Health Information and Quality Authority
Regulation Directorate

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

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

Centre name:	Maryfield Nursing Home
Centre ID:	OSV-0000064
Centre address:	Old Lucan Road, Chapelizod, Dublin 20.
Telephone number:	01 626 4684/626 5402
Email address:	maryholmes4@eircom.net
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	The Frances Taylor Foundation Chapelizod Limited
Provider Nominee:	Mary Holmes
Lead inspector:	Leone Ewings
Support inspector(s):	Shane Walsh
Type of inspection	Announced
Number of residents on the date of inspection:	54
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

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

The inspection took place over the following dates and times

From:	To:
04 April 2016 10:30	04 April 2016 17:30
05 April 2016 09:45	05 April 2016 16:30

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

Outcome	Our Judgment
Outcome 01: Statement of Purpose	Compliant
Outcome 02: Governance and Management	Non Compliant - Moderate
Outcome 03: Information for residents	Compliant
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Substantially Compliant
Outcome 06: Absence of the Person in charge	Compliant
Outcome 07: Safeguarding and Safety	Compliant
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 09: Medication Management	Compliant
Outcome 10: Notification of Incidents	Compliant
Outcome 11: Health and Social Care Needs	Compliant
Outcome 12: Safe and Suitable Premises	Non Compliant - Moderate
Outcome 13: Complaints procedures	Compliant
Outcome 14: End of Life Care	Compliant
Outcome 15: Food and Nutrition	Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Compliant
Outcome 17: Residents' clothing and personal property and possessions	Substantially Compliant
Outcome 18: Suitable Staffing	Compliant

Summary of findings from this inspection

This was an announced inspection and formed part of the assessment of the application for renewal of registration by the provider. This inspection took place over two days and as part of the inspection, practices were observed and relevant documentation reviewed such as care plans, medical records, accident logs, policies and procedures and staff files. The views of residents and staff of the centre and

feedback was sought from pre-inspection questionnaires, which were circulated, completed and returned from both residents and relatives. The responses received and reviewed by the inspectors were largely positive about the quality of service provision and day-to-day life at the centre.

As part of the application for renewal the provider was requested to submit relevant documentation to the Health Information and Quality Authority (the Authority). All documents submitted by the provider for the purposes of application to register were found to be satisfactory.

The centre is a purpose-built designated centre which has 55 places. The service provides long-term, dementia care, palliative care and respite care mainly for older people. As part of the inspection, the inspector met with residents and staff members. The inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files.

The inspector confirmed that the non-compliances had been fully addressed since the previous thematic inspection on 15 April 2014. Improvements were confirmed in terms of care plans to inform and guide staff in nutritional support and end of life care for residents. The provider was in the process of addressing the non-compliances identified relating to the premises, within the original agreed time frame. A detailed plan and project was proposed and in place to support improvements to premises relating to provision of adequate toilets, shower rooms, bedrooms and storage.

The inspectors found that the newly appointed person in charge had a person-centred approach to care and was well supported by a clinical nurse manager.

Findings and areas for improvement are outlined in the body of the report and within the action plan at the end for response. Six actions are the responsibility of the provider, and two the responsibility of the person in charge.

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

Outcome 01: Statement of Purpose
There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:
Governance, Leadership and Management

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

Findings:
The written Statement of Purpose was submitted prior to renewal of registration and described the services provided to reflect Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. However, an updated version was requested to include a description of the four bedrooms which the provider had identified as being suitable for ambulatory residents only.

The revised version was submitted post inspection and found to be compliant.

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 were satisfactory existing governance arrangements in place. The provider nominee was available and worked closely with the general manager and the person in charge. Regular meetings were held with the Board of Management where all areas of clinical
governance were discussed. The person in charge confirmed that there were monthly clinical management meetings in place to monitor the quality and safety of care.

There was a clearly defined management structure that outlined the lines of authority and accountability in the centre, with systems in place to review the quality and safety of life of residents. The person in charge and provider advised the inspectors that adequate resources were made available as required. The person in charge could not evidence a detailed staffing review having been completed by the person in charge to inform the daily practice at the centre. This was discussed with the general manager and person in charge and they confirmed that they would implement this as part of the management meetings.

The provider nominee, person in charge and management team were closely involved with service provision, and review and could evidence some improvements since the last inspection. For example, the incident reports were carefully tracked and evaluated, and a focus on falls prevention was evidenced. This included inputs from the multidisciplinary team including physiotherapist on site.
The physiotherapist worked closely with residents identified as at risk, or following any slip, trip or fall.

The provider and the person in charge were aware of the requirement to prepare an annual report on the overall review of the safety and quality of care of residents. This had not yet been completed in compliance with the regulations. However, preparatory works were ongoing and a major project relating to the premises was planned. There were clearly established systems in place of gaining
feedback from residents and evidence of changes being made following feedback such as improvements to the planned activities, and to changes to menu and the coffee shop.

Judgment:
Non Compliant - Moderate

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:

Residents were provided with an information folder on admission to the centre. The information folder contained a copy of a guide to the centre which included all relevant information about services provided, facilities available, visiting and the complaints process.

Notice boards were located around the centre. Inspectors observed information on display such as the weekly menu, daily activities schedule, advocacy details, the complaints process and contact details for the management in the centre.

Inspectors spoke with residents and they informed them that they were well aware of any planned events that were due to take place in the centre.

All residents had a written contract of care that was signed by the resident or their representative on admission to the centre. The contract outlines the services to be provided by the centre, and includes details of all fees payable for residents in receipt of these services.

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 had changed since the time of the last inspection, she is a registered psychiatric and general nurse and worked full time within the centre. The person in charge was assessed by the inspector and she was deemed to have the required knowledge and experience to hold the post of person in charge. She was knowledgeable about each residents' nursing and social care needs, and had been working at the centre now for six months. She clearly demonstrated a commitment to her continuous professional development.

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 non-compliances from the last inspection had been addressed by the provider relating to records of residents' finances.

The inspectors were satisfied that the records as listed in Part 6 of the Regulations were maintained in a satisfactory manner so as to ensure completeness, accuracy and ease of retrieval. Overall, a satisfactory standard of record keeping could be evidenced throughout the inspection. Staff were familiar with the electronic record keeping system and had received guidance and support implementing and using this system. However, some aspects of the system used were not fully utilised by staff. The person in charge undertook to address this to improve the inputs and outputs of the current system. However, some improvement was required in relation to the documentation of staffing rosters, complaint outcomes and methodology of complaint review, and risk in terms of the risk register, risk management policy and procedures.

A sample of staff files was inspected and all were found to contain all documentation as required in Schedule 2 of the Regulations.

The centre was adequately insured against accidents or injury to residents', staff and visitors, as well as loss or damage to a resident's property.

A directory of residents was maintained which contained all of the matters as set out under Regulation 19.

The designated centre had all of the written operational policies as required by Schedule 5 of the Regulations. However, some policies required review and were currently undergoing this process.

As outlined in Outcome 8 the risk management policy and safety statement required review.

Judgment:
Substantially Compliant

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

Theme:
Governance, Leadership and Management

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

Findings:
There was aware of the responsibility to notify the Chief Inspector of the absence of the person in charge. The provider had notified a change in the deputy to the person in charge in line with regulations and satisfactory arrangements were in place to manage the centre in the absence of the person in charge.

Judgment:
Compliant

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

Theme:
Safe care and support

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

Findings:
The inspectors evidenced that systems were in place to protect residents being harmed or suffering abuse. There was a policy to guide staff and they received appropriate training and refresher training. There were small number of residents with expressive behaviours and an environment which promoted residents' rights was in place.

The centre was guided by policies on the protection of vulnerable adults in place and policies read were updated to reflect the Health Service Executive policy and procedures "Safeguarding Vulnerable Persons at Risk of Abuse".

There was regular staff training in the protection of vulnerable adults. Staff spoken to were knowledgeable of the types of abuse and the reporting arrangements in place. The person in charge was aware of the requirement to notify any allegation of abuse to

HIQA. The inspectors spoke to a number of residents who said that they felt safe and secure in the centre.

A policy on the management of expressive behaviours that guided practice was in place. A small number of residents presented with behaviours associated with dementia and cognitive difficulties. Overall, the residents were well supported and positive behavioural plans were in place. The inspectors found evidenced based tools were utilised to monitor behaviours where required. Staff were familiar with the residents and understood their behaviours, what triggered them and the least restrictive interventions to follow.

There was a separate policy on the use of restraint which reflected the national policy "Towards of Restraint Free Environment". The person in charge ensured that detailed risk assessment took place and the least restrictive intervention was in use,. Alternatives had been trialled prior to the use of bed rails. Residents were supported to maintain their independence.

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 non-compliances relating to review of environmental risk assessments had been addressed further to the last inspection. However, further improvements were required relating to keeping this aspect of risk management under review. Access to stairwells had been reviewed, and handrails provided. A new fire assembly point was clearly in place near the front of the building.

Overall the inspectors found that there was a system in place to ensure that the health and safety of residents, visitors and staff is promoted and protected. However, some improvements were required in terms of risk management and policy updates.

An up to date safety statement was not found to be in place as it related to the health and safety of residents, visitors and staff. The inspectors read the risk management policies which were developed in line with the regulations and guided practice. They included the policies on violence and aggression, assault, residents going missing, self-harm and accidental injuries to residents and staff. However, the centre's health and safety statement was out of date (2013), although it had been signed by the current Person in Charge and Provider Nominee. A new safety statement was in draft but had

not been signed off on.

The risk register was reviewed and contained a number of environmental risks and control measures to mitigate risk. For example risks associated with smoking, absconding, and falls prevention and management. Controls were in place for many of the risks identified. However, the risk controls associated with some environmental risks identified had not been sufficiently mitigated and some risks had not been fully documented in the risk register. For example, oxygen cylinders had been incorrectly stored in a storage room near a radiator, and a small number of windows in residents bedrooms on the first floor were not restricted and could be fully opened. Both risks were brought to the attention of management during the inspection, and the provider and person in charge undertook to address all matters.

The person in charge had arrangements in place for investigating and learning from incidents. For example slips, trips and falls. The person in charge explained that clinical governance formed part of the well established management meetings which met to review incidents, residents' feedback and complaints.

The inspectors reviewed the emergency plan and found that it provided sufficient guidance to staff on the procedure to follow in the event of an emergency. For example, it identified alternative accommodation where residents may be relocated too should a full evacuation of the centre be required.

The inspectors viewed the fire training records and found that staff had received up-to-date mandatory fire safety training and this was confirmed by the person in charge. Fire safety training had taken place and all staff were familiar with actions to take should the fire alarm sound. The inspectors viewed fire records which showed that all the fire safety equipment had been maintained in line with best practice. Fire evacuation procedures are prominently displayed throughout the building. The fire alarm is serviced on a quarterly basis and fire safety equipment is serviced on an annual basis. Fire records are kept which include details of fire drills, fire alarm tests, emergency lighting and fire fighting equipment. Smoke detectors and fire blankets were in place.

A review of staff training records indicated that all staff had been trained in moving and handling, and staff confirmed this during interviews and contact with the inspectors.

The inspectors found that there were adequate measures in place to control and prevent infection. Training had been provided on the induction programme. Staff had access to supplies of gloves, disposable aprons, hand wash basins and alcohol hand gels which were used frequently and readily available. However, the identified risks associated with the dual use of sluice and cleaning rooms would not be fully mitigated until the new building was complete.

While there was a risk management policy in place, as outlined in Outcome 5 of this report it was past its review date. A new policy had been drafted but it had not been finalised or implemented in the centre.

Staff training on fire safety and moving and handling was up to date for all most all staff. A number of new staff were scheduled to attend this training. All staff spoken to

were aware of the procedure if there was a fire, and had taken part in fire drills. Evacuation plans were posted throughout the centre and fire exits were unobstructed. Emergency lighting and the fire alarm had been serviced on a quarterly basis. All fire fighting equipment had been serviced on an annual basis and was provided throughout the centre. Fire drills had been carried out four times in 2015 and once in 2016 a written record was kept of the drills.

Judgment:
Non Compliant - Moderate

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

Theme:
Safe care and support

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

Findings:
The non-compliances relating to medication management had been fully addressed further to the last inspection.

Residents were protected by the centre's policies and procedures for medication management and medications were safely stored and were in line with the policy. Self administration of medication was supported following an assessment.

Medicines were supplied to the centre by a retail pharmacy business in a monitored dosage system that consisted of individual pouches were appropriate. Medicines were stored securely in medication trolleys or within locked storage cupboards. A secure fridge was available to store all medicines and prescribed nutritional supplements that required refrigeration, and temperatures were checked and recorded on a daily basis. Controlled drugs were stored securely within a locked cabinet, and balances of all controlled drugs were recorded in the controlled drugs register. The medication trolleys were stored securely in the clinical room.

All nursing staff had completed medication management training, including a competency assessment further to an induction programme. The inspector observed nursing staff administering medicines to residents during a number of administration rounds. Medication administration practices were found to adhere to current professional guidelines.

Medication management audits were conducted within the centre as part of the quality and clinical governance system in place. This resulted in improved practices. Staff confirmed that pharmacists from the pharmacy who supplied medicines to the centre were facilitated to visit the centre and meet with residents. Staff were familiar with the

safe system in place for receiving medications from the pharmacy and for disposing of unused or out of date medicines.

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:
Inspectors were satisfied a record of all incidents occurring in the designated centre were maintained and notified where required to the Chief Inspector.

The person in charge was familiar with the incidents that required notification in three working days, along with a report of specified incidents to be made every three months.

There was a system to record, report and review all incidents.

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:
The non-compliances relating to review of care planning including assessment of needs had been addressed further to the last inspection.

Each resident's wellbeing and welfare was maintained by a high standard of evidence-based nursing care. The inspectors found that there was a nursing and social care system in place to promote each resident's care and quality of life. There was access to medical and allied health care, including the option of retaining the resident's own General Practitioner (GP). The admissions, transfer and discharge policy informed and guided good practice. Residents confirmed that their health and social care needs were met well, and independence and wellness promoted by all staff.

There is a computerised system of recording the nursing process. There was a range of validated risk assessments fully implemented to assist the nursing staff in developing a person centred care plan based on residents assessed needs. Resident's assessed needs include their physical, psychological, spiritual needs and their social interests and their preferences.

Residents confirmed that they are actively involved in the assessment and care planning process. Care plans are reviewed four monthly or more frequently if required, for example following a change in the residents' condition.

The inspectors evidenced that there was a good system in place for ensuring residents healthcare needs would continue to be met. For example, falls' prevention and management, pain management, wound care and nutritional assessments. The inspectors reviewed policies and found that they were evidence based and would guide and inform practice.

All residents had a pressure ulcer risk assessment completed on admission and this would be updated four monthly or more frequently if there is a change in the residents condition. The inspector found that systems in place to minimise the risk of residents getting a pressure ulcer, for example enough staff on duty to assist the residents to change position regularly, and to manage continence issues. There was an adequate supply of alternating pressure relieving mattresses and availability of pressure relieving cushions. An evidenced based policy on nutrition and hydration was in place and guided practice.

Residents had regular access a GP and doctor-on-call services are in place in the evening time and over the weekend. Referrals were facilitated including speech and language (SALT), chiropody and a dietician. Dental, optical and audiology services are provided locally. Additional physiotherapy can be availed of and occupational therapist will be available on a referral basis.

The service of specialist psychiatry and medicine for the elderly was availed of when required through a referral process. Access to a psychologist can be made through the primary care team as required. Palliative care specialities are available on a referral basis.

Activity and choice of pastimes for residents was fully facilitated and choices respected. Residents gave positive feedback to inspectors about the quality of their daily lives and supports in place to maintain their independence. The residents' right to refuse to be involved with form of planned activity was also fully respected. The inspector was

informed that the hairdresser visited weekly, there were a number of activities in place including pet therapy in place. Residents informed the inspector that they could also be involved with crafts, bingo, knitting, music therapy, walks and going to the coffee shop and other activities. Resident involvement with planning activities within and outside the centre was sought and facilitated by staff.

Judgment:
Compliant

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

Theme:
Effective care and support

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

Findings:
The location, design and layout of the centre was largely suitable for its stated purpose and met most residents' individual and collective needs. However, there were areas for improvement as previously outlined in the registration inspection completed during 2013. For example, there were an insufficient number of assisted toilets and assisted showers to meet residents' expressed needs and preferences. The facilities including bedrooms and bathrooms had been reviewed since the last inspection and five of the resident's bedrooms did not fully meet the requirements of the national Standards. However, the provider had clearly outlined this in the Statement of Purpose that any proposed resident must be ambulatory to use the bedrooms identified on an ongoing basis.

The décor was mostly domestic, with furnishings and pictures throughout. Residents were encouraged to personalise and make their own environment homely if they wished. The building was built during the 1950's. Residents reported that the centre offered a homely comfortable environment and told inspectors that they enjoyed the lifestyle provided. Communal areas such as the day-rooms had a variety of pleasant furnishings and comfortable seating. These spaces were utilized very often by residents and relatives. A large oratory was in place centrally, and a coffee/refreshment area where residents could entertain guests overlooked a central courtyard.

The inspectors found that one of the bedroom corridors had been painted to be more distinguishable for residents with a cognitive impairment. However, the nature of this

change which included a mural was not in fact enhancing the light and visual appearance of the area and this was discussed with the provider and person in charge in order to review the effect from a sensory perspective. For example, a chair had been painted on to a wall, and the access to a bathroom was not clear signed due to addition of this mural.

During this inspection the premises were clean, hygienic and well maintained and in general there were measures in place to control and prevent infection including staff training on infection control. There was a centre-specific policy on infection control. Inspectors noted that staff took appropriate infection control precautions including the use of personal protective clothing while attending to residents' care needs and adhering to hand hygiene precautions displayed in the centre. Hand-washing/sanitising facilities were strategically placed throughout the centre and readily accessible for staff and visitors. However, the ongoing dual use of the sluice and cleaner's rooms presented a risk to infection prevention and control at the centre. Plans were in place to address this but had not been completed to date.

Inspectors observed that the residents had direct access to a safe and secure landscaped garden which was maintained to a good standard. An internal courtyard area had been decked and was accessible. However, the inspectors were advised that the decked area flooring was not safe in wet or damp weather, and there was an absence of signage to indicate this risk.

There were records to show that assistive equipment such as hoists, baths and pressure relieving mattresses had been serviced regularly. Service contracts were in place for equipment. All residents were provided with a call bell to enable residents to summon assistance when they required.

There was private space available where residents could go if they required some quiet time away from other residents.

The kitchen was seen to be spacious. The chef said that all special diets and requirements were catered for on request. Food stocks were adequate and there was a good supply and variety of fresh fruit and vegetables.

Changing and toilet facilities were provided for staff, with separate facilities for catering and clinical staff.

Space for storage was limited in the centre. Inspectors saw that there were a number of hoists stored in bathrooms, and in a bedroom.

The bedrooms did not meet the assessed needs of all residents. For example, due to the restricted space in the resident's en suite bathrooms, residents had to routinely use a commode in their bedrooms. Some of the showers were seen to have a step into them thus making them inaccessible, unless fully independent.

Inspectors found that a small number of residents were located in bed rooms which did not fully meet their assessed dependencies. For example, a resident who used a wheelchair with a small inaccessible en-suite, and limited floor space. There was a plan

in place to provide adequate bath and shower rooms to meet the assessed needs of residents. Currently there are five assisted baths in the centre. There was one assisted toilet and one assisted shower for all of the residents to use.

There were no separate designated cleaner's rooms which meant that cleaning trolleys were stored on the corridor, and in sluice rooms.

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:
The complaints procedure was on display at the main entrance to the centre and each resident received information on how to make a complaint on their admission to the centre. The policy on complaint's management was in line with legislative requirements and had been updated since the last inspection to reflect the right of a resident to access the Ombudsman if required.

A record of both written and verbal complaints, was fully maintained and complaints were being dealt in a timely manner. Each complaint listed the details of the complaint, and the outcome of the complaint. The inspector found that a small number of verbal and one written complaint were received by the centre and these were well managed. There was an up to date complaints policy which listed a nominated complaints officer within the centre and an independent officer was available for appeals.

The complaints records also stated that the complainant was informed of the outcome of each complaint. However, as outlined in Outcome 5 of this report the records of any complaint outcomes and methodology of complaint review required improvement.

There was some evidence of service improvement as a result of feedback received through the complaints process.

Judgment:
Compliant

Outcome 14: End of Life Care

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

Theme:
Person-centred care and support

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

Findings:
All religious and cultural practices were fully facilitated. Daily Mass took place every in the oratory. Religious services were relayed by speaker to bedrooms at the centre. The person in charge confirmed this facility was optional and could be turned off by request to respect quiet time.

The inspectors reviewed a sample of resident's records including those with documented assessments and care plans for end of life wishes. This was extensively reviewed at the time of the last inspection when an unannounced thematic inspection took place.

Arrangements to meet the individual needs were set out in the care plans. The standard of person centred record keeping had improved and was detailed and informed practice. Access to specialised palliative care referrals was fully facilitated, where appropriate. Staff working at the centre had additional training and qualification in this area. The end of life care policy in place was comprehensive and fully guided and informed staff.

Details of any discussions held with residents, family meetings and medical reviews were clearly documented. Resident had their choices and wishes respected in so far as possible. Family and friends were facilitated and welcomed to stay over or be near their loved one when they are dying.

Judgment:
Compliant

Outcome 15: Food and Nutrition
Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.

Theme:
Person-centred care and support

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

Findings:
There were systems in place to ensure residents' nutritional needs were met, and that they did not experience poor hydration. Residents were screened for nutritional risk on admission. Care plans put in place and reviewed as required thereafter. Residents' weights were routinely checked on admission, monitored and monthly weights checks were done when indicated. Nutritional care plans were in place that detailed residents' individual food preferences, and outlined the recommendations of dieticians and speech and language therapists where appropriate. Nutritional and fluid intake records when required were appropriately maintained.

The inspectors observed residents having their lunch in the both dining rooms, and saw that a choice of meals was offered. Residents were generally positive about the meals and daily menu choices. The inspectors found that this was a positive and social atmosphere in the dining room. Residents could dine in their rooms if they wished but residents who spoke with inspectors said they preferred the social aspect of eating in the dining room.

There was an effective system of communication between nursing and catering staff to support residents with special dietary requirements. The chef had an established system of communication with the nursing staff and kept a record of up to date resident requirements in the kitchen. Any residents who needed assistance at mealtimes were assisted in a discreet and sensitive manner. Residents informed the inspectors that they were very satisfied with meals provided in the centre and were well informed of their choice of meals each day. Weekly pictorial menus were on display and the inspectors found that this corresponded with what was being offered to the residents during the inspection. An inspector spoke with the chef and found that the chef was knowledgeable on the residents' dietary needs who were on modified diets. The chef showed the inspector that all residents' assessed dietary needs and their likes/dislikes were documented in a folder that was available to all catering staff. Snacks were available to residents throughout the day. Sandwiches were prepared by the catering staff before their shift ended to ensure snacks were available during the evening and at night. All residents had access to fresh drinking water. Staff provided encouragement to residents with their meals and to monitor that residents actually ate their meal choices.

Mealtimes in the dining room was a social occasion with attractive table settings and plenty of conversation between residents. Additional finger foods were readily available to residents with dementia assessed as requiring snacks and meals on a more frequent basis. The coffee-shop on site was attractive and had comfortable seating, tables and chairs and was a place where visitors could meet their relative or friend.

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

Findings:
The non-compliances relating to review of offering choice relating to care needs had been addressed further to the last inspection.

The inspectors found that the residents were treated in a respectful and dignified manner. Relationships between the staff and the residents was observed to be friendly and sincere. Residents informed the inspectors that they felt the staff were very hard workers and spoke very highly of the service provide by the staff. Staff were observed to respect residents' privacy by always knocking on bedroom doors before entering. Some residents had been offered keys to their own rooms and chose to use the lock when they went out.

Residents' independence was promoted within the centre. Over the two days the inspectors noted that residents had open access to the centre. Although some areas required a key code to open the door, the inspectors noted that many residents had been provided with that code and were seen to use it. The inspectors were informed that some residents leave the centre independently to walk to the local shops or restaurants.

The inspectors noted this to be the case as over the two day inspection a number of residents were seen to leave the centre independently. The centre operated an open visitor policy and there were adequate facilities for residents to receive visitors in private, or in the coffee shop near the front door.

Residents were consulted with about how the centre was run. An independent advocacy group held residents meeting in the centre every two months. Any suggestions that arise from these meetings are forwarded to the Person in Charge. There are also feedback evaluations carried out in regards to mealtimes. These look for suggestions on how to improve the service, and on any possible suggestions of menu change for residents.

Resident had access to television, radio and newspapers. The Person in Charge informed inspectors that access to a private telephone was available to anyone who wished to use it, and a number of residents had their own telephone in their rooms. Rooms were highly personalised with items of residents choosing.

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:
There was appropriate space provided for resident's personal belongings. Each resident had a wardrobe and a bedside locker. Residents clothing was laundered daily. The laundry room was found to be clean and spacious. There were suitable infection control arrangements in place to separate soiled and unsoiled laundry. Clothing was labelled and once dry was placed on a table with the residents' room numbers to try and prevent clothing from getting lost or misplaced.

However, the inspectors found that there was no record or inventory kept of residents' personal belongings. This did not promote appropriate safeguarding of residents' personal belongings. Inspectors noted that there had been some claims that some pieces of residents' clothing had gone missing, yet due to a lack of appropriate record keeping, this was difficult to follow up on. Not all bedrooms had a lockable space where a resident may store personal items.

Judgment:
Substantially 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:
There were appropriate staff numbers and skill mix to meet the assessed needs of the residents, and to the size and layout of the designated centre. All staff were friendly and aware of the line management system and who to approach should they require support or advice in their day to day work. Feedback received from residents and relatives confirmed that staff at the centre were attentive and met their needs in respectful manner. Inspectors interviewed a sample of staff on duty to confirm training received and their knowledge of their duties.

Staff spoken to were aware of residents' needs and they were knowledgeable about individual residents and assessed care plans in place. They were observed interacting respectfully and provided person centred care. The inspectors reviewed the roster which reflected the staff on duty. Resident dependence was assessed using a recognised dependency scale and evidence provided that the staffing rosters were adjusted accordingly. The inspectors were satisfied that there was sufficient staff on duty to adequately meet the needs of residents on the days of the inspection. However, there was no evidence available of a staffing review had been completed by the person in charge to inform the daily practice at the centre and the overall quality and safety as outlined in Outcome 2 of this report.

There was evidence of robust staff recruitment practices and the inspectors found that there was appropriate staff numbers and skill mix to meet the assessed needs of the residents. There was an up to date recruitment policy in place which met the requirements of the Regulations. The human resources manager supported the provider and person in charge. All mandatory training as required by the regulations was completed and planned for.

All registered nursing staff had current registration with Bord Altranais agus Cnáimhseachais na hÉireann (Nursing and Midwifery Board of Ireland). Some staffing rosters did not contain the full names of staff and this was discussed with the person in charge. There was some evidence of staff turnover during 2015 and recruitment was ongoing at the time of the inspection. The person in charge and outlined to inspectors that there was an ongoing reliance on agency and relief staff over recent months. However, this was closely monitored and was improving according to the person in charge. Where agency staff were employed it was on a regular basis to fill gaps in the roster and was planned for in advance.

The person in charge and provider promoted professional development for staff. Staff were provided with training to meet the specific and changing needs of residents. A broad range of training had been provided to staff such as wound care, falls prevention and management and nutrition, managing challenging behaviours.

Staff spoken with all reported that they felt well supported and supervision was provided to all staff. Communication with management and staff meetings took place in an open and supportive environment. A small number of volunteers worked at the centre and all were suitably vetted in line with regulations.

Judgment:

Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	Maryfield Nursing Home
Centre ID:	OSV-0000064
Date of inspection:	04/04/2016
Date of response:	13/06/2016

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:
There was no annual review of quality and safety available for review for 2015.

1. Action Required:
Under Regulation 23(d) you are required to: Ensure there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8

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

of the Act and approved by the Minister under section 10 of the Act.

Please state the actions you have taken or are planning to take:
As discussed during our inspection we experienced a significant turnover of senior nursing staff during 2015 and subsequently we appointed a new Director of Nursing and Clinical Nurse Manager who are key to our registration and service delivery. As a team we are committed to reviewing and improving the quality and safety of care and the quality of life of our residents. We are presently compiling data as part of our annual review which will acknowledge quality care in 2015, identify areas in need of improvement and priorities for 2016

Proposed Timescale: 01/08/2016

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 number of policies had not been reviewed within the three year time frame as outlined by regulations.

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

Please state the actions you have taken or are planning to take:
As noted during inspection some policies were under review and the DRAFT phase is completed. Staff views and changes have been incorporated to reflect more centre specific policies as discussed during inspection.

Proposed Timescale: 08/07/2016

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Records of complaint outcomes and methodology of complaint review required improvement.

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:
We confirm that effective from 6th April 2016 all complaints are now recorded on our Epiccare Nursing Home Management System.

Proposed Timescale: 08/07/2016

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:
The risk management policy in place in the centre was past its review date, and was not informed by most recent environmental audit.

4. Action Required:
Under Regulation 26(1) you are required to: Ensure that the risk management policy set out in Schedule 5 includes all requirements of Regulation 26(1)

Please state the actions you have taken or are planning to take:
Since our inspection an environmental risk assessment has been completed and this has influenced our DRAFT Health & Safety Statement that is due to be circulated to all staff for their feedback etc. The DRAFT H&S Statement will be published on 7th June and the implementation of same for w/c 12th September 2016

Proposed Timescale: 12/09/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all risks in the centre had been identified, assessed and recorded, including windows and storage of oxygen.

5. Action Required:
Under Regulation 26(1)(a) you are required to: Ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.

Please state the actions you have taken or are planning to take:
A full risk assessment has been completed and our risk register is currently been updated. The risk identified regarding the storage of portable oxygen was resolved on the 7th April 2016

In areas where structurally we are limited, the identified risks have been mitigated relating to windows and are kept under review. All residents occupying these identified areas will be risk assessed to ensure that they are suitable.

Proposed Timescale: 24/06/2016

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:
All Schedule 6 requirements had not yet been fully addressed as part of the action plan agreed at the time of the last inspection.

6. 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:
Our capital development project commenced on the 4th May 2016 and the time-line from commencement to completion is 102 weeks. Having spent considerable time in planning for same we are confident that our new facility is substantially future proofed and will surpass all regulatory requirements/standards. As we will continue to operate a live environment for the next two years, we acknowledge that some identified rooms i.e. (5) are not suitable for all resident's care needs and going forward these rooms will be risk assessed before occupancy.

Proposed Timescale: 30/04/2018

Outcome 17: Residents' clothing and personal property and possessions

Theme:
Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Systems to return laundry items were not fully robust.

7. Action Required:
Under Regulation 12(b) you are required to: Ensure each resident's linen and clothes are laundered regularly and returned to that resident.

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

All new resident's personal items and laundry are recorded on admission, and we are currently carrying out an inventory of existing resident's personal items etc. We have also implemented a quarterly review of all personal items retained by residents.

Proposed Timescale: 16/05/2016

Theme:
Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Personal lockable space was not available to all residents.

8. Action Required:
Under Regulation 12(c) you are required to: Provide adequate space for each resident to store and maintain his or her clothes and other personal possessions.

Please state the actions you have taken or are planning to take:
Audit completed of all rooms and locks ordered for areas that require them and the locks are currently being put in place.

Proposed Timescale: 06/06/2016