

**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 Nursing Home
Centre ID:	OSV-0004632
Centre address:	Dublin Road, Edgeworthstown, Longford.
Telephone number:	043 667 1007
Email address:	adminolm@newbrooknursing.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Newbrook Nursing Home
Provider Nominee:	Philip Darcy
Lead inspector:	Catherine Rose Connolly Gargan
Support inspector(s):	Sonia McCague
Type of inspection	Unannounced Dementia Care Thematic Inspections
Number of residents on the date of inspection:	58
Number of vacancies on the date of inspection:	3

About Dementia Care Thematic Inspections

The purpose of regulation in relation to residential care of dependent Older Persons is to safeguard and ensure that the health, wellbeing and quality of life of residents is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer and more fulfilling lives. This provides assurances to the public, relatives and residents that a service meets the requirements of quality standards which are underpinned by regulations.

Thematic inspections were developed to drive quality improvement and focus on a specific aspect of care. The dementia care thematic inspection focuses on the quality of life of people with dementia and monitors the level of compliance with the regulations and standards in relation to residents with dementia. The aim of these inspections is to understand the lived experiences of people with dementia in designated centres and to promote best practice in relation to residents receiving meaningful, individualised, person centred care.

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 compliance with specific outcomes as part of a thematic inspection. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 04 July 2016 09:00 To: 04 July 2016 20:00

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

Outcome	Provider's self assessment	Our Judgment
Outcome 01: Health and Social Care Needs	Substantially Compliant	Non Compliant - Moderate
Outcome 02: Safeguarding and Safety	Substantially Compliant	Substantially Compliant
Outcome 03: Residents' Rights, Dignity and Consultation	Compliance demonstrated	Non Compliant - Moderate
Outcome 04: Complaints procedures	Compliance demonstrated	Substantially Compliant
Outcome 05: Suitable Staffing	Compliance demonstrated	Substantially Compliant
Outcome 06: Safe and Suitable Premises	Non Compliant - Moderate	Substantially Compliant
Outcome 07: Health and Safety and Risk Management		Non Compliant - Moderate

Summary of findings from this inspection

This inspection report sets out the findings of a thematic inspection which focused on specific outcomes relevant to dementia care in the centre. All actions from the last inspection of the centre in October 2014 were satisfactorily completed.

As part of the thematic inspection process, providers were invited to attend information seminars given by the Authority. In addition, evidence-based guidance was developed to guide the providers on best practice in dementia care and the inspection process. Prior to the inspection, the nominee for the provider completed the self-assessment document by comparing the service provided with the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

The design and layout of Camillus, where residents with dementia are integrated with the other residents, met its stated purpose to a good standard. A bedroom painting project in consultation with residents had commenced and the person in charge told inspectors that painting required to other parts of the centre would be completed as part of this project. Overall, inspectors found the management team and staff were committed to providing a quality service for residents with dementia. This commitment was demonstrated in work done to date to create a comfortable and therapeutic environment for residents with dementia.

Inspectors met with residents and staff members during the inspection. They tracked the journey of residents with dementia within the service. They observed care practices and interactions between staff and residents who had dementia using a validated observation tool. Inspectors also reviewed documentation such as care plans, medical records and staff training and employment files. Inspectors examined the relevant policies including those submitted prior to inspection.

There were policies and procedures in place around safeguarding residents from abuse. All staff had completed training, and were knowledgeable about the steps they must take if they witness, suspect or are informed of any abuse taking place. There were also policies and practices in place around managing responsive and psychological behaviour, and using methods of restraint in the service. Residents were safeguarded by staff completing risk assessments and reviewing their needs in relation to any plans of care that were in place to support residents to live independent lives.

Residents' healthcare needs were met, however improvement was required in care plan documentation. Residents had access to a variety of activities which many participated in. However, improvement was required to ensure some residents' needs were appropriately assessed in terms of their interests, capabilities and activities suitable to meet their needs. There was also improvement required in relation to faxed medicine prescriptions.

Some environmental hazards identified on this inspection required risk assessment with implementation of controls to mitigate the level of risk found. Staffing levels and skill-mix were appropriate to meet the needs of residents. However, additional training in care-planning and supervision of care practices was necessary to ensure residents' needs were comprehensively met.

The Action Plan at the end of this report identifies areas where improvements are required to comply 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

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: Health and Social Care Needs

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:

This outcome sets out inspection findings relating to healthcare, nursing assessments and care planning. The findings in relation to social care of residents with dementia in the centre are comprehensively covered in Outcome 3 in this report.

There were a total of 58 residents in the centre on the day of this inspection; nine residents had assessed maximum dependency needs, 19 had high dependency needs and 21 residents had medium and nine residents had assessed low dependency needs. 22 residents had a formal diagnosis of dementia and 15 other resident had psychological symptoms of dementia. Residents with a formal diagnosis of dementia and residents with symptoms of dementia were recorded in a clinical risk register. This process ensured that residents with dementia had any risks posed to them specific to their diagnosis were addressed with appropriate controls to ensure their wellbeing.

Inspectors focused on the experience of residents with dementia on this inspection. They tracked the journey of four residents with dementia and also reviewed specific aspects of care such as nutrition, wound care and end-of-life care in relation to other residents with dementia in the centre.

There were systems in place to optimise communications between the resident/families, the acute hospital and the centre. The person in charge or senior nurse visited prospective residents in hospital or their home in the community prior to admission. Residents were also admitted to the centre for continuing care from intermittent admissions for respite care. Prospective residents and their families were welcomed into the centre to view the facilities and discuss the services provided before making a decision to live in the centre. This gave these residents and their families information about the centre and also ensured them that the service could adequately meet their needs.

A copy of the Common Summary Assessments (CSARs), which details pre-admission assessments undertaken by the multidisciplinary team for residents admitted under the 'Fair Deal' scheme, was made available to the person in charge and kept in residents'

files. The files of residents' admitted to the centre from hospital also held their hospital discharge documentation including a medical summary letter, multidisciplinary assessment details and a nursing assessment. Inspectors examined the files of residents who were transferred to hospital from the centre and found that appropriate information about their health, medications and their specific communication needs were included in transfer documentation. A communication passport was being introduced for each resident going to hospital that included details of their preferences, dislikes and strategies to prevent or to support them with physical and psychological symptoms of dementia. This communication tool will form part of the transfer to hospital documentation for residents with communication difficulties including residents with dementia. Systems were in place to prevent unnecessary hospital admissions. The nutritional and hydration needs of residents with dementia were met and residents were protected by safe medicine management policies and procedures.

Residents had a choice of general practitioner (GP). Documentation and residents spoken with confirmed timely access to GP care including out-of-hours emergency consultation by the on-call GP service. Some residents from the locality were facilitated to retain the services of the GP they attended prior to their admission to the centre. Some residents' GPs attended the centre routinely on a weekly basis. Residents had good access to allied healthcare professionals including physiotherapy on a weekly basis by a physiotherapist employed by the provider. Occupational therapy, dietetic, speech and language therapy, dental, ophthalmology and podiatry services were also available to residents as necessary. Inspectors were told that work was in progress to improve timeliness of access for residents to occupational therapy services which had deteriorated due to the recent retirement of an occupational therapist who had comprehensively supported residents' occupational therapy service needs. Community psychiatry of older age specialist services attended residents in the centre with dementia and supported GPs and staff with managing residents experiencing behavioural and psychological symptoms of dementia (BPSD) as needed. Residents' positive health and wellbeing was optimised with regular physiotherapy and an annual influenza vaccination programme. Residents in the centre had access to palliative care services for support with management of their pain and for symptom management during 'end of life' care if required.

There were suitable arrangements in place to meet the health and nursing needs of residents with dementia. The centre was in the process of transitioning from paper-based documentation to a computerised resident documentation management system. Inspectors found that significant improvement was required to ensure residents' documentation was complete. Findings included;

- There was duplication of some care plans
- Interventions to direct care actions were not clear in all cases
- Some care plans were developed in January 2015 and required up-dating to ensure they comprehensively informed residents' current care needs.

The person in charge expressed her assurances that the centre's usual high standards of documentation management, which was also evidenced on the last inspection in October 2015, would be resumed as a priority with completion of transition to their computerised data management system. The computerised data management system in the process of implementation was password protected to ensure residents' personal information was securely stored. Its implementation was also supported by a support

and training programme for users. The system gave care staff access to residents' care interventions and embraced their input into record keeping of care interventions they completed. Comprehensive assessments were carried out within 48 hours following admission and care plans were developed based on assessments of need and in line with residents changing needs. The assessment process involved the use of validated tools to determine each resident's risk of malnutrition, falls, their level of cognitive function and skin integrity among others. Care plans were updated routinely on a four-monthly basis or to reflect residents' changing care needs as necessary. Inspectors found that all staff spoken with were very knowledgeable regarding residents' likes, dislikes and needs. A 'Named Nurse' system was in place for each resident. 'Key to me' and social/recreational assessment tools were also used to support residents and relatives where appropriate to provide information to inform their communication and activation needs. While there was evidence of involvement of residents and their families, where appropriate' in care plan development, improvement was required to ensure they were involved in care plan reviews thereafter.

Staff provided end-of-life care to residents with the support of their medical practitioner and community palliative care services as necessary. Palliative care services were not supporting any residents in the centre on the day of this inspection. The inspectors reviewed care of residents receiving 'end of life' care and found that their symptoms were well managed including management of pain. A pain assessment tool for residents, including residents who were non-verbal was in use. Inspectors reviewed a number of 'End of life' care plans that outlined the physical, psychological and spiritual needs of residents. Residents' wishes regarding place for receipt of 'end of life' care was recorded but needed regular review to capture any changes in their wishes. Advanced directives were in place for some residents regarding resuscitation. However improvement was required in recording of signatures by all members of the multi-disciplinary team involved in the decision-making process. This documentation recorded family input on behalf of the resident in most cases in the documentation reviewed. However, there was room for improvement in resident involvement in these decisions where appropriate. Residents had access to a large oratory which is available to residents if they wish for removal and funeral services. A room adjacent to the church within, but separated from the residents' accommodation was used by the centre to provide sandwiches and refreshments for mourners at services in the oratory following the death of a resident in the centre. The person in charge told the inspector that residents who deceased in the centre are removed to the centre's oratory to facilitate other residents and staff to pay their respects. The centre has adopted the Hospital Friendly Hospice symbol which is displayed to inform of the death or impending death of a resident in the centre.

Single rooms were available for 'end of life' care and relatives were accommodated to stay overnight with residents at the 'end of life' stage of their lives. Staff outlined how residents' religious and cultural practices were facilitated. Members of the local religious congregation provided pastoral and spiritual support to residents including those at the end stage of their lives in addition to clergy from the various religious faiths. Inspectors observed that staff were trained to administer subcutaneous fluids to treat dehydration and percutaneous endoscopic gastrostomy (PEG) tube replacement in order to avoid unnecessary hospital admissions.

There were comprehensive care procedures in place to prevent residents developing

pressure related skin injuries. The Health Information and Quality Authority (HIQA) were notified of four residents with incidents of pressure-related skin ulcers since 01 January 2015, none of which developed in the centre and were present on admission. Inspectors reviewed procedures in place for wound assessment and care and found that appropriate procedures were in place including photographic monitoring to assess progress with healing. Tissue viability specialist services were available to support management of wounds that were slow to heal. Residents identified as being at risk of developing pressure related skin ulcers had risk assessments completed with corresponding care plans. Pressure relieving mattresses, cushions and repositioning schedules were in use to mitigate risk of ulcers developing.

There were systems in place to ensure residents' nutritional needs were met, and that they did not experience poor hydration. Residents were screened for nutritional risk on admission and reviewed regularly thereafter. Residents' weights were closely monitored and checked routinely on a monthly basis or more frequently where indicated. Nutritional assessment and care plans were in place that outlined the recommendations of dieticians and speech and language therapists where appropriate. Systems were in place for recording residents' nutritional and fluid intake where required. Inspectors saw that residents had a choice of hot meals for lunch and tea. The inspectors saw where some residents requested their meals to be served in a specified way and these requests were met. Inspectors also saw that one resident liked to have their lunchtime meal early and this wish was respected. There was an effective system of communication between nursing and catering staff to support residents with special dietary requirements. Inspectors found that residents on weight-reducing, diabetic and fortified diets, and also residents who required modified consistency diets and thickened fluids, received the correct diets. There was one large spacious dining room available on the ground floor where most resident ate their meals. Mealtimes in the dining room was observed to be a social occasions. The main dining room was in a restaurant style in terms of décor and furnishings. Tables were attractively dressed with flower centre-pieces with a range of condiments provided. Staff sat with residents as necessary and provided discrete encouragement and assistance to them with eating their meal.

There were arrangements in place to review accidents and incidents within the centre, and residents were assessed on admission and regularly thereafter for risk of falls. All incidents involving residents were comprehensively reviewed with the assistance of a computerised risk management programme. There was evidence of identification and implementation of learning in practice as outcomes of review. HIQA were notified of three incidents of residents falling and sustained an injury requiring hospital treatment from January 01 2015 to date. Two of these incidents referenced a bone fracture injury. All residents at risk of falling were appropriately risk assessed and controls such as hip protection equipment, increased supervision and medication reviews were in place. The centre's physiotherapist reviewed all residents post fall incident and was involved in assessment and treatment plan development for residents who fell or were at increased risk of falling.

There were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents which were implemented for residents who were case-tracked. Inspectors found that practices in relation to prescribing and medication reviews met with regulatory requirements and staff were observed to follow

recommended administration practices. However improvement was required to ensure all faxed prescriptions were transferred into one resident's prescription record within 72 hours as advised by the centre's policy documentation.

Each resident's medication was stored in a secure cupboard in their bedrooms. While no residents choose to self-administer their medication, the arrangements in place where medication is stored in the each resident's room promoted a sense of ownership and control for residents over their medicines. The nurse used the time during medication administration as an opportunity to inform residents about the medication they were prescribed. A pain management assessment chart was available to assist with management and monitoring of pain experienced by residents.

The pharmacist who supplied residents' medications was well known to them and was facilitated to meet his obligations to residents. The pharmacist was involved in presenting talks to residents on health topics of interest to them and wrote a medication focused article for the centre's quarterly newsletter. The pharmacist was involved in staff education, completed comprehensive medication audits and supported procedures for return of out of date or unused medications. Systems were in place for recording and managing medication errors.

Judgment:

Non Compliant - Moderate

Outcome 02: Safeguarding and Safety

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

All residents in the centre were protected from harm or abuse. There were policies in place to advise on prevention, detection, reporting and responding to allegations, disclosures or suspicions of abuse. Training records showed that all staff attended annual training on protection of vulnerable adults. Inspectors spoke with staff and they were clear on their responsibilities to protect residents and to report any suspicions or allegations of abuse. Staff spoken to by inspectors also confirmed that they had received training on recognising abuse and were familiar with the reporting structures in place. The provider and person in charge ensured that there are no barriers to disclosing abuse. Residents spoken with on the day of the inspection confirmed to inspectors that they felt safe in the centre. There was evidence that any allegations of abuse were comprehensively addressed.

There was a comprehensive policy and procedures in place that promoted a positive approach to the behaviours and psychological symptoms of dementia (BPSD). The majority of staff had received training in responsive behaviours. Staff spoken with by

inspectors could describe person-centred de-escalation techniques that they would use to manage individual resident's behaviours and psychological symptoms of dementia. Residents had behavioural support care plans in place. However Improvement was required to ensure triggers to physical and psychological behaviours relating to dementia and de-escalation procedures as identified for some residents in their behavioural support plans were implemented in practice. Inspectors saw that additional support and advice were available to staff from the psychiatry services.

There was evidence that efforts were being consistently to promote a restraint-free environment within the centre. There was a policy and procedure in place to advise staff on use of restraint, and a restraint register was maintained in the centre. The use of bedrails was being reviewed frequently by staff with the support of the centre's physiotherapist. There was evidence that alternatives to bed rails were used where possible such as grab rails or low level beds with foam floor mats. As a result, the number of residents using bedrail restraints was low. Some residents were assessed as being at risk of leaving the centre unaccompanied. While, these residents wore electronic alert alarms, the protective system in place did not limit their freedom but alerted staff that they had chose to exit the centre. Inspectors observed that chemical restraint in the form of PRN (as required) psychotropic medication was prescribed and administered under direction and close monitoring by the community psychiatry of older age team. Three monthly reviews of all medications were undertaken by the GPs and the pharmacist.

There were systems in place to safeguard residents' money. The centre kept money on behalf of some residents, and this was securely stored with corresponding records maintained. All transactions were recorded appropriately and signed by a staff member and the resident or their relative. Residents were provided with a lockable space in their bedrooms to facilitate them to independently store personal possessions securely if they wished.

Judgment:
Substantially Compliant

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:
Person-centred care and support

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

Findings:
Residents with dementia were consulted with and supported to participate in the organisation of the centre. Overall residents' privacy and dignity was respected and residents were supported to make choices about their day-to-day lives. There were opportunities for residents to participate in activities that suited their interests and capabilities however, improvement was required to ensure all residents' needs were met

in this area of their care.

Residents' participated in monthly resident forum meetings and there was evidence that residents with dementia attended these meetings. The meetings were minuted and referenced active discussion about life in the centre and areas for review were identified by the participants and actioned in response to issues raised by residents. A quarterly newsletter was produced in the centre to keep residents up to date with events in the centre and featured photographs of residents enjoying events that had taken place. A word search and quiz was also included for residents. Residents had access to Independent advocacy services.

Residents were facilitated to exercise their civil, political and religious rights. Staff sought the permission of residents with dementia in the centre before undertaking any care task and consulted with them about how they wished to spend their day and care issues. Residents expressed their satisfaction with the opportunities provided to them for religious practice, the choice of sitting rooms and their freedom to move around the communal areas in the centre. A large number of residents were assisted to attend daily mass in the centre's oratory. The centre had access to a wheelchair accessible bus one day per week and residents' wishes were prioritised when planning excursion venues. Residents' wishes and preferences also informed their daily routine. There were no restrictions on visitors and there were a number of areas in the centre on all floors, where residents could meet visitors in private. These areas were styled in a way that facilitated quiet rest or meeting with small group of visitors. Residents had access to a kitchenette incorporated into an old-style traditional kitchen where they could enjoy refreshments with their relatives.

The provider and staff demonstrated resourcefulness and imaginative creativity with work done in refurbishment of a kitchenette and sitting room area. These rooms provided a comfortable and therapeutic environment for residents with dementia. These rooms were decorated in a traditional olden style and contained homely furnishings including an old-style stove and other memorabilia. Bird-cages were in place in communal areas on the ground and first floors.

While activity co-ordination staff were employed in the centre, addressing the social needs of residents was also integral to the role of healthcare assistants. There was a variety of activities available to residents in the centre, organised by the activity co-ordinator and facilitated by activity and care staff. Organised activities were extended to 20:00hrs seven days each week. An activity schedule was prominently displayed. Rummage boxes and doll therapy was used by some residents. A music therapist attended the centre one day each week and was observed working with residents on the day of this inspection. The music therapist facilitated 1:1 and group music therapy sessions. Most residents visibly enjoyed the group sessions and were actively engaged in singing along with their favourite songs. The activity co-ordinator maintained a record of the activities residents participated in and their level of engagement. However, inspectors' found that improvement was required in meeting residents' activation needs. While there were activities of interest going on in the communal rooms on two floors, improved assessment for residents with dementia was also needed to ensure that activities provided met the interests and capabilities of residents with dementia including whether 1:1 or small group activities were most appropriate to meet their needs. For example, a sensory focused activity programme was available for residents with

dementia. However, some residents with dementia were not facilitated to participate in this programme on the day of inspection. An absence of access to this sensory programme was also confirmed by inspectors on review of two residents' activity records for four weeks previous to the day of this inspection. There was also evidence from the activity records reviewed that one of these residents did not participate in any meaningful activities for up to eight days.

Inspectors observed the quality of interactions between staff and residents using a validated observational tool to rate and record the quality of interactions between staff and residents at five minute intervals in a sitting room and a dining room area. The scores for the quality of interactions are +2 (positive connective care), +1 (task orientated care, 0 (neutral care), -1 (protective and controlling), -2 (institutional, controlling care). The scores reflect the effect of the interactions on the majority of residents. Inspectors' observations concluded that while there was some evidence of positive connective care with individual residents, this finding was not evident for all residents with dementia present during group activities. In addition not all opportunities were taken when completing tasks of care to positively engage with residents.

Inspectors saw that staff ensured that each resident with dementia received care in a dignified way that respected their privacy. All residents were accommodated in single, twin and one spacious three bedded bedroom; each with en suite facilities. Staff were observed knocking on bedroom and bathroom doors. Privacy locks were in place on all bedroom, bathroom and toilet doors. Residents' privacy and dignity was respected by staff during all interactions observed. Bedroom and toilet doors were closed during personal care activities. Curtain screens in twin and the three bedded room were provided and closed accordantly. Inspectors observed staff interacting with residents in an appropriate and respectful manner, and it was clear that staff and residents knew each other well.

Residents had a section in their care plan that addressed their communication needs, and there was a detailed communication policy in place that included strategies to effectively communicate with residents who have dementia.

Judgment:

Non Compliant - Moderate

Outcome 04: Complaints procedures

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 system in place to ensure that the complaints of residents with dementia or their representative were listened to and acted upon, and they had access to an appeals

procedure.

There was a complaints policy in place, and the complaints procedure was displayed prominently in the centre, and summarised in the residents' guide document. A complaints log was maintained in the centre and there were arrangements for complaints to be followed through to satisfactory resolution. Verbal feedback from residents or resident's representatives was welcomed and arrangements were in place for recording same in line with regulatory requirements. Throughout the inspection it was clear that residents were familiar with the person in charge and found the person in charge easy to approach with any concerns or complaints.

Verbal complaints were recorded. The person in charge advised inspectors that most complaints were managed at a local level. Complaints that could not be resolved locally were escalated up to the person in charge as the complaints officer. The inspectors observed that these complaints were robustly investigated and included details of the investigation and copies of all associated correspondence. However, information on whether the complainant was satisfied or not was not consistently recorded.

There was a nominated person with assigned responsibility for reviewing complaints to ensure they were appropriately managed in line with the policy. The inspector observed that there was evidence of learning with concomitant service improvements following investigation of complaints. Some residents spoken with were aware of the process and identified mainly the person in charge or other staff members as the people whom they would communicate with if they had any issue of dissatisfaction. Residents spoken with told the inspector they did not have cause to complain to date. An independent advocacy service was available to support residents with dementia and their families to raise issues of concern if necessary.

Judgment:

Substantially Compliant

Outcome 05: Suitable Staffing

Theme:

Workforce

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

No actions were required from the previous inspection.

Findings:

There was a stable workforce in the centre with many of the staff having worked in the centre for a number of years. The recruitment procedures in place met the regulatory requirements. All staff had An Garda Síochána vetting completed and recorded on their files. The orientation programme for new staff supported them in their roles. Clinical competency assessment and annual performance management meetings were conducted for staff. A record of the current registration details of all staff nurses working in the centre was maintained and was up to date.

There was a planned staff roster in place, with changes clearly indicated. The staffing in place on the day of inspection was reflected in this roster. The inspector was informed by the person in charge that staffing levels were reviewed on an on-going basis to meet the changing needs of residents and were increased where necessary to meet the needs of residents who were assessed as requiring high levels of care. The inspector found evidence that the staff numbers and skill mix on the days of inspection were appropriate to meet the needs of residents accommodated in the centre. There were handover of care arrangements in place for staff at the beginning and end of each work shift. Carer and nurse representatives from the team allocation on each floor and other key staff met with the person in charge each morning to address any issues and to plan the day. An inspector attended this daily meeting on the day of inspection.

There was an effective system in place to ensure that all staff attended mandatory and refresher training. A member of staff was employed by the provider with sole responsibility for providing training to all staff. A practice development co-ordinator was also employed by the provider and supported staff practice in the centre one to two days each week or more often if required. Discussions with staff by inspectors and training records confirmed that staff had up-to-date mandatory training. Staff also had training in dementia care, the management of behaviours that challenge and professional management of aggression and violence to support their professional practice. Training was provided on other aspects relevant to dementia care such as end-of-life care, the use of incontinence wear, nutrition and dysphagia. Implementation of training was consistently monitored and inspectors observed staff using good practices in relation to de-escalation of incidents of responsive behaviours and safe resident moving and handling techniques. However, findings on this inspection supported staff training needs in the area of care planning. Staff supervision also required improvement to ensure completeness of residents' documentation, that residents' activation needs were met and that new staff were appropriately supervised at all times.

Staff spoken with by inspectors had knowledge of all residents supported by their rotation to the different care teams on a daily basis. Staffing arrangements in place provided for supervision of residents. The majority of care staff had Further Education and Training Awards (FETAC) Level 5 training due mainly to care staff recruited been required to have this qualification and staff employed for some time were facilitated to attend this training.

Members of the staff team spoken with verbalised their commitment to providing a good service to the residents in their care. They were observed by the inspector to be responsive and effective in meeting residents' needs. Residents spoken with complemented the staff team in the centre.

Judgment:
Substantially Compliant

Outcome 06: Safe and Suitable Premises

Theme:

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

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

Findings:

Our Lady's Manor Nursing Home has undergone extension and modification since registration by the Authority in 2012. A major refurbishment programme including the existing original house was undertaken with this work to the building structure and fabric now fully completed. The centre interior provides a spacious, bright and comfortable environment for residents with a variety of communal areas and a large oratory. The grounds are landscaped and include a garden for residents and a walled flower and vegetable garden. The provider and staff team were working to ensure residents with dementia could access a safe external space unaccompanied as appropriate. Residents are accommodated over three floor levels in the centre. The reception and main communal spaces is located on the ground floor. The basement and upper floors can be accessed by stairs or by means of a spacious passenger lift. A mezzanine level off the second floor was accessible by a ramp with handrails fitted on both sides. The lift has a door function delay installed to give residents with reduced mobility to enter and exit the lift. A handrail was fitted on one wall on the interior of the lift. The provider agreed to assess the need for fitting further handrails to meet residents' support needs.

An area off the reception that was part of the original internal building was refurbished in the style of a traditional kitchen and a living room to provide additional communal space for residents including an area where they could avail of quiet time or meet their visitors in private. The centre has a large dining room adjacent to the main kitchen area, which comfortably accommodates the residents in the centre for one sitting at mealtimes. Residents had access to sitting room accommodation on the ground and first floors. There were rooms for quiet rest and relaxation on the ground floor. A small shop was available to residents for toiletries and other items. A letterbox on a stand was placed inside the entrance to the centre at the residents' request for posting their letters.

Residents have access to a large oratory which is also used by the local community for removals and funeral services. Toilet facilities were observed to be within close proximity to communal areas. Circulating corridors were individually named and painted in a variety of colours with handrails painted in contrasting colours to walls to enhance orientation and safety for residents with dementia. Residents' bedroom doors in the older parts of the premises were individually painted in a variety of colours to assist residents with dementia to access their bedrooms. Key areas had clear signage displayed and signs that hung out into the corridors identified communal toilets. These actions afforded residents greater autonomy and increased independence. Inspectors observed that paint was chipped and missing from some wall surfaces in the centre. A bedroom painting programme was underway with some residents' bedrooms painted in colours of their choice. All bedrooms provided a combination of single or twin occupancy and one spacious three bedded room. The floor space in residents' bedrooms varied but each met size, privacy and dignity requirements as outlined in the Authority's Standards

and where provided; en suite facilities were spacious and contained a toilet, shower and wash-hand basin.

Although spacious, the layout of the three-bedded room was found to require review on the last inspection of the centre in October 2014. Inspectors observed that this had been completed and residents' needs were met in this bedroom. Each resident had adequate wardrobe space which they could access and retain control over. Residents were encouraged to personalise their bedrooms and residents' bedrooms were personalised with photographs and ornaments and in some cases items of the residents' own furniture. Grab rails were provided in all toilets and showers, some of which were in contrasting colours to assist residents with visual needs or dementia.

Environmental temperatures were monitored throughout to ensure temperatures were maintained at levels in line with the standards. Hot water temperatures were thermostatically controlled so as not to exceed 43 degrees centigrade at the point of contact by residents. Advantage was taken from use of the many large windows for natural light in communal areas in the centre. Non-patterned floor covering was used throughout to promote safe mobility of residents with dementia.

Judgment:

Substantially Compliant

Outcome 07: Health and Safety and Risk Management

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

This outcome was not examined in full on this inspection and details areas requiring improvement that were identified during the course of this dementia thematic inspection.

The centre had a risk management and health and safety statement in place that had been reviewed for 2016. The risk register was reviewed by an inspector and was found to be comprehensive in that risks identified had robust controls in place. However, some areas of risk required review to ensure they were risk assessed and controls were put in place as necessary and included the following;

- a lock was not placed on the utility room door numbered 120A to prevent unauthorised access,
- gates were placed on the top of some stairs as a control to safeguard some residents, however access was still available for vulnerable residents to ascend stairs. The closure fitting on one stair-gate was worn and safe closure was not assured,
- a door on room 316 opened into a corridor used by residents and was not identified as a hazard in the centre's risk management documentation.

Judgment:

Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Catherine Rose Connolly Gargan
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Action Plan

Provider's response to inspection report¹

Centre name:	Our Lady's Manor Nursing Home
Centre ID:	OSV-0004632
Date of inspection:	04/07/2016
Date of response:	16/08/2016

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 01: Health and Social Care Needs

Theme:

Safe care and support

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

Residents care plan documentation was not comprehensive:

- There was duplication of some care plans
- Interventions to direct care actions were not clear in all cases
- Some care plans were developed in January 2015 and required up-dating to ensure they comprehensively informed residents' current care needs.

1. Action Required:

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

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:

The computerised "epicare " system is in progress since 04/08/2016 and all resident's care plans are being reviewed and updated at present. All residents have a Holistic care plan

Proposed Timescale: 31/10/2016

Theme:

Safe care and support

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

While there was evidence of involvement of residents and their families, where appropriate' in care plan development, improvement was required to ensure they were involved in care plan reviews thereafter.

2. 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:

All resident's and their families will be consulted in the review of the new care plans.

Proposed Timescale: 31/10/2016

Theme:

Safe care and support

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

Residents' wishes regarding place for receipt of 'end of life' care was recorded but needed regular review to capture any changes in their wishes.

3. Action Required:

Under Regulation 13(1)(d) you are required to: Where the resident approaching end of life indicates a preference as to his or her location (for example a preference to return home or for a private room), facilitate such preference in so far as is reasonably practicable.

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

All Residents have an "end of life " document recorded on the computerised system and

this will be reviewed at regular intervals.

Proposed Timescale: 31/10/2016

Theme:

Safe care and support

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

Improvement was required to ensure all faxed prescriptions were transferred into one resident's prescription record within 72 hours as advised by the centre's policy documentation.

4. 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:

The CNM/DON and staff nurses are aware of the timescale and the Policy pertaining to the use of Faxed prescriptions. The residents' GPs will be reminded of same and also the relevant staff to ensure that this practice does not occur in line with the Centre's policies.

Proposed Timescale: 31/10/2016

Outcome 02: Safeguarding and Safety

Theme:

Safe care and support

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

Improvement was required to ensure triggers to physical and psychological behaviours relating to dementia and de-escalation procedures as identified for some residents in their behavioural support plans were implemented in practice.

5. Action Required:

Under Regulation 07(2) you are required to: Manage and respond to behaviour that is challenging or poses a risk to the resident concerned or to other persons, in so far as possible, in a manner that is not restrictive.

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

All resident's will have behavioural care plans and this will clearly outline the behaviours' triggers and de-escalation procedures relevant to each resident who has dementia

Proposed Timescale: 31/10/2016

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

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

Improved assessment for residents with dementia was required to ensure that activities provided met the interests and capabilities of residents with dementia including whether 1:1 or small group activities were most appropriate to meet their needs.

Not all opportunities were taken when completing tasks of care to positively engage with residents.

6. Action Required:

Under Regulation 09(2)(b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests and capacities.

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

The Activities co-ordinator and staff have altered the approach to activities and individual activity plans are in progress for residents with dementia. Rummage boxes have been created for some of the bedrooms and further staff have attended training on PCHT (activities for dementia) so that all staff have the skills to deliver activities to residents with dementia throughout the day. Residents who do not attend a scheduled activity have a care assistant deliver one-to-one activity to create a more personalised approach

Proposed Timescale: 31/10/2016

Theme:

Person-centred care and support

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

Some residents with dementia spent prolonged periods without social interaction and were not facilitated to participate in appropriate occupation and recreation.

7. Action Required:

Under Regulation 09(2)(a) you are required to: Provide for residents facilities for occupation and recreation.

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

Resident's with dementia now have rummage boxes in their individual rooms, staff will provide individualised activities to residents with dementia throughout the day and room visits have been improved and are ongoing.

All residents have an activities plan and this document completed daily.

Proposed Timescale: 31/10/2016

Outcome 04: Complaints procedures

Theme:

Person-centred care and support

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

Information on whether the complainant was satisfied or not was not consistently recorded.

8. Action Required:

Under Regulation 34(1)(f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.

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

All complaints will now be logged on the computerised system and all information pertaining to the complaint, the complainant and the level of satisfaction will be recorded in computerised format.

Proposed Timescale: 31/10/2016

Outcome 05: Suitable Staffing

Theme:

Workforce

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

Findings on this inspection supported staff training needs in the area of care planning.

9. Action Required:

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

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

Further care plan training is planned for nurses. Many nurses have previously attended this training and guidance and support is currently being provided to nurses from Practice Development/DON/CNM and training on the computerised "epicare". The DON will review all new and updated care plans on a weekly basis.

Proposed Timescale: 31/12/2016

Theme:
Workforce

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

Staff supervision required improvement to ensure completeness of residents' documentation, that residents' activation needs were met and that new staff were appropriately supervised at all times.

10. Action Required:

Under Regulation 16(1)(b) you are required to: Ensure that staff are appropriately supervised.

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

All nurses are using the computerised system "Epicare" since 04/08/2016 and all care assistants will start using the computerised system in the coming months. It is expected that supervision of documentation will be more visible and accessible to the nurses/CNM/DON. All nurses are supervising care on a daily basis and nursing hours at weekends have been increased to ensure better supervision.

Proposed Timescale: 31/10/2016

Outcome 06: Safe and Suitable Premises

Theme:
Effective care and support

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

Inspectors observed that paint was chipped and missing from some wall surfaces in the centre.

11. Action Required:

Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

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

Ongoing refurbishment and painting/decorating is in progress and residents are choosing colours for their bedrooms. A particular emphasis is focused on the residents with Dementia.

Proposed Timescale: 31/12/2016

Outcome 07: 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:

some areas of risk required review to ensure they were risk assessed and controls were put in place as necessary and included the following;

- a lock was not placed on the utility room door numbered 120A to prevent unauthorised access,
- gates were placed on the top of some stairs as a control to safeguard some residents, however access was still available for vulnerable residents to ascend stairs. The closure fitting on one stair-gate was worn and safe closure was not assured,
- a door on room 316 opened into a corridor used by residents and was not identified as a hazard in the centre's risk management documentation.

12. Action Required:

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

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

A lock has been installed in the room 120A.

A new Gate is in place since inspection.

The door on room 316 has been adjusted to close properly. This has reduced the risk slightly and this is added to the Risk Register. All staff have been made aware of this risk.

Proposed Timescale: 04/08/2016