**Health Information and Quality Authority**  
**Regulation Directorate**  

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

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>St. Martha's Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0005284</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Glenswilly House, Cappauniac, Cahir, Tipperary.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>052 744 1895</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:info@stmarthasnursinghome.ie">info@stmarthasnursinghome.ie</a></td>
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<tr>
<td>Type of centre:</td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
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<tr>
<td>Registered provider:</td>
<td>St Martha’s Nursing Home Ltd</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Anthony O'Connell</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Gemma O'Flynn</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>None</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Announced</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>22</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>0</td>
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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 following an application to vary registration conditions. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times
From: 03 October 2016 09:00  To: 03 October 2016 18:00
04 October 2016 07:30  To: 04 October 2016 14:40

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

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Our Judgment</th>
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<tbody>
<tr>
<td>Outcome 01: Statement of Purpose</td>
<td>Compliant</td>
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<tr>
<td>Outcome 02: Governance and Management</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 03: Information for residents</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 04: Suitable Person in Charge</td>
<td>Compliant</td>
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<td>Outcome 05: Documentation to be kept at a designated centre</td>
<td>Compliant</td>
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<tr>
<td>Outcome 06: Absence of the Person in charge</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 07: Safeguarding and Safety</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 08: Health and Safety and Risk Management</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 09: Medication Management</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 10: Notification of Incidents</td>
<td>Compliant</td>
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<tr>
<td>Outcome 11: Health and Social Care Needs</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 12: Safe and Suitable Premises</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 13: Complaints procedures</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 14: End of Life Care</td>
<td>Compliant</td>
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<tr>
<td>Outcome 15: Food and Nutrition</td>
<td>Compliant</td>
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<tr>
<td>Outcome 16: Residents' Rights, Dignity and Consultation</td>
<td>Compliant</td>
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<tr>
<td>Outcome 17: Residents' clothing and personal property and possessions</td>
<td>Compliant</td>
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<tr>
<td>Outcome 18: Suitable Staffing</td>
<td>Compliant</td>
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Summary of findings from this inspection
This report sets out the findings of a two day announced inspection of this centre following the provider's application to vary the conditions of the centre's registration. The provider wished to increase occupancy levels from 22 residents to 26 residents. A new wing incorporating six single bedrooms with full ensuite had been constructed to accommodate the new residents and it was the provider's intention to
decommission one twin bedroom in the existing centre and accommodate two residents in the newly constructed wing. The provider had identified a need for additional communal space and planned to convert this twin room into a visitors' room once registration was granted for the newly constructed rooms.

As part the inspection process, the inspector met with residents, relatives, staff, the person in charge and the provider. Residents' views were elicited, practices were observed and documentation was reviewed. Overall, the inspector found that the care was delivered to residents in a homely environment by staff who knew them well and interacted with residents in a manner that was respectful and dignified. Practices observed by the inspector were seen to be person centred and consistent and all staff who spoke with the inspector demonstrated clear knowledge of the residents' needs and wishes. Residents expressed satisfaction with the care and routine of the centre and residents who spoke with the inspector said that they felt safe in the centre and that the staff were excellent.

The inspector examined all 18 outcomes and the judgments in regards compliance are set out in the table above.
Outcome 01: Statement of Purpose
There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:
Governance, Leadership and Management

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

Findings:
The statement of purpose consisted of the aims, objectives and ethos of the centre and a statement as to the facilities and services which were to be facilitated. A minor amendment was required to full set out the sizes of rooms in the centre as required by the regulations. This information was submitted by the provider after the close of the inspection. The statement of purpose was kept under review and had been updated in March 2016. The statement of purpose was displayed in the entrance foyer and was seen to be implemented in practice.

Judgment:
Compliant

Outcome 02: Governance and Management
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.

Theme:
Governance, Leadership and Management

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

Findings:
It was evident that there were sufficient resources in place to ensure the effective
delivery of care, as described in the statement of purpose.

There was a clearly defined management structure. The person in charge was an experienced nurse who was involved in the daily delivery of the service. She was involved in the running of the centre on a regular and consistent basis and this was evident in her interactions with the inspector and the residents and staff throughout the course of the inspection.

The person in charge was supported in her management role by the provider. It was evident that the provider was involved in the running of the centre and accountability and responsibilities for each role were clearly set out. Staff and residents could identify both the person in charge and the provider and they were very supportive of both as managers.

There were management systems in place to ensure that the service provided was safe and appropriate to the residents’ needs. Audits were undertaken in numerous areas such as fall management, medication management, complaints, care plans, elder abuse prevention and hand hygiene. Good information was elicited and full compliance was determined across a number of audits by the person in charge. The inspector found that there was scope to enhance the learning outcomes provided by the audit process if further analysis of the results of the audits took place so as to clearly identify any trends in the centre and allow for further improvements in the quality of care and safety. For example, the results of monthly falls audits were not collated to ascertain any trends in the occurrence of falls in the centre. However, upon review of the individual monthly fall audit records it was evident that falls had reduced in the period July - September 2016. Complaints were reviewed six monthly and the inspector identified how the process could be further enhanced to ensure that audit contributed to the improvement of the service.

An annual review had been completed. This required further development to ensure that it set out the improvements and learnings that had occurred in the preceding year and any plans for improvement in the coming year, for example, changes to the premises, staff training et cetera.

There was evidence of consultation with residents via residents' meetings and a resident/relative survey had been completed in 2015. The person in charge stated that she was planning another survey early 2017.

Judgment:
Substantially Compliant

Outcome 03: Information for residents
A guide in respect of the centre is available to residents. Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

Theme:
Governance, Leadership and Management
Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
There was a guide to the centre available to residents. This was a bound pamphlet style book that was accessible and informative. It gave an overview of the services provided, included information on the complaints process and information about visiting times. It was available in the centre should a resident wish to peruse it.

A contract of care was completed for each resident in a random sample of files reviewed. It dealt with the care and welfare of the resident in the centre and set out the services to be provided. It also included the fees to be charged to residents and included details about those services that the fee didn't include.

Judgment:
Compliant

Outcome 04: Suitable Person in Charge
The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:
Governance, Leadership and Management

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

Findings:
The person in charge of the designated centre was a suitably qualified and experienced nurse manager and had extensive experience in nursing the older adult. She worked full time in the centre and divided her time between full time clinical nursing duties and discharging her administrative role. She worked approximately 24-30 hours per week in a nursing capacity and at a minimum dedicated 10 hours to her administrative function. She stated that this arrangement was subject to ongoing review to ensure all aspects of her role were adequately completed.

She demonstrated sound clinical knowledge of the residents and their needs and demonstrated that she was involved in the governance of the centre on a regular and consistent basis. She had good knowledge of the Regulations governing the centre and was informed regarding her duties under the Act.

Residents and staff could identify her as the person in charge and the general consensus of feedback to the inspector was that the person in charge was approachable and supportive should there be any concerns.
She undertook continuous professional development and had completed courses in dementia care, end of life care and wound management. She had also completed a course in gerontology. She stated she was planning to undertake courses in Parkinson’s care and further wound management prior to the end of 2016.

Judgment:
Compliant

Outcome 05: Documentation to be kept at a designated centre
The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:
Governance, Leadership and Management

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

Findings:
Overall complete records were maintained in the centre. Records were easily retrievable, accurate and up to date. As discussed and actioned in outcome 7 and 11, some improvements were required in the review and updating of resident care plans and restraint documentation.

There were policies that reflected the centre's practice and these were seen to be implemented in practice and understood by staff. Policies reviewed by inspectors had been reviewed and been updated to reflect best practice.

The directory of residents were reviewed and seen to contain the information required by the regulations.

Records of the centre's insurance were available for review.

Judgment:
Compliant

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

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

**Findings:**
A senior nurse, who had been working in the centre for more than twenty years was the person appointed to deputise in the event that the person in charge was to be absent from the centre for 28 days or more. There had been no incidences whereby this had occurred in the recent past.

She was a nurse with many years experience in nursing the older adult. Staff were able to identify her and she was seen to be involved in the delivery of care whilst on duty. She demonstrated excellent knowledge of the residents' needs when discussing same with the inspector.

**Judgment:**
Compliant

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

**Theme:**
Safe care and support

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

**Findings:**
There was a policy in place for the prevention, detection and response to abuse. Staff training was up to date and delivered by the person in charge. All staff who spoke with the inspector demonstrated a very clear understanding of the different types of abuse and how they should respond in the event of an allegation, suspicion or disclosure of abuse. All staff who spoke with the inspector were knowledgeable regarding their reporting responsibilities and there was documentary evidence that these responsibilities were discharged if required.

The person in charge was seen to supervise care and was directly involved in resident care on a regular basis. Residents confirmed that the person in charge was
approachable and they would have no hesitation in speaking with her if they had any concerns. A resident survey had been issued in 2015 and specific questions pertaining to whether residents felt safe in the centre were asked. Positive responses were received in relation to same.

Residents who spoke with the inspector confirmed that staff were good and caring and that they felt very safe in the centre.

There were systems in place for the management of residents' finances. Clear and transparent records were maintained and shown to the inspector. A random check of petty cash held for some residents tallied with records.

There was a policy in place for working with residents who had behaviour that is challenging. All staff had received training and staff who spoke with the inspector confirmed this. There was a small number of residents who required support with behaviours that challenged. Staff interactions were observed by the inspector when these residents required support and interventions were seen to be consistent, respectful and gentle. Distraction techniques were utilised by different staff members and residents were assisted to take part in group activities despite behaviours that challenge. Staff were knowledgeable regarding triggers that may be an underlying cause. Although staff were knowledgeable, improvements were required in the documentation of care plans for residents who required support with behaviours that challenged. For example, a resident who was prone to regular verbal outbursts did not have a specific care plan to support staff in the management of this resident's care to ensure a consistent approach.

There was a policy in place for the use of restraint. Staff demonstrated knowledge in this regard and consistent and safe practices were observed for restraint other that bedrails, such as half hourly checks and opportunities for the restraint to be removed and for the resident to mobilise. Documentation also verified that these safeguards were implemented. A GP (General Practitioner) had signed to confirm they had been involved in the decision making process.

Bedrails were also in use in the centre. Again, robust checks took place to ensure safety as demonstrated by documentary evidence. A risk balance tool was completed for all residents in regards to their suitability for bedrails. However, some improvements were required at the assessment stage, prior to the implementation of the bedrails, so as to clearly demonstrate that the centre's practices were in line with the national policy on restraint. For example, it wasn't always clear that the decision to use bedrails included the input of multidisciplinary professionals and wasn't the decision of one individual. The documentation pertaining to next of kin involvement in the decision to implement restraint required review to ensure it clearly set out the role of next of kin in the clinical decision. The centre had a general risk assessment in regards to the use of restraint in the centre. All controls weren't implemented at all times. For example, a pre restraint assessment tool was to be used before restraint implemented as per the risk assessment, this tool wasn't used prior to the use of bedrails. Alternatives that had been considered prior to the use of bedrails weren't always documented.

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 centre had policies relating to health and safety. There was an up to date health and safety statement. There was a plan in place for responding to major incidents and alternative accommodation had been identified should residents be required to evacuate the building. A risk management policy was in place and overall hazards were well managed. Where hazards had been identified, risk assessments had been completed and controls put in place where required. Risk assessments were reviewed two yearly, in the interim, there were no formal systems in place for identifying new or changing hazards or for ensuring that current controls were implemented and/or proportional to the risk identified. This was discussed with the person in charge and the provider.

There were satisfactory procedures in place for the prevention and control of healthcare associated infections. These were seen to be implemented in practice. The centre was seen to be clean on the days of inspection and free from odour. Residents were complimentary of household staff and the work they did. Some bedrail surfaces had been damaged so that raw wood was exposed, this was a potential infection control issue as the damaged surface would not allow for effective decontamination of same.

An incident book was used to record incidents in the centre. As discussed in outcome two, an audit of falls was completed monthly and included review of such matters as whether or not environmental hazards were a factor and any further interventions required so as to enhance learnings following such an event.

Staff were trained in safer moving and handling techniques.

Overall, the centre took a proactive approach to fire safety management, however, improvements were required in drill practices and the documentation of same. Fire exits were unobstructed and fire evacuation procedures were clearly displayed in numerous areas of the centre. Staff had received up to date training and all staff who spoke with the inspector demonstrated knowledge of what to do in the event of the fire alarm sounding. Fire alarm checks and inspections of fire fighting equipment were maintained in the centre’s fire register.

Residents each had a personal emergency evacuation plan (PEEP) and these were discreetly displayed in bedroom areas. However, these required review to ensure that
they gave sufficient information for all scenarios. For example, one PEEP reviewed stated that a wheelchair should be used to evacuate the resident, upon discussion with the person in charge, it was evident that a ski evacuation sheet should in fact be used.

Fire evacuation drills were taking place as part of a structured training day with an external instructor. Although carrying out drills under the supervision of an external fire safety contractor is considered good practice, additional independent drills carried out with staff are also required to determine if the fire procedures are fit for purpose and staff responses are adequate. Additional drills also identify training, staff and equipment needs. In the absence of these additional drills, there was no evidence, documentary or otherwise, to demonstrate that the plans and practices in place were sufficient to ensure a timely evacuation if the need arose. There was no documentary evidence of what the drill (if any) had entailed, what had gone well and what required improvement. There were no details as to the length of time it would take to evacuate all residents from a specific zone if needed. This was discussed with the provider over the course of the inspection.

**Judgment:**
Non Compliant - Moderate

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**Outcome 09: Medication Management**

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

**Theme:**
Safe care and support

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

**Findings:**
There were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents. There were processes in place for the handling of medicines, included controlled drugs which were in line with current guidelines and legislation.

Medications for residents were supplied by a local community pharmacy. There was evidence of appropriate involvement by the pharmacist in accordance with guidance issued by the Pharmaceutical Society of Ireland.

The inspector accompanied a nurse on part of her medication round and found that medications were given in line with current guidelines and the nurse was familiar with the guidelines pertaining to medication management. The inspector observed and reviewed the practices relating to controlled drugs and found that records tallied with the records kept and checks were carried out as required by nursing staff.

The inspector noted that medicines were stored securely. Medicines requiring
refrigeration were stored appropriately. Medication fridge temperatures were monitored daily and records indicated that the fridge temperature was maintained within normal limits.

The practice of transcription was in accordance with professional guidance issued by An Bord Altranais agus Cnaímhseachais.

Staff with whom the inspector spoke demonstrated good knowledge in relation to medication management. Medication management training was facilitated for staff and was scheduled for October 2016.

A sample of medication and administration records was reviewed. Where medicines were to be administered in a modified form such as crushing, this was individually prescribed by the prescriber on the prescription chart. The inspector noted that medication administration sheets identified the medications on the prescription sheet and allowed space to record comments on withholding or refusing medications.

A medication management audit was completed quarterly and the last audit in July 2016 found practices to be in full compliance, there was no evidence to the contrary over the course of the inspection.

A record of the medications returned to the pharmacy was maintained which allowed for an itemised, verifiable audit trail.

**Judgment:**
Compliant

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**Outcome 10: Notification of Incidents**
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

**Theme:**
Safe care and support

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

**Findings:**
A record was maintained of all incidents occurring in the centre. This was available for review by the inspector and contained good detail of the event as well as any pertinent information regarding immediate follow up. Notifications had been submitted as required by the regulations.

A quarterly report had been submitted to the Authority as required by the Regulations but did not include detail of the environmental restraint in use in the centre. This was resubmitted to the Authority by the person in charge prior to the close of the inspection.
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:  
Overall, the inspector was satisfied that care was delivered to a high standard and met the needs of the residents. Staff who spoke with the inspector demonstrated detailed knowledge of residents' needs and each staff member's account of residents' needs was consistent with their colleagues.

It was evident that residents' health care needs were met through timely access to medical treatment via GP (General Practitioner) services and access to allied health such as dietician and speech and language therapy. Practices enabling the prevention and early detection of ill health were in place. For example, monthly observations such as weight, blood pressure and pulse. Records of blood samples taken for general health checks were on file. An optician's service had recently visited the centre and completed an eye exam for residents. Chiropody services were also delivered in the centre.

Clinical risk assessments were completed using validated tools and included: nutrition, falls risk, skin integrity and dependency levels. A random selection of residents' files were reviewed and these assessments were seen to be update.

Care plans were in place which were informed by the nursing assessments, these were person centred in their approach and overall these directed care well. Some improvements were required in documentation practices to ensure that care plans were in place, fully up to date and the information easily retrievable. For example, a care plan for a resident requiring a diet of modified consistency had not been updated after review of the relevant allied health professional.

Records for a resident with a significant wound demonstrated that wound care was delivered as per the centre's policy and it was evident upon examination of the record what dressing materials were used and the progress of the wound. However, a care plan was not in place to confirm the plan in place was evidence based and fully implemented and where the care had changed from the advice given by a wound care
Care plans for residents with specific communication needs required review to ensure they fully reflected current practice and the communication tools required, although it was evident that this was a documentation issue and not a practice issue as it was evident via staff interactions that they were familiar with the relevant communication strategies. A care plan to meet a resident's social needs was no longer relevant and required updating as confirmed by the person in charge.

It was the centre's practice to review care plans three monthly, however, the process required streamlining to ensure that relevant information was updated in the actual care plan and not in review note. The inspector was satisfied via conversations with and observations of staff that these inconsistencies were a documentation issue and did not impact on staff practices or knowledge of the residents.

Judgment:
Substantially Compliant

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

Theme:
Effective care and support

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

Findings:
The premises was originally a domestic dwelling and this original two-storey structure remained intact, but had been extended so that the facility provided accommodation for 22 residents over two floors. The extensions were all of single-storey construction and a recent construction project had been undertaken to increase occupancy form 22 residents to 26. The location, design and layout of the building was suited to its stated purpose and met the residents’ individual and collective needs.

The new wing could accommodate 6 residents in single occupancy rooms and these were examined over the course of the inspection. These were found to be completed to a high standard and would meet the needs of prospective residents. They were spacious, with a full ensuite and tastefully decorated. They had the furniture required under the Act, including lockable storage. The provider was awaiting the delivered of bedroom chairs and stated there had been a delay in the delivery of same. As part of the renovation, the provider was planning to decommission one twin bedroom and
convert the space into a visitors' room that would also be used to facilitate overnight stays of the families who had a loved one receiving end of life care in the centre. The provider stated that this room would be converted within two weeks of the the twin room being decommissioned. Residents discussed the new build with the inspector and were aware of the provider's plans to increase occupancy of the centre.

The older part of the building was well maintained with suitable lighting, heating and ventilation. It was homely with sufficient furnishings and fixtures and fittings. The centre was clean and suitably decorated, there was signage throughout. Accommodation for six residents was provided on the first floor in two single bedrooms and two twin-bedded rooms, a wash-hand basin was provided in each room. There was one bathroom on the first floor with toilet, wash-hand basin and assisted shower. The remaining residents were accommodated on the ground floor in four twin-bedded rooms, one of which had full ensuite facilities, and eight single bedrooms, five of which had full ensuite facilities. There was a further single toilet for residents’ use provided on the ground floor and a bathroom with assisted toilet, shower and wash-hand basin. Each bedroom seen contained the required furniture, however, privacy screening in shared bedrooms required review to ensure that each resident could access the wash hand basin without compromising the privacy of the other resident, if the other resident had their privacy screening closed.

Residents were supported to individualise their bedrooms with personal effects and there was adequate storage as confirmed by residents who spoke with the inspector. There was a functioning call bell system in place.

Although residents had access to external space, this could not be accessed without staff entering a code to locked exit doors. There was no safe, enclosed, external space available to all residents although residents were seen to use the outside space, which was attractive and well maintained, over the course of the inspection. This was discussed with the provider who undertook to rectify same.

A large, bright open plan area was available which provided adequate communal and dining space for all residents. An entrance foyer provided additional communal space for residents and visiting friends and family. Circulation areas, toilet facilities and shower/bathrooms were adequately equipped with hand-rails and grabrails. Emergency call facilities were in place that were accessible from each resident’s bed and in each room used by residents.

Judgment:
Substantially Compliant

Outcome 13: Complaints procedures
The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:
Person-centred care and support
Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
There were policies and procedures in place for the management of complaints, however this required review to fully meet the requirements of the regulations. For example, there was no person nominated to oversee that all complaints were appropriately responded to and records kept. This person in separate to the person nominated to deal with complaints. The appeals process was not clearly set out in the policy.

The procedure was displayed in prominent locations throughout the centre. Residents who spoke with the inspector said they would have no hesitation in making a complaint if they so had one.

A complaints register was maintained, however, it was evident that there were inconsistencies in the standard of documentation. For example, it wasn't always clear what investigation took place following a complaint or what the learnings were following that investigation. Whether or not the complainant was satisfied with the outcome of the complaints was not always clearly documented as required by the regulations.

Staff who spoke with the inspector said that they would always report complaints to either the senior nurse or the person in charge.

Judgment:
Non Compliant - Moderate

Outcome 14: End of Life Care
Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.

Theme:
Person-centred care and support

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

Findings:
There were written operational policies and protocols in place for end of life care which staff were familiar with. Facilities were in place so that residents received end of life care in way that met their individual needs and wishes and respected their dignity and autonomy. The person in charge had reviewed this area of care since the previous inspection and had brought about many improvements.
Nominated staff had attended specialised training in the end of life care process and a committee had been established in the centre with the purposes of improving and reviewing end of life care practices. Explanations of an end of life care symbol were sensitively displayed in the entrance lobby.

A specific tool had been introduced to gather information regarding residents wishes for their end of life care, family were involved where appropriate. A specific end of life care plan was developed as the resident approached that stage of life as confirmed by the person in charge.

A support booklet, specific to the centre, had been recently developed and this set out relevant information to assist a resident's loved ones in the bereavement process.

The centre had commenced a formal review of the end of life care delivered to residents. This involved feedback from relatives which was seen to be very complimentary of the care provided by the staff in the centre and confirmed that palliative care services were utilised as required.

At the time of the inspection, there were no specific facilities to accommodate relatives overnight, however, as discussed in the premises outcome, the provider had plans to renovate an existing twin room and convert it to a visitors' room with overnight facilities being available.

**Judgment:**
Compliant

**Outcome 15: Food and Nutrition**

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

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

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

**Findings:**
There was a comprehensive policy for the monitoring and recording nutritional intake which was implemented in practice. Processes were in place to ensure that residents did not experience poor nutrition and hydration. A validated nutritional tool was completed and reviewed on a monthly basis. Food and fluid charts were also available if so required and these were seen to be implemented and complete for relevant residents. Nursing staff were seen to supervise mealtimes.

The kitchen staff who spoke with the inspector, demonstrated very good knowledge of
residents' dietary needs and a folder of information pertaining to dietary dislikes and specific dietary requirements was kept in the kitchen and updated monthly by the person in charge.

Residents were offered choice at mealtimes and a menu was displayed on the dining tables. Residents were very complimentary of the standard of food and residents who spoke with the inspector confirmed that the mealtimes suited them. Mealtimes were a relaxed, unhurried affair and assistance was given discreetly by staff at a pace set by the resident.

Access to fresh fluids were available to residents and staff were seen to encourage the fluid intake of residents.

**Judgment:**
Compliant

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

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

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

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

**Findings:**
There was evidence that residents were consulted about how the centre was planned and run. Regular residents’ meetings were held and minutes demonstrated good attendance. Feedback was sought in regards to upcoming outings and events in the centre. Discussions at the residents' meetings included the new build and remembering residents who had passed away. New residents were also introduced.

Information pertaining to external advocacy services was displayed in the centre.

Residents had access to care that accounted for their religious persuasion and backgrounds. Staff demonstrated awareness of residents' personal histories prior to their admission to the centre. Residents told the inspector of how they were facilitated to vote in house and roman catholic mass was celebrated in the centre twice monthly. Arrangements for other faiths were facilitated as required.

There was adequate facilities for recreation. There was a range of activities offered including bingo, arts and crafts, gentle exercise and games. Two of the staff members
were licensed practitioners in a specific therapeutic activity for residents with dementia and a session was facilitated every week. The activities for the day were displayed on a whiteboard in the main day room. The inspector observed photographs of residents participating in activities and trips out displayed throughout the centre. Residents spoke enthusiastically of recent outings to attractions such as a wildlife park, and activities such as a barbeque in the centre and a visit from historical society that involved residents dressing in historical clothing and were thoroughly enjoyed by those who participated as recounted by residents and evidenced in photographs of the day.

A celebration of the 1916 centenary had taken place in the centre and residents were actively involved. Photographs of the day were displayed on noticeboards and also on a monitor in the entrance foyer. Staff were seen to interact with residents during the morning routine by assisting and encouraging them with activities and reading articles from the days newspapers.

Residents could opt out of activities if they wished and some residents enjoyed reading newspapers, watching television or listening to the radio at their leisure.

Visitors were seen to come and go over the course of the inspection, there were no restrictions on visits.

Care was delivered to residents in a manner that was dignified and person centred. Staff demonstrated an awareness of residents individual communication needs.

**Judgment:**
Compliant

### Outcome 17: Residents' clothing and personal property and possessions

**Adequate space is provided for residents' personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.**

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

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

**Findings:**
There was a policy on residents' personal property and possessions. Property was kept safe and each resident had a lockable storage unit in their bedrooms. A robust laundry system was in place and residents who spoke with the inspector confirmed that they had no issues with personal property such as laundry going missing. As part of the provider's plans to increase occupancy levels, it had been decided that a full time laundry person would be employed Monday to Saturday, 8am - 2pm, once the occupancy levels had increased. This person had already been identified.
Resident property lists were maintained in the sample of resident files reviewed

**Judgment:**
Compliant

**Outcome 18: Suitable Staffing**
There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

**Theme:**
Workforce

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

**Findings:**
There was a roster in place. Based on observations, roster review and the findings over the course of the inspection, the inspector was satisfied that the staff numbers and skill-mix were appropriate to meeting the assessed needs of the residents. The inspector spoke with night staff who confirmed that the night staffing arrangements were adequate. Staff who spoke with the inspector stated that management were responsive to the changing needs of residents and extra staff were allocated if required.

The person in charge had a plan to increase care assistant staff by at least one when resident numbers would increase from 22 to 26. Ultimately, this would be subject to further increase as determined by the pre assessment of prospective residents carried out prior to admission. The person in charge stated that a planned, phased admission process would take place for the new residents coming to the centre.

There was a registered nurse on duty at all times and a record is maintained of current registration details of nursing staff. Staff practices were observed over the course of the inspection and found to be of a good standard, person centred in their approach.

There was an education programme in place and the person in charge had completed a recognised ‘train the trainer’ course and facilitated in house elder abuse prevention training. A external training provider was utilised to deliver additional training such as people moving and handling techniques, infection control and fire safety. Mandatory training was up to date for all staff as demonstrated by records and confirmed by the person in charge. Staff confirmed that training was provided.
Staff appraisals were completed on an annual basis and there was evidence of this in the staff files reviewed. A selection of staff files were reviewed and found to contain all matters required by the regulations. A vetting disclosure was in place in the selection of files reviewed and the person in charge confirmed that all staff in the centre had a vetting disclosure in place. The person in charge stated that there were no volunteers visiting the centre.

**Judgment:**
Compliant

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**Closing the Visit**

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

**Acknowledgements**

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

**Report Compiled by:**

Gemma O'Flynn  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority
Provider’s response to inspection report

<table>
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<th>St. Martha's Nursing Home</th>
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<tr>
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<td>OSV-0005284</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>03/10/2016</td>
</tr>
<tr>
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Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 02: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
An annual review had been completed. This required further development to ensure that it set out the improvements and learnings that had occurred in the preceding year and any plans for improvement in the coming year, for example, changes to the premises, staff training et cetera.

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

**Please state the actions you have taken or are planning to take:**
Changes were made to our annual review 2015 to reflect our developments and learning outcomes. This practice will be continued on our annual reviews.

**Proposed Timescale:** 10/10/2016

**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:**
Documentation practices relating to the use of restraint required review to ensure they fully adhered to the national policy on restraint.

For example:
It wasn't always clear that the decision to use bedrails included the input of multidisciplinary professionals and wasn't the decision of one individual. The documentation pertaining to next of kin involvement in the decision to implement restraint required review to ensure it clearly set out the role of next of kin in the clinical decision. As per the centre's risk assessment, a pre restraint assessment tool was to be used before restraint was implemented, this tool wasn't used prior to the use of bedrails. Alternatives that had been considered prior to the use of bedrails weren't always documented.

2. **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:**
Ongoing review of the use of side rails in the centre in accordance with the national policy.
All other alternative options to be considered and documented prior to the use of side rails. A multidisciplinary decision to be made on the use of all restraints. Pre assessment tool to be carried out as per our risk assessment policy.

**Proposed Timescale:** 01/11/2016

**Theme:**
Safe care and support
The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Care plans for residents requiring support in the area of behaviours that challenge weren't always in place to ensure safe and consistent practices were in place to fully guide staff.

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

Please state the actions you have taken or are planning to take:
Amendments made to the care plans of a resident with behaviours that challenge to reflect practices.

Proposed Timescale: 10/10/2016

Outcome 08: Health and Safety and Risk Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Risk assessments were reviewed two yearly, in the interim, there were no formal systems in place for identifying new or changing hazards or for ensuring that current controls were implemented and/or proportional to the risk identified.

4. 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:
Risk assessments commenced on new extension and will be kept updated where new or changing hazards are identified.
Update current system and include new extension to identify new hazards, ensure controls are implemented and review every six months or earlier as new or changing hazards are identified.

Proposed Timescale: 30/11/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in
the following respect:
Some bedrail surfaces had been damaged so that raw wood was exposed, this was a potential infection control issue as the damaged surface would not allow for effective decontamination of same.

5. Action Required:
Under Regulation 27 you are required to: Ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.

Please state the actions you have taken or are planning to take:
Side Rails that were damaged will be repaired, upgraded or replaced to allow for effective decontamination of same.

Proposed Timescale: 30/11/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Fire drills were not taking place outside structured training days. There was no documentary evidence to demonstrate that the plans and practices in place were sufficient to ensure a timely evacuation if the need arose. There was no documentary evidence of what the drill (if any) had entailed, what had gone well and what required improvement. There were no details as to the length of time it would take to evacuate all residents from a specific zone if needed.

Personal emergency evacuation plans (PEEPS) required review to ensure that they gave sufficient information for all scenarios. For example, one PEEP reviewed stated that a wheelchair should be used to evacuate the resident, upon discussion with the person in charge, it was evident that a ski evacuation sheet should in fact be used.

6. Action Required:
Under Regulation 28(1)(e) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and residents are aware of the procedure to be followed in the case of fire.

Please state the actions you have taken or are planning to take:
New documentation to be recorded with next fire drill. Role play a number of fire drills with all staff at different times (night time, afternoon and evening). Documentation to include area of fire, time taken to move residents in danger, time taken to raise alarm (if needed) etc. and a brief description of what happened. Fire drills to take place every six months or earlier if required. Review of PEEP Charts as the residents condition changes.

All PEEP charts have been reviewed and amended to reflect the residents current
Proposed Timescale: 01/11/2016

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:
Some improvements were required in documentation practices to ensure that care plans were in place, fully up to date and the information easily retrievable.

It was the centre's practice to review care plans three monthly, however, the process required streamlining to ensure that relevant information was updated in the actual care plan and not in review note.

7. 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:
Individualised relevant updated information to be recorded in care plan as well as review notes.

Proposed Timescale: 14/10/2016

Outcome 12: Safe and Suitable Premises

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Although residents had access to external space, this could not be accessed without staff entering a code to locked exit doors.
There was no safe, enclosed, external space available to all residents.

Privacy screening in shared bedrooms required review to ensure that each resident could access the wash hand basin without comprising the privacy of the other resident, if the other resident had their privacy screening closed.

8. 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:**
Unlocked door to safe enclosed external space to be provided.
Extra screening to be provided in shared rooms to ensure complete privacy.

**Proposed Timescale:** 01/01/2017

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**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:**
There was no person nominated to oversee that all complaints were appropriately responded to and records kept.

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

**Please state the actions you have taken or are planning to take:**
Another suitable person to be nominated other than the person nominated in regulation 34(1)(c).

**Proposed Timescale:** 01/11/2016

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

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The appeals procedure was not clearly set out in the complaints policy.

**10. 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 appeals procedure to be updated in the complaints policy.
**Proposed Timescale:** 01/11/2016

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

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
It was evident that there were inconsistencies in the standard of documentation. For example, it wasn't always clear what investigation took place following a complaint or what the learnings were following that investigation.

Whether or not the complainant was satisfied with the outcome of the complaints was not always clearly documented as required by the regulations.

**11. 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:**
A detailed record and investigation of any complaint to be recorded in line with regulations.

**Proposed Timescale:** 01/11/2016