<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Sancta Maria Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000449</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Gallow's Hill, Cratloe, Clare.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>061 357143</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:sanctamarianursinghome@gmail.com">sanctamarianursinghome@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>Olivia English</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Olivia English</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Mary Moore</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>Paul Dunbar</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Unannounced</td>
</tr>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>27</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>2</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.
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 un-announced and took place over 2 day(s).

The inspection took place over the following dates and times
From: 08 April 2015 08:50 To: 08 April 2015 18:00
From: 09 April 2015 08:00 To: 09 April 2015 18:00

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

<table>
<thead>
<tr>
<th>Outcome Description</th>
<th>Our Judgment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome 02: Governance and Management</td>
<td>Non Compliant - Major</td>
</tr>
<tr>
<td>Outcome 03: Information for residents</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 04: Suitable Person in Charge</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 05: Documentation to be kept at a designated centre</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 07: Safeguarding and Safety</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 08: Health and Safety and Risk Management</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 09: Medication Management</td>
<td>Non Compliant - Major</td>
</tr>
<tr>
<td>Outcome 11: Health and Social Care Needs</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 12: Safe and Suitable Premises</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 13: Complaints procedures</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 14: End of Life Care</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 16: Residents’ Rights, Dignity and Consultation</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 18: Suitable Staffing</td>
<td>Non Compliant - Moderate</td>
</tr>
</tbody>
</table>

Summary of findings from this inspection
This inspection was the seventh inspection of the centre by the Authority and was undertaken to follow-up on the action plan that issued from the previous inspection undertaken on the 5 and 6 November 2014; that inspection was undertaken to inform a renewal of registration application. The November inspection findings were not satisfactory and a substantial level of regulatory non-compliance was evidenced. Of the eighteen outcomes inspected in November 2014 the provider was judged to be compliant with four, in minor non-compliance with one, in moderate non-compliance with seven and in major non-compliance with six. The non-compliance was in the areas of governance, measures in place and actions taken in response to allegations of abuse, the management of complaints, residents rights dignity and consultation, staffing levels and staff supervision.
Given the concerns of the Authority a meeting with the provider was convened on the 21 November 2014 to discuss the non-compliance and the improvements required. The provider articulated its commitment to its legal obligations and improvement, and identified in the response to the action plan the measures to be taken by the provider to address the identified failings. This current inspection was undertaken to evaluate the implementation of that action plan and judge if the improvement noted was satisfactory.

There were thirty residents living in the centre and two vacant beds; three of the thirty residents were in the acute hospital service at the time of inspection.

The provider was on annual leave and the inspection was facilitated by the person in charge and senior staff nurse. Inspectors were satisfied that they articulated a clear understanding and acceptance of the previous serious failings. It was evident that the provider had taken action including commissioning, in addition to the improvement action plan issued by the Authority, an independent review of aspects of the service to identify the learning and improvement required. There was no evidence of dispute or denial of failings and poor findings; there was evidence of insight and learning. As discussed in the relevant outcomes of this report front line staff articulated an evidence based understanding of behaviours that challenged; there was evidence of the fair and transparent management of complaints. Advocacy services from a recognised service were made available to residents. Measures had been taken to strengthen the governance structure, staffing resources and staffing levels including the appointment of a new person in charge.

Based on the evidence available to inspectors the provider was judged to have satisfactorily addressed twenty-two actions; eight actions were not satisfactorily addressed. The failings identified resulted in the issuing by the Authority of an immediate action plan in relation to medication management; the remaining failings were addressed in the standard action plan and required further action to be taken by the provider in the areas of governance, safeguarding residents, complaint management, end of life care, access to required healthcare and adequate recordkeeping.
Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
As outlined in the provider's response to the action plan measures had been taken to strengthen the existing governance structure.

Prior to this the provider had also assumed the role of person in charge but the roles were now segregated and a new person in charge was appointed on the 23 February 2015. The role of person in charge was fulltime and supernumerary to allow for the supervision of staff, care and services. The staff rota indicated that both the person in charge and the provider were present in the centre on a daily basis Monday to Friday and available to staff on an on call basis at weekends. The person in charge confirmed that she had daily access to the provider. While the governance structure was new feedback received from staff was positive in relation to supportive working relationships.

The provider had allocated additional staffing resources (in addition to the person in charge) and defective equipment for residents had been replaced.

The provider had contracted an independent person to undertake a review of the service in response to the previous inspection findings and three reports emanated from this review and were made available to inspectors; review of complaints and allegations management; health and safety audit and a staffing level report. While further work was required the recommendations from these reports were largely addressed. In addition the person in charge confirmed that staff had completed audits on areas including pressure area care, falls and resident privacy and dignity. Additional measures taken included the completion of meaningful staff appraisals and the integration of all staff into the daily verbal handover to ensure the communication of information to guide appropriate care.
It was reasonable for inspectors to conclude that the focus of the provider since the last inspection were the core regulatory failings and the implementation of the action plan. However, this inspection identified significant failings in medication management systems that required the issuing by the Authority of an immediate action plan; failings were also identified in the facilitation of timely medical care and the maintenance of adequate nursing records. Senior nursing staff spoken with articulated clear responsibility and accountability for the identified failings.

Therefore while improvement was evident inspectors concluded that management systems did not at all times ensure that the service and care provided to residents was safe, appropriate and responsive to residents needs, consistent and effectively monitored.

**Judgment:**
Non Compliant - Major

### 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):

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

**Findings:**
Inspectors were satisfied that contracts of care were now in line with regulatory requirements. The provider had undertaken a review of the contract template on foot of the last inspection findings. All existing residents and new admissions had received a revised contract of care. The contract set out the responsibilities of the provider in terms of the provision of care and services. There was also a section which outlined the fees to be paid by each resident and the additional fees charged for other services not included in the basic fee e.g. chiropody, hairdressing.

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

Findings:
Prior to this inspection the provider had acted as both provider and person in charge. As outlined in the response to the last action plan and as notified to the Authority, the provider appointed a person to the role of person in charge on 23 February 2015 and continued solely as the registered provider.

The newly appointed person in charge was on duty and facilitated the inspection; the provider was on annual leave. The person in charge worked full-time Monday to Friday, was suitably qualified and evidence of her current registration with her regulatory body was available for inspection. The person in charge had the required experience having worked in the area of nursing older persons for the past six years.

The person in charge had completed further relevant education and training including a management development programme in 2011, the prescribed mandatory training in 2014 and 2015, end of life care and medication management training.

The person in charge articulated a solid understanding of regulatory roles and responsibilities, was familiar with the previous inspection findings and the actions taken to effect improvement. The person in charge demonstrated a sound understanding of the needs of the residents and their required supports.

Staff spoken with said that the person in charge set the required standard of care and services to be met on a daily basis in a fair and reasonable manner.

There was evidence that the provider had sought the documents specified in Schedule 2 for the person in charge. However, the person in charge had two concurrent recent employers and there was only one reference in place in respect of a last employer and this person was also the current employer.

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

Findings:
While the actions that emanated from the last inspection had been satisfactorily addressed further failings in the maintenance of records listed in Schedule 3 were identified by inspectors.

The centre now had a closed-circuit television (CCTV) policy implemented which outlined the measures to ensure security of the centre as well as the privacy and dignity of the residents. The centre had also completed and implemented an accident and incident policy and procedure in line with the commitment given in the provider's response to the action plan.

All files relating to nursing staff contained evidence of current registration with their professional body.

The inspectors reviewed all of the nursing staff files in the centre as well as a sample of files relating to other staff grades. With the exception of one file (this is addressed in outcome 4) all of the files reviewed were found to have the documentation required by Schedule 5 of the Regulations.

While there were still some reported challenges there was documentary evidence that the provider sought to secure a record of all medical referrals, follow-up medical appointments, treatment and care provided. Where one record was noted not to be in place there was documentary evidence that this was due to circumstances beyond the control of the provider and the relevant General Practitioner (GP). This will require ongoing monitoring by the provider.

As discussed in medication management based on a random sample of records seen a record of each medication administered signed and dated by the nurse administering the medication was not maintained in accordance with professional body guidelines.

As discussed in outcome 11; Health and social care needs and outcome 14; End of Life care, an adequate and accurate nursing record of the person's health, condition, treatment given, discussions held and changes made was not at all times maintained.

Judgment:
Non Compliant - Moderate

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

**Findings:**
Five actions relating to failings identified in the measures to protect and safeguard residents were issued to the provider by the Authority following the last inspection. In response to the action plan the provider commissioned a further independent review completed over a three month period of complaints and allegations management; seven recommendations were issued from that review.

Three of the actions issued by the Authority were substantially addressed; the recommendations from the review were partially addressed and this was reflected in the findings of this inspection.

A concern for inspectors in the context of the previous inspection findings was the ongoing lack of clarity in policy and practice between a complaint and an allegation of abuse; some staff spoken with were not clear on the difference. The policy on protection which was reviewed by the provider in December 2014 used the terms "complaint" and "allegation" interchangeably and made strong reference to complaints procedures such as recording any alleged abuse as a complaint and referring the person who made the allegation to the "external complaints manager" if they were dissatisfied with the investigation. In the context of the previous inspection findings and the findings of the internal review the policy on protection was not sufficient; clear unequivocal safeguarding policy and procedure was required that allowed for definitive decision making and appropriate investigation utilising the most appropriate protective procedures based on national policy and best practice.

Inspectors reviewed staff training records. The provider had provided recent training in three areas relating to protection and safeguarding, that is to say, abuse, behaviours that challenge, complaints management. Records seen indicated that the format of the training was devised based on staff interviews to ensure that the training was specific to the needs of the centre. Overall inspectors were satisfied that staff articulated learning. Staff spoken with demonstrated an improved understanding of the nature of abuse including potentially its covert nature; greater understanding of the aetiology of behaviours that challenged and how to respond appropriately, empathetically and safely to behaviours that challenged. All staff were clear on the reporting structure should they receive an allegation of abuse. However, staff were unaware of any requirement to document an allegation they had received. This requirement was set out in the provider's abuse policy.

Staff demonstrated an increased awareness of behaviours that challenge and were able to explain to inspectors how they would manage such situations. For example, a number
of staff outlined similar interventions employed in the centre to manage a named resident. This information concurred with the plan of care in place for the resident as seen by the inspector. Staff were also aware of residents' behaviour support plans and knew how to access these on the centre's computer system. The inspector reviewed the system for planning care to avoid and manage behaviours that challenged and found that it was much improved. Behaviours were recorded in the form of an "ABC" chart (antecedent, behaviour and consequence) and care plans were resident and behaviour specific. The care plan set out for staff the nature of the behaviour, the identified triggers and most importantly the interventions to be taken to avoid triggering or escalating behaviours. However, all staff including senior nursing staff were not clear as to how many behaviour management plans were in place. One resident identified by staff as exhibiting behaviours that challenged did not have a care plan in place. The lack of clarity amongst staff would not support that regular staff meetings to discuss behavioural management plans as recommended by the independent review were taking place; minutes of meetings available for inspection indicated that staff meetings were infrequent.

There was evidence of referral to other healthcare professionals such as the GP and mental health services as part of the overall care plan.

The centre had introduced a new system for managing residents' finances. The centre's administrator was responsible for operating this system. All financial transactions were now logged on the centre's computer system. Residents (or their next of kin) received an invoice for services provided on a monthly basis. The invoice detailed the residents' income and stated all of the charges incurred e.g. (accommodation, activities, chiropody etc). Inspectors found that the system was clear and transparent. There was also a 'virtual pocket money' system in place which allowed residents to purchase items within the centre (e.g. cigarettes, newspapers).

Judgment:
Non Compliant - Moderate

**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 provider had reviewed the risk management policy since the last inspection by the Authority. There was now a risk assessment in place for abuse. In addition, the risk register contained the arrangements for the identification, recording, investigation and learning from incidents and accidents.
The previous inspection had identified some deficits in relation to fire safety measures. The inspectors were satisfied that the provider had satisfactorily addressed these matters as outlined in the providers response to the action plan. The work of external service providers (that is to say, alarm technicians, electricians) was now documented and signed off by the senior nurse on duty when completed. This was to ensure that there were no outstanding fire, health and safety concerns upon completion of the work.

There were daily checks being carried out by staff at the centre to ensure that all fire exits were unobstructed. Inspectors viewed a fire exit which was the subject of concern on the previous inspection and found that it was accessible and there were no personal items obstructing it. A fire exit that had a step had previously been inappropriately identified for use in the evacuation of a dependent resident. The provider had now addressed this issue and amended the PEEP. In addition, a redundant key box had been removed.

To augment the catering department staffing resource the provider allocated staff whose primary responsibility was environmental hygiene to the catering department at peak activity times. While staff confirmed that their duties there consisted solely of household rather than food preparation it was not clear if procedures were in place to minimise risk and ensure compliance with food safety requirements.

Judgment:  
Substantially Compliant

<table>
<thead>
<tr>
<th><strong>Outcome 09: Medication Management</strong></th>
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<tbody>
<tr>
<td><strong>Each resident is protected by the designated centre’s policies and procedures for medication management.</strong></td>
</tr>
</tbody>
</table>

**Theme:**  
Safe care and support

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

**Findings:**  
Several failings were identified in the medication management cycle. Practice was significantly non-complaint with regulatory body guidance for nurses on medication management. Given the risk identified the provider was issued with an immediate action plan to ensure that there were safe medication management processes in place including the management of prescriptions, the transcription of prescriptions, the supply of medications, the administration of medications and the maintenance of a record of all medications administered. The provider was also instructed to ensure that there was an effective system in place for reviewing and monitoring the safety of medication management practices.
Nursing staff confirmed that they continued to transcribe prescription records on a routine basis. The records in place were seen to be dated as transcribed in March 2015 and had been countersigned by the relevant GP. Based on a random sample of three transcribed records (10% of the residents currently living in the centre) the inspector noted;
- transcribing errors in that the transcribed record did not correspond to the medication supplied by the pharmacist on the basis of the original prescription
- discrepancies between the administration instructions on labels issued by the pharmacy and the instructions on the transcribed record
- errors in the transcribed dose. For example one original prescription was for 62.5 micrograms (mcg) but was transcribed as 62.5 milligrams (mgs)
- unsigned and undated hand written instructions on a pharmacy printout stating that a medication was discontinued in December 2014 but the medication was still prescribed on the transcribed record dated March 2015
- trade names and generic names for prescribed products were both in use and it was clear that all nursing staff did not have sound knowledge of the generic names used on the transcribed record. It was therefore difficult to see how the accuracy of supplied medications was established as trade names were generally seen to be utilised by the pharmacy
- there was evidence of poor reconciliation of medication regimes when a resident returned to the centre from another healthcare facility. When the inspector reconciled the transcribed record, the pharmacy record of supply and the most recent prescription from the acute services there was a minimum of 15 discrepancies noted between the records
- nursing staff confirmed that none of the records corresponded to the medication supplied
- nursing staff confirmed that despite the discrepancies identified above by inspection there was no evidence (with the exception of one noted on an undated post-it) to support that they had been identified by staff responsible for the administration of medication. Medication was supplied in a medication administration aid "blister-pack". The content of one was checked by nursing staff in the presence of the inspector and it did not correspond with the transcribed record; it did appear to correspond with the most recent original prescription. This prescription was not however in use to guide administration practice and it was therefore not evident how nursing staff verified the accuracy of the prescription and the medications prior to the administration of the content of the blister-pack. This reasonably equated to a medication error but had not been identified as such
- of the three residents reviewed there was no record maintained of medications administered to them on four separate occasions on the days prior to and on the first day of inspection.

Judgment:
Non Compliant - Major

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:
That action that emanated for the last inspection related solely to the management of behaviours that challenged including their assessment and the planning of care that was objective, evidence based and therapeutic as opposed to subjective and problem focussed as was evidenced at the time of the last inspection. The provider had largely addressed these identified failings and this has been discussed in outcome 7: Safeguarding and Safety.

In conjunction with the poor findings in medication management the inspector reviewed the nursing and medical notes of one resident and was concerned that adequate arrangements were not in place to meet the resident’s assessed needs, to maintain health and wellbeing and prevent ill-health. The inspector noted that:
- the resident did not have access to medical review and care that was timely and appropriate to needs
- there was insufficient timely oversight and follow-up of medical review and treatment to ensure well-being and the prevention of ill-health
- an inadequate nursing record was maintained of care and treatment provided, all discussions held and changes made.

The inspector saw that a request for medical review made by nursing staff on the 13 March 2015 with documentary evidence of repeat requests by nursing staff was not facilitated until the 23 March 2015.

There was no evidence to support the follow-up of blood profiling undertaken on the 23 March 2015.

There was no evidence to support the follow-up of a medical query raised in relation to prescribed medications and a fluid restriction regime.

There was no evidence to support how and by whom a fluid intake restriction regime was increased by 500mls daily. While records were maintained of daily fluid intake some seen by the inspector were poorly maintained and none were totalled making it difficult to see how they evidenced compliance with any fluid management plan.

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:
Overall inspectors were satisfied that the provider had implemented the actions required for improvement.

Inspectors saw and staff confirmed that the laundering of general linen had been outsourced and was no longer undertaken in the centre; only residents’ personal clothing was now attended to in the centre. Staff reported good satisfaction with the laundry service and confirmed that adequate stocks of linen were always available.

There was evidence of the repair of defective plasterwork and paintwork.

Overall the centre presented as visibly clean and free of unpleasant odours; the provider had allocated an extra staffing resource to environmental hygiene. Staff with responsibility for environmental hygiene spoke positively of the benefit of the extra resource as it facilitated a rota of focused or “deep” cleaning in addition to the cleaning required on a daily basis. Staff maintained a cleaning schedule and a record of cleaning completed that was signed off on a daily basis by staff and the nurse on duty.

There was evidence of the provision of new equipment to residents including bed-tables and lockers. There was evidence of some that still required replacement but the person in charge was aware of this and the precise number and confirmed that they were scheduled for replacement.

While there was no physical alteration to the available dining space, two sittings were provided for lunch and staff were heard to ask residents if they wished to dine in the main dining room.

Judgment:
Compliant

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

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

**Findings:**
The provider had taken measures to improve the management of complaints within the centre. However, inspectors noted that the action taken did not sufficiently address all of the identified failings and some actions from the previous inspection had not been satisfactorily implemented.

The complaints procedure was displayed in more locations throughout the centre. The centre's complaints policy had been revised in December 2014. The policy identified the person in charge as the complaints officer and an external independent reviewer was available for appeals. In the event that the complaint was about the person in charge the provider was to refer the complaint to an external independent reviewer. However, this is contrary to the action plan response which stated that the person in charge and the provider were both to be complaints officers. The policy also continued to fail to identify a person who would oversee the management of complaints, that is to say, ensure that all complaints are appropriately responded to and that records of complaints were maintained as required by Article 34(3).

In the context of the previous concerning inspection findings, inspectors concluded that there remained an element of confusion in policy and in practice in relation to the distinction between a complaint and an allegation. The centre's policy on abuse used the words 'complaint' and 'allegation' interchangeably. In addition, a number of staff who spoke to inspectors had differing interpretations of what was meant by complaints and allegations. This may correlate to the fact that all staff had received recent training in abuse whereas only 15 staff had received complaints management training. It was intended that all staff would receive complaints management training. This is discussed further under outcome 7: Safeguarding and Safety and outcome 18: Suitable Staffing.

The centre had implemented a new method of documenting and recording complaints on a computerised system. Inspectors reviewed five complaints which were made and logged since the date of the last inspection and found that they were managed in line with regulatory requirements. There was evidence that complainants were listened to, of the investigation and learning from the complaints, of actions taken to address the matters complaints of and the level of satisfaction of the complainant was noted. Actions recorded as taken were seen to be reasonable and proportionate and respected the right of the complainant to complain.

**Judgment:**
Non Compliant - Moderate
**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):**
Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**
As outlined in the provider's response to the previous inspection findings the end of life care policy had been reviewed and there was an explicit record in place for communicating to staff resident specific end of life care decisions/interventions. However, based on a random sample of four explicit decisions to attempt or to not attempt resuscitation reviewed by the inspector, only one of the four decisions was supported by an explicit record of discussion between the resident and nursing and medical staff. The remaining three including an instruction to not attempt resuscitation were not supported by an end of life care plan or any evidence of any discussion including medical review to support how and by whom the decision had been made. While nursing staff spoken with said that discussion had taken place there was no record of these discussions available for inspection.

**Judgment:**
Non Compliant - Moderate

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

**Findings:**
There was evidence of good practice noted and acknowledged at the time of the last inspection. However, the provider overall was judged to be in major non-compliance.
with the requirements of this outcome due to failings in safeguarding and safety and the management of complaints that resulted in the failure to respect and promote the rights and dignity of all residents at all times. Despite the evidence of good practice this resulted in the issuing of four action plans under this outcome.

Inspectors were satisfied that senior nursing staff articulated a clear understanding and acceptance of the previous serious failings. It was evident that the provider had taken action including commissioning an independent review of aspects of the service to identify learning and improvement required in addition to the improvement action plan issued by the Authority. There was no evidence of dispute or denial of failings and poor findings that would indicate to inspectors a risk of reoccurrence. As discussed in the relevant outcomes of this report staff articulated an evidence based understanding of behaviours that challenged, there was evidence of the fair and transparent management of complaints, the use of CCTV had been rationalised. Advocacy services from a recognised service were made available to residents. There was evidence of supports put in place for residents to enhance their level of satisfaction and their quality of life such as access to structured day care services. There was no evidence to support that any resident who had complained since the last inspection was adversely effected by virtue of having made the complaint.

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:
Inspectors were satisfied that the actions identified by the provider as required for improvement were substantially addressed.

The provider had commissioned an independent review of skill mix and staffing levels; the reviewer referenced a recognised staffing tool/guidance. This review was completed in December 2014 and concluded that staffing levels and skill-mix were adequate. At the time of this inspection the provider continued to utilise an objective staffing tool based
on staff ratio and dependency levels and this also indicated that the skill-mix and staffing levels were adequate to meet the assessed needs of the residents. Inspectors did note however that the staff to resident ratio from 16:00hrs to 20:00hrs was higher than recommended at 1:10.6. While there was no definitive evidence of negative outcomes for residents, nursing staff including the person in charge confirmed that this ratio had been identified to the provider as challenging but they were confident that corrective measures would be taken by the provider.

A planned and actual staff rota was maintained and indicated that staffing levels were now maintained in response to planned and unplanned deficits such as staff absence due to illness.

Inspectors saw that an additional staffing resource was in place from 20:00hrs to 08:00hrs; an additional staffing resource had been allocated to environmental hygiene and there was a re-organisation of work with some laundry duties now outsourced. An additional staffing resource was allocated to the catering department at peak activity times. However, it was not clear what procedures were in place if any to satisfy and safeguard food hygiene requirements given that these staff were also responsible for environmental hygiene; this is addressed in outcome 8; Health and Safety and Risk Management.

The provider's action plan arising out of the last inspection gave an undertaking to improve staff supervision. This was to be achieved by reviewing the staff training and development policy, improving reviews after probationary periods and carrying out regular staff appraisals. Inspectors spoke to one recently recruited staff member who confirmed that they had gone through an induction process. This involved a discussion of the operations of the centre and a familiarisation with the centre's policies and procedures. Inspectors also reviewed twenty staff appraisals which had been carried out since January 2015. The appraisals were detailed and sought to address issues identified by the staff member and/or the appraiser. A new staff training and development policy had been introduced in December 2014.

Persons providing regular external services to residents (e.g. hairdressing, entertainment, physiotherapy) now had a file in which their role and responsibilities were explicitly outlined. The files also contained curriculum vitae (CV) and Garda Vetting clearance.

In direct response to the previous action plan a focussed programme of staff training had been provided on protection, responding to behaviours that challenged and receiving and managing complaints. These inspection findings identified a significant deficit in the completion of medication management training for nursing staff. In addition, only 15 staff currently working in the centre had received training in complaints management. The provider had committed to providing this training to all staff.

**Judgment:**
Non Compliant - Moderate
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:

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

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Sancta Maria Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000449</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>08/04/2015</td>
</tr>
<tr>
<td>Date of response:</td>
<td>05/05/2015</td>
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</tbody>
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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

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Management systems did not at all times ensure that the service and care provided to residents was safe, appropriate and responsive to residents needs. consistent and effectively monitored

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

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1 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:
As discussed in Outcome 11 a documented framework is now in place to deal with situations when a GP does not respond in a timely manner to a request from Nursing Staff at the centre for a prompt Medical review. All Nursing Staff have been educated on the framework now in place and it is a usable tool/reference point available in the Nurses station. The overall responsibility for the Management and use of this framework will be monitored by the Person in Charge. GP’s have also been informed in writing of the importance of timely medical reviews when requested. (Completed)

A Staff Nurse meeting has been held to address the importance of contemporaneous nursing notes to ensure continuity of care and ensure all residents’ needs are met in a safe and timely manner. The consistency and effectiveness of same will be monitored by the person in charge on a daily basis. (Ongoing)

As discussed in outcome 9 more robust medication management systems are to be implemented. Same will be monitored and audited on an ongoing basis by the Person in Charge. Effectiveness and ongoing compliance with the system will be discussed with the Registered Provider at Monthly Management Meetings. (Complete & Ongoing)

Proposed Timescale: 05/05/2015

Outcome 04: Suitable Person in Charge

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The person in charge had two concurrent recent employers and there was only one reference in place in respect of a last employer and this referee was also the current employer.

2. Action Required:
Under Regulation 14(5) you are required to: Ensure that the documents specified in Schedule 2 are provided by the person in charge.

Please state the actions you have taken or are planning to take:
A Second reference is now on file for the Person in Charge

Proposed Timescale: 05/05/2015

Outcome 05: Documentation to be kept at a designated centre

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A record of each medication administered signed and dated by the nurse administering the medication was not maintained in accordance with professional body guidelines.

An adequate and accurate nursing record of the persons health, condition, treatment given, discussions held and changes made was not at all times maintained.

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

Please state the actions you have taken or are planning to take:
As discussed in outcome 9 all Nurses have completed HSE Land training on Medication Management. In addition to this a further online training course on the Safe Administration of Medications is also to be completed by all Staff Nurses to reinforce the importance of correct recording of all medications administered.

The Person in Charge has commenced weekly auditing of the Medication Administration Sheets and any discrepancies will be recorded as Medication errors in Epicare under the incident form section. All Staff Nurses employed at Sancta Maria have been informed that failure to comply with Best Practice in Medication Management and Sancta Maria Policy may result in formal disciplinary action. (Completed & Ongoing).

A Staff Nurses meeting has been held to inform all Staff Nurses of same. Medication Management policies have been reviewed and circulated to all Staff Nurses. Our Senior Pharmacy team will also provide training on the system employed at Sancta Maria in relation to the Prescribing, Supply And Administration of all medications. (Completed)

As discussed in out 11 and 14 the importance of accurate, factual and transparent Nursing notes has been discussed at our Nurses Meeting. All our Nurses have agreed to complete online training on Record Keeping and Effective communication. The Nursing notes will be kept under regular review by the Person in Charge to ensure they are contemporaneous, clear and reflect the needs of the residents, referrals made, the treatments given and any follow ups required.

(Training 31.05.15)
(Review and Audit Ongoing)

Proposed Timescale: 31/05/2015

Outcome 07: Safeguarding and Safety

Theme:
Safe care and support
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Staff were not clear as to how many behaviour management plans were in place. One resident identified by staff as exhibiting behaviours that challenged did not have a care plan in place

4. Action Required:
Under Regulation 07(1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.

Please state the actions you have taken or are planning to take:
A meeting with care staff was scheduled on the date of the Inspection but was postponed due to same. This meeting has now taken place. All staff have been made aware of their requirement to document any allegation that they may receive. There is now a standard Reporting form available to all staff, should they require it, to facilitate the accurate reporting of any allegation of abuse. (Completed)

The resident identified as having Behaviours that Challenge now has a Care Plan in place. All staff have been made aware of same (Complete).

The topic of Challenging behaviour is now discussed daily at morning handover and feedback is sought from all members of staff on same in relation to behaviours that may challenge and possible strategies to deal with same in order to defuse any situations that may arise in a timely and effective manner. Identified triggers and management strategies will be added to the Care Plans as they arise (Ongoing)

Proposed Timescale: 05/05/2015

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The policy on protection was not sufficient; the policy was not clear and unequivocal and did not allow for definitive decision making and appropriate investigation utilising the most appropriate protective procedures based on national policy and best practice.

Staff were unaware of any requirement to document an allegation they had received. This requirement was set out in the provider’s abuse policy

5. Action Required:
Under Regulation 08(1) you are required to: Take all reasonable measures to protect residents from abuse.

Please state the actions you have taken or are planning to take:
The Policy on Protection has been reviewed again and more definite decision making has been added. A copy of the disciplinary procedure has been added to the policy as Appendix 3. If an allegation is made against any member of staff they will be suspended pending investigation. Guidelines for investigation are described in Appendix 2 of the policy, if an allegation of abuse is upheld – Automatic dismissal will be enforced. (Complete)

All staff have been made aware that if an allegation of abuse is made to them they may be required to write a report on same as part of the overall investigation of the allegation. The Standard Reporting form for Sancta Maria will be used in these instances, should they arise. (Complete)

**Proposed Timescale: 05/05/2015**

**Outcome 08: Health and Safety and Risk Management**

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Staff whose primary responsibility was environmental hygiene were allocated to the catering department at peak activity times. While staff confirmed that their duties there consisted solely of household rather than food preparation it was not clear if procedures were in place to minimise risk and ensure compliance with food safety requirements.

**6. Action Required:**
Under Regulation 26(1)(b) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the risks identified.

**Please state the actions you have taken or are planning to take:**
The allocation of a member of Domestic staff to the Kitchen for the purpose of cleaning and wash up had been discussed with our Local EHO inspector following our last inspection in November. She expressed no concern in relation to same, once Domestic staff had no direct contact with handling of food. In order to eliminate any possible risk associated with same PPE is provided.

**Proposed Timescale: 31/05/2015**

**Outcome 09: Medication Management**

**Theme:**
Safe care and support
The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

As outlined in detail in the body of the report, failing to ensure that there were safe medication management processes in place including the management of prescriptions, the transcription of prescriptions, the supply of medications, the administration of medications and the maintenance of a record of all medications administered.

Failing to ensure that there was an effective system in place for reviewing and monitoring the safety of medication management practices.

7. Action Required:
Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident’s pharmacist regarding the appropriate use of the product.

Please state the actions you have taken or are planning to take:
A full audit of transcription, prescriptions, Nomad cassettes and cassette insert information and medication administration sheets was carried out on the 11.04.2015 by 2 pharmacists’, the person in charge and the registered provider. It was also repeated on the 28/04/15; all errors have been corrected and recorded.
We have reviewed our policy on transcription following this we no longer intend to continue same, the practice of regular transcription will now only take place in exceptional circumstances for example if a resident is readmitted from hospital out of hours when GP is unavailable. In this instance we will adhere to ABA guidelines (2003) on same.
Copies of all prescriptions generated by GP are now onsite at the centre to cross reference with Drug Cardex which will also be generated by the residents GP (Timeframe ongoing on a 3 Month basis)

We have written to all our GP’s to inform them of the importance of accurate detailed prescribing on all Cardex to ensure we can administer medications safely. We have also requested that from the 14.05.15 that they generate their own Drug Cardex in correspondence with the GMS prescription they provide. (Timeframe 14.05.2015)

All our staff Nurses both current or newly recruited are to complete the HSE land training on Medication Management. Our Pharmacist has also agreed to provide further training in this area with an emphasis on the professional accountability of nurses (Timeframe 31.05.2015)

All errors noted from our audit and going forward will be reported are per our incident reporting policy on Epicare to enhance further learning and help identify areas of improvement or further training requirements.
The person in charge is to carry out medication administration competency assessments with all current staff nurses and as part of induction process for future Nursing staff (Timeframe 31.05.2015)

Our Pharmacist has also agreed to supply our weekly administration cassettes on a
Tuesday morning to facilitate thorough checking of same before administration on the Thursday of each week. These cassettes, associated drug description inserts, prescriptions and Drug Cardex will be thoroughly checked to be correct before any medication will be administered. As the trays are generated on a 4 weekly cycle the Pharmacist will check Week 1 of the cycle with the Person in Charge against the above mentioned criteria on delivery and subsequent checking of each individual cassette will be done by the Person in Charge and a staff nurse on weeks 2,3 & 4. An additional resource of an electronic Medication Identification Tool is also available on site. Furthermore any changes made to the residents’ prescriptions will result in the cassette being returned to the Pharmacy, a new cassette will be issued with the relevant correct cassette insert. Both the Pharmacist and Sancta Maria will now maintain a copy of the GMS prescription and the Drug Cardex for cross reference and checking. Signed evidence will be available for each individual cassette each week.
(Timeframe 27.04.2015)

A subsequent follow up Audit will be completed once the GP’s have provided us with the new Drug Cardex

**Proposed Timescale:** 31/05/2015

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**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:**
Failing to ensure that adequate arrangements were in place to meet a residents assessed needs, to maintain health and wellbeing and prevent ill-health.

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

**Please state the actions you have taken or are planning to take:**
A Framework is now in place on how to deal with the situation when a GP does not respond in a timely manner to a Residents needs, this involves documenting all discussions with the GP’s in the Medical tab of Epicare, Written requests sent and involvement of family members where necessary. As it is the choice of the resident to retain their own GP on admission we must respect this, however we do advise new residents on admission at Pre Admission Assessment of the challenges this may pose due to distance from GP’s surgery and the willingness of the GP to travel. The offer to change to a local GP is always made available but ultimately the Resident’s choice must be adhered to. We have had discussions with GP's and have also written to them; we have been assured of commitment to the resident.(Complete)
As discussed in outcome 2 a staff meeting has been held on the importance of contemporaneous nursing notes has been addressed to ensure that adequate arrangements are in place in order to meet with residents needs and maintain their health and well being and prevent ill health. The importance of clarity and continuity of these records has been reinforced to ensure that at all times there is documentary evidence of all actions taken. (Complete)

**Proposed Timescale:** 05/05/2015

### 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:**
Clarity was required as to who was the agreed complaints officer; there was confusion in policy and practice as to what constituted a complaint and what constituted an allegation.

**9. Action Required:**
Under Regulation 34(1) you are required to: Provide an accessible and effective complaints procedure which includes an appeals procedure.

Please state the actions you have taken or are planning to take:
Both the policies on complaints management and responding to allegations of abuse are to be reviewed again and the necessary amendments made to ensure clarity for all staff on the difference between a complaint and an allegation. The current appeals procedure will remain in place, which provides a named external independent reviewer to review the complaint as part of an appeals procedure if the complainant is not satisfied with the resolution by the Person in Charge. In the event that the Person in Charge is involved in the subject matter of the complaint the Registered Provider will investigate same and may seek assistance from the External Independent Reviewer. (31.05.2015)

**Proposed Timescale:** 31/05/2015

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

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was no person identified to ensure complaints were appropriately responded to and a record maintained.

**10. Action Required:**
Under Regulation 34(3) you are required to: Nominate a person, other than the person
nominated in Regulation 34 (1)(c), to be available in a designated centre to ensure that all complaints are appropriately responded to and that the person nominated under Regulation 34 (1)(c) maintains the records specified under in Regulation 34 (1)(f).

Please state the actions you have taken or are planning to take:
The reviewed complaints policy will identify the Person in Charge as the designated complaints officer and the Registered Provider will be responsible for ensuring all complaints are documented and responded to in a timely manner with a satisfactory outcome for the complainant. Complaints that are logged by the Person in Charge in Epicare will not be closed until the Registered Provider has reviewed them to ensure that they have been dealt with appropriately.

Proposed Timescale: (31.05.2015)

Proposed Timescale: 31/05/2015

Outcome 14: End of Life Care

Theme:
Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Explicit decisions to attempt or not attempt resuscitation were not supported by an end of life care plan or any evidence of any discussion including medical review to support how and by whom the decision had been made. While nursing staff spoken with said that discussion had taken place there was no record of these discussions available for inspection

11. Action Required:
Under Regulation 13(1)(a) you are required to: Provide appropriate care and comfort to a resident approaching end of life, which addresses the physical, emotional, social, psychological and spiritual needs of the resident concerned.

Please state the actions you have taken or are planning to take:
On the date of inspection two residents were without an End of Life Care Plan as they were relatively recent admissions. End of Life Care Plans are now in place for these residents expressing their choices and wishes. The GP's involved have been advised of the need to discuss these wishes with the residents to ensure they are making an informed decision. All discussions and interaction will be documented in resident’s End of Life Care Plan.

Proposed Timescale: 05/05/2015

Outcome 18: Suitable Staffing
Theme: Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A significant deficit was identified in the completion of medication management training for nursing staff. Not all staff had been provided with training in complaints management.

12. Action Required:
Under Regulation 16(1)(a) you are required to: Ensure that staff have access to appropriate training.

Please state the actions you have taken or are planning to take:
All nursing staff who have not completed Medication Management training within the last 12 months are to do so (31.05.15)

The staff members who have not completed Complaints Management Training will have same completed by 31.05.2015

Proposed Timescale: 31.05.15

Proposed Timescale: 31/05/2015