Maria Goretti Nursing Home inspection report, 17-18 April 2012

Health Information and Quality Authority
Social Services Inspectorate

Inspection report
Designated Centres under Health Act 2007

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

Centre name:	Maria Goretti Nursing Home
Centre ID:	0417
Centre address:	Proonts Killmallock Co Limerick
Telephone number:	063-98983
Email address:	mgnm@eircom.net
Type of centre:	☒ Private ☐ Voluntary ☐ Public
Registered providers:	Eamonn O'Mahony, Kathleen O'Mahony, Michael O'Mahony and Helen O'Mahony
Person authorised to act on behalf of the provider:	Helen O'Mahony
Person in charge:	Karen Barron
Date of inspection:	17 April 2012 and 18 April 2012
Time inspection took place:	**Day 1-Start:** 11:45 hrs **Completion:** 19:15hrs **Day 2-Start:** 09:30 hrs **Completion:** 18:00hrs
Lead inspector:	Margaret O'Regan
Support inspector:	Caroline Connelly
Type of inspection	☐ **announced** ☒ **unannounced**
Date of last inspection:	21 June 2011 and 22 June 2011

About inspection

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

In assessing the overall quality of the service provided, inspectors examine how well the provider has met the requirements of the Health Act 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland* under 18 outcome statements. The outcomes set out what is expected in designated centres.

Outcome 1 *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.*
Outcome 2 *The quality of care and experience of the residents are monitored and developed on an ongoing basis.*
Outcome 3 *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*
Outcome 4 *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.*
Outcome 5 *The health and safety of residents, visitors and staff is promoted and protected.*
Outcome 6 *Each resident is protected by the designated centre's policies and procedures for medication management.*
Outcome 7 *Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied healthcare. 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.*
Outcome 8 *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.*
Outcome 9 *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.*
Outcome 10 *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.*

Outcome 11 *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.*
Outcome 12 *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.*
Outcome 13 *The designated centre is managed by a suitably qualified and experienced nurse with authority, accountability and responsibility for the provision of the service.*
Outcome 14 *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.*
Outcome 15 *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.*
Outcome 16 *The records listed in Part 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) 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 2009 (as amended).*
Outcome 17 *A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.*
Outcome 18 *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.*

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

The inspection report is available to residents, relatives, providers and members of the public, and is published on www.hiqa.ie in keeping with the Authority's values of openness and transparency.

About the centre

Location of centre and description of services and premises

Maria Goretti Nursing Home is located approximately two kilometres from the town of Kilmallock in a rural setting. It is a purpose-built, single-storey centre with residential accommodation for 62 residents. The centre was opened in 2000 and an extension was added in 2004. It is a family run business.

The main entrance leads to a wide corridor and into a central atrium which is also the main seating area. There are four corridors leading from the atrium. Bedrooms, sanitary facilities and storage areas are along these corridors. There are two dining areas, an oratory, a clinical room, a designated smoking room, two offices and a reception area.

There are 24 single bedrooms, nine twin-bedded rooms and five four-bedded rooms. All bedrooms, with the exception of one single room, have en suite shower, toilet and wash-hand basin facilities. Two of the rooms are described as apartments. They comprise a single bedroom with en suite facilities, a kitchenette and a sitting room.

Date centre was first established:	2000
Date of registration:	30 June 2012
Number of registered places:	62
Number of residents on the date of inspection:	55 plus 3 in hospital

Dependency level of current residents as provided by the centre:	**Max**	**High**	**Medium**	**Low**
Number of residents	38	6	11	0

Gender of residents	**Male (✓)**	**Female (✓)**
	23	32

Management structure

The nursing home is operated by a four person partnership: Helen O'Mahony, Kathleen O'Mahony, Eamonn O'Mahony and Michael O'Mahony. Helen O'Mahony is the person acting on behalf of this family run business. The Person in Charge is Karen Barron and she is in her post since April 2009. All staff report to the Person in Charge. The Person in Charge reports to Helen O'Mahony.

Staff designation	Person in Charge	Nurses	Care staff	Catering staff	Cleaning and laundry staff	Admin staff	Other staff
Number of staff on duty on day one of the inspection	1	2	8	3	3	1	0

Summary of compliance with 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 report sets out the findings of an unannounced inspection which took place over two days. As part of the inspection process, inspectors met with residents, relatives, and staff. Practices were observed and documentation, such as care plans, medical records, accident logs, policies, procedures and staff files, were reviewed.

The collective feedback from residents and relatives was one of satisfaction with the service and care provided. There was a fondness expressed towards staff and the person in charge. However, inspectors concluded that while staff were well intentioned, the work practices required to be more structured, more considered, and more respectful towards residents. Staff in the main needed more guidance, supervision and training.

It was unclear who had authority, accountability and responsibility for the maintenance and upkeep of the centre, and who had the authority to resource and appoint extra management staff. The level of risk to residents of receiving an inadequate and unsafe quality of care had increased since the previous inspection, primarily due to ineffective governance, communication and management system which had continued for an extended period of time. In light of this significant concern about the management of the centre, the providers were required to take immediate action to address the issue.

Written policies which were in place were well written and easy to follow, however they were not always adhered to. Other documentation, such as resident file notes and care plans were fragmented and sometimes incomplete. Staff files were missing documentation such as references and medical certificates. The activities provided appealed to a number of residents but many others had little or no meaningful engagement for extended periods of the day. Many of the medication management practices were good but there was non compliance in relation to the manner in which transcribed medication charts were managed.

The dependency levels of residents increased considerably since the last inspection. However, staffing levels remained comparatively unchanged and the quality of care had declined. There was a lack of privacy afforded to residents in multi-occupancy rooms when personal care was provided; cleaning practices were poor; many items of furniture were in disrepair; no significant progress had been made in relation to the provision of a secure garden area and practically no audits of practices had been conducted in the past 10 months.

Some of the issues mentioned above had arisen in previous reports, namely: issues around resident dignity and privacy; the detail contained in care plans; the need to put in place a system to review the quality of life and quality of care provided; the compilation of staff files and the need for a more robust management structure.

This report outlines the findings of the inspection.

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*.

1. Statement of purpose and quality management

Outcome 1
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.

References:
Regulation 5: Statement of Purpose
Standard 28: Purpose and Function

Inspection findings

All items listed in schedule 1 of the regulations were detailed in the statement of purpose, which was last reviewed in August 2011. The vision and mission of Maria Goretti nursing home, as stated in the statement of purpose, is one which includes:

- commitment to providing high quality safe services
- endeavours to improve the quality of life of services users and to help them live their lives to the fullest
- preserving the dignity, individuality and privacy of service users and doing this in a manner that is sensitive to their ever-changing needs.

Inspectors found that the aims, vision and mission as set out in the statement of purpose was compromised by the quality of the service provided. For example, quality reviews were not conducted; there was limited involvement of residents and their families in the running of the centre; there were poor care practices in relation

to preserving residents dignity; there was a lack of storage for personal belonging; there was a lack of progress with providing a secure outdoor area for residents; there was a lack of attention to outstanding maintenance issues.

Outcome 2
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

Inspection findings

The culture within the centre was primarily task orientated. Changes to practices, in particular changes and cognisance around residents' dignity and privacy, were slow to change from one inspection to the next. While management staff showed an understanding of what quality was, there was a difficulty in determining what, if any, quality initiatives had been undertaken. The incidence of falls was reviewed by the person in charge and one resident who was at a high risk of falling had extra care hours allocated to him. This was effective in reducing the number of falls he had. However, there was little structure or documentation in place around these fall reviews. They were generally carried out in an ad hoc basis.

Residents were consulted through the residents' forum meetings for their input into the operating of the centre. However, these meetings were infrequent and there was little evidence to show that the matters raised had been attended to. For example, the last resident meeting documented was in November 2011. The issue of a choice of menu was discussed but choice at meal time remained an issue at this inspection, five months later.

There was no structure or organised system of monitoring the quality and safety of care provided to residents. A system needed to be put in place whereby clinical audits, safety and hygiene audits, auditing of documentation and auditing of quality of life issues for residents were routinely undertaken. With this in mind, the inspector requested a quarterly report to be submitted to the Chief Inspector in respect of any future reviews conducted and any changes implemented in relation to practices. This system of review must provide for consultation with residents and their representatives.

Outcome 3
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

Inspection findings

Written operational policies and procedures were in place for the management of complaints. The complaints process was user-friendly and accessible to all residents. It was displayed in a prominent position in the front foyer and residents were aware of it. Residents and relatives stated they had no difficulty in speaking with staff and felt their concerns or queries would be dealt with.

The person in charge was the person nominated to deal with complaints and she maintained a record of the details of the complaint. However, in some instances the results of any investigations, the actions taken and whether or not the resident was satisfied with the outcome of the complaint were not documented. In addition, the last complaint documented was in July 2011 and while this may be an indicator of a general satisfaction with the service provided, there were indications that some complaints dealt with were not recorded. The regulations are specific in this regard when they state "the nominated person maintains a record of all complaints detailing the investigation and outcome of the complaint and whether or not the resident was satisfied".

Over the past 18 months five separate anonymous concerns have been received by the Health Information and Quality Authority (the Authority) in relation to care practices in the centre. These concerns were sources of information which guided this and previous inspections. The fact that there have been such calls to the Authority indicates that the centre probably has, knowingly or unknowingly, more concerns that its complaints book suggests.

Complaints were recorded more than one per page, when each complaint should be recorded separately to maintain residents' confidentiality and make available a record of the complaint to the resident it pertains to, if he/she so requests.

An independent person was not available if the complainant wished to appeal the outcome of the complaint.

2. Safeguarding and safety

Outcome 4
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

Inspection findings

A policy and procedure was in place for the prevention, detection and response to abuse. Staff had received training in understanding elder abuse and implementing the centre's policy including to whom it should be reported. There was no evidence of any barriers to staff or residents disclosing concerns they had in relation to this matter. Residents stated they felt safe and attributed this to the kindness of staff. However, there was a lack of dignity and privacy shown to residents, particularly those in multi-occupancy rooms. Personal care was provided in view of other residents. This suggested that the training provided on the recognition and prevention of elder abuse needed to be further augmented to ensure that it was clearly understood that compromising a resident's dignity showed a level of institutional practice that could be considered a form of abuse. In addition, the issue of privacy and dignity for residents was highlighted in the two previous reports. While some changes had occurred the fact that it remained a significant issue at this inspection suggests there was a lack of learning from the previous reports.

Systems were in place to safeguard residents' money. The person in charge monitored this system by countersigning any withdrawals or lodgements made by residents.

Outcome 5
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

Inspection findings

There were policies and procedures in place relating to health and safety. However, the risk management policy did not outline the precautions in place to control the risks specified in regulation 31 of the Care and Welfare Regulations which included assault, aggression, violence and self-harm. The health and safety statement was dated 2010 and should have been reviewed annually. There was no indication that staff had read and signed that they understood this document.

A policy on infection control was not made available for inspection. The procedures in place for the prevention and control of infection were unsatisfactory. For example, soap from dispensers and paper towels were not available in all toilets; there was no record that staff had received training in hand hygiene and it was unclear what training household staff had received.
A room which had been cleaned had a soiled cloth and soiled dried tissues on the radiator; there was an odour in this room and the windows were closed. There was

dirty bed linen on a number of beds that had already been dressed by staff. Equipment such as the weighing scales was stained and other items such as the legs of bed tables were dirty.

Some measures were in place to prevent accidents. For example, handrails were on corridors, grab-rails were in toilets and the floor covering was safe. However, a number of hazards were identified, including a trailing call bell lead across a doorway; a shelf in the nurses' station which was too narrow to hold the folders placed on it; television flexes not secured to the wall; televisions placed on bed tables; chipped and damaged furniture in bedrooms.

Staff stated they were trained in moving and handling of residents and records were maintained of this training. However, practices observed were not always in line with best practice. For example, incorrect lift technique was used and there was a lack of use of the standing hoist to assist residents with a change of position.

A plan was in place for responding to an emergency caused by a fire. Suitable fire equipment was provided and there were adequate means of escape from the premises. A record was maintained of daily checks in relation to ensuring exits were unobstructed. Arrangements were in place for reviewing fire precautions such as ensuring the alarm panel was working and the testing of fire equipment. While the firm alarm was tested at least on a quarterly basis it was only serviced annually with the other fire equipment. The fire alarm should be serviced on a quarterly basis. There was a procedure for the safe evacuation of residents and staff in the event of fire. It was prominently displayed. Staff received annual training in fire safety and evacuation and fire drills took place on a six-monthly basis. Staff with whom inspectors spoke knew what to do in the event of fire. Records were maintained of all checks and training conducted.

Outcome 6
Each resident is protected by the designated centre's policies and procedures for medication management.

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

Inspection findings

There were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents. However, the policies did not include a policy on transcribing medication charts. Several medication charts which had been transcribed had not been countersigned by a doctor. This was not in line with professional guidelines. Medications which were being administered in a crushed format were not prescribed by a doctor for this form of administration.

A clear process was in place for the handling of controlled drugs. These processes were in accordance with current guidelines and legislation. Medication

administration practices observed demonstrated an adherence to appropriate professional guidelines. Appropriate procedures were in place for the handling and disposal of unused and out-of-date medicines. There was no policy in place for self-administration of medications; however, at the time of inspection all medications were managed by the centre's nurses.

There was no formal system for reviewing and monitoring safe medication management practice. Neither was there a process of three-monthly reviews of medications with the general practitioner (GP) and the pharmacist.

3. Health and social care needs

Outcome 7
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied healthcare. 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

Inspection findings

Residents had timely access to GP services with one local GP visiting twice weekly. Most residents were under his care. Two other GPs also visited the centre. Specialist services and allied health care services such as physiotherapy and occupational therapy were provided for by the centre and private physiotherapy services were also available. The services of an occupational therapist (OT)were available for one day a month. While many residents had a seating assessment, other residents were in need of an occupational therapist's assessment and the OT service needed to be availed of on a more frequent basis or as the needs of residents indicated. The services of the community occupational therapist were available for one younger resident. Chiropody and hairdressing were provided for

inhouse on a private basis. One resident whose care plan indicated a need for regular chiropody did not have a record in her file of when she last had this service.

The accommodation provided for hairdressing and chiropody needed to be customised for such services. Plans were under way on the last inspection for the installation of hairdressing equipment into an infrequently used bathroom. However, while this plan was still in place, progress had not been made in completing it.

Records were seen to be maintained of referrals and follow-up appointments. Clinical care such as falls management, wound care and management of incontinence was in line with evidence-based practice. Consent to treatment such as consent for restraint was obtained from relatives when this was not in line with national policy on restraint.

Residents' health and social care needs were assessed but two case notes from a random sample of six did not have assessments reviewed on a three-monthly basis. Therefore, care plans were not reviewed as frequently as they should. There was no evidence that residents were encouraged and enabled to be actively involved in developing their individualised plan of care.

Staff familiarity with care plans was limited. For example, a resident admitted to the centre with a plan of care which included a fortnightly urinalysis had no record of having this carried out. Some aspects of this resident's complex care needs were followed up on by the person in charge, in particular in relation to her medication needs; however, many other aspects of care were given insufficient attention as evidenced by the documentation available and what was observed on the days of inspection. These needs included appropriate seating, appropriate mobilisation, and appropriate activities. There was insufficient evidence readily available to clearly show that she received an adequate fluid intake to minimise her susceptibility for a urinary tract infection and that her diet met the high calorie and high protein intake as indicated in her care plan. The care plans were such that deviations from planned care were not easily identified.

There were some opportunities for residents to participate in activities that were meaningful and purposeful to them such as bingo, art and music sessions. The visit of the physiotherapist was also well received. Some residents were facilitated to attend a local day centre and others were accompanied on shopping trips. However, overall these opportunities were limited. Many residents were seen seated for extended periods of time without any engaging activity. Several residents had their meals served to them in the sitting room. According to staff this was their preference. However, more effort needed to be put into making mealtimes a pleasant and social occasion, and making it an exception not to go to the dining room instead of it being the norm.

The care and support provided needed to be more reflective of the nature and extent of residents' dependency and needs. For example, residents with a cognitive impairment were not provided with reminiscence therapy, those with an acquired brain injury had limited specialised care plans and those with an intellectual disability had limited expert care available to them. An absence of specialised care

and associated therapies limited residents' capacity to function at their highest possible level. A policy on managing behaviour that is challenging was in place and staff made efforts to identify and alleviate the underlying causes of behaviour that posed a challenge.

The use of restraint was subject to assessment but sometimes this assessment was incomplete. There was no documentation to show that all restraint was regularly monitored and reviewed. The practice needed to change from the routine of all beds having bedrails with the exception being to remove them to a routine of not having them attached to beds and the exception being to erect them.

Systems were in place to ensure that all relevant information about residents was provided and received when they were absent or returned from another care setting, home or hospital.

Outcome 8
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.

References:
Regulation 14: End of Life Care
Standard 16: End of Life Care

Inspection findings

Care practices and facilities in place were designed to ensure residents received end of life care in a way that met their individual needs and wishes and respected their dignity and autonomy. Individual religious and cultural practices were facilitated and family and friends were facilitated to be with the resident when they were dying. Overnight facilities were available for relatives' use. Residents had the option of a single room and access to specialist palliative care services, if appropriate.

On the day of inspection the death of a resident took place. Prayers were facilitated in the centre and arrangements were made for families and residents to pay their respects to the deceased. Refreshments were provided for by the centre for families and residents after the prayer service.

Outcome 9
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

Inspection findings

A policy for the monitoring and documentation of nutritional intake was in place but it was unclear if it was implemented. For example, the policy stated a particular nutritional assessment tool was used but it was not seen in the residents' charts examined. Residents had access to fresh drinking water and the food provided was nutritious and available in sufficient quantities. However, the documentation in relation to ensuring residents had good nutrition and hydration was fragmented and incomplete. For example, residents with nutritional deficits did not always have a nutritional assessment on admission nor have it repeated as their condition indicated; the list of residents' weight provided to inspectors did not include all residents; the list of specialised diets available to kitchen staff included those on diabetic diets but other diets were not listed, such as high protein diets.

Meals and snacks were available at regular intervals but the timing of meals was early and the flexibility around mealtimes was limited. For example, breakfast was served from 06:00hrs, dinner from 12:00hrs and supper from 16:00hrs. Residents stated they were awoken for breakfast and indicated this was not their choice. There was ambiguity as to whether there was a choice available at mealtimes. Management stated that a choice was offered; some residents stated there was no choice; kitchen staff indicated one main dish was prepared each day and where they knew a resident didn't like that dish a different meal was given. Work needed to be done in creating a varied menu that offered choice and was displayed each day.

Residents were given sensitive assistance by staff at mealtimes and mealtimes appeared unhurried. However, meal times lacked a social occasion element to them. The number of residents using the main dining room was low, approximately 15 out of 55. Four other residents used the smaller dining room. Close to forty residents had their meals in the sitting room or their bedrooms. An opportunity for residents to engage, communicate and interact with each other and staff was overlooked.

The number of residents requiring a liquidised diet was 24 (approx 44%). This was a high percentage; however, the person in charge explained to inspectors that this had been reviewed since the last inspection and that changes were made where possible. Dietetic advice was available through a nutritional supplies company but it was unclear to what extent dietetic reviews had been requested or provided for. In light of the number on liquidised diets, the lack of adequate nutritional assessments and the lack of clarity provided to kitchen staff on special dietary requirements, a dietetic review should be carried out for residents where indicated and staff should be provided with education and support on this matter. This area of clinical care must be attended to as a matter of priority.

4. Respecting and involving residents

Outcome 10
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.

References:
Regulation 28: Contract for the Provision of Services
Standard 1: Information
Standard 7: Contract/Statement of Terms and Conditions

Inspection findings

Resident contracts were examined. Contracts set out the services to be provided but details of the fees to be charged were not stated in all contracts.

Outcome 11
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

Inspection findings

The complaints policy was on display in the foyer inviting comments from residents and relatives. The person in charge met with residents on a daily basis and sought feedback through this informal basis. There was evidence that this feedback informed practice. For example, a resident was taken shopping for new clothes and another resident was accommodated in an alternative room as requested. The person in charge had a good rapport with residents, relatives and staff. All groups expressed satisfaction with the manner in which the person in charge supported them. Residents also expressed satisfaction with the care and attention given by other staff.

Residents were consulted, through the residents' forum, concerning the running of the centre. This forum met occasionally (the last meeting was in November 2011); however, it was unclear if the matters discussed had been adequately addressed, such as residents' views on meal choices.

Residents had access to private telephone facilities and a room was available for residents to receive visitors in private. There were no restrictions on visits except when requested by the resident or when the visit or timing of a visit was deemed to pose a risk.

Residents were facilitated to exercise their political rights and voting in recent elections was accommodated in the centre. Residents' religious rights are facilitated through regular visits by the clergy to the centre and the facilitation of services such as mass, rosary and sacrament of the sick.

Many of the routines and practices were institutional in nature. For example, residents were awoken early for breakfast and their morning medications. Residents' capacity to feed themselves was restricted as many residents didn't sit at a proper dining table with cutlery and dishes to facilitate independence. Residents' capacity to maximise their personal autonomy was compromised. For example, there was inadequate storage space for clothing and personal possessions and secure storage was not provided for each resident. Some screening curtains were absent and many others were not wide enough to circle the bed. Bathrooms and toilet doors were unable to be locked, all of which compromised residents' privacy and dignity.

There was no documentation to indicate that residents were consulted about their care plans. Facilities for recreation were limited. The importance of privacy and dignity was emphasised in the statement of purpose but practices, such as those outlined above, did not concur with the statement of purpose.

Staff showed some awareness of the different communication needs of residents. However, there was scope for more emphasis on this as there were several residents who had complex communications needs. Some of these residents did not have specific plans around these needs and there was no evidence that staff had received specific training in this area.

The centre had established links with the community. Volunteers visited and ran the bingo and music sessions. Residents had access to radio and newspapers. Televisions were located in different areas throughout. However, many bedrooms, in particular multi-occupancy rooms, did not have televisions.

Outcome 12
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.

References:
Regulation 7: Residents' Personal Property and Possessions

Regulation 13: Clothing
Standard 4: Privacy and Dignity
Standard 17: Autonomy and Independence

Inspection findings

A policy on residents' personal property and possessions was in place. Appropriate record keeping was maintained of residents' personal finances.

Residents had minimal control over their own possessions as a number of residents had inadequate space for personal possessions and did not have lockable storage space. In addition the majority of the wardrobes seen were in disarray and little or no attention was given to organising residents' clothes in a tidy and easy to access manner.

Laundry facilities were provided for inhouse but the minutes of residents' meetings indicated there were some issues with it such as shrinking of clothes. In addition, several families took home their relatives' personal clothing. An audit of how the laundry system is working and how satisfactory residents and relatives find it should be conducted.

5. Suitable staffing

Outcome 13
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

Inspection findings

The post of person in charge was full time and occupied by the current post holder since 2009. The person in charge was a nurse with experience in the area of nursing the older person. She had clinical knowledge with regards to suitable and safe care. However, factors, including the management structure, impacted on the quality, suitability and safety of care provided. The workload for the person in charge impacted on how she fulfilled her responsibilities. Administration support was part-time resulting in some administration duties falling to the person in charge; the maintenance person was part time resulting in a lot of maintenance issues not being attended to; the providers were contactable by phone but their irregular presence in the centre required the person in charge to attend to issues that could be attended to by the provider; a deputy person in charge had not been appointed despite the centre nearing full capacity and 80% of residents being of maximum to high dependency.

An experienced member of the nursing staff covered duty for the person in charge when she was on regular annual leave. However, this nurse was not appointed as a deputy, did not have management meetings with the person in charge or the provider and was not assigned managerial tasks other than cover for annual leave. The person in charge had not been on extended leave since she commenced in the post but if this was to occur there was no one suitably tutored to take over the running of the centre at short notice for an extended period of time.

Outcome 14
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

Inspection findings

The staffing levels on this inspection were as follows:

08:00hrs to 14:00hrs = 2 nurses and 8 carers = 1:5.5
14:00hrs to 18:00hrs = 2 nurses and 5 carers = 1:8
18:00hrs to 20:00hrs = 2 nurses and 4 carers = 1:9
20:00hrs to 08:00hrs = 2 nurses and 2 carers = 1:14

The person in charge, housekeeping, kitchen and administration staff were in addition to the above ratios.

The staffing levels were similar to the last inspection in June 2011. However, the dependency levels of residents had changed significantly between June 2011 and this inspection. In June 2011 approximately 44% of residents were of maximum to high dependency whereas on this inspection approximately 80% of the residents were in this category. Therefore, the care needs had also changed significantly as did the demands placed on staff. The person in charge stated staffing levels were continuously monitored. While no specific tool was used to assess staffing requirements the person in charge informed inspectors extra staff were employed if a resident required more carer time. One resident was seen receiving extended periods of one-to-one care on the day of inspection. An actual and planned staff rota was maintained. Medications were administered by two nurses and practices observed were in line with professional guidelines.

There was a low staff turnover which was good for the continuity of care. The induction process usually involved the new staff member shadowing another member of staff for a number of days. A more robust and structured induction process should be developed.

The training programme included mandatory training in moving and handling, fire training and elder abuse awareness. Records of this training were kept in staff files. A training matrix to show what training staff had, when they had it and when updates were due was not available. Nurses told inspectors of training they undertook in their own time and at their own expense. This included wound care and venepuncture (the taking of bloods).

Staff supervision and guidance needed to be given more consideration in order to ensure that residents received a high quality of care. More emphasis needed to be placed on ensuring staff understood the regulations and standards pertaining to the nursing home environment in particular in relation to a resident's choice, privacy and dignity. More structured and regular staff meetings were needed and more engagement with staff through a staff appraisal type of initiative. In addition much more emphasis needed to be given to assessing staff training needs. An education and training programme must be drawn up to enable staff to provide care that reflects contemporary evidence based practice. In addition to the current training programme, staff education should also include: caring for residents with dementia; the management of behaviours which are challenging; the provision of meaningful activities for residents; and training in infection control prevention. Cleaning staff required training in cleaning practices. Nurses needed to receive opportunities to update their skills and opportunities for professional development to enable them to provide care in accordance with contemporary evidenced-based practice..

The documentation required for each staff member as per Schedule 2 of the Care and Welfare Regulations was kept in a secure file. Some of the documentation required for each staff member as per Schedule 2 was unavailable. These included references and medical certificates. Volunteers working at the centre received some supervision; however, there was no evidence that they were vetted appropriate to their role and level of involvement.

6. Safe and suitable premises

Outcome 15
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

Inspection findings

The design and layout of the centre was such that a safe environment was achievable if the premises were maintained in a good state of repair. However, there were many maintenance issues outstanding such as:

- overhead bed lights not working
- call bells not available for residents
- broken doors on bedroom furniture
- mismatched drawers in bedside lockers
- scuffed and chipped bedside lockers
- scuffed skirting boards and walls
- handles missing from furniture
- unsightly flexes hanging from walls
- grass not cut
- garden access curtailed
- signs on toilet door missing letters
- beds and bedside tables showing signs of rust.

The maintenance book in place had very few entries and did not appear to be regularly or consistently used or referred to. A programme of routine maintenance and renewal of the fabric and decoration of the premises were not maintained.

The communal and dining areas were comfortable and nicely decorated. There was a comfortable room available for residents to meet visitors in private. The homeliness of the centre was compromised, however, by the number of multi-occupancy bedrooms and the layout of these rooms. Almost two thirds of residents were in shared accommodation with one third (20 residents) in four-bedded rooms. Several of the multi-occupancy rooms had insufficient storage space for clothes as evidenced by over-packed wardrobes; at least one resident had no wardrobe space; a number of bedside lockers had mismatched drawers; handles were missing from a number of drawers making it difficult for residents to open; lockable storage space was not provided for residents other than a secure file in the office for residents' finances.

While some residents had personal effects which helped to personalise their rooms, the majority did not. The general decoration of bedrooms was an area which required attention in order to make them more comfortable. As discussed in outcome 9 screening curtains did not encircle the beds in multi-occupancy rooms. This had been identified in a previous report. Residents stated personal care was regularly given in full view of other residents.

The centre maintained a safe environment for resident mobility with hand rails in circulation areas and corridors. The circulation areas were generally kept clean and tidy but there was a lot of clutter in other areas such as special mattresses on the floor in one toilet area; incontinence wear in the bath when there was space in the storage cupboard for it; several items left on ledges giving an untidy sense to the environment.

There was a general lack of attention paid to ensuring residents had clean linen on their beds. For example, a number of beds which had been dressed had stained bed sheets, stained bed covers and stained pillow covers.

The premises and grounds were poorly maintained, the grass was uncut and minimal progress had been made in relation to the provision of a secure outdoor area.

The room dimensions met the current requirements of the *National Quality Standards for Residential Care Settings for Older People in Ireland* for existing centres. However, the five bedrooms with four beds must be reduced to single or twin occupancy by 2015 in order to comply with these standards.

Each bedroom, with the exception of one, had en suite facilities. There were a sufficient number of toilets, bathrooms and showers to meet the needs of residents. Sluicing facilities were provided; however, there was no bed-pan washer or macerator, which is required by regulation. Equipment was serviced regularly and records were maintained of this. However, many items such as the sit-on weighing scales needed to be cleaned.

There was a well-equipped and well-stocked kitchen. Satisfactory environmental health officer reports were available. Staff facilities included a kitchenette, toilet and coat hanging area. There was no specific changing room or storage lockers for staff. The nurse's station did not have a proper desk on which to carry out report writing and other administration-type work.

7. Records and documentation to kept at a designated centre

Outcome 16

The records listed in Part 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) 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 2009 (as amended).

References:

Part 6: The records to be kept in a designated centre
Regulation 26: Insurance Cover
Regulation 27: Operating Policies and Procedures
Standard 1: Information
Standard 29: Management Systems
Standard 32: Register and Residents' Records

Inspection findings

The manner in which records were stored made it complicated to retrieve data pertaining to a resident. Different pieces of resident information were stored in different files. Resident files were kept secure and were accessible to the residents to whom they referred, if requested. Records were maintained for not less than seven years after the resident to whom they related ceased to be a resident in the centre. Reports relating to other inspections such as environmental health reports and fire safety reports were maintained in the centre and seen by the inspector.

Some care plans were incomplete in that they had not been reviewed for over three months. Details such as references and medical certificates were absent from some staff files. The directory of residents was incomplete in parts. For example, the cause of a resident's death was not recorded in one instance; there was no GP details recorded for another resident and details informing where a resident had been admitted from was absent from another.

Policies were well written, referenced and were dated. In some instances practices outlined in the policies were not adhered to; for example, the nutrition policy stated a particular assessment tool was used and the challenging behaviour policy indicated the mini-mental state examination assessment tool was used; however, there was no evidence of the use of these assessment tools.

On the day of inspection a copy of the Residents' Guide and details of the insurance cover were requested to be sent to the inspector but were not received.

Outcome 17
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

Inspection findings

Notifiable incidents such as an outbreak of an infectious disease and the presence of pressures sores grade 2 were not notified to the Chief Inspector as is required by regulation.

Quarterly reports were provided, as required.

Outcome 18
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.

References:
Regulation 37: Notification of periods when the Person in Charge is absent from a Designated Centre
Regulation 38: Notification of the procedures and arrangements for periods when the person in charge is absent from a Designated Centre
Standard 27: Operational Management

Inspection findings

As stated at the outset of the report an immediate action plan was issued to the providers due primarily to inspector concerns about the manner in which the centre was managed. It was unclear who had authority, accountability and responsibility for the maintenance and upkeep of the centre and who had the authority to resource and appoint extra management staff.

The lack of a robust management structure resulted in poor practices developing which in turn culminated in poor outcomes for residents. The person in charge lacked adequate administrative support, lacked the support of a full-time maintenance person, the support of having a provider regularly in the centre and the support of a deputy person in charge. Thus, there was a risk to residents of receiving an inadequate and unsafe quality of care. Evidence of these risks were seen by the level of furniture and fittings in disrepair, the lack of progress with the garden facility, the lack of quality control systems, of an efficient communication system between management personnel and the lack of attention paid to ensuring that care practices did not compromise residents' privacy, dignity and quality of life.

Closing the visit

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

Acknowledgements

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

Report compiled by:

Margaret O'Regan
Inspector of Social Services
Social Services Inspectorate
Health Information and Quality Authority

24 April 2012

Health Information and Quality Authority
Social Services Inspectorate

Action Plan

Provider's response to inspection report*

Centre:	Maria Goretti Nursing Home
Centre ID:	417
Date of inspection:	17 April 2012 and 18 April 2012
Date of response:	17 May 2012

Requirements

These requirements set out the actions that must be taken to meet the requirements of the Health Act 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care settings for Older People in Ireland*.

Outcome 1: Statement of purpose and quality management

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

The aims and objectives set out in the statement of purpose are to provide a homely and safe environment. However, this homely environment was compromised by the lack of attention to maintenance issues; the minimal personalisation of bedrooms; and the number of multi-occupancy rooms.

The importance of privacy and dignity was emphasised in the statement of purpose but practices such as a lack of screening curtains, the absence of locks on toilet doors, and lack of storage space for personal possessions, did not concur with what was stated in the statement of purpose.

Action required:

The statement of purpose must be kept under review and practices carried out in the centre must reflect what is written in the said document.

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

Action required:

The registered provider must ensure the premises are suitable for the purpose of achieving the aims and objectives set out in the statement of purpose, and that the premises are appropriate to the needs of residents.

Reference:

Health Act, 2007
Regulation 5: Statement of Purpose
Regulation 19: Premises
Standard 28: Purpose and Function
Standard 25: Physical Environment

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The current statement of purpose will be reviewed before the end of June, and yearly review dates set thereafter. Maintenance action plan: An external maintenance supervisor will be contracted, to develop with the providers in liaison with the director of nursing, a plan for the maintenance needs of the premises and environs. This will include short, medium and long term maintenance goals for the centre, with set review dates for all plans/goals. The supervisor will be responsible for the implementation of the plan and will report to the providers re the progress of the plan. For day-to-day inhouse maintenance the current system will continue, which is managed by the director of nursing who sources local contractors i.e. plumber, electrician, carpenter when required. The contractors will invoice the accounts department, and the providers will approve payment. The centre also has on staff a maintenance man, who works two to three days every week. To address the outstanding maintenance issues the maintenance man will be appointed to a full-time position for a period of three months, which has commenced following recent inspection. A maintenance requisition book will be implemented immediately. The requisition will be signed by the maintenance man as works are completed. Original copy will then be logged by clerical support staff. This will commence immediately. Inhouse requests will be approved and sanctioned by the director of nursing, larger works will be approved and sanctioned by the provider. Replacement for furniture in disrepair is currently on order.	30 June 2012 17 May 2012 31 May 2012 1 May 2012

All beds will be audited by the provider, and replacement beds will be ordered. Audit will commence immediately and priority list will be compiled.	
All bedside lockers will be audited by the provider, and replacement lockers will be ordered. Audit will commence immediately. Locks will be fixed to the top drawer of each locker to support residents maintaining their private property securely.	31 May 2012
Painting: An audit of all rooms/living areas will be completed immediately. All areas in need of immediate painting will be attended to immediately. Thereafter the maintenance plan will include painting and decorating.	In place
A checklist has been compiled, whereby weekly checks of the following are completed by the maintenance man: call bells, lighting and overhead bed lighting, state of repair of furniture and fixtures, flooring, curtains and rails, decor of the room, en suites.	In place
Extra wardrobes will be purchased.	Ordered
Curtain rails encircling beds are currently being replaced, and will be continuously audited going forward by the maintenance man. He will complete a checklist which he will submit to the director of nursing.	30 June 2012
All bathroom/toilet/en suite doors will have safety locks fitted, to promote and respect residents' privacy and dignity. (These locks can be opened from outside in an emergency).	30 June 2012
Secure garden area: Garden plan completed, works on developing will commence in June 2012. This secure area will have green area, plants, flowers, single solid chairs and garden benches/furniture. The long-term vision would be to develop this garden further into a sensory garden for residents.	15 June 2012
An environmental risk assessment will be completed immediately by the director of nursing, the provider and the maintenance supervisor.	30 August 2012.
The health and safety statement for the home will be reviewed	

immediately, including a sign-off sheet for all staff to sign when they have read the document.	
Personal items, such as photographs, books, albums, and memorabilia will be positioned where residents can view them and gain easy access to them in the privacy of the bedrooms, in particular the multiple occupancy rooms. Residents will be supported in this area with immediate effect by frontline staff and the maintenance man. Televisions will be safely installed, all flexes will be secured to the walls by mid June.	In place
Management Structure: From 28 May 2012 to facilitate the director of nursing and provider an external consultant will be appointed ten to twelve hours per week for a three-month timeframe to offer immediate support to the director of nursing in the management of the centre, its staff, staff training, and its policies, procedures and guidelines in compliance with the Authority's standards. This external consultant has significant experience at a management level and holds a formal training in quality and standards. This person will audit current practices and support and mentor the director of nursing in key areas of practice, and support her in the practice of completing audits of all aspects of care delivery. A training needs analysis will be completed by the provider and the external management support person. This analysis will be completed by reviewing current training records, staff completing individual training needs analysis tool, the director of nursing identifying training needs for all grades of staff and personal professional development and also the recent Authority inspection report identifying immediate training needs. A gantt chart will be completed planning this training by the end of June 2012. Staff training will be facilitated in the following areas, the training needs analysis will identify further areas for training: Health Information and Quality Authority Standards person centered care planning auditing risk assessment infection control hygiene audits restrictive practices medication management refresher manual-handling courses where required. care of the person with dementia care needs and associated behaviours, creative diversional recreation for the elderly reflective practice.	Ongoing

Outcome 2: Reviewing and improving the quality and safety of care

2. The provider and person in charge are failing to comply with a regulatory requirement in the following respect:

The monitoring of the quality and safety of care and the quality of life of residents was inadequate. There was a lack of structure and formality to it. It did not cover such issues as clinical audits, safety and hygiene audits, or auditing of documentation and auditing of quality of life issues for residents.

Action required as per immediate action plan:

The providers are required to put in writing by 4 May 2012 details of their system for monitoring the safety and the quality of care provided to residents. This must include consultation with residents and/or their representatives.

Action required:

Make a quarterly report in respect of reviews conducted and submit a copy of the reports to the Chief Inspector.

Reference:

Health Act, 2007
Regulation 35: Review of Quality and Safety of Care and Quality of Life
Standard 30: Quality Assurance and Continuous Improvement

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response:	
Refer to action in outcome number 1 re audit process.	30 May 2012
Resident and family involvement in care delivery and decision making. Residents will be informed and involved in all decisions around their care. The resident or representative will sign that they have been informed, this signed log will be stored in the individual's care plan. The same applies to relatives, with the resident's consent. Residents will be offered the choice of completing/partaking in a "patient satisfaction survey"; families will be offered the same.	Ongoing
Residents will be consulted in relation to choice of menus, with support of family or staff. This menu choice log will be in place by June 2012. This will be coordinated by the catering staff in conjunction with the director of nursing.	30 June 2012
In September 2012, a residents' forum will be facilitated by the provider, the director of nursing and an independent advocate.	30 September 2012

Going forward these forums will be facilitated bi-monthly. As part of this forum all policies and procedures in operation in the centre will be shared with and explained to the residents and their opinions sought and suggestions valued and acted upon. A quarterly report will be submitted in respect of reviews conducted from September 2012.	

Outcome 3: Complaints procedures

3. The provider is failing to comply with a regulatory requirement in the following respect: In some instances the results of investigations into complaints, actions taken and whether or not the resident was satisfied with the outcome of the complaint were not documented. Complaints were recorded more than one per page, when each complaint should be recorded separately to maintain residents' confidentiality and make available a record of the complaint to the resident if he/she so requested. An independent person was not available if the complainant wished to appeal the outcome of the complaint.
Action required: The nominated person must maintain a record of all complaints detailing the investigation and outcome of the complaint and whether or not the resident was satisfied.
Action required: Each complaint must be recorded on a separate page.
Action required: The complaints procedure must contain an independent appeals process, the operation of which is included in the policies and procedures.
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 person in charge/nominated person will maintain a record of	In place

all complaints, each complaint will be recorded on a separate sheet in a bound book. A detailed account of actions taken or support given will be written and held in a record. The person in charge will liaise and report on all complaints and follow-up/ outcomes to the provider/fit person. The policies and guidelines will be reviewed to include an independent person to address appeals.	 31 July 2012

Outcome 4: Safeguarding and safety

4. The provider and person in charge are failing to comply with a regulatory requirement in the following respect:

Personal care was provided in view of other residents. This suggested that the training provided on the recognition and prevention of elder abuse needed to be further augmented to ensure that it was clearly understood that compromising a resident's dignity showed a level of institutional practice that could be considered a form of abuse.

The issue of privacy and dignity for residents was highlighted in the two previous reports. While some changes had occurred the fact that it remained a significant issue at this inspection suggests there was a lack of learning from the previous reports.

Action required:

Suitable and sufficient care must be provided to maintain the residents' welfare and wellbeing, having regard to the nature and extent of the residents' dependency and needs.

Action required:

All necessary arrangements must be made, including training and supervision of staff, at preventing residents being placed at risk of harm or abuse.

Action required:

Arrangements must be made for the learning from events such as those outlined in reports and which involve residents.

Reference:

Health Act, 2007
Regulation 6: General Welfare and Protection
Regulation 31: Risk Management Procedures
Standard 8: Protection

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: Reflective practice will be actioned, training will be delivered to all staff enabling them to understand the value of reflecting on practice issues and scenarios that have arisen. Training in "Elder Abuse" will be sourced from the HSE as soon as the HSE can provide a trainer. Supervision and support for staff will be given by the Fit Person, the director of nursing and the independent external consultant.	 30 June 2012 Immediately Immediately

Outcome 5: Health and safety and risk management

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

The risk management policy did not outline the precautions in place to control the risks specified in regulation 31 of the Care and Welfare Regulations, which included assault, aggression, violence and self-harm.

The health and safety statement was dated 2010 and should be reviewed annually. There was no indication that staff had read and signed that they understood this document.

A policy on infection control was not made available for inspection. The procedures in place for the prevention and control of infection were unsatisfactory. For example, soap and paper towels were not available in all toilets; there was no record that staff had received training in hand hygiene and it was unclear what training household staff had received. A room which had been cleaned had a soiled cloth and soiled dried tissues on the radiator, there was an odour in this room and the windows were closed. There was dirty bed linen on a number of beds that had been dressed. Equipment such as the weighing scales was stained and other items such as the legs of bed tables were dirty.

A number of hazards were identified, including: a trailing call bell lead across a doorway; a shelf in the nurses' station which was too narrow to hold the folders placed on it; television flexes not secured to the wall; televisions placed on bed tables; chipped and damaged furniture in bedrooms.

Moving and handling practices observed were not always in line with best practice. For example, incorrect lifting techniques were used and there was minimal use of the standing hoist to assist residents with a change of position.

Action required:

The risk management policy must cover, but is not limited to, the following:

- the identification and assessment of risks throughout the centre
- the precautions in place to control the risks identified
- the precautions in place to control the following specified risks: assault; accidental injury to residents or staff; aggression and violence; self-harm.

Action required:

The health and safety statement must be updated on an annul basis. Staff must sign to indicate they have read and understood the policy.

Action required:

Responsibility for infection prevention and control must be clearly defined and there must be clear lines of accountability for infection prevention and control throughout the centre.

Action required:

Staff must receive training in hand hygiene and cleaning staff require training in cleaning practices.

Action required:

Policies and procedures must be place around infection control practices. These policies and procedures must be consistent with current national guidelines on infection prevention and control systems and include hand washing and the cleaning of equipment in order to prevent cross-contamination.

Action required:

At all times, the premises must be clean, hygienic and free from offensive odours.

Action required:

All reasonable measures must be taken to prevent accidents to any person in the centre including rectifying the hazards identified on inspection.

Action required:

Ensure staff are trained in the moving and handling of residents and are appropriately supervised.

Reference: Health Act, 2007 Regulation 30: Health and Safety Regulation 31: Risk Management Procedures Standard 26: Health and Safety	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The health and safety statement will be reviewed by 31 July 2012, a log of staff signatures will be attached, and follow up with staff to establish their level of understanding of the statement, and input given around same. A risk assessment to support residents who present with/or are exposed to challenging behaviour will be completed and actions implemented from same. This will be completed by August 2012. Infection control will be the responsibility of the provider. This will include guideline and policy development, staff training in all aspects including the cleaning of equipment, barrier nursing, monitoring of practices with the director of nursing and audit. This local policy and guidelines will be sourced from the HSE infection control manual 2011. The external consultant and the provider will implement hand hygiene training for all grades of staff before 30th June 2012. Hygiene audits will be introduced, first audit to be completed by end of September 2012. Regarding clinical incidents/accidents a regular audit of recording forms will be completed.	 31 July 2012 August 2012 Commencing immediately May 2012 June 2012 Ongoing

Outcome 6: Medication management

6. The provider and the person in charge are failing to comply with a regulatory requirement in the following respect:
The medication policies did not include a policy on transcribing medication charts. Transcribing medication charts had not been signed by a doctor. Medications which were being administered in a crushed format were not prescribed by a doctor for this form of administration.

Action required:

Ensure there are suitable and appropriate practices and written operational policies relating to the transcribing and prescribing of medicines to residents.

Action required:

The person in charge must ensure that staff are familiar with medication policies and procedures, including the procedure for transcribing and administrating crushed medications.

Reference:

Health Act, 2007
Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines
Standard 14: Medication Management

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response:	
The medication policy will be reviewed by the director of nursing, the external consultant and the provider by 31 July 2012.	31 July 2012
Additions to this policy will include transcribing of medication, prescriptions over the phone and administration of medication, i.e. if not prescribed to be crushed by a GP then practice cannot occur.	31 July 2012
Training for medication management will be delivered and all staff nurses will familiarise themselves with up-to-date medication legislation/guidelines from ABA. These ABA guidelines will be made available to staff in the facility where staff do not have their own copy.	31 July 2012

Outcome 7: Health and social care needs

7. The provider and person in charge are failing to comply with a regulatory requirement in the following respect:

While many residents had a seating assessment, other residents were in need of such a review. There was no record that a resident who required regular chiropody had received this.

Consent for restraint was obtained from relatives which is not in line with the national policy on restraint.

Residents' health and social care needs were assessed but out of a random sample of six case notes, two did not have assessments reviewed at least on a three-monthly basis.

There was no evidence that residents were encouraged and enabled to be actively involved in developing their individualised plan of care.

Staff familiarity with care plans was limited and the care plans were such that deviations from planned care were not easily identified.

Many residents were seen seated for extended periods of time without any engaging activity.

For several residents their meals were served to them in the sitting room. According to staff this was their preference. However, there needed to be more effort put into making mealtimes a pleasant and social occasion and to making it the exception not to go to the dining room for meals.

Restraint assessment was incomplete. There was no documentation to show that all restraint was regularly monitored and reviewed.

Action required as per immediate action plan:

Management systems must be in place that support and promote the delivery of quality care services. The systems in place must ensure that care is provided in line with contemporary-based practices.

Action required:

Ensure residents are facilitated to access allied health services such as occupational therapy and chiropody as their needs require.

Action required:

The person in charge must ensure each resident's needs are set out in an individual care plan developed and agreed with the resident and that any deviations from the plan of care are easily identified.

Action required:

The resident's care plan must be kept under formal review as required by the resident's changing needs or circumstances and no less frequent than at three-monthly intervals.

Action required:

Residents must be provided with opportunities to participate in activities appropriate to their interests and capacities.

Action required:

More effort must be put into making mealtimes a pleasant and social occasion.

Action required:

A record must be maintained of any occasion on which restraint is used, the nature of the restraint and its duration. Restraint practices must be in line with national guidelines including the guidelines on obtaining consent.

Reference:

Health Act, 2007
Regulation 6: General Welfare and Protection
Regulation 8: Assessment and Care Plan
Regulation 9: Health Care
Regulation 25: Medical Records
Standard 3: Consent
Standard 10: Assessment
Standard 11: The Resident's Care Plan
Standard 13: Healthcare
Standard 21: Responding to Behaviour that is Challenging

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response:	
Residents currently are in receipt of chiropody, a log of treatment and advice given will be available in the individual resident's care plan. A specific chiropody log with other MDT members recording sheets will be included in the care plans. This will be implemented in all care plans. This log/recording sheet will be in place in each file by 30 June 2012.	30 June 2012
A complete review of the current system of care planning will be completed by 31 July 2012 and the revised plan will be implemented for all residents in a three-month period. All information regarding a resident will be accessible in one file, clear review dates will be entered in each care plan and review will take place in that time frame with the staff and the resident.	31 July 2012
Activities such as bingo, fitness for the elderly with physio, art, music are currently in place. Liaising with residents and their families a broader activity based itinerary will be introduced to cater for residents of varying needs and abilities.	15 September 2012.
Training and audit re restraint will be implemented by 31 August in line with national guidelines. Obtaining consent from residents will be a key component in this training.	31 August 2012

Outcome 9: Food and nutrition

8. The provider and person in charge are failing to comply with a regulatory requirement in the following respect:

The policy on the monitoring and documentation of nutritional intake stated a particular nutritional assessment tool was used but it was not seen in the resident charts examined.

The documentation in relation to ensuring residents had good nutrition and hydration was fragmented and incomplete. For example, residents with nutritional deficits did not always have a nutritional assessment on admission nor have it repeated as their condition indicated; the list of residents' weight provided to inspectors did not include all residents; the list of specialised diets available to kitchen staff included those on diabetic diets but other diets were not listed, such as high protein diets.

Meals were served early with limited flexibility with regards to timing. For example, breakfast was served from 06:00hrs, dinner from 12:00hrs and supper from 16:00hrs.

There was ambiguity as to whether there was a choice available at mealtimes. Management stated that a choice was offered; some residents stated there wasn't a choice; the kitchen staff indicated one main dish was prepared each day and where they knew a resident didn't like that dish a different meal was given.

Mealtimes lacked a social occasion element to them. The number of residents using the dining room was low, approximately 15 out of 55. Forty residents had their meals in the sitting room or their bedroom.

In light of the number of residents on a liquidised diet, the lack of adequate nutritional assessments and the lack of clarity provided to kitchen staff on special dietary requirements, a dietetic review must be carried out for residents where indicated and staff must be provided with further education and support on this matter.

Action required:

A comprehensive policy and guidelines for the monitoring and documentation of nutritional intake must be implemented.

Action required:

The person in charge must ensure that meals, collations and refreshments are available at such times as may reasonably be required by residents.

Action required:

The person in charge must ensure that each resident is provided with food and drink in quantities adequate for their needs, which is properly prepared,

cooked and served; is wholesome and nutritious; offers choice at each mealtime; is varied and takes account of any special dietary requirements; and is consistent with each resident's individual needs.	
Action required: Each resident must receive their meals in pleasant surroundings at times convenient to them.	
Action required: A dietetic review must be carried out for residents where their nutritional status is compromised.	
Action required: Staff must be provided with further education and support on nutrition.	
Reference: Health Act, 2007 Regulation 17: Training and Staff Development Regulation 20: Food and Nutrition Standard 19: Meals and Mealtimes Standard 24: Training and Supervision	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: A policy on recording and monitoring of residents' intake and output will be developed. This will include also the importance of the social occasion that is associated with mealtimes, the importance of presentation of meals, and the need to always offer residents choice. A dietician will be sourced to assist in this area. Change of mealtimes as recommended in last inspection has been implemented already. Residents will be offered whatever quantity of food they request to meet their needs. Food will be nutritious and special diets will be presented in an attractive manner using moulds as recommended. Fluids will be easily accessible to residents who can help themselves and will be offered to those who need support. Staff training in these areas of nutrition will be provided by a dietician; this is organised and training will commence in the next six weeks.	31 July 2012 In place 1 July 2012

Outcome 10: Contract for the provision of service

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

In some instances residents' contracts of care did not detail the fees to be charged.

Action required:

The contract of care must detail the services to be provided for that resident and the fees to be charged.

Reference:

Health Act, 2007
Regulation 28: Contract for the Provision of Services
Standard 7: Contract/Statement of Terms and Conditions

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The contract of care document will be reviewed and updated and will include all details regarding fees charged. This will be actioned by the provider and the director of nursing.	30 June 2012

Outcome 11: Residents' rights, dignity and consultation

10. The provider and person in charge are failing to comply with a regulatory requirement in the following respect:

Many of the routines and practices were institutional in nature. For example, residents were awoken early for breakfast and their morning medications; residents' capacity to feed themselves was restricted as many residents did not sit at a proper dining table with cutlery and dishes to facilitate independence.

Residents' capacity to maximise their personal autonomy was compromised. For example, there was inadequate storage space for clothing and personal possessions and secure storage was not provided for each resident.

Some screening curtains were absent and many others were not wide enough to circle the bed. Bathrooms and toilet doors were unable to be locked, all of which compromised residents' privacy and dignity.

Some of the residents with complex communication needs did not have specific plans around these needs and there was no evidence that staff had received specific training in this area.

Action required:

Residents must be facilitated to have the freedom to exercise choice. This includes choice of mealtimes.

Action required:

The registered provider must ensure that adequate space is provided for a reasonable number of personal possessions and that each resident retains control over their personal possessions.

Action required:

Privacy must be provided to each resident, insofar as is reasonably practicable, to the extent that the resident is able to undertake personal activities in private.

Action required:

Each resident must be facilitated and encouraged to communicate and where indicated a care plan must be place around this need.

Reference:

Health Act, 2007
Regulation 5: Statement of Purpose
Regulation 10: Residents' Rights, Dignity and Consultation
Regulation 11: Communication
Standard 4: Privacy and Dignity
Standard 17: Autonomy and Independence
Standard 18: Routines and Expectations

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response:	
Mealtimes and choice around same has been actioned since April 2012.	30 April 2012
Additional wardrobes have been purchased, personal lockers that were in poor repair have been replaced, locks for same are on order and will be in place mid July 2012. Locks for the bathrooms/toilets are on order and will be fitted by mid July.	30 July 2012
Independence will be supported and privacy afforded to all residents, in line with their capacity and ability.	30 July 2012
Screening curtains encircling beds are on order.	30 July 2012

A speech and language therapist will be sourced to give input for residents who have complex communication needs. Staff will also receive training in this area.	30 September 2012

Outcome 12: Residents' clothing and personal property and possessions

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

Several residents did not have secure storage space. In addition the majority of the wardrobes seen were in disarray and little or no attention was given to organising residents' clothes in a tidy and easy to access manner.

Action required:

Suitable storage facilities, including secure storage, must be provided for the use of residents.

Action required:

Adequate facilities must be provided for residents to appropriately store, maintain and use their own clothes.

Reference:

Health Act, 2007
Regulation 13: Clothing
Regulation 19: Premises
Standard 4: Privacy and Independence
Standard 17: Autonomy and Independence
Standard 25: Physical Environment

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response:	
Additional wardrobes and chests of drawers are on order. Some have been delivered and are on site, others yet to be delivered.	In place and ongoing
A designated staff member will be responsible for the organisation in a tidy and accessible manner of the resident's clothes and personal items.	In place

Outcome 13: Suitable person in charge

12. The provider and person in charge are failing to comply with a regulatory requirement in the following respect:

The workload for the person in charge impacted on how she fulfilled her responsibilities. Administration support was part time resulting in some administration duties falling to the person in charge; the maintenance person was part time resulting in a lot of maintenance issues not being attended to; the providers were contactable by phone but their irregular presence in the centre required the person in charge to attend to issues that could be attended to by the provider; a deputy person in charge had not been appointed despite the centre nearing full capacity and 80% of residents being of maximum to high dependency.

There was no one suitably tutored to take over the running of the centre if the person in charge had to take leave for an extended period of time.

Action required as part of the immediate action plan:

There must be a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for areas such as maintenance, recruitment of staff and overseeing management practices.

Action required as part of the immediate action plan:

The person in charge must ensure that applicable legislation, regulatory requirements, best practice and relevant codes of practice are met.

Reference:

Health Act, 2007
Regulation 15: Person in charge
Regulation 31: Risk Management Procedures
Standard 26: Health and Safety
Standard 27: Operational Management
Standard 29: Management Systems

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Management Structure: The following structure identifies the lines of authority, accountability and responsibilities within the centre. Eamon and Michael O'Mahony will hold overall responsibility for the maintenance of the centre and will liaise with the maintenance supervisor, initially on a weekly basis and going forward on a monthly basis.	 In place In place

With immediate effect, Helen O'Mahony will monitor closely and oversee any maintenance inhouse issues. Helen O'Mahony will liaise with the director of nursing and the maintenance man and there will be documented evidence of these meetings.	
Helen O'Mahony will have the authority to resource and appoint extra management staff. All additional frontline staffing posts will be sanctioned by Helen O'Mahony. The director of nursing will have the autonomy to interview staff for these posts with another interviewer.	In place
Kathleen O'Mahony will be responsible for the management of the catering department and will monitor equipment in the kitchen area. Kathleen will consult with both chefs and will be actively involved in coordinating menus of choice for the residents.	In place
Whilst the four partners have individual areas of responsibility, all information/development/issues regarding maintenance and catering will be communicated to Helen O'Mahony, ensuring that the named provider is at all times fully informed of all aspects of the centre. There will be structured meetings, monthly or more frequently if required. All these meetings will be minuted and records will be available if required.	In place
Helen O'Mahony will continue to be the person responsible for the centre.	In place
From 28 May 2012 to facilitate the director of nursing and provider an external consultant will be appointed ten to twelve hours per week for a three-month time frame to offer immediate support to the director of nursing in the management of the home, its staff, staff training, and its policies, procedures and guidelines in line with the Authority. This external consultant has significant experience at a management level and has formal training in quality and standards. This individual will review current management structures in place and make recommendations of the additional management grades and frontline staff grades required. The person will audit current practices and support and mentor the director of nursing in key areas of practice, and support her in the practice of completing audits of all aspects of care delivery.	28 May 2012
The external consultant will develop with the director of nursing an induction and orientation plan for all grades of staff recruited by the home.	30 June 2012
At the time of inspection one of the administration support staff was on maternity leave. This staff member is due to return in July	30 July 2012

2012, at which point the hours of clerical support will be reviewed and increased. Professional Development Plans: A training needs analysis will be completed by the provider and the external management support person. This analysis will be completed by reviewing current training records, staff completing individual training needs analysis tool, the director of nursing identifying training needs for all grades of staff and personal professional development and also the recent Authority inspection report identifying immediate training needs. A gantt chart will be completed planning this training by the end of June 2012. Staff training will be facilitated in the following areas, and the training needs analysis will identify further areas for training: Health Information and Quality Authority Standards person centered care planning auditing risk assessment infection control hygiene audits restrictive practices medication management refresher manual handling courses where required. care of the person with dementia care needs and associated behaviours. creative diversional recreation for the elderly reflective practice Health Act 2009 communication needs/complex communication difficulties for residents - this will be delivered by a speech and language therapist.	30 June 2012

Outcome 14: Suitable staffing

13. The provider and person in charge are failing to comply with a regulatory requirement in the following respect:

There was a lack of staff supervision and guidance in order to ensure that residents received a high quality of care.

There was a lack of emphasis placed on ensuring staff understood the regulations and standards pertaining to the nursing home environment in particular in relation to a resident's choice, privacy and dignity.

An education and training programme for staff was not available.

Some of the documentation required for each staff member as per Schedule 2 of the Care and Welfare Regulations was unavailable. This included references and medical certificates.

There was no evidence that volunteers working in the centre were vetted appropriate to their role and level of involvement.

Action required:

The person in charge must ensure that all staff members are supervised on an appropriate basis pertinent to their role.

Action required:

The person in charge must ensure that all staff members are made aware of the provisions of the Health Act and all regulations and rules resulting from the Act, the statement of purpose and with any policies and procedures dealing with the general welfare and protection of residents.

Action required as per immediate action plan:

The person in charge must ensure that professional development plans are in place for staff which are supported by training and education programmes. This applies to all grades of staff. A copy of these staff training plans must be submitted to the inspector by 4 May 2012

Action required:

The person in charge must ensure that staff members have access to education and training to enable them to provide care in accordance with contemporary evidence-based practice. In addition to the current training programme, staff education must include caring for residents with dementia; the management of behaviours which are challenging; the provision of meaningful activities for residents; and training in infection control prevention.

Action required:

Cleaning staff must receive training updates on cleaning practices.

Action required:

Nurses must receive opportunities to update their skills and received opportunities for professional development.

Action required:

Staff must not be employed until the provider has obtained in respect of that person the information and documents specified in Schedule 2 of the Care and Welfare Regulations.

Action required: The person in charge must ensure volunteers are vetted appropriate to their role and level of involvement in the centre.	
Reference: Health Act, 2007 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	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Action to be taken as outlined under management structure and maintenance in provider's response to action plan number 1 and in action plan number 13.	
Criteria for interview using a competency based method will be developed and implemented going forward for all staff appointments for the Maria Goretti Nursing Home. In addition revised job descriptions and person profiles will be drawn up for each frontline staff and management grade to be appointed to the centre, these will clearly outline essential experience and qualifications required by applicants for specific jobs. The external consultant will work closely with the director of nursing and providers in developing these new guidelines and criteria for selection and recruitment of staff.	31 August 2012
All staff with immediate effect will have Garda vetting prior to employment. Garda vetting will commence immediately for current volunteers in the centre.	In place
The external consultant will develop with the director of nursing an induction and orientation plan for all grades of staff recruited by the home.	30 June 2012
An external supplier is currently updating cleaning staff regarding products, their uses and cleaning standards.	In place

Outcome 15: Safe and suitable premises

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

Many maintenance issues were outstanding such as:

- overhead bed lights not working
- call bells not available to residents
- broken doors on bedroom furniture
- mismatched drawers in bedside lockers
- scuffed and chipped bedside lockers
- scuffed skirting boards and walls
- handles missing from furniture
- unsightly flexes hanging from walls
- grass not cut
- garden access curtailed
- signs on toilet door missing letters
- beds and bedside tables showing signs of rust.

There was a lot of clutter in some areas such as special mattresses on the floor in one toilet area; incontinence wear in the bath; several items left on ledges giving an untidy sense to the environment. Equipment such as the sit-on weighing scales needed to be cleaned.

Beds which had been dressed had soiled linen and stained pillow covers.

The premises and grounds were poorly maintained, the grass was uncut and minimal progress had been made in relation to the provision of a secure outdoor area.

There were no specific staff changing room or staff storage lockers.

The nurse's station did not have a proper desk on which to carry out report writing and other administrative type work.

Action required as per immediate action plan:

The provider is required to submit a maintenance plan for the premises and its environs by 4 May 2012.

Action required:

The premises must be kept in a good state of repair externally and internally.

Action required:

All parts of the centre must be kept clean, tidy and suitably decorated.

Action required:

Bed linen must be changed as frequently as may be required.

Action required as per immediate action plan: The provider is required to provide a secure garden area for residents without delay and submit to the inspector by 4 May 2012 a timeline for completion of this work.	
Action required: The external grounds must be maintained in a proper manner and made suitable and safe for use by residents.	
Action required: Adequate storage and changing facilities must be provided for staff.	
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: Action to be taken outlined under management structure and maintenance in provider's response to action plan numbers 1 and 13 above. There will be a guideline developed to direct staff in relation to the changing of bed linen. The current bed linen will be audited immediately by the provider and new bed linen sources. The provider will liaise with the person in the laundry re the proper care of bed linen. In the staff "rest room" a locked unit will be available to staff for bags/personal items. A staff changing facility/room will be included in the maintenance plan.	 In place 30 June 2012

Outcome 16: Records and documentation to be kept at a designated centre

15. The provider and person in charge are failing to comply with a regulatory requirement in the following respect: It was difficult to retrieve data pertaining to a resident. Different pieces of resident information were stored in different files and some pages of the file were loose. The directory of residents was incomplete in parts. For example, the cause of a resident's death was not recorded in one instance; there were no GP details recorded for another resident and details of where a resident had been admitted from was

absent from another.

In some instances practices outlined in the policies were not adhered to, such as the nutritional policy which stated a particular assessment tool was used when it was not; the challenging behaviour policy indicated the mini-mental state examination assessment tool was used and there was no evidence of its use.

On the day of inspection a copy of the Residents' Guide and details of the insurance cover were requested to be sent to the inspector but these were not received.

Action required:

Records held in relation to residents must be maintained in a manner so as to ensure completeness, accuracy, ease of retrieval and kept up to date.

Action required:

The person in charge must ensure that the directory of residents includes the information specified in Schedule 3 paragraph (3) of the Care and Welfare Regulations.

Action required:

The provider must ensure that all written operational policies and procedures are reviewed to make sure they are in line with actual practice.

Action required:

A copy of the Residents' Guide must be provided to the Chief Inspector.

Action required:

Details of the insurance cover for the centre must be forwarded to the inspector.

Reference:

Health Act, 2007
Regulation 21: Provision of Information to Residents
Regulation 22: Maintenance of Records
Regulation 23: Directory of Residents
Regulation 26: Insurance Cover
Regulation 27: Operating Policies and Procedures
Standard 1: Information
Standard 29: Management Systems
Standard 32: Register and Residents' Records

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: A complete review of the current system of care planning will be completed by 31 July 2012 and the revised plan will be implemented for all residents in a three-month period. All information regarding a resident will be accessible in one file, clear review dates will be entered in each care plan and review will take place in that time frame with the staff and the resident. A guideline for staff regarding the directory of residents will be developed by the director of nursing. The director of nursing will review this on a monthly basis and log that it has been reviewed. The director of nursing will emphasise to staff the importance of keeping this up to date. The provider will audit all policies and guidelines and liaise with the director of nursing where required. These documents will be reviewed by the provider annually. Review date will be noted on the document and signed each time it is reviewed. The insurance documents have been sent in the post following inspection, a copy of the Residents' Guide has been emailed to the Authority by the director of nursing. Further copies have been posted today 18 May 2012.	31 July 2012 In place and ongoing In place

Outcome 17: Notification of incidents

16. The provider is failing to comply with a regulatory requirement in the following respect: Notifiable incidents such as an outbreak of an infectious disease and the presence of pressures sores (grade 2) were not notified to the Chief Inspector as is required by regulation.
Action required: The person in charge must ensure that notice is given to the Chief Inspector without delay of the occurrence in the designated centre of an outbreak of an infectious disease and the occurrence of pressure sores which are grade 2 or greater.
Reference: Health Act, 2007 Regulation 36: Notification of Incidents Standard 29: Management Systems Standard 30: Quality Assurance and Continuous Improvement

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: Following conclusion of inspection which was held on 18 April 2012, the director of nursing clarified with the inspectors that there was no grade two pressure sore in the centre, the resident has a skin condition and is attending a consultant re same. Outbreak of infectious diseases: The director of nursing is seeking clarity from the Authority regarding this. One resident had "C" difficile condition, and the director of nursing queries if this is classified as an outbreak as it pertains to one resident only.	Completed Completed

Outcome 18: Absence of the person in charge

17. The provider is failing to comply with a regulatory requirement in the following respect: A robust management structure was not in place which resulted in poor practices developing which in turn culminated in poor outcomes for residents.
Action required as per immediate action plan: The provider is required to identify to the inspector by 4 May 2012 who has the authority to access funds which are required to upgrade and maintain the premises and who has the authority to appoint appropriate levels of management staff.
Action required as per immediate action plan: The organisational structure and support systems must be such that the nominated provider and the person in charge are supported in their roles.
Action required as per immediate action plan: The provider is required to appoint additional management personnel to assist the person in charge in carrying out her duties. Details of such appointments or details of plans for these appointments should be submitted to the Authority by 4 May 2012.
Reference: Health Act 2007 Regulation 37: Notification of Periods of when the Person in Charge is absent from a Designated Centre Standard 27: Operational Management

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response:	
Please refer to outcome 14 and 15 re management structures and maintenance. The current system is one where a staff nurse is in receipt of a responsibility allowance to have a management function in the absence of the director of nursing. The process review will assist in identifying the management grades required.	August/ September 2012.
Please refer to the attachments submitted from the providers accountant outlining the business status of the centre in action plan, submitted to the Authority on 17 May 2012. The business generates adequate cash flow in order to provide sufficient funding to ensure the safe and proper operation of the Maria Goretti Nursing Home.	Completed
All four providers in the partnership have signing authority on the account.	In place
Helen O'Mahony has the authority to appoint the appropriate complement of management staff in consultation with the other three providers and the director of nursing.	In place
Helen O'Mahony will support the director of nursing in her role.	In place

Recommendations

These recommendations are taken from the best practice described in the *National Quality Standards for Residential Care Settings for Older People in Ireland* and the registered provider should consider them as a way of improving the service.

Standard	Best practice recommendations
Standard 25: Premises	Plans to provide appropriate accommodation for hairdressing services and chiropody services should proceed without delay.
Standard 29: Management Systems	Policies should be audited to ensure compliance.
Standard 15: Medication Monitoring and Review	There should be a formal system for reviewing and monitoring safe medication management practice in conjunction with the GP and the pharmacist.
Standard 18: Routines and Expectations	A review should be conducted as to whether those residents who do not have televisions in their bedrooms would like to have one.
Standard 2: Consultation and Participation	Matters discussed at residents' meetings should be seen to have been adequately addressed.
Standard 30: Quality Assurance and Continuous Improvement	An audit of how the laundry system is working and how satisfactory residents and relatives find it should be conducted.
Standard 24: Training and Supervision	A more robust and structured induction process should be developed.

Standard 24: Training and Supervision	A training matrix to show what training staff had, when they had it and when updates were due should be maintained.
Standard 29: Management Systems	An improved communication system should be put in place to communicate maintenance issues arising.
Standard 25: Physical Environment	The general decoration of bedrooms is an area which requires attention in order to make them more comfortable and personalised.
Standard 24: Training and Supervision	More structured and regular staff meetings are needed and more engagement with staff through a staff appraisal type of initiative.
Standard 25: Physical Environment	Plans should be drawn up as to how the current multi-occupancy rooms with be restructured by 2015 in order to comply with the *National Quality Standards for Residential Settings for Older People in Ireland*.
Standard 25: Physical Environment	A bed pan washer or macerator should be installed.
Standard 26: Health and Safety	Fire alarms should be serviced on a quarterly basis.

Any comments the provider may wish to make:

Provider's response:

We the providers wish to acknowledge the support and guidance given from the Authority inspectors during their recent visit. We have gained knowledge, insight and hope to achieve the required standards as set out by the Authority in order to provide a quality service to the people in our care. We acknowledge the deficits and welcome the positive aspects in the draft report.

Provider's name: Helen O'Mahony

Date: 20 May 2012