<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Our Lady of Lourdes Care Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>ORG-0000265</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Kilcummin Village, Killarney, Kerry.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>064 664 3012</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:murray.maggie9@gmail.com">murray.maggie9@gmail.com</a></td>
</tr>
<tr>
<td>Type of centre:</td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>Melbourne Health Care Limited</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Margaret Murray</td>
</tr>
<tr>
<td>Person in charge:</td>
<td>Linda Smith</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Col Conway</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>None</td>
</tr>
<tr>
<td>Type of inspection:</td>
<td>Announced</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>70</td>
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<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>4</td>
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</table>
**About monitoring of compliance**

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

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

Regulation has two aspects:

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

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

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

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.
Compliance with Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration renewal decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times
From: 04 March 2014 10:10
To: 04 March 2014 17:50
From: 05 March 2014 08:30
To: 05 March 2014 18:50

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

<table>
<thead>
<tr>
<th>Outcome 01: Statement of Purpose</th>
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<tbody>
<tr>
<td>Outcome 02: Contract for the Provision of Services</td>
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<tr>
<td>Outcome 03: Suitable Person in Charge</td>
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<tr>
<td>Outcome 04: Records and documentation to be kept at a designated centre</td>
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<tr>
<td>Outcome 05: Absence of the person in charge</td>
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<tr>
<td>Outcome 06: Safeguarding and Safety</td>
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<td>Outcome 07: Health and Safety and Risk Management</td>
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<td>Outcome 08: Medication Management</td>
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<tr>
<td>Outcome 09: Notification of Incidents</td>
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<tr>
<td>Outcome 10: Reviewing and improving the quality and safety of care</td>
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<tr>
<td>Outcome 11: Health and Social Care Needs</td>
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<td>Outcome 12: Safe and Suitable Premises</td>
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<tr>
<td>Outcome 13: Complaints procedures</td>
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<tr>
<td>Outcome 14: End of Life Care</td>
</tr>
<tr>
<td>Outcome 15: Food and Nutrition</td>
</tr>
<tr>
<td>Outcome 16: Residents Rights, Dignity and Consultation</td>
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<tr>
<td>Outcome 17: Residents clothing and personal property and possessions</td>
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<tr>
<td>Outcome 18: Suitable Staffing</td>
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</table>

Summary of findings from this inspection
Our Lady of Lourdes was registered in June 2011 following an application to the Authority for registration as a designated centre for dependent persons. A registration inspection was undertaken in April 2011, a follow up inspection in April 2012 and further monitoring inspections in March and October 2013.

Inspection reports from all of the above mentioned inspections can be viewed on the Authority’s website, www.hiqa.ie, using centre identification number 0265.

During this registration renewal inspection, the inspector met with some of the residents and staff members and reviewed the premises, observed practices and
reviewed documentation such as residents’ nursing care plans, residents’ medical records, accident and incident logs, policies and procedures and some records maintained on staff files.

There was evidence that residents received overall a good standard of care, they had access to medical and allied health professionals and staff knew the individual resident’s needs well. However, some improvements were required in relation to:
  • the written contracts of care
  • some of the required policies and procedures
  • the directory of residents
  • maintenance of staff records
  • the premises
  • provision of staff training
  • management of some risks
  • documentation of complaints
  • provision of appropriate activities for each individual resident.

The Action Plans at the end of this report identify areas where improvements are needed to fully meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.
 Outcome 01: Statement of Purpose  
There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:  
Leadership, Governance and Management

Outstanding requirement(s) from previous inspection:  
No actions were required from the previous inspection.

Findings:  
A written statement of purpose that contained all of the information that is required as per Schedule 1 of the regulations was made available to the inspector. It accurately described the service and care that was provided.

Judgement:  
Compliant

Outcome 02: Contract for the Provision of Services  
Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

Theme:  
Leadership, Governance and Management

Outstanding requirement(s) from previous inspection:  
No actions were required from the previous inspection.

Findings:  
The provider supplied the inspector with a list that detailed the status of all the residents' contracts of care. It was identified that at the time of inspection there were nine residents that did not have an agreed contract of care within one month of being admitted to the centre. The provider outlined the various reasons for same as well as the actions being taken to get the contracts agreed with the individual residents or their representative.

There were agreed contracts of care in place for the remaining 61 residents that detailed the services to be provided as well as the standard weekly fee, however, the additional fees that were stated for involvement in the recreational activities programme
as well as chiropody were not current and it was not detailed what was being charged for physiotherapy or hairdressing.

**Judgement:**
Non Compliant - Moderate

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### Outcome 03: Suitable Person in Charge

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

**Theme:**
Leadership, Governance and Management

**Outstanding requirement(s) from previous inspection:**
No actions were required from the previous inspection.

**Findings:**
The person in charge holds a full-time post in the centre and based on information supplied to the Authority as part of the application, she is a suitably qualified registered nurse and she has the required nursing experience. There was evidence that the person in charge had a commitment to her own continued professional development as she had attended training sessions.

**Judgement:**
Compliant

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### Outcome 04: Records and documentation to be kept at a designated centre

*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).*

**Theme:**
Leadership, Governance and Management

**Outstanding requirement(s) from previous inspection:**
No actions were required from the previous inspection.

**Findings:**
In relation to maintaining the records as listed in Part 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended), there were copies of the Residents' Guide available in the centre and it
included all of the required information. There was substantial compliance in regard to maintaining medical records and there was documented evidence of insurance cover being in place.

In relation to the 18 required policies and procedures as required by Schedule 5 of the regulations being in place, three were under review at the time of inspection. These included the risk management, health and safety and records management policies and procedures. The risk management and health and safety policies and procedures will be further addressed in Outcome 7.

While there was a directory of residents in place that included the majority of information that is required as per Schedule 3 of the regulations, the cause of death of a resident was not always stated.

Records to be maintained for staff as required by Schedule 2 of the regulations will be addressed in Outcome 18.

**Judgement:**
Non Compliant - Minor

<table>
<thead>
<tr>
<th><strong>Outcome 05: Absence of the person in charge</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>

**Theme:**
Leadership, Governance and Management

**Outstanding requirement(s) from previous inspection:**
No actions were required from the previous inspection.

**Findings:**
The inspector was informed that the person in charge had not been absent for a length of time that required notification to the Chief Inspector.

The person in charge was supported in her role by three clinical nurse managers (CNMs) and the inspector formed the view based on observations in the centre that the CNMs could provide the required service in the absence of the person in charge.

**Judgement:**
Compliant

<table>
<thead>
<tr>
<th><strong>Outcome 06: Safeguarding and Safety</strong></th>
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<tbody>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>
Theme:
Safe Care and Support

Outstanding requirement(s) from previous inspection:
No actions were required from the previous inspection.

Findings:
As required by the regulations, there was a written policy on residents’ personal property and possessions. The inspector reviewed a sample of the records kept of handling any residents’ monies and appropriate procedures and documentation were in place to manage same in a transparent manner.

There was a centre-specific written policy and procedures for the prevention, detection and response to abuse. Staff that the inspector spoke with were aware of the signs and symptoms of abuse and their responsibilities with regard to reporting an allegation of abuse.

Training records indicated provision of elder abuse awareness training and this was also confirmed by staff that the inspector spoke with. However, the training records indicated that at the time of the inspection there were some staff that needed to receive elder abuse awareness training and others that required an update or refresher course.

Judgement:
Non Compliant - Moderate

Outcome 07: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Safe Care and Support

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

Findings:
The inspector found evidence of some good risk management practices:

- there was a health and safety statement
- there was an adequate supply of protective personal equipment for staff such as disposal aprons and gloves as well as anti-microbial hand gel dispensers
- appropriate infection control measures were implemented in regard to overall cleaning practices as well as laundry and waste management
- records indicated that clinical and non-clinical equipment throughout the centre was checked and maintained regularly
- lighting was sufficient, hand and grab rails were in the required places and corridors
and exits were unobstructed.

However, the risk management and health and safety policies and procedures were under review at the time of inspection so it was not clearly documented what priority hazards needed frequent monitoring to ensure the necessary control measures were in place.

Written confirmation from a competent person that all the requirements of the statutory fire authority had been complied with had been forwarded to the Authority and records that the inspector reviewed confirmed that fire equipment, fire prevention and suppression system checks were up-to-date. Training records indicated that the majority of staff had received fire safety training, however, some staff did not have any training date identified and some of the staff required an update. There was also an identified fire door that was not held open with an appropriate device.

There was potential for injury to residents as:

- possible risks associated with identified residents using cigarette lighters was not documented and the smoking area did not have all the required safety measures in place
- training records indicated some staff required moving and handling practice updates
- bed rail restraint risk assessments were not documented at least every three months or more frequently if a resident's circumstances changed
- some windows did not have the opening space restricted.

Judgement:
Non Compliant - Major

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**Outcome 08: Medication Management**  
*Each resident is protected by the designated centres policies and procedures for medication management.*

**Theme:**  
Safe Care and Support

**Outstanding requirement(s) from previous inspection:**  
No actions were required from the previous inspection.

**Findings:**  
The inspector reviewed a sample of residents’ individual medicine prescription charts and they were all clearly labelled, they had photographic identification of each resident and they were legible. There was evidence that residents’ medicine prescriptions were reviewed at least every three months by a medical practitioner.

There was an up-to-date and centre-specific written medication management policy and procedures for the ordering, prescribing, storing and administration of medicines and handling and disposal of unused or out of date medicines. Review of records and
observation of practices indicated compliance by nursing staff in adhering to professional guidelines and regulatory requirements in regard to storage and administration of medicines.

**Judgement:**
Compliant

### Outcome 09: Notification of Incidents

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

**Theme:**
Safe Care and Support

**Outstanding requirement(s) from previous inspection:**
No actions were required from the previous inspection.

**Findings:**
The inspector reviewed the records that were maintained of any incidents and accidents that had occurred in the centre and the documentation in place clearly outlined any event, the ongoing management and follow up of same.

Notifications as required by the Regulations had been forwarded to the Authority.

**Judgement:**
Compliant

### Outcome 10: Reviewing and improving the quality and safety of care

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

**Theme:**
Effective Care and Support

**Outstanding requirement(s) from previous inspection:**
No actions were required from the previous inspection.

**Findings:**
There was evidence that quality improvement activity was being undertaken as there were reports of audits of practice and associated action plans. They included reviews of nursing documentation, medication management and general infection control practices.

Residents informed the inspector that the provider, person in charge and the CNMs frequently asked them for feedback regarding the service based on their own experiences. Residents and/or their representatives had also been given opportunities to
formally provide feedback as they had completed questionnaires about their satisfaction with the service and care that was provided.

**Judgement:**
Compliant

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**Outcome 11: Health and Social Care Needs**

*Each resident’s wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. 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.*

**Theme:**
Effective Care and Support

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**Outstanding requirement(s) from previous inspection:**
Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**
Staff were observed providing care in a respectable and sensitive manner and it was obvious to the inspector that staff knew residents and their individual care needs well and this was also confirmed by residents.

There was evidence that residents had frequent review by general medical practitioners and if required they also had access to specialist medical care. Residents’ records also indicated they had access to allied health services such as physiotherapy, speech and language therapy, occupational therapy and dietician services. There was evidence that nursing staff provided care in accordance with any specific recommendations made by medical and/or allied health professionals.

In the sample of residents’ nursing records that were reviewed by the inspector there was evidence that nursing staff used well recognised assessment tools to identify specific care needs. Assessment of any resident that required bed rail restraint has already been addressed in Outcome 7.

Written nursing care plans were in place, they were up-to-date, they outlined the required care for individual residents and there was evidence they were reviewed at least every three months or more frequently if a resident’s condition or circumstances changed. The inspector found evidence that appropriate nursing care was planned and provided and residents’ progress was closely monitored, subsequently recorded and daily nursing notes were completed that were in accordance with relevant professional guidelines.
There were three staff employed to facilitate an activities programme and there was evidence that residents were provided with a variety of group and/or one-to-one activities. However, assessment of each resident’s actual capacity to undertake specific activities had not been completed and personalised social and recreational plans were not in place for all residents.

**Judgement:**
Non Compliant - Minor

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**Outcome 12: Safe and Suitable Premises**

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

**Theme:**
Effective Care and Support

**Outstanding requirement(s) from previous inspection:**
No actions were required from the previous inspection.

**Findings:**
The centre was warm, clean and tidy and residents confirmed that this was usual in the centre. The environment was bright with light decorative colours and the fittings, fixtures and furniture overall were of good quality. The necessary assistive equipment was available such as, hoists, wheelchairs, commodes and shower chairs.

There was sufficient communal space as there were various dining and lounge areas as well as places for residents to meet visitors that were separate to bedroom accommodation. There was an enclosed outdoor area for residents’ use that was accessible from within the centre and it included outdoor furniture as well as potted plants.

Bedroom accommodation consisted of single and twin rooms. There were appropriate beds and mattresses to meet residents’ needs. The design and layout of the single bedrooms provided sufficient space for each resident. However, residents’ privacy and dignity could be compromised in some of the twin bedrooms as the design and layout of the rooms did not provide adequate space around some of the beds.

There were both en suite and communal toilet and washing facilities. Upgrading was required to both of the communal shower and toilet rooms in Dun Beag unit as they were not suitably maintained. An identified twin bedroom en suite facility also required upgrade as a built-in wardrobe was located in the en suite and a curtain was in place instead of a door.

Paintwork throughout the centre was generally in a good state of repair, however, in a small number of identified bedrooms it required some attention.
Floor covering throughout the centre was generally well maintained, however, it required upgrading on the first floor in: the communal toilet next to the reception area, the main lounge and dining areas and the male communal toilet in Dun Beag unit.

Judgement:
Non Compliant - Moderate

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

Theme:
Person-centred care and support

Outstanding requirement(s) from previous inspection:
No actions were required from the previous inspection.

Findings:
A written complaints policy was available in the centre and the written procedure for making a complaint was hung in a prominent place. An independent complaints appeals process was identified.

The inspector reviewed the complaints log and the records that were maintained detailed any complaint and the management of same, however, the complainants’ level of satisfaction was not always recorded.

Judgement:
Non Compliant - Minor

Outcome 14: End of Life Care
Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.

Theme:
Person-centred care and support

Outstanding requirement(s) from previous inspection:
No actions were required from the previous inspection.

Findings:
The inspector reviewed the records of a resident who had received end-of-life care and there was documented evidence that the resident had been medically reviewed on a frequent basis and had received individualised nursing care. Upon referral specialised community palliative care services were available for residents if required. There was an
oratory in the centre with pastoral care available if requested and the inspector was informed by the provider that relatives were facilitated to stay overnight if required.

**Judgement:**
Compliant

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### Outcome 15: Food and Nutrition

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

**Theme:**
Person-centred care and support

**Outstanding requirement(s) from previous inspection:**
No actions were required from the previous inspection.

**Findings:**
Residents were provided with opportunities to eat their meals while seated at dining tables in communal dining areas and they were also facilitated to eat in their bedroom accommodation if they wished. Residents who needed assistance with eating their meals and drinking were observed being assisted by staff using appropriate techniques in a respectful manner.

Residents had access to fresh drinking water, both hot and cold drinks and snacks between main meal times.

There was evidence that residents’ individual preferences and dietary requirements were communicated to the catering staff.

There was evidence in residents’ records that their body weights were taken regularly, a well-recognised nutritional assessment tool was used frequently to monitor each resident’s nutritional status and residents that required it were closely observed for their daily food and fluid intake.

If required referrals were made to dietician services and there was documented evidence of communication of any special instructions and evidence of implementation by nursing staff of same. Residents that required specific diets and/or special consistencies of food were facilitated accordingly.

**Judgement:**
Compliant

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### Outcome 16: Residents Rights, Dignity and Consultation

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

Theme:
Person-centred care and support

Outstanding requirement(s) from previous inspection:
No actions were required from the previous inspection.

Findings:
There was evidence available that indicated residents were provided with opportunities to provide feedback regarding the service via satisfaction questionnaires as already identified in Outcome 10.

At the time of inspection independent advocacy services were not available for residents and the inspector was informed that the residents’ forum/group had ceased six months prior. The provider informed the inspector that as an interim measure residents had been approached on an individual basis for feedback and summary notes had been maintained. The records identified residents’ suggestions and requests.

There was potential for residents to have their privacy and dignity compromised as some of the twin bedrooms did not have adequate screening curtaining around the bed spaces.

There was strong evidence that family and friend contacts were maintained as visitors were welcomed at various times of the day and there were areas for residents to meet their visitors that were separate to bedroom accommodation. Home visits and outings were also facilitated as requested.

There was evidence that religious needs were facilitated and residents had access to an oratory/ prayer area within the centre.

Judgement:
Non Compliant - Moderate

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

Theme:
Person-centred care and support

Outstanding requirement(s) from previous inspection:
No actions were required from the previous inspection.
**Findings:**
Each resident had their own wardrobes to store clothing and personal items, however, some of the residents did not have adequate sized bed side lockers/cabinets. It was noted that residents were facilitated to personalise their bedrooms with items such as pictures, photos and small items of furniture and records were maintained of residents' personal property.

Laundry facilities were on-site for washing and drying of residents' personal clothing and there were arrangements in place for off-site laundering of linen. Appropriate procedures were observed to be in place for the segregation of dirty and clean laundry as well as the return of residents’ personal clothing items.

**Judgement:**
Non Compliant - Minor

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

**Theme:**
Workforce

**Outstanding requirement(s) from previous inspection:**
Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**
Both the person in charge and the provider work full-time in the centre as do the three CNMs and staff and residents confirmed they were readily available. Duty rosters were maintained for all staff, they were available for review and during the two days of inspection it was observed that the number and skill mix of staff working was appropriate to meet the needs of the current residents. This was also confirmed by residents and staff.

There was a recruitment policy, however, it did not state all of the documents that need to be maintained for staff or the process for authenticating validity of references. In the sample of staff records that were reviewed by the inspector there was some staff whereby the required documents were not maintained as required by Schedule 2 of the Regulations.

Mandatory training has already been addressed in Outcome 7. Opportunities had been provided for some staff to attend other training, such as, medication management, infection control and management of dysphagia (swallowing difficulty). However, dementia specific training had not been provided to staff.
Judgement:
Non Compliant - Moderate

Closing the Visit
At the close of the inspection a feedback meeting was held to report on the inspection findings, which highlighted both good practice and where improvements were required.

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

Report Compiled by:

Col Conway
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider’s response to inspection report

<table>
<thead>
<tr>
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<tr>
<td>Date of inspection:</td>
<td>04/03/2014</td>
</tr>
<tr>
<td>Date of response:</td>
<td>17/04/2014</td>
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Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure 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.

Outcome 02: Contract for the Provision of Services

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all residents had a contract of care agreed within one month of admission.

Action Required:
Under Regulation 28 (1) you are required to: Agree a contract with each resident within one month of admission to the designated centre.

Please state the actions you have taken or are planning to take:
The Provider strives to agree a contract with each resident within one month of admission. The provider facilitates this via a written and telephone protocol. However the provider acknowledges the inspector was provided information evidencing several contracts were not in place despite this protocol. Several contracts became compliant during the inspection and the remaining contracts are now in place. Two contracts were

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
also identified by the provider on inspection with the supporting documentation evidencing a refusal to sign at the time or in the future despite rendering the provider as non compliant under the Regulation.

**Proposed Timescale:** 16/04/2014

**Theme:**
Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
All the current fees to be charged were not detailed on the agreed contracts of care.

**Action Required:**
Under Regulation 28 (2) you are required to: Ensure each residents contract deals with the care and welfare of the resident in the designated centre and includes details of the services to be provided for that resident and the fees to be charged.

Please state the actions you have taken or are planning to take:
The provider acknowledges that despite the presence of contracts of care there was an absence of the allied health professional, therapy and hairdressing fees from this document at time of Inspection. Schedules of fees for all these services have now been included in all new contracts. Schedule of fees has also been prepared and sent out to all existing residents and their next of kins for their initialing and attachment to existing contracts of care.

**Proposed Timescale:** 30/04/2014

**Outcome 04: Records and documentation to be kept at a designated centre**

**Theme:**
Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was not a policy and procedures specific to the centre in regard to the creation of, access to, retention of and destruction of records.

**Action Required:**
Under Regulation 22 (2) you are required to: Put in place written policies and procedures relating to the creation of, access to, retention of and destruction of records.

Please state the actions you have taken or are planning to take:
The provider acknowledges a centre-specific policy was not fully evident during inspection. However data protection and research documentation were evident and an interim policy was applied as the policy was being reviewed. This policy is almost ready for staff perusal and signing.
<table>
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<tr>
<th>Proposed Timescale: 07/05/2014</th>
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<tr>
<td><strong>Theme:</strong></td>
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<td>Leadership, Governance and Management</td>
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**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The cause of death of some residents is not recorded in the directory of residents.

**Action Required:**
Under Regulation 23 (2) you are required to: Ensure that the directory of residents includes the information specified in Schedule 3 paragraph (3) of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 as amended.

**Please state the actions you have taken or are planning to take:**
The provider and the person in charge acknowledge the absence of correct records in the Directory of Residents on inspection. At time of inspection an electronic based resident records system was still being introduced in the facility. The system has taken much longer than anticipated due to delays in centre-specific applications. Since inspection all current residents are now entered into electronic directory, ceasing the paper format. The administration staff has located missing information and updated documentation.

| Proposed Timescale: 16/04/2014 |

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**Outcome 06: Safeguarding and Safety**

**Theme:**
Safe Care and Support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Not all staff had been provided with up-to-date elder abuse awareness training.

**Action Required:**
Under Regulation 6 (2) (a) you are required to: Make all necessary arrangements, by training staff or by other measures, aimed at preventing residents being harmed or suffering abuse or being placed at risk of harm or abuse.

**Please state the actions you have taken or are planning to take:**
The provider and person in charge acknowledge on the day of inspection that they provided a training matrix to the inspector which clearly identified the current status of all employees attendance at mandatory training. The provider and person in charge wish to express their absolute commitment to the safety and welfare of the residents at the facility. The continual education for all staff for the awareness of elder abuse has always been a priority with the continuous supply of training. The provider has repeated extensive mandatory elder abuse awareness training since inspection with the last session scheduled for 30 April 2014 ensuring 100% compliance for all employees with exception to those on protective leave.
### Proposed Timescale: 01/05/2014

#### Outcome 07: Health and Safety and Risk Management

**Theme:**
Safe Care and Support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
A health and safety policy that included all of the information as required by the Regulations was not in place at the time of inspection.

**Action Required:**
Under Regulation 30 you are required to: Put in place written operational policies and procedures relating to the health and safety, including food safety, of residents, staff and visitors.

**Please state the actions you have taken or are planning to take:**
The provider has reviewed the health and safety policy that was in place on day of inspection and now has all relevant documentation in place. The risk management policy is also under review to allow it to become a stand alone document with all relevant information as per Regulation 30. Priority hazards are identified as part of these policies to ensure the control measures necessary. The newly formed health and safety committee will meet for the first time on 5 May 2014 to continually improve and review processes.

**Proposed Timescale: 30/05/2014**

**Theme:**
Safe Care and Support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
A risk management policy that included all of the information as required by the Regulations was not in place at the time of inspection.

**Action Required:**
Under Regulation 31 (1) you are required to: Put in place a comprehensive written risk management policy and implement this throughout the designated centre.

**Please state the actions you have taken or are planning to take:**
The provider recognises that although there was a risk management policy on hand during inspection it did not meet all of the requirements of Regulation 31. The risk management policy is currently under review to allow it to become a stand alone document with all relevant information as per Regulation 31.

**Proposed Timescale: 30/05/2014**
**Theme:**
Safe Care and Support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Training records indicated that some staff had not received training in moving and handling and some were due a refresher programme.

**Action Required:**
Under Regulation 31 (4) (f) you are required to: Provide training for staff in the moving and handling of residents.

**Please state the actions you have taken or are planning to take:**
The provider acknowledges on the day of inspection a training matrix was provided to the inspector which clearly identified the current status of all employees attendance at mandatory training. The provider wishes to express the absolute commitment to the safety and welfare of the residents and staff at the facility. The continual training and awareness in moving and handling has always been a priority with the continuous supply of training. The provider is currently rescheduling mandatory training in this area ensuring 100% compliance for all employees with exception to those on protective leave.

**Proposed Timescale:** 30/05/2014

**Theme:**
Safe Care and Support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was potential for injury to residents as:

- possible risks associated with identified residents using cigarette lighters was not documented and the smoking area did not have all the required safety measures in place
- bed rail restraint risk assessments were not documented at least every three months or more frequently if a resident's circumstances changed
- some windows did not have the opening space restricted.

**Action Required:**
Under Regulation 31 (4) (a) you are required to: Take all reasonable measures to prevent accidents to any person in the designated centre and in the grounds of the designated centre.

**Please state the actions you have taken or are planning to take:**
The provider at all times takes all measures to prevent accidents within the centre. The Inspector identified the records of three resident that choose to smoke whilst residing at the facility and they all had an assessment tool in place identifying and recording their individual risks and capabilities which had been created in consultation with the
residents. All residents who choose to smoke are required to wear protective smoking aprons and all lighters and cigarettes must be stored in a locked cupboard at each nurses desk. All smoking takes place in two designated external areas. The outdoor smoking areas have been totally reviewed and the necessary fire protection equipment has now been installed. Staff have been prohibited from smoking on the upper external area to ensure a safe area for residents. In an effort to promote the highest standards in fire safety the provider scheduled a compulsory fire awareness session for all staff facilitated by an external consultant on 14 and 25 April 2014.

The provider strives for a restraint free environment  and bed rails are used as per assessments and resident requests as evidenced by the inspector. However, we acknowledge that despite the presence of assessments on all residents where bed rails were in place the three monthly review of assessments although carried out could have been more comprehensive. This format has now been reviewed and is being implemented as part of the electronic resident’s record system for completion by nursing staff three monthly and as required. A full assessment of all residents requiring bed rails has been performed and recorded post inspection.

The provider at all times strives to reduce the incidence of any accident and to date has no reported incidents regarding the accidental injury or escape due to lack of window restrictors. However, as a committed provider the fitting of restrictors has been actioned. The Dunbeag Unit has now received a total fit out of these restrictors. The other two units are currently awaiting the same fit out but due to the large number of restrictors required we are awaiting supply. Ongoing until 30 September 2014.

**Proposed Timescale:** 30/09/2014

**Theme:**
Safe Care and Support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
An identified fire door was not held open with an appropriate device.

**Action Required:**
Under Regulation 32 (1) (c) (i) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

**Please state the actions you have taken or are planning to take:**
The provider at all times makes adequate arrangements for detecting, containing and extinguishing fires and the provider acknowledges that during the inspection a fire door was identified to have an inappropriate device holding it in an open position. As a result the provider contacted the companies fire prevention contractors during the inspection and the outcome of this was that on 6 April 2014 an appropriate fire door opening and closure system was fitted. Fire awareness training was immediately scheduled for all staff and is now complete as a consequence of this event. The provider identified an additional fire door within the facility and this has also been fitted with the same system.
**Proposed Timescale:** 16/04/2014

**Theme:**
Safe Care and Support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Training records indicated that not all staff had received fire safety training and some were due an update.

**Action Required:**
Under Regulation 32 (1) (e) you are required to: Ensure, by means of fire drills and fire practices at suitable intervals, that the staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire, including the procedure for saving life.

**Please state the actions you have taken or are planning to take:**
The provider acknowledges on the day of inspection the inspector was provided with a training matrix which clearly identified the current status of all employees attendance at mandatory training including fire safety training. The provider wishes to express their absolute commitment to fire safety and welfare of the residents and staff at the facility. The continual training and awareness in fire safety has always been a priority with the provision of continuous training and the provider engaged in late 2013 to create a facility based fire training programme. The facility manager with a team of staff joined an external consultant and developed a centre-specific program. The programme was introduced with personalised training sessions to facilitate individual groups such as night staff as well as residents. The provider has now supplied two further mandatory fire safety training sessions by the contracted external fire consultant as per our centre-specific program ensuring 100% compliance for all employees with exception to those on protective leave.

**Proposed Timescale:** 16/04/2014

**Outcome 11: Health and Social Care Needs**

**Theme:**
Effective Care and Support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
While there was evidence that residents were provided with a variety of group and/or one-to-one activities, each resident’s actual capacity to undertake specific activities had not been completed and personalised social and recreational plans were not in place for all residents.

**Action Required:**
Under Regulation 6 (3) (d) you are required to: Provide opportunities for each resident to participate in activities appropriate to his/her interests and capacities.
Please state the actions you have taken or are planning to take:
The provider has always provided a superior activities and social programme and the residents have always been provided with opportunities to participate in activities that are meaningful, purposeful, that suited their needs, interests and capacities. A full range of activities are facilitated by three activities coordinators seven days per week as per the evidenced timetable and rosters. The provider identified to the inspector that due to the electronic resident records system being implemented since 2013 the written documentation regarding the full assessment of individual's needs pertaining to social needs were not as per the Regulations. Since the inspection the assessment tool continues to be implemented whilst the electronic system is being compiled by the IT company.

Proposed Timescale: 30/05/2014

Outcome 12: Safe and Suitable Premises

Theme:
Effective Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The design and layout of some of the twin bedrooms did not provide adequate space around some of the beds.

Action Required:
Under Regulation 19 (3) (f) you are required to: Ensure the size and layout of rooms occupied or used by residents are suitable for their needs.

Please state the actions you have taken or are planning to take:
The provider and the person in charge based on their experience in the provision of elderly care services are confident that a high standard of care is and will always be provided ensuring person centred care to all residents. We are confident that the location, design and layout of the premises are suitable for its stated purpose. It is accessible, safe, spacious, well maintained and meets the individual and collective needs of residents in a comfortable and homely method.

We acknowledge that some of the rooms do not meet the criteria and trials have been carried out in these rooms as to the use of assistive equipment where it is currently required. Better outcomes were also achieved by some minor changes to the arranging of furniture for use of these devices. Screening to ensure privacy is currently also under review. Building professionals have been engaged to advise on the more difficult room configurations. The provider and person in charge are at all times cognisant of the placement of any resident residing at the centre. Our comprehensive pre-admission assessments and conditions specified in the contract of care aid the suitability of placement in relation to meeting specific needs of residents’ at all times. It is envisaged that the required work will be undertaken incrementally in bedrooms 111,112, 114 and 115 between July 2014 and June 2015.
Proposed Timescale: 30/06/2015

Theme:
Effective Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The communal shower and toilet rooms in Dun Beag unit were not maintained in a suitable state of repair.

An identified twin bedroom en suite facility also required upgrade as a built-in wardrobe was located in the en suite and a curtain was in place instead of a door.

Action Required:
Under Regulation 19 (3) (b) you are required to: Ensure the premises are of sound construction and kept in a good state of repair externally and internally.

Please state the actions you have taken or are planning to take:
The provider and the person in charge are committed to maintaining a high standard of construction and repair in the centre. The levels of resident and family satisfaction are well evidenced throughout the many years of delivering elderly services to the community in this area. The communal shower and toilet rooms have been reviewed by maintenance team and the repairs have commenced. The provider acknowledges the less than ideal existence of a curtain rather than a door in the twin bedroom identified.

A temporary door is in the process of being fitted to this bathroom and the provider is awaiting the company’s building professionals to comment on a more permanent fixture. Due to the capital investment to configure this area the works required are currently being reviewed, assessed and quotes are being sought by the company’s building professionals. The provider is confident that the layout is suitable for its purpose; the area is hygienic, accessible and well maintained. It is envisaged that all of the required work will be completed by 30 June 2015.

Proposed Timescale: 30/06/2015

Theme:
Effective Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Paintwork in a small number of identified bedrooms required attention.

Floor covering required upgrading on the first floor in: the communal toilet next to the reception area, the main lounge and dining areas and the male communal toilet in Dun Beag unit.

Action Required:
Under Regulation 19 (3) (b) you are required to: Ensure the premises are of sound construction and kept in a good state of repair externally and internally.
Please state the actions you have taken or are planning to take:
The provider has reviewed the continual maintenance schedule to this unit and has addressed all painting issues with the maintenance department. The continuous maintenance of paintwork is currently being addressed and proposed time frame is 30 May 2014.

Floor covering to the two toilet areas have been assessed and are scheduled for replacement with proposed time frame 17 June 2014.

Flooring to dining and lounge area is of a laminate nature, although scratched is subject to a three times per day cleaning schedule with monthly buffing and sealing maintenance. The replacement of both of these floors requires a significant capital outlay and the provider believes it currently meets the needs of the residents.

Proposed Timescale: 17/06/2014

Outcome 13: Complaints procedures

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The complainants level of satisfaction was not always documented.

Action Required:
Under Regulation 39 (7) you are required to: Maintain a record of all complaints detailing the investigation and outcome of the complaint and whether or not the resident was satisfied.

Please state the actions you have taken or are planning to take:
The provider is committed to the delivery of excellence in care and service and has at all times maintained a record of all complaints detailing our investigations and outcome. The process is regularly audited and the process altered depending on outcomes. The provider acknowledges that although the outcome was documented it may not have reflected the level of customer satisfaction on all entries. The complaints register has now been reviewed and altered to reflect this non-compliance.

Proposed Timescale: 16/04/2014

Outcome 16: Residents Rights, Dignity and Consultation

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some twin bedrooms did not have adequate screening curtaining around bed spaces.
**Action Required:**
Under Regulation 10 (c) you are required to: Provide residents with privacy to the extent that each resident is able to undertake personal activities in private.

**Please state the actions you have taken or are planning to take:**
The provider is working with the companies building professionals currently. If the provider is to comply with Regulation 10 (c) but also observe Regulation 19 (3) ( f ) the addition of screening may not be adequate. To comply with all Regulations the built in wardrobes would need to be removed in the identified bedrooms and stand alone smaller units would be put in their place, also the relocation of a door in one of the identified rooms to facilitate the resident’s privacy to the extent of being able to undertake personal activities in private. A number of the rooms identified are situated in the new registered build of 2009, therefore, to be highlighted in this outcome was unexpected. Therefore capital expenditure needed had not featured in our current strategic plan. Where possible the provider has provided extra screening and repositioned furniture to comply in the interim. Proposed timescales for the required work are: completed in Deenagh Unit, Tus Nua Unit 30 August 2014 and Dun Beag Unit 6 March 2015.

**Proposed Timescale:** 06/02/2015

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**Outcome 17: Residents clothing and personal property and possessions**

**Theme:**
Person-centred care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Some residents did not have adequate sized bed side lockers/cabinets.

**Action Required:**
Under Regulation 7 (3) you are required to: Provide adequate space for a reasonable number of each residents personal possessions and ensure that residents retain control over their personal possessions.

**Please state the actions you have taken or are planning to take:**
The provider at all times ensures the person-centred care of all residents living in the centre, however, the provider acknowledges the deficit on day of inspection in the older section of the centre (DunBeag Unit) and has replaced 16 lockers that were deemed unsuitable.

**Proposed Timescale:** 16/04/2014

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**Outcome 18: Suitable Staffing**

**Theme:**
Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement**
in the following respect:
Staff had not been provided with relevant end of life care or dementia specific training.

Action Required:
Under Regulation 17 (1) you are required to: Provide staff members with access to education and training to enable them to provide care in accordance with contemporary evidence based practice.

Please state the actions you have taken or are planning to take:
The provider and the person in charge had provided an extensive schedule of training in 2013 to ensure evidence based practice and the delivery of high standards of person-centred care. We collectively support and encourage staff at all levels to keep their knowledge base current. Training needs were established for each staff member by way of appraisal system. The provider and person in charge identified deficits in end of life care on the day of inspection. The person in charge and provider had only recently attended the Authority’s information sessions and had published the facility’s end of life care policy in the preceding weeks. The person in charge was in the process of planning for an ongoing education programme for all staff at time of inspection.

The provider recognises that dementia specific education had not been delivered in 2013. Due to a change in the person in charge position the delivery of many other specialist subjects as well as staff availability meant the usual training updates in this area of interest were not scheduled during 2013. The person in charge has now established a programme of training for 2014.

Proposed Timescale: 17/05/2014

Theme:
Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The recruitment policy did not include all of the documents that are to be maintained for staff or the procedure for verifying the authenticity of references.

Action Required:
Under Regulation 18 (1) you are required to: Put in place written policies and procedures relating to the recruitment, selection and vetting of staff.

Please state the actions you have taken or are planning to take:
The provider is committed to the recruitment of suitable, fit persons to work at the centre. The Provider has reviewed the policy available on the day of inspection and all documentation as set out in Regulation 18 (1) has now been added to the policy. The procedure for verifying authenticity of references has been reviewed and the recruitment policy has been altered to reflect Regulation 18 (1). The human resource manager has been furnished with a copy of the newly reviewed policies and has been requested to review all staff files in line with these changes.
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
All of the required documents were not maintained for staff.

Action Required:
Under Regulation 18 (2) (a) and (b) you are required to: Put in place recruitment procedures to ensure no staff member is employed unless the person is fit to work at the designated centre and full and satisfactory information and documents specified in Schedule 2 have been obtained in respect of each person.

Please state the actions you have taken or are planning to take:
The provider adheres to the company recruitment procedures and is aided by an external human resource provider to ensure the highest levels of compliance. The provider supplied the inspector with a matrix of all employees and their status as to their compliance with Regulation 18 (2) (a) and (b) and Schedule 2 on inspection. The provider also evidenced to the inspector proof of the relentless efforts made to obtain the specified documentation under this Regulation and the continual methods of engagement with the staff to obtain compliance. Several of the missing documents have already been supplied to the human resource manager and he continues to liaise with staff who have failed to supply documents with a deadline set in place.

Proposed Timescale: 30/05/2014