

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	St. Luke's Home
Centre ID:	OSV-0000290
Centre address:	Castle Road, Mahon, Cork.
Telephone number:	021 435 9444
Email address:	info@stlukeshome.ie
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	St Lukes Home (Mahon) Limited
Provider Nominee:	David O'Brien
Lead inspector:	Breeda Desmond
Support inspector(s):	Mairead Harrington
Type of inspection	Announced
Number of residents on the date of inspection:	126
Number of vacancies on the date of inspection:	2

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.

Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration decision. This monitoring inspection was announced and took place over 3 day(s).

The inspection took place over the following dates and times

From:	To:
06 May 2015 10:30	06 May 2015 18:00
07 May 2015 09:00	07 May 2015 17:00
08 May 2015 08:00	08 May 2015 11:00

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

Outcome 01: Statement of Purpose
Outcome 02: Governance and Management
Outcome 03: Information for residents
Outcome 04: Suitable Person in Charge
Outcome 05: Documentation to be kept at a designated centre
Outcome 06: Absence of the Person in charge
Outcome 07: Safeguarding and Safety
Outcome 08: Health and Safety and Risk Management
Outcome 09: Medication Management
Outcome 10: Notification of Incidents
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

Summary of findings from this inspection

This report sets out the findings of an announced registration renewal inspection and it was the sixth inspection undertaken by the Authority in St Luke's Home. The provider applied to renew the registration which will expire on 21 May 2015. This renewal of registration inspection took place over three days. Inspectors met with the Provider Nominee, Person in Charge, Deputy Person in Charge, the Clinical Nurse Managers (CNMs), staff members, residents and relatives. The inspectors observed practices and reviewed all governance, clinical and operational documentation to inform this re-registration application.

The provider nominee and person in charge displayed excellent knowledge of the

standards and regulatory requirements and were found to be committed to providing quality person-centred evidence-based care for the residents. They were proactive in response to the action required from the previous inspection.

A number of completed questionnaires (10 residents and 6 relatives) were received and inspectors spoke with many residents and relatives during the inspection. The collective feedback from residents and relatives was one of satisfaction with the service and care provided.

Overall, the inspector found that residents' wellbeing was central to service provision in the nursing home. There was evidence of good care practices in meeting the day-to-day needs of residents. Staff were kind and respectful to residents and demonstrated good knowledge of residents and intervention necessary for those with divergent needs. Visitors interviewed concurred with this and gave positive feedback regarding care and welfare. The activity staff provided a wide variety of social and recreational activities as well as community involvement.

All staff had received training in elder abuse prevention and protection to safeguard residents in their care. Staff levels and skill-mix appeared adequate to meet the assessed needs of residents.

In general the physical environment was suitable for its stated purpose and was comfortable and bright with adequate communal and secure outdoor space. However, the design and layout of the twin and four-bedded rooms required attention to ensure compliance with the regulations and this will be discussed under Outcome 12 Suitable and Safe Premises.

In summary, the inspectors were satisfied that the centre was generally operating in compliance with the current conditions of registration granted to the centre. The inspectors identified aspects of the service requiring improvement to enhance the findings of good practice on this inspection.

These improvements included:

- 1) the design and layout of four-bedded and twin bedrooms
- 2) infection prevention and control
- 3) emergency escape plans
- 4) policies and procedures.

The action plan at the end of this report sets out the actions necessary to ensure compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

Outcome 01: Statement of Purpose

There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The statement of purpose was reviewed and updated in May 2015. It described a service which aimed at providing individualised care for all residents. Services and facilities were described. All items listed in Schedule 1 of the Regulations were detailed in the statement of purpose. A copy was given to residents on admission and there was one on display at main reception. The statement of purpose was reviewed annually.

Judgment:

Compliant

Outcome 02: Governance and Management

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

There was an embedded quality assurance dynamic programme in place which was continuously reviewed and updated. Their policy described a quality assurance strategy which was integrated into practice, communicated, evaluated and then documented through the assurance cycle and this was evidenced in practice. CNMs discussed the

audits completed and the action plans developed with responsibilities and timelines assigned. Completed audits for 2015 included care plan documentation, medication management, dysphagia (swallowing difficulties), infection prevention and control, health and safety and risk. Staff members were involved in auditing as part of the governance and responsibility process. They articulated several examples of on-going improvements following audits including the benefit of further staff training, for example dysphagia and food consistency and actions and response to an outbreak of infection. Nonetheless, inspectors requested that they review their auditing questionnaires to ensure they elicited pertinent information.

An annual review of the quality and safety of care to residents was completed by the person in charge and was for further evaluation following the inspection to ensure compliance with Regulation 23.

Judgment:

Compliant

Outcome 03: Information for residents

A guide in respect of the centre is available to residents. Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

Contracts of care were securely maintained by the finance manager. The contracts detailed fees to be charged as well as additional fees. Samples of contracts of care for residents were examined and were signed and dated by either the resident or their next of kin in line with best practice. Contracts were renewed with change of fees and/or change of conditions and services provided.

A residents' guide was available in compliance with the Regulations. It formed part of the admission pack given to new residents to St Luke's Home.

Judgment:

Compliant

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The post of the person in charge was full time and held by a registered nurse with the required experience of nursing dependant people. He demonstrated excellent knowledge and understanding of the Regulations and National Standards as well as clinical knowledge to ensure suitable and safe care. Clear management and accountability structures were in place. The person in charge was engaged in governance, operational management and administration associated with his role and responsibilities. There was evidence that the person in charge had a commitment to his own continued professional development and had completed many courses such as safety health and welfare and leadership and management. The person in charge along with support staff demonstrated a clear commitment to delivering quality care to residents, continually striving for excellence.

Judgment:

Compliant

Outcome 05: Documentation to be kept at a designated centre
The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:

Governance, Leadership and Management

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

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

Findings:

The inspectors were satisfied that the records required in Schedule 2 (staffing records),

Regulation 19 (directory of residents), Schedule 4 (general records), Regulation 25 (medical records), Regulation 21 (provision of information to residents) of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 were maintained in a manner so as to ensure completeness, accuracy and ease of retrieval; they were maintained and stored in line with best practice and legislative requirements. There were items missing from Schedule 3 (residents' records) which will be discussed under Outcome 9 Medication Management. However, there was one policy missing from the Schedule 5 list (fire safety management) and other policies required review to ensure they were centre-specific and comprehensive and these will be discussed under the relevant outcomes and the remedial actions will occur under this outcome.

There was a policy awareness programme in operation whereby all staff signed on an itemised schedule acknowledging they had read and understood the policies.

Judgment:

Substantially Compliant

***Outcome 06: Absence of the Person in charge
The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.***

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The person in charge was aware of his responsibilities relating to Regulation 32 and 33 regarding notification to the Authority should the occasion arise. Appropriate deputising arrangements were in place to ensure care and welfare of residents, whereby the deputy person in charge assumed responsibility when the person in charge was on annual leave. There was a CNM 2 in post and CNMs 1 in each unit responsible for the day-to-day running of their unit. The CNMs demonstrated a good awareness of their regulatory responsibilities as well as clinical and risk management knowledge.

Judgment:

Compliant

Outcome 07: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

Measures were in place to protect residents from being harmed or suffering abuse. The training matrix detailed completed training for staff in adult protection. Staff spoken with demonstrated their knowledge of protection of residents in their care and actions to be taken if care was untoward.

A comprehensive induction programme for new staff was demonstrated which included safeguarding and safety of vulnerable adults. Staff were supervised as part of their quality assurance programme to ensure safety of residents. Feedback from residents was positive and many stated they felt 'safe, secure, and happy' in the centre. There was an up-to-date policy for adult protection which contained the information as stipulated in Regulation 31 regarding immediate notification of an allegation of abuse. The policy was reflective of the knowledge and practice demonstrated by management and staff of this Regulation.

Photographic identification required for each resident as part of safe medication management, unexplained absence of a resident and other legislative requirements, was in place. Consent for such photographs was necessary and was obtained from residents or their next-of-kin.

Residents' finances were maintained by the finance manager in line with best practice.

However, the policy for restrictive practices required review as it was not comprehensive to ensure that the implementation of bedrail restraint was evidence-based which resulted in an under-reporting of use of restraint; the assessment to support the decision for bedrail restraint was not risk based and required attention.

Judgment:

Substantially Compliant

Outcome 08: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

The risk management policy contained comprehensive details on the identification and prevention of risks in conjunction with the recording, investigation and learning from serious or untoward incidents or adverse events. The emergency plan was available with alternative accommodation detailed, should the need arise. While the emergency plan described actions to be taken in the event of a fire however, the procedures to be followed in the event of a fire were not prominently displayed throughout the centre; a fire safety management policy as described in the Regulations was not in place to support the fire safety management practices. The fire safety register demonstrated that daily, weekly and monthly checks were completed. All staff had completed their mandatory fire training. Fire drills were completed six-monthly and this was evidenced by fire training records reviewed. Current relevant fire certification for maintenance and servicing was evidenced.

There was a current policy in place for infection prevention and control (IP&C). A multi-disciplinary IP&C committee was established in February 2014. A major IP&C audit was completed by an external nurse specialist and the report with associated action plans was demonstrated with responsibilities and timelines assigned. Improvements were noted however IP&C issues were identified during this inspection which included:

- inappropriate storage of toiletries in en suites
- inappropriate placement of storage units for protective equipment in en suites
- poor state of floor covering in some en suites preventing effective cleaning
- poor paintwork in some en suites
- the protective coating of vanity units and bedside lockers was eroded preventing effective cleaning.

Advisory signage for best practice hand washing was displayed over most hand wash sinks. There were hand hygiene gel dispensers available throughout. Advisory signage for best practice use of hand hygiene gels was displayed and the inspector observed that opportunities for hand hygiene were taken by staff. Staff had completed training in infection prevention and control and hand hygiene; six staff completed a course to enable them give this training in the centre. The designated areas for storage of chemicals were secure to prevent unauthorised access.

All staff had completed their mandatory moving and handling of residents.

A current insurance policy was demonstrated which included residents personal

property.

A record was maintained of incidents and accidents' and these were reviewed by the inspectors. They correlated with notifications submitted to the Authority and residents' care plans were reflective of interventions documented in the incidents and accident forms completed. Review of incident and accidents formed part of the quality assurance strategy and an example of learning and remedial action comprised a review of their pre-admission assessment of residents to involve a multi-disciplinary assessment for comprehensiveness.

The laundry system was inspected and was found to be satisfactory. The manager outlined best practice workflows to mitigate the risk of cross infection and this was facilitated by the design and layout of the laundry. Appropriate use of protective equipment such as disposable plastic aprons and gloves was observed. There were three sinks in the 'dirty' laundry, however, advisory signage for their purpose/function was not displayed including lack of hand-washing notice.

Feedback was relayed in completed questionnaires regarding laundry services which reported that clothes generally did not go missing but sometimes knitted items would shrink. This had been brought to their attention by residents or their families and a review of laundry practices was undertaken. Laundry was segregated at source and alginate pages were available for contaminated items; distinctive colour-coded alginate bags were introduced for woollen clothing items which were washed separately.

The smokers' room was inspected and contained an extractor fan as well as adequate natural ventilation, fire safety equipment, aprons and call bell alarm.

Judgment:

Non Compliant - Moderate

Outcome 09: Medication Management

Each resident is protected by the designated centre's policies and procedures for medication management.

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

There was a centre-specific up-to-date medication management policy detailing procedures for safe ordering, prescribing, storing and administration of medicines and handling and disposal of unused or out-of-date medicines. Medication trolleys were securely maintained within the nurses' station. A nurses' signature sheet was in place as described in professional guidelines. Nursing staff with whom the inspector spoke demonstrated best practice regarding administration of medicines. Photographic

identification was in place for residents as part of their prescription/drug administration record chart. New drug prescription/administration records were in place and staff gave positive feedback regarding them; there were separate sections for regular/as required (PRNs)/single dosage/short prescriptions. While there was a code for non-administration of medications however, this was not always used; in addition the nurse administering or withholding medications did not always initial the record (in the sample of drug charts reviewed) in line with best practice guidelines and the centre policy. Controlled drugs were maintained in line with best practice professional guidelines, however, the controlled drug book did not enable staff to record discarded/unused medications.

Medication management audits were completed regularly and these were evidenced during inspection. Medication reviews were completed at least every three months and this was evidenced on residents' prescriptions. Antibiotic usage was recorded as part of residents' medication management documentation and this formed part of the medication review.

Judgment:

Substantially Compliant

Outcome 10: Notification of Incidents

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

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

Notifications received by the Authority were reviewed upon submitted and prior to this inspection. Notifiable incidents and quarterly returns submitted to the Authority were timely and comprehensive. A record was maintained of incidents occurring in the centre and these correlated with residents' care plans. Appropriate interventions were documented as well as a risk analysis post the intervention to ensure the risk of recurrence was mitigated.

Under-reporting of use of bedrail restraint was discussed under Outcome 7 Safeguarding and Safety.

Judgment:

Compliant

Outcome 11: Health and Social Care Needs

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

Theme:

Effective care and support

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

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

Findings:

The previous inspections identified that care planning required review to ensure they were person centred and that residents were involved in the care planning process along with their next-of-kin when appropriate. It was evident from the sample of care plans examined on each unit that significant work was done to ensure that residents' care plans and risk assessments were robust, resident-centred and reflected an in-depth knowledge of each individual. However, occasionally records were not signed or dated by the staff completing the entry. The end-of-life care plan was augmented by the advance care directive for persons lacking capacity; while some residents had either one or both completed to inform care, others had neither. There were policies in place regarding end-of-life care and advance care directives but they did not comprehensively inform staff.

A multi-disciplinary pre-admission assessment was completed with a further assessment review post admission to ensure all the information was captured accurately. The in-house social worker was responsible for these assessments and welcomed all new residents upon their arrival to the centre.

Residents had timely access to GP services and allied health services including dietician, speech and language therapy, optician, dental and chiropody services. Residents' weights and other observations were completed on a monthly basis and more frequent if their clinical condition warranted and there was evidence of this. A daily activities flow chart and narrative was maintained on each resident documenting progress. Consent was obtained from the resident or in the case of those with cognitive impairment, discussion with their next of kin. Resident and relative feedback forms indicated that care planning was discussed with them.

There was a physiotherapist on-site who completed an assessment of each resident on admission regarding their mobility and assistance needs. A four-monthly assessment was completed for all residents; residents were seen upon referral in addition to maintenance physiotherapy. The physiotherapist was involved in the falls risk assessments of residents with unit staff, where risk was balanced with independence and quality of life. Occupational therapist (OT) was available upon referral and the

physiotherapist and OT worked together to maximise the benefit for residents.

Judgment:

Substantially Compliant

Outcome 12: Safe and Suitable Premises

The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:

Effective care and support

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

No actions were required from the previous inspection.

Findings:

St Luke's Home was a split level two-storey, purpose-built facility. Residents' accommodation and services, some administration offices, a five day per week day centre, chapel, physiotherapy facility, art room, activities room with a residents' bar, family meeting room with computer access for residents, main kitchen and restaurant, laundry and pharmacy were located on the ground floor. Occasional seating was available in alcoves along corridors with views of the enclosed gardens, bird tables and courtyards. Other administrative services were on the first floor. The education centre was located on campus and ample car parking was available.

The premises was purpose-built and could accommodate a maximum of 128 residents which comprised 84 single bedrooms, 10 twin bedrooms and six four-bedded rooms all with toilet, shower and hand-wash basin en suite facilities. It was divided into four units as follows:

- Gregg House (30 beds) Wise House (30 beds) and Exham House (30 beds) each with – single rooms x 18, twin bedrooms x 2, four-bedded rooms x 2
- Maguire House (38 beds) – single rooms x 30, twin bedrooms x 4.

Residents' accommodation was located at the end of the main concourse; Gregg House, Wise House and Exham House catered for residents of varying degrees of dependency and Maguire House was a dementia specific unit.

Communal living space in Exham, Wise and Gregg houses units consisted of two sitting rooms and a dining room. Each unit also contained staff facilities, a sluice facility, a kitchenette, storage areas, treatment room, additional shower and toilet facilities.

Maguire House was a secure dementia-specific unit. Communal living space consisted of four sitting areas and two dining rooms. The layout of Maguire House was configured to enable residents with cognitive impairment to mobilise freely within a secure environment. There were staff facilities, a kitchenette, storage areas, sluice facilities, treatment room, a visitor's toilet and a snoezelen (multi-sensory) room.

Specialist assistive equipment was available in each unit with appropriate storage space provided. Beds were profiling and many were low-low beds to enable residents to move freely. Hand rails were provided in circulation areas and grab rails were in bath/shower/toilet areas. The single bedrooms were adequate, however, the design and layout of the twin and four-bedrooms required attention as the accessibility to personal storage space was compromised; in addition because of the design and layout a bedside chair could not be accommodated. While the inspectors acknowledged residents' choice regarding decorating their bed space, some bed areas were devoid of character or décor. There was a shelf beside each bed which served little function and often prevented a bedside locker being placed alongside the bed. In addition, there was a shelf above vanity units in many bedrooms which was a safety risk due to its position and the degree it protruded. Linen trolleys were stored in residents' four-bedded rooms which were not in keeping with the ethos espoused in the Statement of Purpose regarding respect for residents' dignity

There were several enclosed gardens, courtyards and decking areas to enhance outdoor activities, with views of Cork harbour. There were seating areas and walkways around the landscaped gardens.

Judgment:

Non Compliant - Moderate

Outcome 13: Complaints procedures

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

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

A synopsis of the complaints procedure was displayed prominently at main reception. The person in charge monitored complaints; the CNMs on each unit endeavoured to resolve issues as soon as they arose. The complaints policy was up-to-date and detailed the complaints officer as well as the independent appeals process. Comprehensive records were maintained of complaints which were not resolved at local level including interviews by the complaints officer and the independent appeals officer; outcomes were recorded also.

Judgment:

Compliant

Outcome 14: End of Life Care

Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

Some residents were receiving end of life care during the inspection; care practices observed and the layout of the centre ensured residents received end of life care in a way that met their individual needs. Family members spoken with gave positive feedback regarding the care and attention their relative received during this time. Divergent spiritual needs were facilitated and clergy attended the centre regularly. Residents had access to palliative care homecare as well as the hospice services. Staff had completed professional development regarding end-of-life care and palliative care.

Judgment:

Compliant

Outcome 15: Food and Nutrition

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

Theme:

Person-centred care and support

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

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

Findings:

There was a policy in place for risk assessment, monitoring and documentation of nutritional status and residents care plans reflected their specialist dietary requirements. Catering staff discussed specialist diets with inspectors and demonstrated their knowledge regarding specialist diets and consistency for residents. Staff had completed training in modified consistency food preparation. Residents' weights were documented

on a monthly basis or more often if their clinical condition warranted. Residents had access to fresh water and other fluids throughout the day and feedback from residents spoken with concurred that meals and meal time was a positive experience. Choice of fluids, meals, snacks was provided. Residents had choice where to dine for their meals as there was a dining room in each unit and a large restaurant on the main concourse. The inspectors observed breakfast and lunch time in the dining rooms and restaurant which appeared to be a pleasant and relaxed experience. Residents were assisted in an appropriate manner, respectful of residents' dignity. Menus with choice were displayed in the dining rooms and restaurant.

Judgment:

Compliant

Outcome 16: Residents' Rights, Dignity and Consultation

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. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

The in-house social worker provided support and facilitated the residents' council and family meetings. He organised an outreach person from the citizens' advice bureau to attend the centre on a regular basis to address any issues residents may have regarding their rights.

The residents' council offered residents the opportunity to participate and engage in the running of the centre, for example, residents made suggestions about meals, activities and outings. Minutes of meetings were displayed on notice boards in each unit.

Residents had opportunities to participate in meaningful activities appropriate to their interests and needs. The activities co-ordinator outlined that residents were consulted with to establish their interests and hobbies which informed their activities and recreation programme. Residents' art, poetry and photographs were displayed throughout. There was an extensive activities programme facilitated by the activities co-ordinator, activities staff and art therapist; this 7-day activities programme was displayed on notice boards for consultation.

The open visiting policy was observed throughout the inspection. Completed relatives questionnaires commended staff on how welcoming they were to all visitors. The

manner in which residents were addressed by staff was seen by inspectors to be appropriate and respectful. The inspectors observed the residents' privacy and dignity being respected and promoted by staff in the provision of personal care.

A culture of openness and transparency was observed in a relaxed atmosphere. Relatives and residents spoken with gave positive feedback regarding communication and involvement with their care and the ease of access to staff to discuss matters.

Judgment:

Compliant

***Outcome 17: Residents' clothing and personal property and possessions
Adequate space is provided for residents' personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.***

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

Locked storage space was provided for residents to store valuables as required. Some residents' bedrooms were personalised with residents' own cushions, ornaments, armchairs, pictures and photos. While storage space was provided in residents' bedrooms for their clothing and belongings, often this was not accessible due to the layout of the bedroom and this was discussed under Outcome 12 Suitable and safe premises.

There was a policy on residents' personal property and possessions. There were two property records maintained, one for valuable possessions and the second for clothes and furniture.

Judgment:

Compliant

Outcome 18: Suitable Staffing

There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

Theme:

Workforce

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

No actions were required from the previous inspection.

Findings:

The numbers and skill-mix of staff appeared adequate to meet the assessed needs of residents. A staff roster was in place which identified management as well as staff speciality. Staff were supervised appropriate to their role and responsibilities and this was enabled through the CNMs, senior staff and supervisors. Management meetings occurred weekly. Minutes of staff meetings were evidenced and some of the items discussed included person-centred communication, PRN monitoring and performance management.

Current registration with regulatory professional bodies was in place for all nurses. There was evidence from records and staff interviewed that there was a consistent management commitment to continuous development of staff. A needs analysis was completed as well as staff appraisals to inform further staff training and education. The staff training matrix examined demonstrated that mandatory training was undertaken. Other staff training completed in the last year comprised end of life care, manual handling, dysphagia, challenging behaviour, infection prevention and control, wound management, falls prevention, end-of-life care and fire. Two nurses were enrolled to start their Masters in Gerontology.

A sample of staff files examined demonstrated that all items listed in Schedule 2 were available for staff and volunteers. These were securely maintained by the human resources manager.

Judgment:

Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	St. Luke's Home
Centre ID:	OSV-0000290
Date of inspection:	06/05/2015
Date of response:	17/06/2015

Requirements

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

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

Outcome 05: Documentation to be kept at a designated centre

Theme:

Governance, Leadership and Management

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

A fire safety management policy as described in Schedule 5 was not in place.

Action Required:

Under Regulation 04(1) you are required to: Prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.

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

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

The existing emergency plan details the fire management plan. The Home will now complete a separate fire management policy in accordance with schedule 5.

Proposed Timescale: 31/07/2015

Theme:

Governance, Leadership and Management

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

There were policies in place regarding end-of-life care and advance care directives but they did not comprehensively inform staff.

Action Required:

Under Regulation 04(3) you are required to: Review the policies and procedures referred to in regulation 4(1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.

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

The end of life policy and A.C.D policy will be reviewed by the Multi-Disciplinary team.

Proposed Timescale: 31/12/2015

Theme:

Governance, Leadership and Management

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

While there was a code for non-administration of medications, this was not always used; in addition the nurse administering or withholding medications did not always initial the record (in the sample of drug charts reviewed) in line with best practice guidelines and the centre policy.

Controlled drugs were maintained in line with best practice professional guidelines, however, the controlled drug book did not enable staff to record discarded/unused medications.

Action Required:

Under Regulation 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

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

All Nursing staff have received medication Management training.

An SOP and policy is in place to guide correct medication recording practices.

All nursing staff will be reminded of the need to initial all entries in addition to completing and signing the non-administration of medications sheet in the medication administration record.

Proposed Timescale: 30/06/2015

Outcome 07: Safeguarding and Safety

Theme:

Safe care and support

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

The policy for restrictive practices required review as it was not comprehensive to ensure that the implementation of bedrail restraint was evidence-based which resulted in an under-reporting of use of restraint.

Action Required:

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

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

All bed rails used will be reported on 3 monthly notifications.

An alternate risk assessment tool for bed rails is being piloted, on completion and learning from this process, the new tool will be introduced.

Proposed Timescale: 31/07/2015

Outcome 08: Health and Safety and Risk Management

Theme:

Safe care and support

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

There was:

- inappropriate storage of toiletries in en suites
- inappropriate placement of storage units for protective equipment in en suites
- poor state of floor covering in some en suites preventing effective cleaning
- poor paintwork in some en suites
- the protective coating of vanity units and bedside lockers was eroded preventing effective cleaning.

Action Required:

Under Regulation 27 you are required to: Ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.

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

All inappropriate storage in en suites was removed during the inspection.

The placement of PPE storage units in communal rooms will be reviewed

An audit of our refurbishment needs has been commenced on a unit by unit basis, and a systematic program of redecoration, to include public areas, bed rooms, en-suites, built-in furniture, and floor coverings has already started in Wise House, and will be replicated across all four care units.

Priority will be given to rooms that are vacated during this period.

Timescale: Wise House – end July; Gregg House end September; Exham House end November, Maguire House end January 2016.

Proposed Timescale: 31/01/2016

Theme:

Safe care and support

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

There were three sinks in the 'dirty' laundry, however, advisory signage for their purpose/function was not displayed including lack of hand-washing notice.

Action Required:

Under Regulation 27 you are required to: Ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.

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

All appropriate notices have been placed.

Proposed Timescale: 12/06/2015

Theme:

Safe care and support

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

While the emergency plan described actions to be taken in the event of a fire, the procedures to be followed in the event of a fire were not prominently displayed throughout the centre.

Action Required:

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

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

Larger A3 size Evacuation Route posters to replace the existing evacuation route posters; and new Fire Action notices will be posted in the Home.

Proposed Timescale: 31/07/2015

Outcome 11: Health and Social Care Needs

Theme:

Effective care and support

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

The end-of-life care plan was augmented by the advance care directive for persons lacking capacity; while some residents had either one or both completed to inform care, others had neither.

Action Required:

Under Regulation 05(3) you are required to: Prepare a care plan, based on the assessment referred to in Regulation 5(2), for a resident no later than 48 hours after that resident's admission to the designated centre.

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

The end of Life policy will be reviewed.

A Residents wishes and spirituality are assessed within 48 hours of admission; all Residents have their wishes incorporated into their care plan. Additionally, the Home's chaplaincy team are notified who also become involved with the Residents. It is not always appropriate to begin ACD discussion within the first 48 hours of admission.

Proposed Timescale: 31/12/2015

Theme:

Effective care and support

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

Occasionally, residents' care plans or assessment records were not signed or dated by the staff completing the entry.

Action Required:

Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise

it, after consultation with the resident concerned and where appropriate that resident's family.

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

All staff will be reminded to sign all entries.

Proposed Timescale: 30/06/2015

Theme:

Effective care and support

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

The assessment to support the decision for bedrail restraint was not risk based.

Action Required:

Under Regulation 06(1) you are required to: Having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care for a resident, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais.

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

All bed rails used will be reported on 3 monthly notifications. An alternate risk assessment tool for bed rails is being piloted, on completion and learning from this process, the new tool will be introduced.

Proposed Timescale: 30/09/2015

Outcome 12: Safe and Suitable Premises

Theme:

Effective care and support

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

The design and layout of the twin and four-bedrooms required attention as the accessibility to personal storage space was compromised; in addition because of the design and layout a bedside chair could not be accommodated.

While the inspectors acknowledged residents' choice regarding decorating their bed space, some bed areas were devoid of character or décor.

There was a shelf beside each bed with served little function and often prevented a bedside locker being placed alongside the bed.

There was a shelf above vanity units in many bedrooms which was a safety risk due to its position and the degree it protruded.

Linen trolleys were stored in residents' four-bedded rooms.

Action Required:

Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

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

1. Our architects have visited and drawn up options to reorganise the layout of the twin and four bedded rooms. The nurse managers have considered these and indicated their preference. The architects are currently working on more detailed drawings, and checking the usable space provided with relation to the standards.

Once agreed, the work will be costed and tendered for, to present to the Board at their October 2015 meeting for a final decision on the expenditure. On approval, work on the four x four bedded, and six by two bedded rooms involved will commence at latest after Christmas on a room by room basis to minimise loss of capacity/income and lessen the disruptive impact on residents. To enable us work on a vacant room we have to co-ordinate the work to vacancies as they arise.

2. All rooms 'devoid of character or décor' will be provided with suitable framed pictures or other wall hangings by end July 2015.

3. Protruding shelves will either be removed or repositioned by end June 2015 where appropriate.

4. Fixed bedside shelves will be replaced by bedside lockers by end August 2015

5. Linen trolleys have been removed from the 4 bed rooms and are now stored elsewhere.

Proposed Timescale: 31/12/2016