

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Our Lady's Manor
Centre ID:	OSV-0000080
Centre address:	Bulloch Castle, Dalkey, Co. Dublin.
Telephone number:	01 280 6993
Email address:	ourladysmanor1@eircom.net
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Our Lady's Manor Incorporated
Provider Nominee:	Sr. Bernadette Murphy
Lead inspector:	Deirdre Byrne
Support inspector(s):	Jim Kee;Leanne Crowe
Type of inspection	Unannounced
Number of residents on the date of inspection:	102
Number of vacancies on the date of inspection:	16

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 monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 31 March 2016 09:30 To: 31 March 2016 19:30

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

Outcome	Our Judgment
Outcome 02: Governance and Management	Non Compliant - Major
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Substantially Compliant
Outcome 07: Safeguarding and Safety	Non Compliant - Moderate
Outcome 08: Health and Safety and Risk Management	Compliant
Outcome 09: Medication Management	Non Compliant - Moderate
Outcome 11: Health and Social Care Needs	Non Compliant - Moderate
Outcome 13: Complaints procedures	Substantially Compliant
Outcome 18: Suitable Staffing	Compliant

Summary of findings from this inspection

This inspection took place to assess ongoing compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Standards of Residential Care Settings for Older People in Ireland 2009.

As part of this inspection, inspectors met with residents' and staff members. They observed practices and reviewed documentation such as care plans, accident logs, policies and procedures. Inspectors met the person in charge who was present during the inspection. An area of significant improvement was identified in the completion of residents' assessments and care plans which the provider was required to take immediate action to address. A satisfactory action plan was submitted after the inspection. This is discussed within the report.

Inspectors observed staff who interacted with residents' in a kind, dignified and respectful manner. The staff in turn were knowledgeable of the health care needs of residents, along with their social care needs.

There were measures in place for the prevention of abuse and the provider ensured a restraint free environment was promoted. The staffing levels and skill mix were adequate to meet the assessed needs of residents, and robust recruitment arrangements were followed. Staff received mandatory as well as a wide range of training to meet the identified needs of the residents.

However, along with the issues outlined above, there were other areas of improvement identified, and these are described in relation to Outcomes on: governance, safeguarding and safety, medication management and health and social care needs.

There were no actions from the previous inspection of August 2014.

The issues are outlined in the body of the report and Action plan at the end of the report.

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 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:

Inspectors found there was a clearly defined management structure that outlined the lines of authority and accountability in the centre. However, improvements were identified regarding the ongoing review of the quality and safety of life of residents' and completion of an annual report as per the regulations.

The registered provider of the designated centre is Our Lady's Manor Incorporated. The person in charge worked full time in centre, and was also the person nominated to represent the provider (the provider). The person in charge reported formally to the provider on an annual basis. The provider in turn carried out annual inspections of the service in which recommendation and findings were presented in a report. The reports of these inspections were not seen by inspectors.

There were systems in place for the management of the centre. The person in charge had delegated responsibility at unit level with a clinical nurse manager grade 2 (CNM2) overseeing their management. The three CNM2s reported directly to the person in charge. There were staff meetings at each unit on a three monthly basis and the recent minutes of these were read. A range of topics were discussed in the minutes of the most recent meeting read. For example, incidents, staff issues, and risk management.

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 most recent meeting held on the 1 February 2016 was read by inspectors. Issues in relation to nutrition and care planning had also been discussed at the meeting however, no action plan had been developed to address them. This was an area also found to require improvement as discussed in Outcome 11,

There were some systems in place to monitor the quality and safety of care. Inspectors

reviewed audits of falls prevention and complaints. The prevention of falls was also discussed at the risk management meetings and the general staff meetings. However, audits on other areas which were identified as requiring improvement in the course of the inspection were not completed for example, care planning, medication practices and weight monitoring, therefore the system required improvement.

The person in charge collected a range of key performance indicators each month for example, falls, use of restraint, psychotropic medications, pressure sores and episodes of behaviour that challenge. However, there was no analysis of the information for trends, therefore it could not be ascertained what improvements and learning had taken place.

The provider had yet developed an annual report on the overall review of the safety and quality of care provided residents'. This was discussed with the person in charge, who assured inspectors a review would be completed and forwarded to the Authority in due course.

Judgment:

Non Compliant - Major

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:

Inspectors were satisfied that the centre was managed full time by a registered nurse with experience in care of the elderly. This outcome is compliant however, and where improvements were identified, they are actioned under the outcomes referred to below.

The person in charge is suitably qualified and experienced. She is a registered general nurse with many years experience in the area of care of the elderly and in the management of the centre. Inspectors found there were some gaps in the person in charge's knowledge of the relevant legislation and her responsibilities therein, as evidenced and reported on in the following area: aspects of residents' healthcare needs and care planning/assessment (outcome 11). These matters were discussed with the person in charge during the inspection, who acknowledged this and assured inspectors improvements would be carried out.

The person in charge was knowledgeable of the residents' and their assessed health and social care needs. It was evident she very familiar with the residents', and was observed stopping to greet and talk with residents.

The person in charge continued her own professional development, through attendance at various training days, seminars and talks. She had a gerontology qualification.

She was deputised and supported in her role by an assistant administrator who worked full time in the centre and was a registered general nurse. In addition, the CNM2s also deputised in her absence.

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):
No actions were required from the previous inspection.

Findings:
Inspectors found an area of improvement in the review of policies and a gap in the service records required to be kept for fire fighting equipment.

There were policies and procedures in place as required by schedule 5 of the regulations. Inspectors found most policies were up-to-date. However, the policies on the management of nutrition and hydration and the protection of vulnerable adults were not fully up-to-date to guide staff practice. This is detailed under outcome 7 and 11.

A gap was found in the maintenance of service records for extinguishers and the fire alarm system. This is discussed under outcome 8.

Judgment:
Substantially 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:

Inspectors found measures were place to protect residents and the management of the risk of abuse. The provider ensured a restraint free environment was promoted. However, an area of improvement was identified.

There was a policy on restrictive practices that reflected the National Policy "Towards a Restraint Free Environment". It was evident a restraint free environment was promoted in the centre. Since the last inspection, there was a large reduction in the number of bedrails in use in the centre. Records were read by inspectors that confirmed only six residents' required bedrails (on both sides) to be used. The person in charge attributed this to the on-going and regular discussion with residents' and the risk assessment process.

The use of all physical restrictive practices were reviewed and monitored through regular assessment. However, the implementation of the policy required improvement. For example, care plans were not developed when bed rails were required (this is discussed under Outcome 11). In addition, there was inconsistent evidence that consent in the use of bed rails had been obtained from residents'. Consultation took place with a representative where required. While the alternatives to bed rails were documented, they did not fully reflect those outlined in the policy. For example, low beds, crash mats or other means were not considered in the first instance.

Inspectors reviewed incident reports in relation to resident's behaviour, and it was seen that a follow up of each incident was carried out with a risk assessment, and identification of any changes needed to reduce the possibility of it occurring again. However, there was no corresponding care plan developed to guide staff (see Outcome 11).

There was a policy on the protection of vulnerable adults in place that was dated 2015. However, it was not updated to reflect or reference the Health Service Executive Safeguarding Vulnerable Persons at Risk of Abuse, National Policy & Procedures of 2014 (see outcome 5). 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. They also explained what they would do if they were concerned about a colleagues behaviour. Records were read that 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.

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. A receptionist was based in the centre during the day.

Judgment:

Non Compliant - Moderate

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

Theme:

Safe care and support

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

The provider had ensured 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.

Inspectors reviewed an up to date safety statement for the service. The provider had policies on risk management that met the requirement of the regulations. 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, and the learning to prevent reoccurrence. There had been 20 documented incidents involving residents' between January 2016 and the end of February 2016. 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 falls audit was completed however, there was no analysis or trending of the data by management to identify any areas for change or improvement. This is discussed in Outcome 2 (Governance).

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.

Adequate arrangements were in place for the containment and prevention of the spread of fire. There were suitable fire fighting equipment provided for example, extinguishers, fire doors, emergency lighting and alarm equipment. It was evident the equipment was regularly serviced. However, there was no record of the most up-to-date service reports for the fire extinguishers and fire alarm. This was discussed with the person in charge, who told inspectors all equipment had been routinely serviced, and in future all documentation would be in place. See Outcome 5 (documentation).

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 six months. 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.

Judgment:

Compliant

Outcome 09: Medication Management

Each resident is protected by the designated centre's policies and procedures for medication management.

Theme:

Safe care and support

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

There were medication management policies and procedures in place however, they were not fully implemented in practice to ensure residents' were safe.

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, on occasion some staff did not check the prescription sheet before administering medications. This is not in line with professional guidelines. See outcome 11. Inspectors also found that there was a discrepancy between the prescribed dose for one medicine for one resident and the dose being administered. The nurse in charge of the floor contacted the prescriber to clarify the issue.

There was a medication management policy in place that provided comprehensive guidance to staff. However, it was not fully implemented in practice in relation to 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 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 thermometer stated 13 degrees Celsius, and this had been the temperature recorded every day for the month of March which was not within acceptable limits. No action had been taken to correct it. This was brought to the attention of nursing staff and the person in charge.

Nursing staff reported that medications which are out of date or dispensed to a resident but are no longer needed are stored in a secure manner, segregated from other medicinal products and are returned to the pharmacy for disposal. However, an inspector observed that the date of opening was not recorded for a formulation that had a reduced expiry when opened. Therefore, staff could not identify when this medicine was due to expire.

There were systems in place to review residents' medications every three months. A multi-disciplinary team consisting of a 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 forms 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.

The pharmacy service audited and reviewed medication practices. However, records of the audit findings were not maintained. Inspectors were unable to ascertain what improvements or learning had come about from the audits. A monthly quality report included a review of medication management however, it did not include medication practices, storage and errors. See outcome 2.

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 a sample of balances and found them to be correct.

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

Judgment:

Non Compliant - Moderate

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 found nursing staff had a very good knowledge of the residents' healthcare needs however, improvements were required in the management and monitoring of weight loss and the documentation and review of care plans.

Inspectors found all residents' were comprehensively assessed on admission to the centre. There were recognised tools used to assess residents' clinical needs. However, these tools were not utilised to re-assess healthcare needs on a four monthly basis. Instead a screening tool was regularly used to assess residents' needs for risk of falls, nutrition, dependency level, skin integrity and cognition. Inspectors found residents' information was documented clearly on a daily basis in their nursing notes or within the vital signs records completed on a monthly basis for example, body mass index, weight, blood pressure, temperature.

The nursing staff were familiar with the residents' and spoke knowledgeably of their healthcare needs however, the documentation and review of care plans in the centre require improvement:

- The care plans for some residents' did not reflect staff practices or the care to be delivered to residents. For example, bedrails use, falls prevention, catheter care, diabetes management and weight loss.
- Care plans were not consistently updated or reviewed on four monthly basis or as their needs changed, and some had not been reviewed in nearly one year.
- The recommendations of allied health professionals were not consistently incorporated into care plans e.g. dieticians prescribed treatment.

- There was inconsistent evidence that the residents and where appropriate the next of kin had been consulted in relation to the development of care plans.

These matters were discussed with the person in charge who assured inspectors appropriate action would be taken to address the issues identified. The person in charge submitted a satisfactory action plan after the inspection that outlined the all of the measure taken.

There were policies in place for the management of residents' nutritional needs. However, these were not fully implemented in practice in relation to the monitoring of residents' at risk of weight loss. Inspectors read the records of three residents' who had lost in excess of 3kg in over three months. While two residents' had been referred to a dietician, one resident was not. The care plans for the resident was not fully implemented in practice. For example, weekly weights were stated to be carried out but these were not being done in practice. These issues had been identified at recent management meetings however, action had yet to be taken to address them. The person in charge assured inspectors that appropriate action would be taken, and following the inspection, an action plan was submitted that confirmed a review of all residents at risk of weight loss had been reviewed.

Inspectors reviewed practices in the management of falls. A falls policy was in place that provided direction to staff. It included guidance on the post fall procedures to be followed. Neurological observations were completed after a fall and records read by inspectors confirmed this. An accident/incident form was completed following each fall. Care plans were developed for residents assessed as risk of falls. However, as outlined above care plans were not consistently updated after a fall to include the interventions to be put in place to prevent falls occurring in the future or if residents' mobility needs changed.

Inspectors found policies and procedures were in place for the management of wound care. Staff were familiar with wound care procedures.

Residents' healthcare needs were supported by good access to GP services and an out-of-hours GP service was available. The residents' had good access to a range of allied health professionals for example, dietician, speech and language therapist and psychiatric services. A full time physiotherapist was employed by the service. Letters of referrals and appointments were seen on residents' files, with one area of improvement as outlined above.

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:

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:

Inspectors found the provider had a proactive approach to the management of complaints in the centre. A small area of improvement was identified.

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. A nominated person was responsible for investigating complaints however; this person's details were not reflected in the complaints procedure.

There is 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.

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):

No actions were required from the previous inspection.

Findings:

Inspectors found there were good practices in place for the recruitment of staff and there was an adequate staff and skill mix on the day of the inspection. Staff completed mandatory training, and a wide ranging training programme was available to all staff.

It was evident the provider took a proactive approach to facilitating training to meet the assessed needs of residents' and to enhance staffs knowledge. There was a training calendar developed on an annual basis. A range of training events took place on a regular basis both in the centre and off site. Staff were provided with time to attend this training. Training provided included: infection control, care plan review, venepuncture, dementia care, medication management and movement and handling.

The staff had completed mandatory training required by the regulations. Staff were required to complete annual fire safety and prevention of abuse training. Some staff had also completed training in the management of challenging behaviours. Inspectors spoke to staff who confirmed they had completed the training and were familiar with procedures in these areas.

The records of training consisted of attendance sheets signed by staff or training certificates. Inspectors noted there was no formal system to record any deficits such as the staff who had not attended training or were out of date. Therefore it was not possible to ascertain any gaps in mandatory training. This was discussed with the person in charge who assured inspectors all staff had completed annual training.

Inspectors were satisfied there was an adequate staff and skill mix on the day of the inspection. A planned roster was read by inspectors, and this confirmed that adequate staff were in place. The person in charge described the procedures if new staff commenced work. There was a formal induction programme and checklists were completed by staff during their probationary period. There was an annual appraisal system for staff in place.

A recruitment policy was in place that was implemented in practice. Inspectors reviewed four staff files and they contained all of the information required by 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

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:

Deirdre Byrne
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 report¹

Centre name:	Our Lady's Manor
Centre ID:	OSV-0000080
Date of inspection:	31/03/2016
Date of response:	19/05/2016

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:

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

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

monitored.

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

1. We have arranged training for the risk management team, including the person in charge, CNMs and staff nurses on

- trending and analysis of quality and safety data collected on a monthly basis.
- Identifying improvement activities required based on the analysis.
- Developing action plans for improvement.
- Monitoring improvement plans and updating as required.

This training has been arranged for the 11/05/2016.

2. We have arranged training also for the above staff to enter incidents, complaints and other quality and safety data into the electronic system in use, so that accumulated data can be retrieved easily to facilitate trending and analysis at risk management team meetings – week ending 27/05/2016.

3. Commencing May 30th, all complaints, incidents and events will be recorded onto the electronic system in place.

4. Commencing at the risk management meeting in the first week of July, all quality and safety data will be trended and analysed at these meetings and action plans developed to address improvements required. These actions will be added to the clinical governance improvement plan for the centre, which will be updated at each meeting.

5. An annual audit programme will be developed for our centre that will outline the following audit activity:

- Collection of key quality and safety data on a continuous basis.
- Trending and analysis of this data at risk management team meetings.
- Clinical 'criteria' based audits that will be carried out on a scheduled basis and additional 'criteria' based audits that will be undertaken as indicated by trending and analysis of key quality and safety data – week ending 27/05/2016.

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:

There is no annual review of the quality and safety of care delivered to residents.

2. 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 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:

We will undertake a comprehensive annual review of the quality and safety of our service against the regulations (2013) and national standards (2016) – week ending 01/07/2016.

Proposed Timescale: 01/07/2016

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:

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:

We will review and update our policies on prevention of abuse and nutrition and hydration to ensure that they are reflective of national policies and guidance and to direct resident care.

Proposed Timescale: 27/05/2016

Theme:

Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Not all fire-fighting records were maintained for inspectors to review.

4. 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:

The fire maintenance records are now up to date.

Proposed Timescale: 19/05/2016

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 inconsistent documented evidence that all alternatives to the use of restraint were considered.

There was lack of consultation with all residents in the use of restrictive practices.

5. Action Required:

Under Regulation 07(3) you are required to: Ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.

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

We will review and update our policy to ensure that it provides detailed guidance to staff on the need to consider and record alternatives tried prior to the initiation of any form of restraint.

As part of the plan submitted to the inspectors for care planning, consultation with residents about proposed restrictive practices will be undertaken and recorded in the care plan meetings section of the electronic care plan. Where a resident declines or is unable to take part in consultation, this will also be recorded in the resident's care plan.

Proposed Timescale: 03/06/2016

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 date of opening on some containers of medications was not provided therefore it could not be ascertained the use by date of the medication.

The thermometer readings on the medication fridge indicated temperatures were in excess of best practice guidelines.

6. Action Required:

Under Regulation 29(4) you are required to: Store all medicinal products dispensed or supplied to a resident securely at the centre.

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

A new thermometer is now in use for medication fridges and the form for recording the

thermometer states the required temperature range so as to alert nursing staff to inform the person in charge of any reading that exceeds this range.

We will meet with nursing staff to remind them of the need to record the date of opening on eye drops and other similar medications and other findings of this inspection related to medication management. A notice of reminder will be displayed in each nurses' office.

Proposed Timescale: 27/05/2016

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 medications did not clearly outline the rationale for the use and administration of these medications to guide staff practice. The maximum dose to be administered within a 24 hour time period was not consistently documented on the prescription sheet. There was a discrepancy between the prescribed dose for one medicine as documented on the prescription sheet and the dose being administered to the resident.

7. Action Required:

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

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

1. We will liaise with the prescribing GPs and dispensing pharmacist to ensure that prescriptions are written in accordance with the requirements.
2. With regard to the discrepancy between a prescribed dose and the dose being administered, the resident's prescriber had instructed the staff to administer the dose that was given on the day of inspection. A prescription for same was written and sent to the pharmacy for dispensing. The prescriber had not amended the prescription sheet to reflect the changed order. Following the query by the inspector, the prescriber was called to verify that the dose administered was correct.

We will meet with staff nurses to reinforce that either a written prescription or remote order that has been received and recorded in accordance with professional guidance must be in place in order to administer a medicine to a resident.

Proposed Timescale: 27/05/2016

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:

Evidence based tools to assess residents' health-care needs were not consistently used by nursing staff.

Care plans were not consistently reviewed at a minimum every four months.

There was no evidence of residents or their representatives' involvement in their care plan review.

8. Action Required:

Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.

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

Since the inspection, we commenced an action plan to ensure that residents' care plans are reviewed four monthly with the involvement of each resident and / or representatives. The specific actions in the plan include:

Reduction in respite and convalescence admissions until all residents care plans have been reviewed and updated.

The involvement of residents where possible and/or representative in care plan reviews will be recorded in the designated "care plan meetings" section on the residents' records electronic system.

Each resident is designated a named nurse who will assume responsibility for ensuring the residents care plan is reviewed and updated on a scheduled basis at a minimum of every four months.

Where there is a change in a resident's condition or care within the period, the nurse on duty will assume responsibility for updating the residents care plan on the day.

The Clinical Nurse Manager on each floor will oversee this process informally on a day to day basis and formally through an audit on a scheduled basis.

A comprehensive schedule of care plan review dates for each resident has been developed and displayed at the nurses' station on each floor.

Again the CNM on each floor will oversee the adherence to and maintenance of this schedule.

A meeting with all nursing staff was held to inform them of the above information and to discuss care plan reviews over the coming 6-8 weeks.

Additional training on care planning was provided to nurses and clinical nurse managers.

Proposed Timescale: 31/05/2016

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 professional were not consistently incorporated into care plans.

9. 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:

As per previous section and specifically, clinical nurse managers will be auditing care plans on a scheduled basis.

Proposed Timescale: 31/05/2016

Theme:

Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The management and monitoring of weight loss requires improvement.

10. Action Required:

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

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

A meeting was held with staff following the inspection. It was agreed that in future weights will be measured by experienced staff who would inform the clinical nurse manager or nurse in charge of the floor of all weights recorded. The CNM or nurse in charge will check all weights against the previous weight measurement and where there was any significant change, the CNM or nurse in charge will follow up on this.

Proposed Timescale: 19/05/2016

Outcome 13: Complaints procedures

Theme:

Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The complaints procedures did not reflect the details of person nominated to investigate complaints.

11. Action Required:

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

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

The complaints procedure states that the person in charge is the complaints' officer for the centre. The person in charge will sign each complaint received and the response to same.

We will review and update our complaints policy and procedures to ensure that practice with regards to complaints management is in accordance with national statutory requirements.

Proposed Timescale: 03/06/2016