaint forms will also be	 27 March 2013 21 April 2013

recorded in the Unit Complaint Book. A sample Resident Complaint Report form will be submitted with this Action Plan A Complaint Register will be developed for each of the Nursing & Care Units. This Register will record all complaints received each month and will give an overview of the type of complaint, how this was dealt with, the Outcome and Appeal if Resident is not Satisfied with Outcome. The Unit Complaint Book and the Resident Complaint Report Form now details the - Outcome of Complaints - The date the Client is informed of the Outcome - If Client Satisfied and If Not - Further Action Including Client Being Provided with the Appeals Process. The Centre's Complaints Procedure is prominently displayed throughout the Centre and Units detailing the Appeals process.	 8 May 2013 27 March & 21 April 2013

Outcome 15: Food and nutrition

The provider is failing to comply with a regulatory requirement in the following respect: Appropriate assistance was not provided to one resident with eating and drinking. Some residents did not receive their modified consistency diets as recommended by the speech and language therapist.	
Action required: Provide appropriate assistance to residents who, due to infirmity or other causes, require assistance with eating and drinking.	
Action required: Provide each resident with food and drink that takes account of any special dietary requirements and is consistent with each resident's individual needs.	
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:	
An occupational therapy assessment was carried out for this resident at 2pm on Wednesday 27th March 2013 in relation to her seating. A copy of the OT Report of this assessment was sent by e-mail to the Inspector on 28 March 2013. The Occupational Therapist sourced a chair in the Nursing Unit stockroom which was more suitable to the residents needs and this is now in use. With the Occupational Therapy assessment there is a mealtime positioning chart for this resident which has been added to the resident's care plan which has been updated to meet her needs with regard to staff assistance with her meals. A Health Care Assistant is assigned to this resident to monitor her during mealtimes	28 March 2013
The Clinical Services Manager met with the Unit Clinical Nurse Manager, the Catering Manager and Chefs to discuss the prescribed diets. The outcome of this meeting is that the meals for residents on prescribed diets are now plated in the main kitchen by the Chefs. Each plate is labelled with the residents name and the texture type of diet. Laminated posters from the Irish Nutrition and Dietetic Institute detailing the diet types are now displayed in the main kitchen and in the kitchenette on the Unit. A "St. Oliver's Speech and Language Diet Plan" is now laminated and also displayed in both areas. The Nursing Staff have been instructed to inspect each individual meal before being served. The Catering Manager is communicating with Nursing Staff on a daily basis to ensure the system is working.	27 March 2013
The Centre's Dietician met with the Catering Staff on April 15th 2013 to provide up to date education on diets and nutrition. The Dietician and Catering Manager devised a new tea menu for the special diets. A separate page for the residents with special diets has been also been added to the Unit's Menu Book to ensure each resident receives their choice of meal.	19 April 2013
The Dietician will liaise with the CNM II and the Catering Manager with regard to organising staff to attend an educational evening session on Nutrition.	Date to be confirmed
Care plans have been updated for residents who, due to infirmity or other causes, require assistance with eating and drinking. Nursing and Care Staff have been instructed to make themselves aware of the updates with regard to these residents' care plans.	28 March 2013
Training in Dysphagia from a Speech & Language Therapist will be arranged in the near future.	Date to be confirmed

Any comments the provider may wish to make[1]:

Provider's response:

St Mary's Centre found the inspection to be a positive experience. We agree with the findings and have taken on board all of the suggestions made by the inspector to improve the service.

Provider's name: Maura Masterson
Date: 02/05/2013

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