**Centre name:** Our Lady of Fatima Home  
**Centre ID:** OSV-0000264  
**Centre address:** Oakpark, Tralee, Kerry.  
**Telephone number:** 066 712 5900  
**Email address:** info@fatimahome.com  
**Type of centre:** A Nursing Home as per Health (Nursing Homes) Act 1990  
**Registered provider:** Dominican Sisters  
**Provider Nominee:** Sr. Teresa McEvoy  
**Lead inspector:** Caroline Connelly  
**Support inspector(s):** None  
**Type of inspection:** Announced  
**Number of residents on the date of inspection:** 66  
**Number of vacancies on the date of inspection:** 0
About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

The inspection took place over the following dates and times

From: To:
11 January 2017 10:50 11 January 2017 18:50
12 January 2017 08:50 12 January 2017 15:40

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

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Summary of findings from this inspection

This report sets out the findings of an announced registration renewal inspection. The provider had applied to renew their registration which is due to expire on 26 April 2017. As part of the inspection the inspector met with the residents, the person in charge, the provider, relatives, two General Practitioners (GP), Assistant Director Of Nursing (ADON), the Clinical Nurse Manager (CNM), the dentist and numerous staff members. The inspector observed practices, the physical environment and
reviewed all governance, clinical and operational documentation such as policies, procedures, risk assessments, reports, residents' files and training records to inform this application. The provider, person in charge and the staff team displayed good knowledge of the regulatory requirements and they were found to be committed to providing person-centred evidence-based care for the residents.

There was a new person in charge in post since the previous inspection and an interview was conducted with her in the HIQA office in 2016. There was also a new CNM since the last inspection and an interview was conducted with her during the inspection. Both displayed a good knowledge of the standards and regulatory requirements and were found to be committed to providing quality person-centred care to the residents. The ADON deputised in the absence of the person in charge and the provider was in the centre daily. The inspector was satisfied that there was a clearly defined management structure in place. The management team were proactive in response to the actions required from the previous inspection and the inspector viewed a number of improvements throughout the centre which are discussed throughout the report.

A number of quality questionnaires were received from residents and relatives and the inspector spoke to many residents and relatives throughout the inspection. The collective feedback from residents and relatives was one of general satisfaction with the service and care provided. However a number of relatives and some residents identified a lack of staff as an issue and also they would like to see residents out of their rooms more and involved in more activities. These issues are looked into and discussed further in the body of the report. Family involvement was encouraged with relatives and residents stating they are welcomed at any time. The inspector saw numerous visitors in and out of the centre during the two day inspection. There was an residents committee which facilitated the residents' voice to be heard and this was run by an external advocate.

The inspector found the premises; fittings and equipment were very clean and well maintained and that there was a good standard of décor throughout. There was evidence of individual residents' needs being met and the staff supported residents to maintain their independence where possible. Resident's health and social care needs were met. Residents had comprehensive access to (GP) services, to a range of other health services, and the nursing care provided was found to be evidence-based. Residents could exercise choice in their daily life and were consulted on an ongoing basis. Residents could practice their religious beliefs. In summary, the inspector was satisfied that the centre was generally operating in compliance with the current conditions of registration granted to the centre.

The inspector identified aspects of the service requiring improvement to enhance the findings of good practice on this inspection. These included a review of staffing in the afternoon and evening, enhancement of the dining experience for residents who do not attend the dining room and the provision of communal space in one of the units. These are discussed under the outcome statements. The related actions are set out in the Action Plan under the relevant outcome. These 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 Standards for Residential Care Settings for Older People in Ireland 2016. The provider was required to complete an action plan to address these areas.
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 Standards for Residential Care Settings for Older People in Ireland.

**Outcome 01: Statement of Purpose**

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

**Theme:**
Governance, Leadership and Management

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

**Findings:**
The statement of purpose and function was viewed by the inspector, and it clearly described the service and facilities provided in the centre. It identified the staffing structures and numbers of staff in whole time equivalents. It also described the aims, objectives and ethos of the centre. This ethos was reflected in day-to-day life, through the manner in which staff interacted, communicated and provided care.

The statement of purpose included the registration date, expiry date and the conditions attached by the Chief Inspector to the designated centre’s registration under Section 50 of the Health Act 2007. There was evidence that the statement of purpose was kept under review and readily available for residents and staff to read. The statement of purpose was found to meet the requirements of legislation.

**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:
The inspector found that there was a clearly defined management structure in the centre that outlined the lines of authority and accountability. The provider was in the centre on a daily basis and was involved in the overall governance and management of the centre. The provider reported to an active board of management who met on a regular basis.

There was a new person in charge appointed in June 2016, in post since the previous inspection and an interview was conducted with her in the HIQA office prior to the inspection. The person in charge was supported in her role by an ADON and there was also a new CNM appointed since the last inspection and an interview was conducted with her during the inspection. As the person in charge was new to the managerial role the board of management had arranged for the previous person in charge to be present in the centre two days a week to provide support and guidance if required. The management team were proactive in response to the actions required from the previous inspection and the inspector viewed a number of improvements throughout the centre which are discussed throughout the report.

The management team and staff demonstrated a commitment to continual improvement and quality assurance. There was evidence of ongoing quality improvement strategies and monitoring of the services. A quality management system was in place which included weekly collection of data on quality of care and quality indicators included pressure ulcers, falls, the use of psychotropic medications, bed rails, medication management and administration, the assessment of risk and health and safety. There was a system of audit in place with a monthly programme of audits being undertaken to review and monitor the quality and safety of care and the quality of life of residents. There was evidence of corrective action reports completed and actions undertaken as a result of the audits. There was evidence that audit findings were communicated to staff in the staff meetings. There was evidence of good consultation with residents and relatives. Residents and relatives’ questionnaires generally reflected satisfaction with care received in the centre. There was evidence that residents’ meetings were convened on a regular basis.

Following a recent outbreak of influenza a full review of all infection control practices was undertaken and further control measures were put in place. There was evidence of the generation of a report, inclusive of findings and an action plan being implemented.

The management team had completed a very comprehensive annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by HIQA under section 8 of the Act for 2015. The annual review outlined service developments, building works, audits undertaken, staff training, complaints, results and feedback from resident and relatives’ surveys. It outlined the improvements made in 2015 and outlined the quality improvement plan for 2016. The person in charge said they were currently compiling the annual review for 2016. The inspector was satisfied that the quality of care is monitored and developed on an ongoing basis and that the action taken in response to findings or trends identified generally resulted in enhanced outcomes for residents in areas audited.
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:
A sample of residents’ contracts of care were viewed by the inspector. The inspector found that contracts had been signed by the residents/relatives and found that the contract was clear, user-friendly and generally outlined all of the services and responsibilities of the provider to the resident and the fees to be paid. The contracts also detailed what was included and not included in the fee however there was no evidence of the costs for extra services to be provided and one contract seen had out of date fees included.

A Residents' Guide was also available which included a summary of the services and facilities provided, terms and conditions relating to residence, procedure respecting complaints and the arrangements for visits. This guide was found to meet the requirements of legislation.

Judgment:
Substantially 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:
As previously outlined there was a new person in charge appointed and in post since the previous inspection. She commenced her role in June 2016 and a interview was
conducted with her in the HIQA office prior to the inspection. She displayed a good knowledge of the standards and regulatory requirements and was found to be committed to providing quality person-centred care to the residents.

The inspector interacted with the person in charge throughout the inspection process. There was evidence that the person in charge was engaged in the governance, operational management and administration of the centre on a day-to-day basis. The inspector was satisfied that she was a registered nurse, was suitably qualified and had a minimum of three years experience in nursing of the older person within the previous six years, as required by the regulations. She had a commitment to her own continued professional development and she had regularly attended relevant education and training sessions which was confirmed by training records. Staff, residents and relatives all identified her as the person who had responsibility and accountability for the service and said she was approachable and that she always made herself available to them whenever they needed to discuss anything with her.

Judgment:
Compliant

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

Theme:
Governance, Leadership and Management

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

Findings:
Residents' records were reviewed by the inspector who found that they complied with Schedule 3 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. The records listed in Schedule 4 to be kept in a designated centre were all maintained and made available to inspectors.

The inspector reviewed the centre's operating policies and procedures and noted that the centre had policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and these were reviewed and updated at intervals not exceeding three years as required by Regulation 4. The centre-specific policies reflected the care given in the centre and informed staff with regard to up to date evidenced best practice or guidelines. The
inspector viewed the insurance policy and saw that the centre is adequately insured against accidents or injury to residents, staff and visitors.

The person in charge informed the inspector that no staff commenced employment until satisfactory Gardaí vetting, references and all the requirements of schedule 2 of the regulations had been attained. The inspector reviewed a sample of staff files and found that they contained all of the information required under Schedule 2 of the Regulations.

The inspector was satisfied that the records listed in Part 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 were maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. Overall records were seen to be maintained and stored in line with best practice and legislative requirements.

**Judgment:**
Compliant

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**Outcome 06: Absence of the Person in charge**

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

**Theme:**
Governance, Leadership and Management

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

**Findings:**
There was a new person in charge in post since the previous inspection. The authority had received the correct notification in relation to the absence of the previous person in charge and the appointment of the current person in charge.

Suitable deputising arrangements were in place to cover for the person in charge when she was on leave. The ADON who is in the post of ADON for a number of years was in charge when the person in charge is on leave. There was also a newly appointed CNM since the last inspection and the inspector met and interviewed the CNM during the inspection and she demonstrated an awareness of the legislative requirements and her responsibilities and was found to be a suitably qualified and experienced registered nurse.

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

Findings:
The inspector found that there were measures in place to protect residents from suffering harm or abuse. Staff interviewed demonstrated a good understanding of safeguarding and elder abuse prevention and were clear about their responsibility to report any concerns or incidents in relation to the protection of a resident. The inspector saw that safeguarding training was on-going on a very regular basis in-house and training records confirmed that staff had received this mandatory training. This training was supported by a policy document on elder abuse which defined the various types of abuse and outlined the process to be adopted to investigate abuse issues should they arise.

The centre maintained day to day expenses for a number of residents and the inspector saw evidence that complete financial records were maintained. The inspector reviewed the systems in place to safeguard residents’ finances and valuables which included a review of a sample of records of monies and valuables handed in for safekeeping. Money and valuables were kept in a locked area in the reception area. Residents’ monies and valuables were stored in individual plastic envelopes with the name of the resident. All lodgements and withdrawals were documented and were signed for by two staff members and the resident where possible. The inspector was satisfied that the system in place was sufficiently robust.

There was a policy on responsive behaviour and staff were provided with training in the centre on responsive behaviours. There was evidence that residents who presented with responsive behaviour were reviewed by their GP and referred to psychiatry of old age or other professionals for full review and follow up as required. The inspector saw evidence of positive behavioural strategies and practices implemented to prevent responsive behaviours and staff spoke about the actions they took. Records of behaviours were recorded with included the triggers to these behaviours and what facilitated the resident following the behaviour. Care plans reviewed by the inspector for residents exhibiting responsive behaviours were seen to reflect the positive behavioural strategies proposed. These were clearly outlined in residents’ care plans and therefore ensured continuity of approach by all staff using person-centred de-escalation methods.

There was an up to date policy on restraint. There was evidence that the use of restraint was in line with national policy. The inspector saw that there was a comprehensive assessment form was in place for the use of bedrails, which clearly identified what alternatives to bed rails had been tried to ensure bed rails were the least restrictive
method in use. The inspector was assured by the practices in place and saw that alternative measures such as low profiling beds and alarm mats were being used to reduce the use of bed rails in the centre over recent times and there had been a continued reduction in bed rail usage. There were 11 residents using bedrails on the days of the inspection which had been reduced from 15 using bedrails in September 2016. Where bedrails were required for a resident, the inspector saw evidence that there was regular checking of residents, discussion with the resident’s and family.

**Judgment:**
Compliant

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**Outcome 08: Health and Safety and Risk Management**

*The health and safety of residents, visitors and staff is promoted and protected.*

**Theme:**
Safe care and support

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

**Findings:**

The inspector saw that the fire policies and procedures were centre-specific. The fire safety plan was viewed and found to be comprehensive. There were notices for residents and staff on “what to do in the case of a fire” appropriately placed throughout the building. Staff demonstrated an appropriate knowledge and understanding of what to do in the event of fire. The inspector saw that fire training was provided to staff on a number of dates in 2016 and staff had up to date fire training. The person in charge told the inspector and records showed that fire drills were undertaken regularly with different staff in attendance the actions taken and outcome of the fire drill was documented in a number of drills but not in all. The inspector examined the fire safety register with details of all services and tests carried out. All fire door exits were unobstructed and fire fighting and safety equipment had been tested in December 2016 and the fire alarm was last tested in January 2017.

Accidents and incidents were recorded on incident forms and were submitted to the person in charge and there was evidence of action in response to individual incidents. There were reasonable measures in place to prevent accidents such grab-rails in toilets and handrails on corridors. There was a centre-specific emergency plan that took into account all emergency situations and detailed an agreement with a local hotel where residents could be relocated to in the event of being unable to return to the centre. Clinical risk assessments were undertaken, including falls risk assessment, assessments for dependency, assessments for malnutrition and assessments for pressure ulcer formation. The provider has contracts in place for the regular servicing of all equipment and the inspector viewed records of equipment serviced which were all up-to-date.

The environment was observed to be very clean and personal protective equipment,
such as gloves, aprons and hand sanitizers were located throughout the premises. All hand-washing facilities had liquid soap and paper towels available. There were policies in place on infection prevention and control and staff that were interviewed demonstrated knowledge of the correct procedures to be followed. Hand hygiene training was on-going and staff demonstrated good hand hygiene practice as observed by the inspector. Arrangements for the disposal of domestic and clinical waste management were appropriate. As discussed in outcome two, audits of infection control were on-going particularly following the recent outbreak of Influenza. Infection control training is ongoing and provided to staff on a regular basis.

The health and safety of residents, visitors and staff were promoted and protected. The health and safety statement seen by the inspector was centre-specific and up-to-date. The risk management policy as set out in Schedule 5 did include all the requirements of Regulation 26(1) The policy covered, the identification and assessment of risks and the precautions in place to control the risks identified. It included the measures and actions in place to control the following specified risks, 1) Abuse, 2) the unexplained absence of a resident, 3) accidental injury to residents or staff, 4) aggression and violence, and 5) self-harm and therefore was found to meet the requirements of legislation. The risk register was up to date and it identified and outlined the management of clinical and environmental risks. Corrective action reports were completed for any deviation and risks identified.

Records viewed by the inspectors indicated that staff had received up to date moving and handling training. Hoists were serviced on a regular basis as required by legislation and records of same were seen by the inspector. The person in charge and CNM confirmed that they regularly observe the staff undertaking manual handling practices and have corrected any deficiencies noted. New hoist slings and equipment were also purchased following an audit identifying the need for replacement of some slings.

Judgment:
Compliant

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

Theme:
Safe care and support

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

Findings:
Inspectors noted that there were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents which were up-to-date. Staff wore red tabards indicating that they were not to be disturbed while administering medications. Staff were observed adhering to appropriate medication management practices. Medication trolleys were secured and the medication keys were held by the
nurse in charge of the unit. The inspector observed a nurse administering the tea time medications, and this was carried out in line with best practice. Medications were generally administered and disposed of appropriately in line with An Bord Altranais and Cnámhseachais na hÉireann Guidance to Nurses and Midwives on Medication Management (2007). Controlled drugs were stored in accordance to best practice guidelines and nurses were checking the quantity of medications at the start of each shift. The inspector did a count of controlled medications with the nurse which accorded with the documented records.

The inspector reviewed a number of medication prescription charts and noted that all included the resident's photo, date of birth, general practitioner (GP) and details of any allergy.

There was a system in place for reviewing medications on a three monthly basis by the GP and pharmacist and this was documented in residents’ notes. The inspector saw that for residents that required their medications in an altered format such as crushed medications this was not seen to be prescribed as such for each individual medication that required crushing. On some medication records the instruction to crush was written on the top of the prescription sheet and some were signed by the GP and some were not. Therefore nursing staff were administering medication to residents in crushed format although it had not been specifically prescribed on the prescription sheet and there was no list available of medications that cannot be crushed maintained. As required medications stated frequency of dose therefore ensuring there was a maximum dose in 24 hours that could not be exceeded.

A comprehensive system of ongoing audit and analysis was in place for reviewing and monitoring safe medication management practices. The clinical nurse manager was assigned this role. Medication errors were recorded and there was evidence that appropriate action was taken as a result of same. Nursing staff undertook regular updates in medication management training as evidenced by training records.

There were appropriate procedures for the handling and disposal of unused and out of date medicines and the documenting of same. Fridges containing medications were available and there was evidence that the temperature of the fridge was monitored daily.

Judgment:
Compliant

**Outcome 10: Notification of Incidents**

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

**Theme:**
Safe care and support

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

**Findings:**
The inspector saw that there was a comprehensive log of all accidents and incidents that took place in the centre.

Incidents as described in the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 have been reported in accordance with the requirements of the legislation. There were timely quarterly returns and written notifications were received within three days of accidents and incidents as required.

**Judgment:**
Compliant

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**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

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

**Findings:**

There was evidence that residents could keep the service of their own general practitioner (GP) and there were a large number of GP's attending residents in the centre. The inspector met and spoke to two GP's who was doing a routine visit to some of their residents during the inspection. One GP confirmed that his practice visited the centre on a regular basis. There was evidence that three monthly reviews of residents medications was undertaken by the GP and the person in charge informed the inspector that she wrote to the GP to inform them a review was due. The inspector saw a very comprehensive review undertaken by one of the GP practices in a residents file.

Residents’ medical records were inspected and these were current with regular reviews including medication reviews, referrals, blood and swab results, and therapy notes. Residents’ additional healthcare needs were met. Physiotherapy services were available in house and all residents were assessed on admission for mobility and falls prevention. Dietician and speech and language services were available as required. All supplements were appropriately prescribed by a doctor. Optical assessments were undertaken on residents in-house by an optician from an optical company. The inspector met the dentist who was in the centre doing a check visit on a resident and he confirmed that he undertook routine dental work including cleaning and fillings in the centre and residents only had to attend the surgery for more complex procedures and x-rays.

Residents in the centre also had access to the specialist mental health of later life services. Community mental health nurses attended the centre to review and follow up.
residents with mental health needs and residents who displayed behavioural symptoms of dementia. Treatment plans were put in place which were followed through by the staff in the centre. Follow-up to consultations were completed by psychiatrists as required. Residents and relatives expressed satisfaction with the medical care provided.

The inspector saw that residents had a comprehensive nursing assessment completed on admission. The assessment process involved the use of a variety of validated tools to assess each resident’s risk of deterioration. For example, risk of malnutrition, falls, level of cognitive impairment and pressure related skin injury among others. Pain charts in use reflected appropriate pain management procedures. The inspector saw that there had been substantial improvements in care planning since the previous inspection. Each resident had a care plan developed within 48 hours of their admission based on their assessed needs. There were care plans in place that detailed the interventions necessary by staff to meet residents’ assessed healthcare needs. They contained the required information to guide the care and were regularly reviewed and updated to reflect residents’ changing needs. There was evidence that residents and their family, where appropriate participated in care plan reviews. There was documentary evidence that the care plan had been discussed with the resident or relative as required and this discussion of care plans was confirmed by residents and relatives. Consent to treatment was documented. Nursing notes were completed on a daily basis.

The inspector found that the care plans guided care and were very person centred and individualised. Nursing staff and health care assistants spoken with were familiar with and knowledgeable regarding residents up to date needs.

Nursing staff told the inspector that a detailed hospital transfer letter was completed when a resident was transferred to hospital. There were no residents with pressure sores at the time of the inspection and nursing staff advised the inspector that Staff had access to support from the tissue viability nurse if required.

The inspector observed that residents appeared to be well cared for, which was further reflected in residents’ comments that their daily personal care needs were well met. Residents, where possible, were generally encouraged to keep as independent as possible and the inspector observed some residents moving freely around the corridors, in communal areas and in the grounds of the centre.

**Judgment:**
Compliant

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**Outcome 12: Safe and Suitable Premises**

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

**Theme:**
Effective care and support
Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
Our Lady of Fatima Nursing Home is a single-storey building that commenced operation in 1968 and it provides continuing, convalescent and respite care for up to 66 residents. On the previous inspection the provider had applied to register nine new bedrooms which were to replace the six bedded room and three twin rooms were to be converted to single rooms. The new rooms were in a purpose built wing which contained nine large single en-suite rooms, a sluice room, storage rooms and a nurses station. The inspector saw that the new rooms were very large with plenty of storage space including locked storage space, they also contained a seating area for table and chairs. They were completed to a high specification with large en-suite bathrooms. There were two call bells in each room one by the bed and one for the seating area. The six bedded was converted into an activities room which was seen by the inspector to be of a high standard and contained comfortable seating areas decorated in a homely theme, activity areas, exercise areas and was home to tropical fish and budgies in a cage. The new sluice room was extra large and contained all the required equipment.

The centre now consisted of 47 single en-suite bedrooms four twin en-suite bedrooms and eleven en-suite bedrooms/suites that also contained a sitting room. Overall the inspector found the premises and residents bedrooms to be of a high standard and much personalised throughout. There was an enclosed garden area which used and enjoyed by residents in the fine weather. The premises and grounds were seen to be well-maintained. Appropriate lighting and ventilation were provided. The inspector noted that the premises and grounds were free from significant hazards. The centre was warm and comfortable and suitably decorated. A sufficient number of toilets, bathrooms and showers and an assisted bathroom were provided.

Communal space for residents consists of three sitting rooms, a dining room, a sunroom, a room for residents to meet visitors and an internal smoking room. There is also internal access to an attached chapel which is used by the local community. On the previous inspection the inspector identified the lack of a communal space in the new unit or in the proximity of the new unit with the main sitting and dining room being a long walk for residents. The person in charge informed the inspector of the plans to put a seating area outside of the new unit where the old nurses station currently is as this will be replace with the new nurses station. On this inspection the inspector saw that although some seating had been put in this area it was not adequate for the residents in that area and a sitting room and some dining facilities were required for residents who were unable to go to the main dining room. This is discussed further under outcome 15 Food and Nutrition. The centre had a separate main kitchen complete with cooking facilities, equipment, dry stores, cold rooms and shelving. Catering staff had designated changing and toilet facilities.

Equipment seen by the inspector was found to be fit for purpose and up-to-date service records were available for all equipment on the days of the inspection.

Judgment:
**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 was a policy and procedure for making, investigating and handling complaints. The policy was displayed in the main reception area and was also outlined in the statement of purpose and function and in the Residents’ Guide. There was evidence that complaints were discussed at staff meetings and informed changes to practice.

Staff interviewed conveyed an understanding of the process involved in receiving and handling a complaint. The inspector viewed a comprehensive complaints log and saw that complaints, actions taken and outcomes were documented in accordance with best practice and that feedback is given to the complainant.

There was an independent appeals person nominated and the policy had been updated to include the facility to refer to the Ombudsman if required.

**Judgment:**
Compliant

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**Outcome 14: End of Life Care**

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

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

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

**Findings:**
The centre is run by a religious order and the inspector observed that religious beliefs were facilitated as there was a chapel attached to the building. There was a religious service for the wider community held daily, which residents could attend if they wished.
and it was also televised so they could watch from their rooms. Residents also had access to ministers from other religious denominations as required. Residents and relatives confirmed that the spiritual and religious needs of residents were very well met.

The inspector reviewed the centre's policy on end-of-life care which was seen to be comprehensive to guide staff in providing holistic care at the end of life stage. The inspector reviewed a sample of residents' care plans with regards to end-of-life care and noted that they comprehensively recorded residents' preferences at this time. All information was accessible to staff and staff indicated that relevant information was shared at report handover time. A number of residents with whom the inspector spoke were positive about the care available in the centre. Most residents stated that in the event that their needs changed in the future they would prefer to be cared for in the centre.

Staff training records indicated that a number of staff had attended training on palliative care issues including spiritual care, psychological support, pain management and communicating with the bereaved relatives. The person in charge stated that the centre was well supported by the specialist team from the local community. Records which the inspector viewed indicated that the palliative team were responsive to the GP and the staff in providing specialist advice in pain relief and symptom management.

Families were facilitated to be with residents at end of life and facilities were provided to ensure their comfort. The nuns from the religious order often sat with residents at end stage of life offering spiritual care and support. Overall the inspector found that care practices and facilities in place were designed to ensure residents received end of life care in a way that met their individual needs and wishes and respected their dignity and autonomy.

**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:**
The centre had a comprehensive policy for the monitoring and documentation of nutritional intake which was seen to be implemented in practice. A record of staff
training seen by the inspectors indicated that staff had attended a broad range of training and that internal education sessions were on going.

There were systems in place to ensure residents' nutritional needs were met, and that the residents received adequate hydration. Residents were screened for nutritional risk on admission and reviewed regularly thereafter. Residents' weights were checked on a monthly basis and more frequently if evidence of unintentional weight loss was observed. There was good access to dietetic services and the services of the speech and language therapist. Files reviewed by the inspector confirmed this to be the case. Nutritional supplements were administered as prescribed. All staff were aware of residents who required specialised diets or modified diets and were knowledgeable regarding the recommendations of the dietician and speech and language therapist.

Residents were provided with a choice of nutritious meals at mealtimes and all residents spoken to were complimentary about the food provided. However the menu was not available on residents dining tables nor was it displayed outside the dining room. There was no picture menu available for residents who did not comprehend a written menu. The provider said they had purchased items to display menus but this had not been completed to date. There was an effective system of communication between nursing and catering staff to support residents with special dietary requirements. All special diets were catered for and meals were presented in an attractive and appetising manner.

There was only one dining room in the centre which was bright and spacious but would not be large enough to accommodate all 66 residents. The inspector observed that many residents had their meals in their bedrooms and the person in charge confirmed that about half of residents only attended the dining room. The inspector observed mealtimes including lunch, and tea time in the dining room which was seen to be a social occasion. The inspector required that mealtimes and access to the dining room was reviewed for all residents, the lack of dining space is actioned under outcome 12 premises.

Inspectors reviewed records of resident meetings and any issues residents raised in relation to food had been addressed and Overall residents were generally complementary of the food on offer in the centre and said issues previously identified such as cold porridge and tea in the morning had generally been addressed.

Relatives with whom the inspector spoke said that the food was very good and that they were informed of any changes in the nutritional status of their relative.

Judgment:
Substantially Compliant

Outcome 16: Residents’ Rights, Dignity and Consultation
Residents are consulted with and participate in the organisation of the centre. Each resident’s privacy and dignity is respected, including receiving visitors in private. He/ she is facilitated to communicate and enabled to exercise choice and control over his/ her life and to maximise his/ her independence. Each resident has opportunities to participate in meaningful
activities, appropriate to his or her interests and preferences.

Theme:
Person-centred care and support

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

Findings:
Residents were facilitated to exercise their civil, political and religious rights. The inspector was told that residents were enabled to vote in national referenda and elections as the centre registered to enable polling. The inspector observed that residents’ choice was generally respected and control over their daily life was facilitated in terms of times of rising /returning to bed and whether they wished to stay in their room or spend time with others in the communal room. However as already identified lack of communal space in some areas of the centre meant residents did not always avail of communal space.

Respect for privacy and dignity was evidenced throughout both days of inspection. Staff were observed to knock on doors and get permission before entering bedrooms. Screening was provided in twin bedrooms to protect the residents privacy. Staff were observed communicating appropriated with residents who were cognitively impaired as well as those who did not have a cognitive impairment. Effective communication techniques were documented and evidenced in some residents care plans. Residents were treated with respect. The inspector heard staff addressing residents by their preferred names and speaking in a clear, respectful and courteous manner. Staff paid particular attention to residents’ appearance, dress and personal hygiene and were observed to be caring towards the residents. Residents choose what they liked to wear. The hairdresser visited weekly and some residents told the inspector how important this was to them.

Numerous visitors were observed throughout both days of inspection where staff members knew the names of visitors and vice versa. Staff took time to talk with family members both when they visited and when they rang to enquire about their relative. Visitors told the inspector that they were always made welcome and that there were plenty areas in the centre to visit in private if they wished to. They said that if they any concerns they could identify them to the person in charge, ADON or staff and were assured they would be resolved.

Residents had access to the daily newspaper and several residents were observed enjoying the paper both mornings of inspection. Residents had access to radio, television, and information on local events.

There was an active residents’ committee which met regularly and this was chaired by an external advocate. Minutes from these meetings demonstrated that there was good attendances at the meetings and a variety of topics were discussed. However there was no evidence that all issues identified by residents were followed up and actioned and feedback on same given to the residents. This was discussed with the person in charge.
and she assured the inspector that this would take place in the future.

It was evident to the inspector that many residents had opportunities to participate in activities that were meaningful and purposeful to them and that suited their needs, interests, and capacities. A large range of activities were facilitated, for example, newspapers, prayers/mass, live music sessions, exercises, imagination gym, Sonas activities, hairdressing, movies, crosswords, outings, arts and crafts, cookery. An activities coordinator was employed full time and other staff also did specific activities with the residents. The inspector saw that a variety of activities taking place throughout the two days of the inspection. Residents and relatives were very complimentary about the activity programme and the activity staff. However it was identified on the questionnaires returned to HIQA that they would like to see more activities especially for residents who do not always attend the activity room.

**Judgment:**  
Substantially Compliant

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**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):**

**Findings:**  
There was a centre-specific policy on residents' personal property and possessions and in the sample of residents' records that were reviewed by the inspector and there were records in place of individual resident's clothing and personal items.

Laundry facilities were on-site, they were maintained in good order and appropriate arrangements were in place for the regular laundering of linen and clothing and procedures were in place for the safe return of residents’ personal clothing items. The inspector spoke to the laundry staff, who was found to be knowledgeable about appropriate procedures in regard to infection control. Residents and their relatives informed the inspector that clothing was well looked after.

The inspector noted that bedrooms were personalised and residents were facilitated to have their own items, such as furniture and pictures. Each resident had plenty of furniture in their bedrooms to store clothing and personal items in their own bedside cabinets and wardrobes. Locked storage was provided and a further safe was available if required.
Compliant

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

Theme:
Workforce

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

Findings:
Residents and relatives spoke positively about staff and indicated that staff were caring, responsive to their needs, and treated them with respect and dignity. Staff demonstrated an understanding of their role and responsibilities to ensure appropriate delegation, competence and supervision in the delivery of person-centred care to the residents. Inspectors observed positive interactions between staff and residents over the course of the inspection and found staff to have excellent knowledge of residents' needs as well as their likes and dislikes. However it was identified by both relatives and some residents that there was not enough staff available during the afternoon and evening to meet the needs of the residents.

An actual and planned roster was maintained in the centre. The inspector reviewed staff rosters which showed that the person in charge was on duty Monday to Friday. Nurses were on duty and allocated on all three units during the day however at night time this reduced to two nurses and three care staff. The inspector found that when the nurses were busy doing their medication round and should not be disturbed this left a care staff responsible per unit and was not sufficient if residents needed the assistance of two people. The inspector also noted a high number of residents stayed in their rooms during the day and required assistance from staff. The inspector observed that it was at times difficult to find staff as they were busy attending to residents and call bells took time to be answered. The inspector required that the staffing levels in the afternoon and evening time were reviewed to ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre. The provider and person in charge said at the feedback meeting that they would address this and review staffing levels.

Training records viewed by the inspector confirmed that there was a high level of training provided in the centre with numerous training dates scheduled for 2017. Staff
told the inspectors they were encouraged to undertake training by the person in charge. Mandatory training was on-going and staff had attended a number of trainings. Mandatory training in manual handling and safeguarding was also found to be up to date. Staff also attended training in areas such as the prevention of falls, infection control and medication management. The person in charge discussed staff issues with the inspector and proper protocols and records were seen to be in place where concerns had been identified.

Inspectors reviewed a sample of staff files which included the information required under Schedule 2 of the Regulations. Registration details with An Bord Altranais for 2016 for nursing staff were seen by inspectors. The person in charge and the provider confirmed Garda vetting was in place for all staff and no staff commenced employment until this was in place.

**Judgment:**
Non Compliant - Moderate

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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:**

Caroline Connelly  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority
Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider’s response to inspection report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Our Lady of Fatima Home</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000264</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>11/01/2017</td>
</tr>
<tr>
<td>Date of response:</td>
<td>07/02/2017</td>
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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 03: Information for residents

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The contracts of care detailed what was included and not included in the fee however there was not evidence of the costs for extra services to be provided and one contract seen had out of date fees included.

1. Action Required:
Under Regulation 24(2)(d) you are required to: Ensure the agreement referred to in

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
regulation 24 (1) includes details of any other service which the resident may choose to avail of but which is not included in the Nursing Homes Support Scheme or which the resident is not entitled to under any other health entitlement.

Please state the actions you have taken or are planning to take:
All contracts have been reviewed and residents’ who have out dated contracts will be updated.
Private residents are informed in writing to any change in bed fees and their contract includes an annual review of fees, which is signed by the resident.
All new contracts will include an appendix clearly outlining additional costs of services and this will form part of their contract. This will also be included in the residents’ booklet.
Residents in receipt of Nursing Home Support (Fair Deal) are not effected financially with the fluctuation in bed fees provided by the National Treatment Purchase Fund (NTPF).

Proposed Timescale: 01/03/2017

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:
There was not enough communal space in close proximity to one of the units as had been identified on the previous inspection.
There was not enough dining space to accommodate all 66 residents in the dining room.

2. 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:
St Dominic’s lounge, which is a large lounge, will be utilised as an additional dining area.
Activities within the home will be reviewed to facilitate residents spending time out of their rooms, as we have a number of lounges that do not get used on a daily basis.

Proposed Timescale: 01/03/2017

Outcome 15: Food and Nutrition

Theme:
Person-centred care and support
The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Ensure menus are available so residents can make an informed choice

3. Action Required:
Under Regulation 18(1)(b) you are required to: Offer choice to each resident at mealtimes.

Please state the actions you have taken or are planning to take:
Menus are now available and are on display with choices available. Menus are available in the dining rooms, at each nurses’ station, reception and the sun lounge.

Proposed Timescale: 30/01/2017

Outcome 16: 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:
Feedback is not always made available to residents about issues they raise in the residents committee meeting.

4. Action Required:
Under Regulation 09(3)(d) you are required to: Ensure that each resident is consulted about and participates in the organisation of the designated centre concerned.

Please state the actions you have taken or are planning to take:
The PIC had a meeting with the residents’ council meeting facilitator.
It was agreed that the PIC and facilitator would meet before and after each meeting to facilitate feedback.
Written minutes of the residents’ council meetings and feedback will continue.
The residents have been informed that they will be afforded the opportunity to meet with the PIC, Chef, activity co-ordinator etc at the meetings if requested.

Proposed Timescale: 25/01/2017

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some residents and relatives stated there was not enough activities made available and residents spent long periods of time on their own in their bedrooms.
5. **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:**
We will revise our activity schedule, especially in the afternoon. We have a sensory room which will be used more for one-to-one sessions and small group work. We will also revise our activity schedule for residents who are unable to leave their rooms.

**Proposed Timescale:** 01/03/2017

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### Outcome 18: Suitable Staffing

**Theme:**
Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The staffing levels in the afternoon and evening time required review to ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

6. **Action Required:**
Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

**Please state the actions you have taken or are planning to take:**
We are reviewing our staffing schedules to implement additional staff to cover the afternoon/evening shift. This has gone to the Board of Management as we are currently reviewing staff wages, and shift schedules will be reviewed concurrently.

**Proposed Timescale:** 01/04/2017