Health Information and Quality Authority
Regulation Directorate

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

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Our Lady’s Manor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000080</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Bulloch Castle, Dalkey, Co. Dublin.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>01 280 6993</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:ourladysmanor1@eircom.net">ourladysmanor1@eircom.net</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>Our Lady’s Manor Incorporated</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Sr. Bernadette Murphy</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Sheila McKevitt</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>Shane Walsh (Day 2 only)</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Announced</td>
</tr>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>104</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>14</td>
</tr>
</tbody>
</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.

Please note the definition of the following term used in reports: responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).
This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration renewal decision. This monitoring inspection was announced and took place over 2 day(s).

**The inspection took place over the following dates and times**

<table>
<thead>
<tr>
<th>From:</th>
<th>To:</th>
</tr>
</thead>
<tbody>
<tr>
<td>01 November 2016 09:30</td>
<td>01 November 2016 18:00</td>
</tr>
<tr>
<td>10 November 2016 08:30</td>
<td>10 November 2016 16:30</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Our Judgment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome 01: Statement of Purpose</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 02: Governance and Management</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 03: Information for residents</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 04: Suitable Person in Charge</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 05: Documentation to be kept at a designated centre</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 06: Absence of the Person in charge</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 07: Safeguarding and Safety</td>
<td>Substantially Compliant</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 - Moderate</td>
</tr>
<tr>
<td>Outcome 10: Notification of Incidents</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 11: Health and Social Care Needs</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 12: Safe and Suitable Premises</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 13: Complaints procedures</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 14: End of Life Care</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 15: Food and Nutrition</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 16: Residents’ Rights, Dignity and Consultation</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 17: Residents' clothing and personal property and possessions</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 18: Suitable Staffing</td>
<td>Compliant</td>
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**Summary of findings from this inspection**

The inspection was carry out in response to the provider's application to renew the certificate of registration. Inspectors conducted an announced inspection of the centre on 01 and 10 November 2016. Inspectors inspected against eighteen outcomes and followed up on non compliances identified in six outcomes during a previous inspection of the centre in March 2016.
As part of the inspection, inspectors reviewed documentation submitted as requested to renew the registration of the centre. Inspectors then met with residents, visitors and staff members. They also observed practices and reviewed documentation such as care plans, accidents and incident forms, medical and nursing records and policies and procedures.

Overall inspectors were satisfied that the centre's level of compliance had improved since the last inspection. Evidence of good practice was found across all outcomes. The centre was found to be in compliance with nine outcomes, substantial compliance with seven outcomes and moderately non complainant with two outcomes.

Inspectors noted some improvements in the areas of governance and management, the standard of nursing documentation and the adherence to the National restraint policy. However, further improvements were required in nursing documentation, the standard of auditing clinical practices and supervision by the senior management team. The area where inspectors saw minimum improvements was in medicines management. However, inspectors were given assurances that on this occasion the non compliances would be addressed without delay. The contracts of care also required a complete review to ensure they met the legislative requirements.

The action plan at the end of the report identifies those areas where improvements were required in order to comply with the regulations.
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:**
A statement of purpose was submitted as part of the application to renew registration application and a revised version was given to inspectors on this inspection. It had been reviewed in October 2016 and outlined the overall aim of the centre and other details as specified in Schedule 1 of the Regulations. The staffing levels reflected those working in the centre. Staff were familiar with its content and a copy was on display in the centre.

**Judgment:**
Compliant

### Outcome 02: Governance and Management

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

**Theme:**
Governance, Leadership and Management

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

**Findings:**
Inspectors found that there was a strong management team in the centre. A quality assurance manager (QAM) had joined the management team in September 2016. This
appointment was made following the last inspection by HIQA as gaps were found in the systems in place to ensure service provided was safe, appropriate, consistent and effectively monitored. There was some evidence that improvements had been made in that an annual review had been completed, the standard of nursing documentation particularly care plans had improved on two of the three floors however, other areas of practice such as medicines management required improvement.

The registered provider of the designated centre is Our Lady’s Manor Incorporated. They had a robust management structure in place to manage the centre which was reflected in the statement of purpose. Members of the management team included the person nominated to represent the provider (the provider) also the person in charge, two assistant directors of nursing (ADONs) and the quality assurance manager.

The provider reported to a board of management and formally to the registered provider on an annual basis. She had held the dual role since 1982, worked full time in centre and was well supported. The two assistant directors of nursing (ADONs) were both registered general nurses, one managed auxiliary services the other managed clinical services. The ADON responsible for auxiliary services had certificates in leadership practices and the ADON responsible for clinical practices had a Masters in Gerontological nursing. One ADON was named as person participating in management on the application to renew and inspectors were informed she would take over the management of the centre in the absence of the person in charge.

Each floor had a clinical nurse manager grade 2 (CNM2) overseeing their management. The three CNM2s reported directly to the ADON responsible for clinical practice. There were staff meetings on each floor on a three monthly basis and the recent minutes of these were read. A range of topics were discussed including incidents, falls, staff issues and risk management which were identified on the monthly key performance indicators gathered for each floor.

There were clinical governance meetings held to review clinical risk in the centre. These were held on average every three months. The minutes of the these meetings were read by inspectors and showed that risks identified were actioned.

There were systems in place to monitor the quality and safety of care. The CNM2 on each floor completed monthly key performance indicators on falls, use of restraint, psychotropic medications, pressure sores and episodes of behaviour that challenge. These were now being submitted, reviewed, analysed and trended by the quality assurance manager. These were then being discussed at clinical governance meetings and or risk management meetings.

Inspectors reviewed audits of falls prevention, care plans, medicines management and complaints. The standard of some of these audits such as those linked with falls and care plans/nursing documentation had improved. There was evidence that an improvement in the standard of auditing together with the analysis and trending of key performance indicators had lead to an improvement in the standard and quality of care being delivered. For example, inspectors found the standard of care plans/nursing documentation had improved (since the inspection of March 2016) on two of the three floors. In addition, results of fall audits now had an action plan to show how falls could
be prevented. These were then discussed at the risk management meetings, at staff meetings on floor level and this process had lead to a reduction in falls. However, audits on other areas of practice were identified as requiring improvement in the course of the inspection included medication management practices and evidence based nursing care.

The management team had identified the need for more senior clinical supervision on all of the three floors. They had managed this by ensuring the ADON responsible for clinical practices was relocated from managing the fifth floor to overseeing clinical practice over all three floors.

**Judgment:**
Substantially Compliant

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**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:**
Inspectors found that there was a guide available in respect of the centre and a written contract of care in place for each resident.

There was a guide provided given to each resident on admission. Inspectors saw a number of copies readily available at reception. The guide contained all the required information as per regulation 20.

Inspectors reviewed a sample of residents' contracts of care. All those reviewed contained information relation to the care and welfare of the resident and the services that would be provided to the residents. However, five of the six reviewed did not include the fee to be charged to the resident or the possible additional monthly charges that may be charged for the provision of ‘additional services’.

Each contract of care had been signed by the provider and the resident or their next of kin.

**Judgment:**
Non Compliant - Moderate

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**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 (PIC) was on duty during the inspection. She commenced in her dual role as provider and person in charge of the centre in 1981. She has been deemed fit to hold the post of PIC by HIQA. She submitted written evidence of her nursing experience and recent qualifications which assured HIQA she had 3/6 years experience of working with older people. She is contracted to work fulltime, is a registered nurse and has consistently kept herself up-to-date by attending conferences and courses in relation to the provision of care to older persons.

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

Findings:
Inspectors found the records listed in schedules 2, 3 and 4 of the regulations were maintained in a manner to ensure completeness, accuracy and ease of retrieval.

Inspectors reviewed residents' records. The directory of residents contained all of the information required in schedule 3. A sample of resident's files reviewed contained all of the health and medical information as listed in schedule 3.

Inspectors reviewed the centre's operational policies. The policies were found to be
regularly reviewed and all were up to date. However, inspectors found that some policies were not reflected in practice. This is mentioned in more detail under the specific outcome to which the policy relates too. This is a repeated non compliance.

All other records as per schedule 4 were maintained and readily available.

A sample of staff files were reviewed during the inspection and were found to contain all the requirements as per schedule 2 of the regulations.

**Judgment:**
Substantially Compliant

<table>
<thead>
<tr>
<th>Outcome 06: Absence of the Person in charge</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>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.</strong></td>
</tr>
</tbody>
</table>

**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 was aware of the requirement to notify the Chief Inspector of any proposed absence for a period of more than 28 days. There were appropriate arrangements in place for the management of the centre during any such absence.

**Judgment:**
Compliant

<table>
<thead>
<tr>
<th>Outcome 07: Safeguarding and Safety</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>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.</strong></td>
</tr>
</tbody>
</table>

**Theme:**
Safe care and support

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

**Findings:**
Inspectors found measures were in place to protect residents from abuse. Residents
spoken with felt safe and secure in the centre. A receptionist was based in the centre during the day and the front door was locked at night. There was a visitor’s book at reception, which all visitors, staff and work persons were required to sign on arrival and exit from the centre. Closed circuit television was in place in the grounds so night could see persons at door seeking admission to the centre.

There was a policy on restrictive practices that reflected the National Policy "Towards a Restraint Free Environment". It was reflected in practice as inspectors saw a restraint free environment was promoted. There was a minimum use of bedrails in use in the centre. The use of all physical restrictive practices were reviewed and monitored through regular assessment. These assessments clearly outlined the alternatives trialled, tested and failed prior to bed rails being used as a form of restraint. There was evidence that the resident and /or their next of kin were involved in this decision and had a care plan in place directing the care required for those with bed rails in use.

Residents' who displayed responsive behaviours had a corresponding care plan in place which reflected the triggers, de-escalation and management of such behaviours. There was no use of chemical restraint in the centre.

There was a policy on the protection of vulnerable adults, it referenced the Health Service Executive Safeguarding Vulnerable Persons at Risk of Abuse, National Policy & Procedures of 2014. There had been no incidents of suspected abuse in the centre that required notification to HIQA. The person in charge was familiar with the procedures to follow if an investigation was required. Inspectors spoke with staff who knew what action to take if they witnessed, suspected or had abuse disclosed to them. A sample of records reviewed confirmed that staff had received training on recognising and responding to elder abuse.

The centre was managing the finances of some residents on their behalf. There were satisfactory safeguarding arrangements, which were reviewed with a senior staff member. A clear system of recording all transactions was in operation. Residents' and where required two staff signed the records all cash transactions. However, although inspectors were informed these systems were being audited on a frequent basis, there was no record of these audits being kept and therefore the frequency of such audits was not evident. The policy read did not reflect the fact that they were audited.

**Judgment:**
Substantially Compliant

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**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:**
There were systems to protect and promote the health and safety of residents', visitors and staff. There were arrangements in place for the prevention and containment of fire. The management team were pro-active in managing risk.

Inspectors reviewed an up to date safety statement for the service. The risk management policy reflected the regulatory requirements. A risk register was maintained at centre. Risk assessments read were clear and detailed the controls in place to mitigate the likelihood of an adverse event, the risk rating, and the actions to protect residents from harm. Assessments included risk of assault through challenging behaviour and unexplained absence.

There were systems in place to manage and document accidents and incidents. Inspectors read records of accidents and events in the centre. The records included details of the incident, actions taken, risk rating and the learning to prevent reoccurrence. The majority of incidents were as a result of falls. It was noted that a very low number of serious injuries had resulted from the falls. Inspectors observed that residents were encouraged to mobilise and staff supervision was a priority.

A health and safety committee met every three months to review non clinical risks in the centre. A health and safety inspection was also completed on a monthly basis. Any issues would be brought to the maintenance department for their attention and to be addressed.

Staff had completed training in movement and handling and in the use of assistive equipment such as hoists. A physiotherapist employed full time in the centre facilitated the training. In addition, the physiotherapist assessed a resident if they had a fall and developed treatment plans for residents'. There were non-slip safe floor surfaces, handrails provided on staircases and hallways and call bells, to support residents and to mitigate the risk of harm coming to residents in the centre. The centre was clean and well maintained.

There were systems in place to reduce the risk of infection. There were wash hand basins in communal areas, and a sufficient supply of hand gel dispensers, plus disposable gloves and aprons. There were infection control guidelines to guide staff practice. The staff had also completed training in infection control measures. An emergency plan in place.

The provider got fire consultants in to review the centre for compliance with fire regulations. They had recommended work which required completion and at the time of the inspection a team of workers were in the centre completing this work. It was due to be completed within six weeks. The provider agreed to confirm in writing to the inspector when this work was completed. There were suitable fire fighting equipment provided for example, extinguishers, fire doors, emergency lighting and alarm equipment. Records were available to reflect that fire extinguishers were serviced on an annual basis, the fire alarm and emergency lighting on a quarterly basis. However, work in progress included the upgrading of the fire alarm system throughout the centre.
The fire evacuation procedures were prominently displayed in the centre. The staff were trained in fire safety, which they attended on an annual basis. Inspectors found staff were knowledgeable of their role and the evacuation of residents' in the event of fire. There were fire drills conducted every three/four months. There was plans to repeat these once the upgrading of fire systems were completed. The records included outcomes and observations to bring about improvement in efficiency of evacuation. The fire exits were unobstructed and twice daily checks were completed by staff. Personal fire evacuation plans were available in each residents' file.

Judgment:
Substantially Compliant

<table>
<thead>
<tr>
<th>Outcome 09: Medication Management</th>
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</thead>
<tbody>
<tr>
<td>Each resident is protected by the designated centre’s policies and procedures for medication management.</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: |
| There were medicines management policies and procedures in place. However, not all practices were reflected in policy. There had been some improvements made under this outcome since the last inspection, however further improvements were required. |

Inspectors observed the practices of nursing staff administering medications in two units. Nurses spoken with were knowledgeable with the policies and familiar with best practice in the administration of residents' medications. However, medication prescriptions did not clearly state the dose of the medication to be administered. This lack of a clarity had the potential to lead to administration errors and was a repeated non compliance.

There was a medicines management policy in place that provided comprehensive guidance to staff. However, it was not fully implemented in practice in relation the administration of medications on an as and when required (PRN) basis. For example, the rationale for the use of the PRN medication was not stated on the prescription sheet to ensure consistent practices were followed. The maximum dose to be administered within a 24 hours time period was not consistently indicated on all prescription sheets.

Medications were securely stored in each unit in a dedicated a treatment room inside a locked trolley. A secure fridge was also provided in each unit for medications that required specific temperature control. Inspectors noted that the temperature on the recorded every day was now within acceptable limits that is five degrees Celsius or less.
Inspectors saw that there was safe procedures for the disposal of medications which were out of date or dispensed and no longer needed. All medication returns were recorded, signed by a nurse and the pharmacist prior to being returned to the pharmacy for disposal.

There were systems in place to review residents' medications every three months. A multi-disciplinary team consisting of the in-house general practitioner (GP), pharmacy and a nurse met every three months to review all residents’ medications.

Where medication errors had occurred in the centre, there were incident form completed that included details of an investigation carried out. There was evidence of appropriate action taken, and shared learning with staff to bring about improvements in practice. All medication error record forms had been signed off by the person in charge and medication errors were included in monthly key performance indicators.

The pharmacy service audited and reviewed medication practices. However, Inspectors were unable to ascertain what improvements or learning had come about from the audits. A monthly quality report included a review of medicine management however, it did not include medication practices. Inspectors noted that there was no audit being completed by the senior nursing management team to ensure medication practices including prescriptions and administration practices reflected the centres policy and evidence based practice.

Medications that required strict control measures (MDAs) were carefully managed and kept in a secure cabinet at unit level. This was in keeping with professional guidelines. Nurses kept a register of MDAs. The stock balance was checked and signed by two nurses at the change of each shift. Inspectors checked balances and found them to be correct.

All nurses had completed annual medicines management training in February 2016.

**Judgment:**
Non Compliant - Moderate

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**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 cross referenced notifications submitted to the Authority since the last inspection with records of all accidents and incidents recorded in the centre. All
reportable accidents and incidents had been notified to the Authority by the person in charge in a timely manner.

**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):

No actions were required from the previous inspection.

**Findings:**
Inspectors were satisfied that the healthcare needs of residents' were being met. Improvements in the standard of nursing documentation was evident in two of three floors.

Residents had access to general practitioner (GP) services on site as there was a in-house general practitioner (GP) available at all times to residents’. Residents' had access to a full range of other services on referral including speech and language therapy (SALT), dietetic services, physiotherapy and occupational therapy. Chiropody, dental and optical services were also provided. Psychiatry for older persons community services were also been consulted. Letters of referrals and appointments were seen on residents' files.

Inspectors saw evidence that residents' had a pre-admission assessment completed prior to admission and were comprehensively assessed within 48 hours of admission. Nursing assessments, care planning and additional clinical risk assessments were carried out for residents using evidence based assessments tools. Residents and/or relatives confirmed they were involved in the development of their care plans. Inspectors reviewed a sample of residents’ records and found that on one of the three floors some improvements were still required. On this one floor inspectors found gaps in relation to nursing documentation particularly resident assessments and care plans. The issue was that they did not always reflect the resident's status, needs and had not been updated to reflect recommendations made by allied health care team members.

There were policies in place for the management of residents’ nutritional needs and a falls management policy. There was evidence that through clear consistent auditing systems being implemented that these areas of clinical practice had improved since the
last inspection. Inspectors found policies and procedures were in place for the management of wound care. Staff were familiar with wound care procedures and wounds identified at the beginning of the inspection were managed in accordance with evidence based practice.

Areas of nursing care identified by inspectors on day one of the inspection as requiring review to ensure they reflected evidence based practice included: the use of additional bed sheets used on the beds of residents with maximum dependency who were assessed as being incontinent and the storage of incontinence disposal units in corridors. On day two of the inspection the use of additional sheets on maximum dependent residents' beds had ceased. The incontinence disposal units were now stored in the dirty utility on each floor.

Inspectors found the social care needs of residents' were fully met. There was a detailed and up-to-date programme of activities displayed in the reception area and throughout the building. Inspectors noted activities took place two or three hours a day and consisted mostly of group activities such as exercise classes, bingo, and on other days, music sessions. There was a café that residents could also visit. Inspectors observed residents attending morning mass, going to the coffee shop or partaking in the activities. Residents' who spoke to inspectors confirmed they had a wide range of interesting things to do during the day. In addition, a number of external service providers also visited the centre to facilitate activities.

Judgment:
Substantially 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):
No actions were required from the previous inspection.

Findings:
The premises reflected that stated in the statement of purpose and met the needs of residents'.

The centre was clean and homely throughout. All bedrooms were single with a toilet and wash hand basin ensuite. Residents' told inspectors that they were encouraged to personalise their bedroom and inspectors saw evidence of this. Residents' had access to a lockable storage space in their bedroom.
Residents occupied the third, fourth and fifth floor of the centre. There were a number of sitting rooms and a dining room available on each floor. Residents on the third floor had access to the garden and residents on the fourth floor had access to a balcony which had views over Dalkey harbour. There was also a secure enclosed outdoor seating area which residents could access independently. There was a kitchenette located on each floor which staff accessed to prepare light meals and refreshments for residents.

There were enough assisted toilets, toilets and bathrooms on each floor to meet the needs of residents. There was also a treatment room, dirty utility and adequate storage space for equipment on each floor.

The large industrial style laundry was segregated for clean and dirty laundry and contained all required equipment. There had been additional signage throughout the floors occupied by residents enabling them to navigate their way around the centre.

There was a lift accessible to residents linking all floors. The corridors were wide with handrails on both sides.

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 procedure.

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:**
Inspectors found the provider had a proactive approach to the management of complaints in the centre.

There were policies and procedures in place for the management of complaints that met the requirements of the regulations. The procedure was on display throughout the centre. The person in charge was responsible for investigating complaints.

There was a nominated person responsible for ensuring that all complaints were appropriately responded to and that records are maintained. An independent person was available if complainants wished to make an appeal.

Inspectors reviewed a complaints log which clearly documented the complaints received in the centre. The records included details and the action taken in response to
complaints and how the complaints were resolved. The satisfaction of the complainant with the outcome of the complaint was also recorded.

Inspectors spoke to various residents’ and staff members, and found that they were aware of the complaints procedure. Residents' expressed a high level of satisfaction with the care they received and spoke positively about living in the centre.

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:
Residents received a good standard of end of life care, which respected their individual needs. There were written operational policies and protocols in place and these were reflected in practice.

inspectors reviewed a sample of residents end of life assessments and care plans. The plans covered the residents identified needs, and any wishes that they had expressed. They covered resident’s preference for treatment, preferred place for death, any religious and spiritual wishes, and any plans they wanted to be carried out following their death, for example the type of service they wanted and where they would like to be buried. They were extremely detailed and person-centred.

There were some ‘do not attempt resuscitation’ orders recorded in some general practitioner (GP) notes for individual residents. They recorded the outcomes of residents and relative meetings to discuss their wishes, and the decision made, agreed by the GP where appropriate. This was recorded in their end of life care plan, there was also a colour coded system used, so the information could be accessed at a glance. Decisions were seen to be reviewed by the GP.

Palliative care services were available to those who needed it, and staff spoken with said the service was very supportive of residents in the centre. The in-house Doctor was available to review residents as required. All of the bedrooms in the centre were single, and afforded the resident privacy. There was a spare room available for use by residents’ family at the time of death.

On the first day of this inspection there was one resident receiving end of life care. The
staff were seen to know the needs of the residents well, respecting their choices and preferences and a member of staff was allocated to sit with the dying resident in the absence of family.

The person in charge stated residents were notified individually of a resident’s death, and Mass would be offered in the chapel where other residents, staff, family and friends can attend.

**Judgment:**
Compliant

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**Outcome 15: Food and Nutrition**

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

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

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

**Findings:**
Inspectors observed lunch time service in two dining rooms. Residents spoken with told inspectors they enjoyed the food and the choices available to them.

Dining areas were appropriately furnished and welcoming. Inspectors saw table settings were pleasant, included condiments, napkins and appropriate place settings for all residents. The atmosphere was calm with music playing softly in the background. Residents were offered a choice at lunch time and they obtained their preferred food and drink. There was good supervision by staff and assistance was offered to residents and provided to those who required it in a professional discreet manner. However, to ensure residents’ dignity was maintained to a high standard the routine use of long cheque protective clothing on residents’ in the dining room on the 5th floor required review.

A variety of snacks, hot and cold drinks were offered to residents’ between meals.

There was a policy in place to guide and inform staff on the procedures to ensure residents’ nutritional and hydration needs were met. Residents’ nutritional status were monitored. Documentation reviewed showed that each residents’ weight was checked routinely on a monthly basis. However, where the residents nutritional status had changed and weekly weights were required, these were not always recorded (this is actioned under outcome 11). In addition, residents had a Malnutrition Universal Screening Tool (MUST tool) completed on admission and every three months thereafter. Those at risk were referred to multidisciplinary team members for assessment without
delay. Each resident had a care plan in place which reflected their nutritional care needs.

Staff spoken with both catering and care staff had a good knowledge of residents’ nutritional needs. Records held by catering staff did not reflect each residents preferred diet, required diet and consistency when cross referenced with their most recent assessment. This was identified on day one of the inspection and on day two inspectors saw this had been addressed and a system put in place to ensure records routinely reflected the residents nutritional assessed needs. The person in charge was now responsible for updating the catering department once per week with this information.

**Judgment:**
Substantially Compliant

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

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

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

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

**Findings:**

There were policies in place to address communication in the centre including the communication needs of residents’. Inspectors saw residents were facilitated and encouraged to communicate.

A programme of activities was in place and displayed throughout the centre. Activities were scheduled seven days per week. Residents spoken with were satisfied with the wide variety of activities available to them. They confirmed that they were given the choice to take part or not. There were activity sessions to meet the needs of residents diagnosed with dementia sensory and music prompts. Staff also did 1:1 activities with residents who spent extended periods of time in their bedroom. Inspectors saw staff sitting with a number of residents' while they played bingo, a resident had been nominated as the caller and appeared to be proficient in carrying out this role.

Residents confirmed that they were treated with respect and dignity at all times and said that they felt valued. Feedback was sought from them in relation to how the centre was run and this was feedback via a residents' representative appointed from each of the three floors. The resident representatives attended the residents meetings which took place every quarter. They were facilitated by an external facilitator, the person in charge was sent a copy of the minutes and she followed up on any required actions prior to the next meeting. Minutes of the three residents’ meetings which had taken place to date in
2016 were available for review. Copies of the minutes of these meetings were on display on residents' notice boards on each floor, together with contact details of an advocacy service.

All residents were registered to vote and those spoken with told inspectors they were facilitated to vote within the centre at election and or referendum time. The religious needs of residents were met. The centre had a chaplain available 24/7 and Mass was said in the centres large oratory daily. Resident families were welcomed to attend. Church leaders from other religions were also welcomed in the centre. The local Church of Ireland priest visited the centre once every few weeks to visit a small number of residents.

Televisions were available in each residents' bedroom and in communal sitting rooms. These were connected to a standard number of televisions channels. Residents had a choice of having a private telephone in their bedroom and they had access to a portable telephone at the nurses’ station on each floor. A number of residents' had completed a basic computer skill course which was facilitated by age action and the activities co-ordinator was in the process of arranging a refresher course for January 2017. Internet was available in the centre and Skype could be set up on a computer if required however, those who used it had this facility on their personal device.

External trips were organised for day time and evening events outside of the centre. However, there was not always a high numbers of attendees.

Inspectors observed a lot of residents' leaving the home independently. The home is situated within walking distance of Dalkey village and directly in front of a picturesque harbour. There were lots of visitors in and out of the home, some attending Mass. Facilities provided for visitors included private visitor rooms and access to the manned coffee shop situated close to the main reception desk.

Inspectors observed that residents knew the person in charge by her first name and residents’ and relatives who completed these questionnaires wrote positively about her.

**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 a policy in place on residents' personal property, finances and possessions. Inspectors saw that a list of residents' personal possessions was recorded on their admission to the centre.

There were suitable laundry facilities to ensure linen and residents' clothes would be regularly laundered and returned to the relevant floor. Inspectors were informed residents clothing was labelled with their room number and observed that two of three pieces of clothing in the laundry did not contain a room number. This process required review to ensure it was robust enough to prevent clothing going missing.

There was adequate storage in the form of a locker and a wardrobe for each resident, and all had a lockable storage area in their bedroom.

**Judgment:**
Substantially Compliant

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**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):**
No actions were required from the previous inspection.

**Findings:**
There were sufficient numbers of staff with the right skills, qualifications and experience to meet the assessed needs of the residents in the centre at the time of this inspection.

There was an actual and planned staff rota, the actual rosters reflected the name and role of each staff member on duty.

Records submitted and reviewed post the inspection confirmed that most staff had mandatory education and training in place. Staff had also been provided with in-house education on a variety of topics, such as, food hygiene and infection control. Staff nurses had completed training in medication management and cardio pulmonary resuscitation.
Staff meetings were held and minutes of these meetings were available for review. The management team had sourced a revised appraisal template for staff appraisals. Inspectors were informed that appraisals using the new template were due to begin and a timeframe had been set for all staff to have one completed within the next 6 months.

A recruitment policy was in place and that was implemented in practice. Inspectors reviewed four staff files. They contained all the requirements outlined in schedule 2 of the regulations. There were copies of each nurses registration details with An Bord Altranais agus Cnaimhseachais na hEirneann (Nursing and Midwifery Board of Ireland) for 2016.

**Judgment:**
Compliant

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**Closing the Visit**

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

**Acknowledgements**

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

**Report Compiled by:**

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

<table>
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<tr>
<th>Centre name:</th>
<th>Our Lady's Manor</th>
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<td>OSV-0000080</td>
</tr>
<tr>
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<td>01/11/2016</td>
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<tr>
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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:
The management systems in the centre were not fully effective and required improvement.

1. Action Required:
Under Regulation 23(c) you are required to: Put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Please state the actions you have taken or are planning to take:
Robust audit processes have been put in place to ensure audits in medication management practices as well as other evidence based nursing audits bring about learning from monitoring and auditing and to monitor the quality and safety of care delivered to residents. These processes will enhance the monthly auditing of monthly key performance indicators already in place.

**Proposed Timescale:** 09/12/2016

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### Outcome 03: Information for residents

**Theme:**
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Contracts of care did not clearly set out the fees and or additional fees being charged/may be charged to the resident.

2. **Action Required:**
Under Regulation 24(2)(b) you are required to: Ensure the agreement referred to in regulation 24 (1) relates to the care and welfare of the resident in the designated centre and includes details of the fees, if any, to be charged for such services.

Please state the actions you have taken or are planning to take:
Since the inspection all residents have had a revised contract of care outlining the fee charged to the resident and the additional charges which may be incurred.

**Proposed Timescale:** 09/12/2016

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### 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:
The policies on the prevention of abuse and nutrition and hydration did not fully guide staff practice.

3. **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:
The prevention of abuse and nutrition policies are currently being reviewed to ensure best local practice. All staff have been advised on the importance of adhering to local policies and ensuring that practice is reflective in care delivery.

Proposed Timescale: 31/01/2017

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:
There was no evidence that the management of resident finances were being audited on a consistent basis.

4. 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:
A robust system which is in place will now keep records of audits being conducted on residents finances and will be part of the overall audit strategy. These audits will be completed monthly.

Proposed Timescale: 09/12/2016

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:
Confirmation of compliance with fire regulations is required to be submitted post the completion of current work on the fire systems

5. Action Required:
Under Regulation 28(1)(a) you are required to: Take adequate precautions against the risk of fire, and provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.

Please state the actions you have taken or are planning to take:
The existing works are now completed and certificate of compliance has been forwarded.
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:
The prescription of PRN medicines did not clearly outline the rationale for the use and administration of these medicines to guide staff practice.
The maximum dose to be administered within a 24 hour time period was not consistently documented on the prescription sheet.
The prescription of medicines were not clear. The dose of the drug to be administered was not always clear.
There was no system in place to audit medicine management.

6. 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:
Since the inspection the medication prescription sheet has been changed and the dose is now clear of dosage to be administered. The use of PRN administration of medications is now clearly stated on the prescription sheet to ensure consistent practices. The maximum dose to be administered within a 24-hour time period will be identified for all appropriate medications as indicated by the prescribing GP.

The pharmacy audits will be part of the audit strategy for the centre and will identify areas of improvement and learning from the audits.

Monthly audits are now in place by senior nursing teams to ensure medication practices including prescriptions and administration practices reflect the centre’s policy and evidence based practice.

Proposed Timescale: 31/01/2017

Outcome 11: Health and Social Care Needs

Theme:
Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Care plans were not developed for all residents assessed needs.

Care plans did not consistently reflect good practice or guide the care to be delivered to residents.

The recommendations of allied health professionals were not consistently incorporated into care plans.

7. **Action Required:**

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

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

All residents have care plans developed for their individual needs and the nurses are working to ensure that care plans reflect and guide the individual care required. This will be monitored by audit on an ongoing basis.

The in-house physiotherapist works closely with nursing staff to ensure that care plans reflect multidisciplinary team recommendations. Systems are now in place to ensure that the care is reflected in the nursing care plans and will be monitored through regular audits. A policy for external allied health professionals has been put in place to ensure that the recommendations are reflected in the care plans.

**Proposed Timescale:** 31/12/2016

**Outcome 15: Food and Nutrition**

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

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

The routine use of protective clothing in the dining room on the 5th floor required review to ensure the dignity of residents was maintained.

8. **Action Required:**

Under Regulation 18(3) you are required to: Ensure that an adequate number of staff are available to assist residents at meals and when other refreshments are served.

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

Dignity and respect is our priority to all residents. After reviewing the existing protective clothing we have researched two alternatives and are testing them at present. All residents have it clearly documented in their care plans that they would like to protect their clothes at meal times. Only residents who require protective clothing are assessed and their dignity is maintained always by ensuring their clothes are kept clean and dry.
Proposed Timescale: 09/12/2016

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:
The process for labelling resident clothing required review to ensure it was robust enough to prevent clothing going missing.

9. 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:
Audit of the laundry will take place monthly to ensure all clothes are labelled. New residents are reminded to label clothes. Next of kin of existing residents who need new clothes since inspection have been asked to label the items. The residents who have no immediate next of kin will have new clothing labelled by care staff.

Proposed Timescale: 09/12/2016