<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Our Lady’s Manor Nursing Home</th>
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</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0004632</td>
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<tr>
<td>Centre address:</td>
<td>Dublin Road, Edgeworthstown, Longford.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>043 667 1007</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:adminolm@newbrooknursing.ie">adminolm@newbrooknursing.ie</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>Newbrook Nursing Home</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Philip Darcy</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Catherine Rose Connolly Gargan</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>44</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>11</td>
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About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.
Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

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

The inspection took place over the following dates and times

<table>
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<tr>
<th>From:</th>
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<tr>
<td>09 October 2014 10:00</td>
<td>09 October 2014 17:30</td>
</tr>
<tr>
<td>10 October 2014 09:00</td>
<td>10 October 2014 18:00</td>
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The table below sets out the outcomes that were inspected against on this inspection.

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<th>Outcome 01: Statement of Purpose</th>
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<td>Outcome 02: Governance and Management</td>
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<td>Outcome 03: Information for residents</td>
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<td>Outcome 04: Suitable Person in Charge</td>
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<td>Outcome 05: Documentation to be kept at a designated centre</td>
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<td>Outcome 06: Absence of the Person in charge</td>
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<td>Outcome 07: Safeguarding and Safety</td>
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<td>Outcome 08: Health and Safety and Risk Management</td>
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<td>Outcome 09: Medication Management</td>
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<td>Outcome 10: Notification of Incidents</td>
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<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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<td>Outcome 13: Complaints procedures</td>
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<td>Outcome 14: End of Life Care</td>
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<td>Outcome 15: Food and Nutrition</td>
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<td>Outcome 16: Residents' Rights, Dignity and Consultation</td>
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<td>Outcome 17: Residents' clothing and personal property and possessions</td>
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Summary of findings from this inspection

This was the tenth inspection of the centre by the Authority and was completed in response to an application by the provider to renew registration and for change of entity from Lady Edgeworth Nursing Home to Newbrook Nursing Home. The provider nominee who is also the CEO and directors will remain unchanged with the change of entity. All required application documentation was received as required by the Authority. The person in charge is Paula Gavagan. The inspector found that she was knowledgeable and met all the requirements of the legislation for the person in charge role.

The inspector reviewed all eighteen outcomes in addition to progress with completion of the action plan from the last inspection of the centre on 13 March 2014 to assess
compliance of the centre with the legislation and standards. The inspector found that all actions plans were satisfactory completed. The Authority received information from members of the public in three cases which were notified to the provider and are under investigation in two cases with requested additional information provided to the Authority as required.

During the inspection the inspector met with residents, relatives and staff members. Residents who could verbalize their views were also complimentary about the meals provided, choices, the staff team who cared for them and the level of recreational activity provided. The Inspector found that residents and relatives were also generally positive in their feedback to inspectors on the day of inspection and expressed satisfaction with the facilities, services and care provided. Nine pre-inspection questionnaires were returned, five completed by residents in the centre and four by relatives of residents. Overall feedback was positive with regard to the aspects of the quality and safety of the service surveyed with the exception of one relative who expressed dissatisfaction with management of their relatives clothing which was communicated to the provider and person in charge. The inspector findings in relation to management of residents' personal possessions including clothing evidenced compliance with the regulations on this inspection. This finding is further discussed in outcome 17 of this report.

The premises were found to be fit for purpose. Although adequate, the layout of one three bedded room required review to ensure that the floor space available was maximized for each resident given the large amount of space available. Television viewing arrangements also required review to ensure each resident had uninterrupted viewing enjoyment.

Other areas requiring improvement found on this inspection included care plan development for each residents assessed needs. The guidelines for subcutaneous fluid administration required review to inform staff when initiation of fluid is appropriate, especially in circumstances where medical prescription facilitates nurse autonomy and critical decision making.

The Action Plan at the end of this report identifies improvements that must be made to 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.
Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

### Outcome 01: Statement of Purpose

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

**Theme:**  
Governance, Leadership and Management

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

**Findings:**  
There was a written statement of purpose for Our Lady’s Manor Nursing Home which consisted of a statement of the aims, objectives and ethos of the centre, detailed the facilities and services provided for residents and contained information in relation to the matters listed in schedule 1 of the Regulations. A copy of the statement of purpose was forwarded to the Authority. It was last updated on the 02 September 2014. The provider was aware of the need to keep the document under no less often than annual review. The statement of purpose provides a clear and accurate reflection of the facilities and services provided and are implemented in practice in the centre.

**Judgment:**  
Compliant

### Outcome 02: Governance and Management

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

**Theme:**  
Governance, Leadership and Management

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

**Findings:**
There was a clearly defined management structure in place that identified the lines of accountability and authority in addition to evidence that the provider worked with the person in charge on a consistent and supportive basis in the governance and management of the centre. The inspector observed that meetings were held at multiple staff levels. The person in charge told the inspector that this practice ensures good inter-team communication, gave staff a forum to address issues and promoted interdisciplinary team cohesion to ensure staff were informed and supported to comprehensively meet residents’ needs as described in the statement of purpose document.

The inspector found that there were sufficient resources in terms of facilities, staffing, skills and equipment to ensure effective delivery of care in accordance with the centre’s statement of purpose on the days of inspection. Service records were reviewed and found to be up to date. There was evidence that staff could get equipment for residents to meet their needs. A procurement template was made available to the person in charge to be used for ordering resources. A monthly meeting was scheduled and minuted between the provider and person in charge with risk management in the centre as a standing agenda item.

The inspector found that there was a culture of quality monitoring and improvement with systems in place to ensure that the service provided was safe, appropriate to meet resident needs, consistent and regularly monitored. Improvements in the quality and safety of the service and the quality of life for residents in the centre from review were evidenced. An auditing schedule was established to ensure aspects of the quality and safety of care and the quality of the residents’ experience in the centre were monitored. The inspector reviewed a safety audit completed earlier in the year which was analysed and presented in the form of an action plan with completion dates stated. The action plan was reviewed on the 18 September to ensure completion of the actions stated. While the inspector found that there was comprehensive auditing of many aspects of the service including quality of meals for residents with individual analysis and completion of quality improvements, action completion timescales were not always stated and action was taken in some areas in the absence of a stated area of deficit. This practice of not stating deficits found posed a risk of areas requiring improvement being missed and weakened the effectiveness of the review process.

Judgment:
Non Compliant - Minor

Outcome 03: Information for residents
A guide in respect of the centre is available to residents. Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

Theme:
Governance, Leadership and Management

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

Findings:
The residents’ guide available which was reviewed by the inspector and found to be frequently updated to reference any changes to keep residents informed. It contained all the information as required by the legislation. The information in this document functioned to assist prospective residents to make a decision regarding choosing a placement and also informed current residents of the services available to them.

The centre published a quarterly newsletter that was found to be populated with interesting information including reminiscence articles provided by residents, the activity schedule, the history of the centre, a staff profile and information on a health issue of interest to residents.

Each resident had a written contract of care which outlined the services provided and the fee to be paid to the centre. Charges for other services available to residents were included. The centre did not charge residents for social activities. All contracts of care reviewed were signed and dated. The inspector observed that many residents signed their own contract of care.

Residents had access to a hairdresser who attended the centre; a price list was displayed to enable residents to make a choice about the service they required.

Judgment:
Compliant

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

Theme:
Governance, Leadership and Management

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

Findings:
The person in charge of the centre is Paula Gavagan. She was appointed in this role on 20 January 2014. She is a registered general nurse with Bord Altranais agus Cnáimhseachais na hÉireann. She has completed a postgraduate gerontology course and has three years experience in her previous role as person in charge of a designated centre for older people.

The person in charge worked in the centre on a full-time basis. There was adequate evidence of positive developments made since she commenced in her role in January 2014 to support clinical practice including care plan documentation review with an aim...
of promoting enhanced person-centred care and strengthening resident assessment and documentation of resident care needs. She demonstrated that she was engaged in the governance, operational management and administration of the centre on a consistent basis. The person in charge was knowledgeable about individual resident's needs and their individual choices. Residents knew the person in charge and the inspector observed residents consulting with her.

During this inspection the person in charge demonstrated that she had good knowledge of the Regulations, the Authority's Standards and her responsibilities as person in charge of the centre. The person in charge is supported in her role by a clinical nurse manager and a team of nursing staff, care assistants, catering administrative and ancillary staff. The group clinical practice co-ordinator also attends the centre one day per week or more often to support development and implementation of new initiatives. Administrative systems were well established and documentation was accessible, information was easy to retrieve and was managed with appropriate attention to security of residents' personal information.

**Judgment:**
Compliant

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

**Theme:**
Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
The inspector found that 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) were maintained in a way so as to ensure completeness, accuracy and ease of retrieval. There was evidence of adequate insurance against accidents or injury to residents, staff and visitors.

All of the written operational policies as required by Schedule 5 of the Regulations were available and up to date.

The directory of residents was reviewed and found to contain all required information.
Records to be maintained in respect of each resident as described by the regulations were in place.

**Judgment:**
Compliant

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**Outcome 06: Absence of the Person in charge**

_The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence._

**Theme:**
Governance, Leadership and Management

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

**Findings:**
The provider and person in charge were aware of their responsibility to notify the Chief Inspector of the absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during her absence. The person in charge had not been absent from the centre for more than 28 days to date.

The deputy person in charge was working in the centre on the day of the inspection and was met by an inspector. She was knowledgeable about residents care and social needs.

**Judgment:**
Compliant

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**Outcome 07: Safeguarding and Safety**

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

**Theme:**
Safe care and support

**Outstanding requirement(s) from previous inspection(s):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
The inspector found that there were satisfactory arrangements in place to safeguard
residents on this inspection. Arrangements were put in place following findings requiring improvement during the last inspection of the centre in March 2014 in relation to monitoring of completion of the visitors' book and staff training in protection of vulnerable adults. A CCTV viewing unit located in the staff office enabled staff to monitor and control access to the centre. A receptionist worked from a location inside the front door to the centre and monitored access while on-duty five days per week. The front doors were secured and staff assumed access control when the receptionist was off duty.

The inspector was provided with a copy of a staff training record which confirmed that all staff had completed training in elder abuse prevention, recognition and management. All staff files reviewed on the days of inspection had evidence of completed appropriate vetting procedures. Staff spoken with were knowledgeable with regard to their role and responsibilities in protecting residents and reporting any suspicions or disclosures made to them. A policy document titled prevention and protection of residents from elder abuse was dated 01 June 2014 to inform staff. This policy was supported by a procedure document advising staff on responding to suspicion, allegation or evidence of abuse or neglect and dated 01 May 2014. A whistle blower policy dated 10 March 2014 was also available to support staff with disclosure if necessary.

Residents spoken with by the inspector and entries in pre inspection resident questionnaires supported residents' feelings of safety. Residents said they 'were treated with respect' 'staff were kind and went out of their way to assist' them. The inspector observed staff - resident interactions on the days of inspection and found that while all staff interactions were satisfactory and responsive, some staff members went to good lengths to support residents with challenging behaviour in response to a diagnosis of dementia. Call bells were observed to be answered promptly by staff.

There was evidence that any incidents of staff interactions with residents of a less than adequate standard were fully investigated and residents were adequately protected while investigated. From investigation documentation reviewed and actions taken, the inspector observed evidence of a 'no tolerance' attitude by the provider and person in charge for less than respectful and appropriate resident care practices by staff.

Resident finances were reviewed as part of this registration renewal inspection process. The provider acts as agent for collecting some residents’ pensions and some residents’ monies was lodged into their named account within the account for the centre. On review of this practice, inspector found that all procedures involving residents’ finances were transparent and residents were able to access their money when they wished. Supporting policy and procedural documentation to inform management of residents' finances were reviewed during inspection to ensure that all aspects of this arrangement was supported and informed by a comprehensive policy. This policy was dated 26 August 2014. Residents had access to a lockable facility in their bedroom.

A policy document was in place to inform management of behaviour that challenges exhibited by residents and promotion of a positive approach to managing same whilst supporting the resident concerned. The person in charge informed the inspector that some of the residents currently residing in the centre exhibited behaviour that challenged. Some staff had attended training in managing challenging behaviour and
Judgment:
Compliant

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

Theme:
Safe care and support

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

Findings:
The centre had a risk management and health and safety statement in place that had been reviewed on 06 June 2014. A risk management strategy document dated 15 August 2014 informed risk management activity in the centre. Two Health and Safety representatives, nominated by staff had attended two days training to prepare them for their role and seven staff had attended training on risk management. The centre's health and safety representatives attend quarterly risk management meetings with the provider, person in charge and the group practice development co-ordinator. In addition risk management was a standing item on the agenda of the monthly governance meetings in the centre.

The risk register was reviewed by the inspector and found to be comprehensive in that all risks were identified with concomitant controls in place. The inspector observed that a risk identification and assessment process had taken place to protect residents, staff and visitors from accidental injury during recent refurbishment work to the exterior grounds around the centre including the access roadway. Traffic calming measures were in place. A Health and Safety audit was completed on 11 July 2014 with evidence that the risk register was updated following same. This audit was revisited on the 18 September 2014 by the provider to ensure controls in place to mitigate risks identified were effective. There was evidence of learning from serious incidents involving residents informed by a process of root-cause analysis of all such incidents. The inspector found the outcomes of same to be meaningful following in-depth critical analysis with both proactive and reactive measures identified to correct deficits and prevent reoccurrence.

There were four residents identified in the risk register as being at increased risk as they engaged in smoking. While each resident was individually risk assessed, other measures were put in place to enhance emergency procedures in the event of an adverse incident to any of this resident group including a smoking apron and a full body blanket in the vicinity of the designated smoking room. The missing person procedure was tested by a
drill and a resource box was held in preparation for emergency action in response to a vulnerable resident leaving the centre unaccompanied. The box was observed to contain a profile of each resident with their photograph to assist the emergency services in expediting their recovery if necessary, torches, whistles and high visibility vests. Vulnerable residents identified as being at risk of leaving the centre unaccompanied were enabled to go outside accompanied by staff. The inspector observed one vulnerable resident walking with a staff member through the walled garden.

Risk assessments were also completed for residents using of bedrails, restraint, the use of hazardous substances, the management of clinical waste and infection control. These assessments were centre specific, current and reviewed regularly. As the centre comprised of three floors, lift access was in place in addition to a staircase between each floor. Staircases were risk assessed and the top and last steps of each staircase were coloured red to alert users to change in floor level. In addition the top of each staircase had a stair-gate fitted to mitigate risk of injury to vulnerable residents.

The centre had weekly access to a minibus and was also risk assessed with stated controls to mitigate risks identified.

During inspection in March 2014, the inspector observed that the surface of the drive into the centre was uneven and posed a risk of trip or fall to residents and visitors who chose to walk on it. This risk was found to be resolved on this inspection with tarmac ad surfacing throughout. Speed restriction and alert signage was appropriate placed to advise motorists of potential pedestrian hazards.

Fire safety arrangements were reviewed and satisfactory arrangements were in place. The inspector found that staff were aware of the procedures to follow in the event of the fire alarm sounding. Nearest exits were clearly stated and fire action signs were displayed at regular intervals throughout the building to guide staff and residents in an emergency. The inspector observed that horizontal evacuation procedures were in place supported by compartment configuration of the building throughout. Staff training records confirmed attendance of all staff at annual fire training and participation in fire drill simulation. Evidence of night and day time drills was documented as completed to ensure staffing levels were adequate to execute evacuation if necessary. In addition to testing of personal emergency evacuation plans developed for each resident which detailed their equipment and staff resource needs to evacuate safely. Fire alert and fire fighting equipment was serviced regularly as required. A checking schedule of fire preventative and safety procedures was routinely completed and documented. A declaration of fire safety compliance was received by the Authority as part of the application for renewal of registration documentation.

Safe moving and handling training was documented as completed by all staff in response to the last inspection in March 2014. The group physiotherapist attended the centre twice weekly and was involved in assessing residents’ moving and handling needs.

**Judgment:**
Compliant

**Outcome 09: Medication Management**
Each resident is protected by the designated centre’s policies and procedures for medication management.

Theme:
Safe care and support

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

Findings:
The inspector carried out a review of medication prescription and administration records belonging to residents in the centre and attended a medication round in the centre. Discontinued medications were signed and dated by the residents’ GP and maximum doses of 'as required' (PRN) medications were stated. The medication management policy was dated 30 January 2014 and informed all aspects of medication management practices. Inadequate facsimile prescription procedures were identified on the last inspection in March 2014, the inspector found that this procedure was satisfactory on this inspection and was supported by a policy document.

A medication error was recorded in the incident records in September 2014 and evidenced that the resident concerned did not suffer any adverse effects. A medication competency assessment was completed with the staff member concerned in addition to refresher training. All newly recruited staff nurses to the centre undergo a medication competency assessment as part of their induction procedures and assessment. Most staff nurses had completed medication management refresher training on the days of inspection as referenced on staff training records.

Residents who were allergic to individual medications had the medication concerned clearly stated and highlighted on a yellow background on their medication prescription sheets. The inspector observed that each resident's medication was stored in a secure press in their bedrooms. While none of the residents choose to self administer their medication, the person in charge told the inspector that the arrangements in place where medication is stored in the each resident’s room promoted a sense of ownership and control over their medicines. The inspector attended a medication administration round and found that all practices during same were in line with professional standards. The staff nurse used this time as an opportunity to inform residents about the medication they were prescribed. A pain management assessment chart was available to assist with management and monitoring of pain experienced by residents.

The pharmacist who supplied many of the residents’ medications was well known to them and was facilitated to meet his obligations to residents including giving talks to residents on health topics of interest to them, for example a talk on insomnia. The pharmacist completed a comprehensive medication audit and supported procedures for return of out of date or unused medications.

Judgment:
Compliant
Outcome 10: Notification of Incidents
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

**Theme:**
Safe care and support

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

**Findings:**
A record of all incidents that occurred in the centre was maintained and was classified into incident types for ease of access. All notifications were forwarded to the Authority as required by the legislation. The inspector observed reference to the requirement to send notification in policy documents such as the falls management and protection policies.

Any serious incidents where residents sustained an injury underwent root cause analysis examination to identify areas for improvement and learning to prevent recurrence.

**Judgment:**
Compliant

Outcome 11: Health and Social Care Needs
Each resident’s wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident’s assessed needs are set out in an individual care plan, that reflect his/ her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/ her changing needs and circumstances.

**Theme:**
Effective care and support

**Outstanding requirement(s) from previous inspection(s):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
There were 44 residents accommodated over three floors on the days of inspection.

Their assessed dependency levels were 14 residents with maximum care needs, 7 with high dependency needs, 12 with medium dependency needs and 11 with low dependency needs.

Residents in receipt of long term care had a variety of age related conditions, some of which were complex including dementia and challenging behaviour. Comprehensive assessment of needs included mental well-being. Each resident had a mood and
behaviour pattern, cognitive and emotional status, mental health and anxiety/depression assessments. There were 11 residents exhibiting challenging behaviour symptoms. Six of which presented with intermittent episodes of verbal aggression, two had intermittent physical aggression and two residents were vulnerable and at risk of leaving the centre unaccompanied. One of these two residents wore an alert bracelet which activated if the resident passed through the doors to go outside the centre. All residents had access to psychiatry of older age services and together with staff in the centre were generally supported with positive behaviour strategies to promote their quality of life in the centre and mental well-being. The inspector observed staff guiding, reminding and orientating residents with memory deficits to ensure they were involved in the daily life of the centre and were afforded opportunities to participate where able or desired.

The Authority received information in relation to the health and personal care of a resident, which was being investigated by the provider and person in charge at the time of this inspection.

The inspector reviewed a sample of residents care plans and associated documentation in addition to speaking with residents on the days of inspection. The person in charge confirmed to the inspector that none of the residents had pressure related skin breakdown. All residents were assessed and those identified as being 'at risk' had a variety of pressure relieving equipment in place including mattresses and cushions incorporated into their care to mitigate potential risk.

The inspector found that residents had good access to allied health professionals. A physiotherapist was employed by the group and provided residents with consistent rehabilitative care and assessment post falls on a weekly basis. Many residents spoken with spoke positively about the physiotherapy service provided and attributed the service was to their improved mobility and recovery. In addition residents had various items of specialist assistive equipment supplied, prescribed by the physiotherapist on assessment to promote their independence and safety.

An occupational therapist assessed residents’ needs as required, some residents had assistive chairs. The inspector was informed that when a resident required an assistive chair they were afforded opportunity to trial a variety of suitable chairs and make a choice on the one they preferred with the support of the occupational therapist.

Residents dietary risk of malnutrition assessment was reviewed weekly using an accredited tool. The provider employed the services of a dietician on a contract basis to ensure timely accessibility for all residents but especially those at increased risk of dietary imbalance. There was also evidence of assessment by speech and language therapy services and recommendations made by all health professionals were translated in practice in the resident documentation reviewed on the days of inspection. Residents had access to GP services and there was evidence of regular review and as required. Palliative care services were attending two residents in the centre with life limiting illnesses.

Each resident had a care plan informed by comprehensive assessment procedures. Each care plan was in a folder which also contained relevant information including contract of care, record of personal possessions and records of documented consent by residents or their families to various procedures including photography. The inspector found the care plans reviewed to be personalised and interventions prescribed reflected residents’
personal choice and routine. The person in charge and the practice development co-
ordinator had worked on improving accessibility of information on interventions to meet
residents’ needs since the last inspection in March 2014. The inspector found that care
plans were developed in response to assessed needs for all residents evidenced in the
documentation reviewed with the exception of one resident. This resident was blind and
did not have an activity/recreation care plan or a care plan to manage an assessed
medium risk of pressure related skin damage. However, the inspector observed from an
audit completed that this resident required enhanced contact by staff to avoid isolation
arising from a personal choice to remain in their bedroom. A schedule of room visits was
put in place as an outcome to meet her needs. However, in the absence of a
documented care plan to address this area, there is a potential risk of overlooking
assessment of the value of the visiting schedule to ensure this intervention was
adequate and demonstrated in positive outcomes for this resident. Daily progress notes
were completed by nurses in addition to a daily record by care staff which enhanced
evaluation of care interventions.

The inspector observed a comfortable and relaxed atmosphere in the centre, on the
days of inspection. This finding was enhanced by the numerous communal rooms and
areas off corridors provided for residents in addition to space for residents to move
around the centre. Activities were provided on two floors under the leadership of an
activity co-ordinator. The inspector observed that the management team also promoted
the role of carers in making each interaction meaningful for residents and as such this
resulted in an enhanced quality of life for residents in the centre. Activities were
facilitated on the first floor for residents with advanced dementia care needs which the
inspector observed. These activities were individualised resident focused sensory based
pursuits and were observed by the inspector to interest and engage the residents
positively. Completion of a sensory based activity training programme by staff facilitating
activities for residents with dementia would further support and underpin good practices
observed with theoretical knowledge and in turn further benefit residents with dementia
care needs.

All communal areas were adequately supervised by staff on this inspection. Some
residents told the inspector that they enjoyed the activities arranged for them and that
they could choose whether they wanted to participate or not.

Judgment:
Non Compliant - Moderate

Outcome 12: Safe and Suitable Premises
The location, design and layout of the centre is suitable for its stated purpose
and meets residents’ individual and collective needs in a comfortable and
homely way. The premises, having regard to the needs of the residents,
conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and
Welfare of Residents in Designated Centres for Older People) Regulations
2013.

Theme:
Effective care and support
**Outstanding requirement(s) from previous inspection(s):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
Our Lady’s Manor Nursing Home has been extended and modified since registration by the Authority in 2012. A major refurbishment programme including the existing original house was undertaken and this work to the building structure and fabric is now fully completed to a good standard. The centre interior provides a spacious and comfortable environment for residents with a variety of communal areas. Residents are accommodated over three and a half floor levels. The reception and main communal spaces is located on the ground floor. The basement and upper floors can be accessed by stairs or by means of a spacious passenger lift. A level off the second floor is accessible by a ramp with handrails fitted on both sides.

Redesign of a large twin room in the past year on the first floor to a sitting room was observed to improve the communal facilities for residents accommodated there who may not wish to access the communal area on the ground floor. An area off the reception that was part of the original internal building was recently refurbished in the style of a traditional kitchen and a living room to provide additional communal space for residents including an area where they could avail of quiet time or meet their visitors in private. This work was managed so as not to impact on the residents’ safety or quality of life.

The centre has a large dining room adjacent to the main kitchen area, which comfortably accommodates the residents in the centre for one sitting at mealtimes.

Residents have access to a large oratory which is also used by the local community for removals and funeral services. Toilet facilities were observed to be within close proximity to communal areas. In recent times, circulating corridors were individually named and painted in a variety of colours with handrails painted in contrasting colours to enhance orientation and safety for residents with dementia care needs. Residents' bedroom doors were each individually painted also in a variety of colours to assist residents with orientation needs to access their bedrooms. This action afforded residents greater autonomy and increased independence. All bedrooms provided a combination of single and twin occupancy with the exception of one three bedded room. The floor space in the residents' bedrooms varied however, each met size, privacy and dignity requirements as outlined in the Authority's Standards and where provided en suite facilities were spacious and contained a toilet, shower and wash-hand basin.

The inspector reviewed the three bedded room to ensure privacy, dignity and space needs of residents could be met. The inspector found that the floor space of the room measured 55 meters squared providing each resident with floor space of 18.33 meters squared. The layout of the room required review to ensure each resident was afforded floor space available. One large screen television was available in the room which also required review to ensure each resident was provided with choice of television viewing. Each resident currently had adequate wardrobe space which they could access and retain control over. While there was potential space for personal items and storage of possessions, personalisation of their personal space required enhancement by provision
of shelving. The room has a spacious en-suite shower, toilet and wash basin with grab rails in contrasting colours to assist residents with visual or dementia care needs.

Environmental temperatures were monitored throughout and the inspector found temperatures to be maintained at levels in line with the standards. Hot water temperatures were thermostatically controlled so as not to exceed 43 degrees centigrade at the point of contact by residents.

A walled vegetable and flower garden was available to residents who wished to go there. Paths were in place throughout. There was also an enclosed landscaped garden which could be used by vulnerable residents. Seating was available at intervals around this garden.

Hand hygiene facilities were provided and used appropriately by staff. The centre was clean and well organised throughout. Most residents’ rooms were personalised with photographs and ornaments and in some cases items of the residents' own furniture. The surfaces of the external roadway were recently resurfaced with tarmacadem with traffic calming measures in place.

**Judgment:**
Non Compliant - Moderate

**Outcome 13: Complaints procedures**

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

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

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

**Findings:**
A complaints log was maintained in the centre and there were arrangements for complaints to be followed through to satisfactory resolution. Verbal feedback from residents or resident’s representatives was welcomed and arrangements were in place for recording same in line with regulatory requirements. The inspector observed that three complaints were recorded in the log with adequate documentation recording investigation. Satisfaction by complainants of outcome was ascertained. The complaints procedure was prominently displayed and the requirements of the regulations were met in terms of the process. There was one complaint under investigation at the time of inspection. An appeals procedure was in place if complainants were dissatisfied with the outcome of investigation by the centre.

The inspector observed that there was evidence of learning with concomitant service improvements following investigation of complaints. Staff were encouraged to take
ownership of complaints made and to be involved in action plans. Some residents spoken with were aware of the process and identified mainly the person in charge or other staff members as the people whom they would communicate with if they had any issue of dissatisfaction. Residents spoken with told the inspector they did not have cause to complain to date. There was a named advocate available if required by residents and a process was in place for auditing the complaint procedure.

**Judgment:**
Compliant

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**Outcome 14: End of Life Care**

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

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

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

**Findings:**

The inspector reviewed the end of life policy dated 17 February 2014. The policy informs staff on procedures for last offices, property of the deceased and post mortem. While there were two residents in receipt of palliative care services, there were no residents in receipt of end of life care on the days of this inspection. A review of residents' care plans evidenced that their end of life wishes were discussed and documented. Members of the local religious congregation provide pastoral and spiritual support to residents who are at the end stage of their lives in addition to clergy from the various religious faiths. The centre has a large oratory which is available to residents if they wish for removal and funeral services. A room adjacent to the church within, but separated from the residents' accommodation is used by the centre to provide sandwiches and refreshments for mourners at services in the oratory following the death of a resident in the centre. The person in charge told the inspector that residents who deceased in the centre are removed to the church to facilitate other residents and staff to pay their respects. The centre has adopted the Hospital Friendly Hospice symbol which is displayed to inform of the death or impending death of a resident in the centre.

Settlement of fees was not initiated in respect of deceased residents until one month after their death. Information received by the Authority in September 2014 evidenced dissatisfaction with care of a resident after death and a deficit in staff knowledge in relation to end of life care of a resident in 2012. The inspector found on inspection that the policy on end of life care practices had been updated this year to inform staff practice. In addition end of life care was already identified by the person in charge following staff competency assessment as an area requiring improvement. The inspector observed that the person in charge and practice development co-ordinator were in the
process of developing an experiential learning programme for staff to support policy documentation and classroom learning in this area of resident care. In addition, staff training was scheduled for October 2014 by the Irish Hospice Foundation. The centre provides accommodation and refreshments for relatives of residents at the end stage of their lives to facilitate residents to have their families with them at this time.

**Judgment:**
Compliant

**Outcome 15: Food and Nutrition**

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

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

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

**Findings:**

There was satisfactory evidence that residents were provided with adequate fluid and dietary intake to meet their needs on the days of inspection. The inspector found that each resident’s individual nutritional and dietary needs were met and that they were offered a nutritious and varied diet that provided them with choice of a hot dish at each mealtime. The inspector observed residents at mealtime and found that those that required assistance received same in a dignified and discrete way by one of three members of staff who were assigned to ensure residents were appropriately assist if necessary. Many residents used mealtimes as a social occasion and chatted with others at their table. The menu was clearly displayed and was also placed on the dining tables for residents’ convenience. The person in charge in consultation with the dietician changed the main drink available at mealtimes to milk to enhance residents’ nutritional intake. Residents who did not like milk were offered an alternative.

Residents had access to fresh water in their bedrooms and communal areas. Staff were observed to engage in monitoring and encouraging residents to take fluids and fluid balance charts observed were completed and totalled. The inspector observed that one resident had a low fluid intake and while prescribed for subcutaneous fluids if required, there was no clear indication or treatment protocol in place to advise when subcutaneous fluid administration should be initiated. There was a policy document available to support staff in all aspects of nutritional and hydration care including percutaneous endoscopic gastrostomy (PEG) feeding and subcutaneous fluid administration procedures. Residents’ weights were monitored and those identified as at risk had evidence of monitoring and review by dietetic services. One resident was receiving close monitoring and while their weight was low, all supports were in place including food fortification recommended by the dietician. There had been no further
weight loss since January 2014. The chef was aware of and accommodated residents with specific nutritional support needs, support plans and preferences. The chef had copies of the recommendations made by speech and language and dietetic therapy services. Care plans were in place to inform care of residents with nutrition and hydration needs which were satisfactorily linked to monitoring and treatment plans and were evaluated in daily progress notes.

The dining room was spacious. Residents spoken with told the inspectors that they enjoyed the food provided in the centre. Staff training was in place to inform staff on use of the nutrition assessment tool in assessing and monitoring procedures, food fortification and fluid thickening procedures used.

**Judgment:**
Compliant

**Outcome 16: Residents' Rights, Dignity and Consultation**
Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

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

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

**Findings:**
The inspector was satisfied that residents were enabled to make choices about how they lived their lives in a way that reflected their individual preferences and diverse needs. There were monthly residents' meetings chaired by the activity coordinator which were minuted. There was evidence of action taken in response to issues raised by residents at this forum, for example, residents wanted to be able to post their letters and a postbox was installed to facilitate same. Some residents wanted their bedrooms to be warmer which resulted in a change in the heating system to a more efficient sustained system being installed. A window changing programme was also completed to improve temperature control in bedrooms. The inspector observed that residents views were valued in decisions on the décor of the centre.

There were many examples where residents were encouraged and facilitated to maintain their independence, for example residents who were assessed as able were facilitated to go outside the centre. Some other residents went independently to the local town. A small shop was recently opened in the centre to facilitate residents to buy personal items and was stocked by the centre.
There was a communication policy in use to inform communication strategies especially with residents who had illnesses and medical conditions that resulted in them having communication deficits. The Inspector also observed that residents had a variety of local and national newspapers available to them and some were observed reading them. The centre also had a mobile phone which residents could use if they wished to speak to relatives in private. Residents' confirmed that they had regular visitors and could choose where they would like to meet them. There was a residents’ communication board where items of interest to the residents were displayed.

Residents’ privacy and dignity needs were observed to be met on the days of inspection as described in the centre’s statement of purpose document. Mass was celebrated each morning in the centre’s oratory and was attended by a large number of residents. There were arrangements in place to ensure the needs of residents of non catholic faiths.

Judgment:
Compliant

Outcome 17: Residents' clothing and personal property and possessions

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

Theme:
Person-centred care and support

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

Findings:
The inspector found that residents had adequate space to store their clothes and personal belongings. Residents could retain control over their personal possessions. There was a policy to inform management of residents' personal property and possessions which was up to date. A record of each resident’s property was completed and up to date in their care plan documentation. The centre does not have access to a laundry on-site and residents clothing is sent for laundering to one of the other centres owned by the company with daily collection and delivery arrangements in place. Linen collection skips were available that appropriately segregated used linen in line with the national policy. Residents spoken with told the inspector that their clothing was managed to their satisfaction. The inspector observed that clothing worn by residents and stored in a sample of wardrobes reviewed were in good condition and were clean. Items of residents clothing viewed by the inspector had the residents identification on them.

Loss of items of residents' clothing was the subject of an action plan developed from
findings during inspection in July 2013. While these complaints were resolved to the satisfaction of the residents concerned, information received by the Authority in August 2014 referenced that residents’ clothing was not adequately segregated and posed a risk of further loss of items of residents’ clothing. This area continues to require close monitoring to ensure residents’ clothing is managed securely and residents do not experience loss of personal possessions.

Inspectors observed that there was adequate space provided for residents’ clothing, personal property and possessions in their rooms. Residents also had access to a locked facility in their bedrooms for secure storage of personal possessions.

**Judgment:**
Compliant

**Outcome 18: Suitable Staffing**

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

**Theme:**
Workforce

**Outstanding requirement(s) from previous inspection(s):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
The staffing rota confirmed that there was a registered nurse on duty in the centre at all times. The inspector was informed by the person in charge that staffing levels were reviewed on an on-going basis to meet the changing needs of residents and were increased where necessary to meet the needs of residents who were assessed as requiring high levels of care. The inspector found evidence that the staff numbers and skill mix on the days of inspection were appropriate to meet the needs of residents accommodated in the centre.

The inspectors were provided with copies of the staff rotas and staff files as requested which were reviewed to assess compliance with the legislation in each case. The duty rotas given to the inspectors for review referenced the full name of all staff working in the centre and hours of duty worked as required. The staffing rota reviewed indicated that the person in charge position was staffed five days per week.

There was a recruitment policy in place and the sample of staff files reviewed contained the required documentation. A record of the current registration details of all staff
nurses working in the centre was maintained and was up to date.

The majority of care staff had Further Education and Training Awards (FETAC) Level 5 training due mainly to care staff recruited been required to have this qualification and staff employed for some time were facilitated to attend this training. The person in charge ensured that staff had adequate training appropriate to their roles. All staff had attended mandatory training in fire safety, protection of vulnerable adults and safe moving and handling procedures. Additional training was facilitated to support staff competency skills and professional development. The company employs a practice co-ordinator who was on-site for most of the inspection and attended the feedback meeting. She provides training and clinical support to staff and the person in charge in the centre at least weekly. Members of the staff team spoken with verbalised their commitment to providing a good service to the residents in their care. They were observed by the inspector to be responsive and effective in meeting residents' needs. Residents spoken with spoke well of the staff in the centre and were complimentary of the respect and kindness shown to them by staff. One resident said he ‘felt cared about’. Residents spoken with also spoke positively in relation to staff competence and skill in meeting their needs. Staff spoken with were knowledgeable about the residents' needs. Residents told the inspector that they felt safe said that call bells were answered promptly when they required help.

**Judgment:**
Compliant

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**Closing the Visit**

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

**Acknowledgements**

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

**Report Compiled by:**

Catherine Rose Connolly Gargan
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider’s response to inspection report

<table>
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<th>Centre name:</th>
<th>Our Lady's Manor Nursing Home</th>
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<td>09/10/2014</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 the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

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

Outcome 02: Governance and Management

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<th>Theme:</th>
<th>Governance, Leadership and Management</th>
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The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The monitoring process required improvement to explicitly state outcomes of analysis of some quality and safety audits, documentation of actions to be taken to resolve deficits with concomitant timescales for completion of same.

Action Required:
Under Regulation 23(c) you are required to: Put in place management systems to

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The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
ensure that the service provided is safe, appropriate, consistent and effectively monitored.

**Please state the actions you have taken or are planning to take:**
We will in the future ensure that any action plans arising from audits have stated the area of deficit and include a completion/review date.

Proposed Timescale: Completed

**Proposed Timescale:**

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

**Theme:**
Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all residents had a documented care plan to meet all their assessed needs.

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

**Please state the actions you have taken or are planning to take:**
Care plans are being reviewed on an ongoing basis to ensure that they meet the assessed needs of the residents.

**Proposed Timescale:** 28/02/2015

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**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 layout of a three bedded room accommodated by residents required review to ensure each resident’s needs were met.

Personalisation of residents’ space in the three bedded room was compromised by the absence of adequate shelving.

Each resident in the three bedded room did not have unobstructed and freedom of choice with viewing the television provided in the three bedded room.
**Action Required:**
Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

**Please state the actions you have taken or are planning to take:**
The layout of the three-bedded room is currently under review to ensure that the room meets the privacy and dignity of the residents.

The following specific actions will be taken:

1) Additional shelving/bookcases will be provided where appropriate.
2) An additional TV will be provided.
3) The layout of the room will be reviewed to assess if any additional measures need to be taken.

**Proposed Timescale:** 28/02/2015