Health Information and Quality Authority
Regulation Directorate

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

Centre name:	Maria Goretti Nursing Home
Centre ID:	OSV-0000417
Centre address:	Proonts, Kilmallock, Limerick.
Telephone number:	063 989 83
Email address:	mgnh@eircom.net
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Maria Goretti NH Partnership
Provider Nominee:	Helen O'Mahony
Lead inspector:	John Greaney
Support inspector(s):	Mary Costelloe
Type of inspection	Unannounced
Number of residents on the date of inspection:	53
Number of vacancies on the date of inspection:	8

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).

Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
13 September 2016 09:30	13 September 2016 17:15
14 September 2016 09:30	14 September 2016 14:15

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

Outcome	Our Judgment
Outcome 01: Statement of Purpose	Compliant
Outcome 02: Governance and Management	Non Compliant - Major
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Substantially Compliant
Outcome 06: Absence of the Person in charge	Compliant
Outcome 07: Safeguarding and Safety	Substantially Compliant
Outcome 08: Health and Safety and Risk Management	Substantially Compliant
Outcome 09: Medication Management	Compliant
Outcome 11: Health and Social Care Needs	Compliant
Outcome 12: Safe and Suitable Premises	Substantially Compliant
Outcome 13: Complaints procedures	Substantially Compliant
Outcome 15: Food and Nutrition	Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Non Compliant - Moderate
Outcome 18: Suitable Staffing	Substantially Compliant

Summary of findings from this inspection

Maria Goretti nursing home is located in a rural area of Co. Limerick approximately 1.5 kilometres from the town of Kilmallock. It is a single storey premises that is registered to accommodate 61 residents in 21 single bedrooms, nine twin bedrooms and five four-bedded rooms. There are also two apartments and each one consists of a single bedroom, sitting room and a small kitchen.

This inspection was unannounced and took place two days. The purpose of the inspection was to monitor on-going compliance with regulations and standards. As part of the inspection, the inspectors met with residents, relatives, and staff members. Inspectors observed practices and reviewed documentation such as care plans, medical records, accident/incident logs, policies and procedures, complaints

log and staff files.

Residents' care was provided to a good standard and staff were seen to interact with residents in a respectful manner. Residents were complimentary of the staff and stated that they were caring and kind. Residents received a comprehensive assessment on admission and at regular intervals thereafter. Care plans were developed based on these assessments and these were seen to be person-centred and provided good guidance on the care to be delivered. Residents had access to the services of a GP, including out-of-hours, and to specialist/allied health services such as physiotherapy, dietetics, speech and language, occupational therapy, and palliative care.

Residents' independence was supported and promoted and relationships with family, friends and the local community were maintained, as far as reasonably possibly. There was a varied programme of activities and residents stated that there was always something to do. Residents and relatives were consulted both formally and informally in relation to how the centre was planned and run. There was a comprehensive programme of audits and evidence of action in response to issues identified.

While care was provided to a good standard, concerns identified on previous inspections in relation to governance and management remained. There continued to be limited formal communication between the four partners that owned the centre. There were no formal management meetings, and day to day responsibility for running the centre was given to the provider nominee. However, the provider nominee only had limited autonomy and there no formal management structure to support decision-making, to determine access to resources or to develop and implement business plans to ensure the centre would be in compliance with regulations and standards.

Some improvements were required in relation to the premises and how it impacted on privacy and dignity of residents. There were a number of shared bedrooms, including twin and four bedded rooms. The design and layout of some of the bedrooms presented a challenge to staff to respect the privacy and dignity of residents when providing care. For example, a bed in one room had to be moved in order use a hoist to assist a resident in and out of bed. Additionally the curtains surrounding the beds in one room did not encircle either of the beds when closed. Other improvements required in relation to the premises included the absence of hand washing facilities in the laundry and inadequate room to segregate clean and dirty linen.

Other required improvements included:
• the complaints procedure was not on prominent display and was difficult to understand
• a person responsible for oversight of the complaints process was not identified
• the safeguarding policy required review to ensure it incorporated most recent guidance
• staff files were not complete

The action plan at the end of this report identifies where improvements are needed to meet the requirements of 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.

Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

Outcome 01: Statement of Purpose
There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:
Governance, Leadership and Management

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

Findings:
There was a written statement of purpose that included a statement of the aims, objectives and ethos of the centre and described the facilities and services to be provided for residents.

Judgment:
Compliant

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

Theme:
Governance, Leadership and Management

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

Findings:
The person in charge was also the provider nominee and was one of four partners that owned the centre. The person in charge was supported by a clinical nurse manager 1 and a clinical nurse manager 2, both of whom were stepping down from these positions to resume their previous roles as staff nurses. A new clinical nurse manager 2 had been

recruited and was due to take up the position approximately four weeks following this inspection.

Concerns identified on previous inspections in relation to the governance and management of the centre remained. There continued to be limited formal communication between the four partners. There were no formal management meetings, and day to day responsibility for running the centre was given to the provider nominee. However, the provider nominee only had limited autonomy and there no formal management structure to support decision-making, to determine access to resources or to develop and implement business plans to ensure the centre would be in compliance with regulations and standards. The response to the action plan from the previous inspection stated that the management structure was undergoing a change of entity that would clarify lines of accountability. This, however, had not happened.

There was a comprehensive programme of audits that included audits of issues such as the environment, restraint, medication management, food and nutrition and falls management. There was a suite of key performance indicators on clinical issues such as the number of falls, incidence of pressure sores, use of restraint and the number of residents confined to chairs and beds. There was a recent audit completed against the judgement framework used by HIQA for dementia thematic inspections to identify where improvements were required. There was an associated action plan identifying progress in implementing required improvements. An annual review of the quality and safety of care had commenced, however, this had not yet been completed.

Judgment:
Non Compliant - Major

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

Theme:
Governance, Leadership and Management

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

Findings:
There was a suitably qualified and experienced person in charge, who worked full time in the centre. The person in charge was supported in her role by a clinical nurse manager 2 and a clinical nurse manager 1. There was evidence that the person in charge demonstrated a commitment to her own continued professional development as evidenced by training records showing attendance at a number of recent training programmes.

Residents, relatives and staff spoken with by the inspector stated that the person in

charge had a daily presence in the centre and was available to answer any queries or concerns. Staff spoken to by the inspector were aware of the reporting relationships.

Throughout the inspection the person in charge demonstrated an adequate knowledge of 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. The inspector was satisfied that the person in charge was a suitably experienced nurse with authority, accountability and responsibility for the provision of the service.

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:
The records listed in Schedules 2, 3, and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 were kept secure, readily available and easily retrievable. The policies listed in Schedule 5 of the regulations were available and up-to-date.

A sample of staff files reviewed contained most of the requirements of the regulations, however, a small number of curriculum vitaes did not contain a satisfactory explanation for gaps in employment history and some references were not verified.

There was a policy on, and procedures in place for, the prevention, detection and response to abuse. Even though the policy was most recently reviewed in December 2015, a further review was required to incorporate the 2014 HSE Safeguarding Vulnerable Persons at Risk of Abuse policy.

Judgment:
Substantially 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:
There was no period in excess of 28 days when the person in charge was absent from the centre. There were adequate arrangements for the management of the centre in the absence of the person in charge.

Judgment:
Compliant

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

Theme:
Safe care and support

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

Findings:
There was a policy on, and procedures in place for, the prevention, detection and response to abuse. Even though the policy was most recently reviewed in December 2015, a further review was required to incorporate the 2014 HSE Safeguarding Vulnerable Persons at Risk of Abuse policy.

Training records indicated that most, but not all, staff had received up-to-date training in recognising and responding to abuse. Staff spoken with by inspectors were knowledgeable of what constitutes abuse and knew what to do in the event of an allegation, suspicion or disclosure of abuse, including to whom any incidents should be reported. Residents spoken with by inspectors stated that they felt safe.

There was a policy on, and procedures in place, for managing responsive behaviour.

Where there was evidence of responsive behaviour, care plans contained adequate detail in relation to the communication needs of residents and identified any antecedents to responsive behaviour and de-escalation techniques.

A restraint free environment was promoted. The only form of restraint evident in the centre on the days of inspection was in the form of bedrails. Where bedrails were in place, there was a risk assessment completed prior to the use of restraint, and safety checks while restraint was in place. There was evidence of efforts to minimise the use of restraint, such as the use of low low beds and crash mats.

Based on a sample of records viewed there were adequate measures in place to safeguard residents' finances. Where transactions were made by or on behalf of residents, there were two signatures, including the residents' signatures, where possible.

Judgment:
Substantially Compliant

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

Findings:
There was an up-to-date safety statement. There was a risk management policy and associated risk register that included clinical, operational and environmental risks and was in compliance with the regulations. There was evidence of the on-going review of risks and the risk register was updated regularly. There was an emergency plan that gave clear guidance to staff as to their responsibilities in the event of various emergencies, including the evacuation of the centre. Records indicated that staff had been provided with training on the safety statement in April 2016.

There were measures in place for the prevention and control of infection such as wash hand basins and hand gel dispensers located at suitable intervals throughout the centre. There was an up-to-date policy on infection prevention and control that provided good guidance to staff on issues such as hand hygiene, management of waste and the management of an outbreak of infectious disease. Infection prevention and control training had been made available to staff and most staff attended. The person in charge had completed a module on infection prevention and control and had recently purchased equipment to support hand hygiene audits. Housekeeping staff spoken with were knowledgeable of infection prevention and control procedures and of the colour coded cleaning system. Improvements, however, were required in relation to the laundry. For

example, the layout of the laundry did not support the effective segregation of clean and dirty linen. Additionally, there were no sinks or wash hand basins in the laundry. The person in charge stated that work was about to commence on reconfiguring the laundry to make it larger and to install hand washing facilities.

Inspectors reviewed the fire safety register. Fire equipment, fire alarm and emergency lighting preventive maintenance was up-to-date. There were records of weekly and monthly fire safety checks. Training records indicated that staff had attended annual fire safety training, however, a number of recently recruited staff required training. These staff had received informal fire safety training as part of their induction. Staff spoken with by inspectors were knowledgeable of what to do in the event of a fire. There records of fire drills that contained adequate detail of the scenario practiced and any learning. A small number of doors were held open with door wedges or other items, which was not good fire safety practice. Personal emergency evacuation plans were in place for all residents indicating the most appropriate means of evacuation in the event of an emergency. Ski sheets were in place under a number of beds to aid evacuation and a number of ski pads were appropriately located throughout the centre.

Training in manual handling had been facilitated for staff and a significant number of staff had attended. Certificates of attendance, however, had not been made available by the instructor.

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

Findings:
There was a medication management policy for ordering, prescribing, storing and administration of medicines. The inspector viewed a sample of residents' prescriptions and all contained appropriate information including a recent photograph of the resident; the name, dosage and route of administration for all medicines; and the maximum dosage for prn (as required) medications. There was a system in place to ensure that medications delivered to the centre matched what was prescribed.

The inspector found that practices in relation to prescribing and medication reviews met with regulatory requirements and staff were observed to follow appropriate administration practices.

There were regular medication audits carried out by staff in the centre and also by a visiting pharmacist; improvements were made as a result of issues identified. Medication errors were recorded and actions identified to minimise the risk of reoccurrence. There was evidence of attendance at medication management training by nursing staff.

Medications requiring special control measures were managed appropriately. Records indicated that these were counted by two nurses at the end of each shift. The safe used for storing these medications was broken on the first day of inspection but was replaced at the earliest opportunity and prior to the end of this inspection. Medications requiring refrigeration were stored appropriately. The temperature of the fridge and the ambient temperature in to room was monitored and recorded. There was an adequate system in place for the return of unused and out-of-date medicines to the pharmacy.

Judgment:
Compliant

Outcome 11: Health and Social Care Needs
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

Theme:
Effective care and support

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

Findings:
Inspectors found that residents' healthcare needs were met and they had access to appropriate medical and allied healthcare services. Each resident had opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

All residents had access to a choice of general practitioner (GP) services. There was an out-of-hours GP service available. Based on a sample of records reviewed, GPs visited the centre on a regular basis to review residents.

Residents had good access to allied health/specialist services. Dietetic and speech and language services were provided by a nutritional supply company and there was evidence of appropriate referral, assessment and review. A physiotherapist was employed in the centre for three days each week. All new residents received a physiotherapist assessment on admission and a plan was put in place based on the assessment. The physiotherapist also worked with other residents to promote and support mobility and independence, and also to advise on manual handling practices. Records indicated a review by occupational therapy, opticians and chiropody. Records

also indicated that any advice and recommendations were incorporated into care plans.

Inspectors reviewed a sample of residents' files including the files of residents with restraint measures in place, at high risk of falls, at risk of malnutrition and with communication issues. Residents received a comprehensive assessment at admission using evidence based assessment tools for issues such as risk of falls, risk of malnutrition and risk of developing a pressure sore. A pre-admission assessment was carried out by the person in charge to ascertain that the centre could meet the needs of the resident. Care plans were developed based on issues identified on assessment and these were found to be person centred and provided adequate guidance on the care to be delivered. A record was maintained of residents/relatives involvement in the development and review of their care plans.

The inspectors were satisfied that weight loss was closely monitored. Residents were weighed monthly or more frequently if staff had concerns about weight loss. Appropriate referrals were made and advice followed. The inspectors reviewed the files of residents who were at high risk of falls and some who had fallen recently. There was evidence that falls risk assessments and falls care plans in place were updated following falls. Additional measures including low low beds and crash mats had been put in place for some residents. There was evidence of adequate wound assessments, care plans and wound progress notes in place.

Staff were aware of the different communication needs of residents and care plans set out the ways in which those who had a communication impairment required intervention.

There was a programme of meaningful and interesting activities available for residents and this is discussed in more detail under Outcome 16.

Judgment:
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:
Maria Goretti nursing home is located in a rural area of Co. Limerick approximately 1.5

kilometres from the town of Kilmallock. It is a single storey premises that is registered to accommodate 61 residents in 21 single bedrooms, nine twin bedrooms and five four-bedded rooms. There are also two apartments and each one consists of a single bedroom, sitting room and small kitchen. All of the bedrooms were en suite with toilet, shower and wash hand basin.

On the days of inspection the centre was bright, clean and in a good state of repair. Communal space comprised two sitting rooms, a visitors/family room and two dining rooms. There was a small oratory. There was also a smoking room that was ventilated to the external air by natural and mechanical means. There was a fire blanket and fire extinguisher located outside the smoking room. There was an enclosed garden that was readily accessible to residents with raised flower beds, a large water feature, garden furniture and lots of potted plants that were chosen by residents. Some residents were involved in maintaining the garden and were supported by staff to do so.

An audit of the centre by the person in charge identified the need to improve the environment in areas such as signage and colours to support residents with dementia navigate around the centre, including to their own bedroom. This is supported by the findings of this inspection that identified some chipped paintwork and damaged floor sealant. Improvements had been made to a number of bedrooms, which had been redecorated with a new coat of paint and new curtains. Residents of the bedrooms had been consulted in relation to choice of colours. Additional improvements to the premises included the purchase of a number of new beds, new hoists and slings, and colour coded waste bins. There was, however, insufficient storage for equipment such as hoists, which were stored in bathrooms.

Records of the preventive maintenance of equipment such as beds, hoists and boilers were available. The kitchen was well equipped and the most recent environmental health officers report demonstrated an adequate level of compliance.

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

Findings:
There were policies and procedures in place for the management of complaints that was most recently reviewed in May 2016. The policy identified the complaints officer and an independent appeals process. The policy, however, did not identify the person

responsible for overseeing the complaints process to ensure all complaints are responded to and that adequate records are maintained. The complaints process was on display, however, it was not located in a prominent position and it the process was difficult to follow. The person in charge informed inspectors that a user friendly complaints procedure had been developed that included pictorial prompts. However, this was with the printers at the time of inspection.

Inspectors reviewed the complaints log that contained a record of the complaint and included verbal complaints. Records indicated that each of the complaints were resolved and were reviewed by the person in charge. The record, however, did not detail the satisfaction, or otherwise, of the complainant with the outcome of the complaints process. Residents spoken with by inspectors stated they had no problem in discussing any matter with the person in charge or any member of staff.

Judgment:
Substantially 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 policy on meeting the nutrition and hydration needs of residents that was most recently reviewed in February 2016. Residents received a nutritional assessment on admission and at regular intervals thereafter. Residents were weighed monthly and more frequently where there was evidence of weight loss. There was evidence of appropriate referral and review by dietetic and speech and language services. Where supplements or modified consistency diets were prescribed, records indicated that these were administered accordingly.

There was a menu on display, including a pictorial menu. Residents were seen to be offered choice at mealtimes, including residents that were prescribed modified consistency diets. The chef and catering staff spoken with were knowledgeable of residents preferences and nutritional needs. Residents spoken with were complimentary of the variety of food available and the dining experience. While there were set mealtimes, residents were seen to be availing of meals outside of these times, when the mealtime coincided with another engagement. Residents were seen to have breakfast at different times throughout the morning.

There were two dining rooms, one of which was predominantly used by residents requiring assistance with their meals. An audit of the dining experience had been carried

out by the person in charge. However, this was only done for one of the dining rooms. Issues identified for improvement were in the process of being addressed, such as the use of pictorial menus and more communication with residents regarding food choices. It was evident that there was a distinct difference in the environment in the second dining room, such as the absence of table cloths and plainer dinnerware. This dining room was predominantly used by residents with high needs and most required assistance with their meals. The person in charge stated that she had plans to audit the second dining room and implement any required improvements. Residents requiring assistance were assisted by staff in a discreet and respectful manner.

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

Findings:
There was evidence of consultation with residents through monthly residents meetings. Records indicated that issues raised at these meetings were addressed such as the commencement of a movie night and introduction of day trips for residents. Additional evidence of consultation included the choice of colour offered to residents when their bedrooms were being redecorated and consultation by the chef in relation to the menu.

There was access to advocacy services and evidence of the involvement of the advocate, for example, to support one resident return to their own home. The advocate has also attended residents' meetings and met with staff.

Residents' independence was supported and promoted. For example, one resident was facilitated to cook their own meal. Another resident continued to drive their car and visited home on an almost daily basis. Some residents were allowed to walk around the grounds of the centre following an appropriate risk assessment. There was ready access to the enclosed garden for all residents and some were involved in its maintenance, for example, planting shrubs and flowers. Residents were also assisted to go to the shops periodically.

There was adequate communal space and adequate space for residents to meet with visitors in private, should they so wish. Staff were seen to treat residents with courtesy

and respect. Residents were complimentary of the staff, stating that they were caring and kind.

There were a number of shared bedrooms, including twin and four bedded rooms. The design and layout of some of the bedrooms presented a challenge to staff to respect the privacy and dignity of residents when providing care. For example, two residents in one of the twin bedrooms required a hoist for transfer to and from the bed. In order to access the resident in the inner bed in this bedroom with the hoist, it was necessary to move the outer bed out of the way, which was occupied by the other resident. The layout of one of the other twin bedrooms had been reconfigured resulting in the beds being moved. However, the curtains surrounding the beds remained in the original position and no longer encircled either of the beds when closed. Inspectors were informed that they were awaiting delivery of new curtain rails from overseas, but these had not yet arrived.

There was a recently recruited activities coordinator present in the centre each day from Monday to Friday. An art therapist visited the centre for one day each week and residents' art was framed and on display throughout the centre. There were also some volunteers that visited the centre to facilitate activities such as bingo. The activities coordinator was in the process of communicating with families in order to develop life stories for residents. A memory board had been created, which contained old tools and implements, such as hammers and chisels. Records were maintained of residents' participation in activities and wide range of activities were available, such as arts and crafts, music, bingo, quizzes, card games, baking, flower arranging, farming art group and mindfulness. There was a recent outing to Bunratty Folk Park and other short daytrips were planned. Residents spoken with stated that there was always something to do.

Residents religious preference were respected and facilitated. Mass was celebrated in the centre weekly and there were prayer sessions each day. There was access to television, radio and local and national newspapers.

Judgment:
Non Compliant - Moderate

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

Theme:
Workforce

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

No actions were required from the previous inspection.

Findings:
There were adequate numbers of staff and skill mix to meet the needs of residents, and to the size and layout of the centre. An actual and planned roster was maintained in the centre with any changes clearly indicated. The roster, however, did not always detail when the person in charge was on duty.

Records viewed by the inspector confirmed all staff had attended mandatory training in areas such as safeguarding and prevention of abuse and manual handling. While training in manual handling had been facilitated for staff and a significant number of staff had attended, certificates of attendance, however, had not been made available by the instructor. Staff also had access to a range of education on areas such as infection prevention and control, medication management, dementia, hand hygiene, risk assessments, and dysphagia.

Staff were supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. A sample of staff files reviewed contained most of the requirements of the regulations, however, a small number of curriculum vitaes did not contain a satisfactory explanation for gaps in employment history and some references were not verified.

Judgment:
Substantially Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

John Greaney
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Provider's response to inspection report[1]

Centre name:	Maria Goretti Nursing Home
Centre ID:	OSV-0000417
Date of inspection:	13/09/2016
Date of response:	24/10/2016

Requirements

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

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

Outcome 02: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Concerns identified on previous inspections in relation to the governance and management of the centre remained. There continued to be limited formal communication between the four partners. There were no formal management meetings, and day to day responsibility for running the centre was given to the provider nominee. However, the provider nominee only had limited autonomy and there no formal management structure to support decision-making, access to resources or to develop and implement business plans to ensure the centre would be in compliance

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

with regulations and standards.

1. Action Required:
Under Regulation 23(b) you are required to: Put in place a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

Please state the actions you have taken or are planning to take:
A meeting has been scheduled for Thursday 27th of October with the partners for the purposes of commencing the implementation of a governance and management framework for the centre. It is envisaged that this framework will set out the management structure, identify the lines of accountability and authority, and detail responsibilities and roles including those of the partnership for all areas of service at the centre. Proposed timescale 8 weeks. This action is to address Outcome 2.

Proposed Timescale: 27/12/2016

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
An annual review of the quality and safety of care had commenced, however this had not yet been completed.

2. Action Required:
Under Regulation 23(d) you are required to: Ensure there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.

Please state the actions you have taken or are planning to take:
The annual review of the quality/safety of care audit is in progress and will be completed by 02/11/2016

Proposed Timescale: 02/11/2016

Outcome 05: Documentation to be kept at a designated centre

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was a policy on, and procedures in place for, the prevention, detection and response to abuse. Even though the policy was most recently reviewed in December 2015, a further review was required to incorporate the 2014 HSE Safeguarding

Vulnerable Persons at Risk of Abuse policy.

3. Action Required:
Under Regulation 04(3) you are required to: Review the policies and procedures referred to in regulation 4(1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.

Please state the actions you have taken or are planning to take:
The policy on elder abuse has now been updated so as to incorporate the 2014 HSE safeguarding vulnerable persons at risk of abuse policy.

Proposed Timescale: 07/10/2016

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A sample of staff files reviewed contained most of the requirements of the regulations, however, a small number of curriculum vitaes did not contain a satisfactory explanation for gaps in employment history and some references were not verified.

4. Action Required:
Under Regulation 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

Please state the actions you have taken or are planning to take:
A checklist has been devised as per schedule to ensure that all Curriculum Vitae's contain a satisfactory explanation for gaps in employment history. Due by end of 30/12/2016. B) Verification of references are in progress and will be completed by 01/11/2016

Proposed Timescale: a) 30/12/2016 and b) 01/11/2016

Proposed Timescale: 01/11/2016

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The staff roster did not always detail when the person in charge was on duty.

5. Action Required:
Under Regulation 21(1) you are required to: Ensure that the records set out in

Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

Please state the actions you have taken or are planning to take:
The Provider/PIC will ensure that the staff roster reflects the working hours of all staff members inc PIC

Proposed Timescale: Immediate and ongoing

Proposed Timescale: 13/09/2016

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:
Training records indicated that most, but not all, staff had received up-to-date training in recognising and responding to abuse.

6. Action Required:
Under Regulation 08(2) you are required to: Ensure staff are trained in the detection and prevention of and responses to abuse.

Please state the actions you have taken or are planning to take:
All staff who have not attended up to date safeguarding training are scheduled to attend 12/10/2016 and 26/10/2016

Proposed Timescale: October 2016

Proposed Timescale: 26/10/2016

Outcome 08: Health and Safety and Risk Management

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Improvements, however, were required in relation to the laundry. For example, the layout of the laundry did not support the effective segregation of clean and dirty linen. Additionally, there were no sinks or wash hand basins in the laundry.

7. 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:
Reconfiguration of the laundry will be completed by 01/11/2016

Proposed Timescale: 01/11/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Training records indicated that staff had attended annual fire safety training, however, a number of recently recruited staff required training.

8. Action Required:
Under Regulation 28(1)(d) you are required to: Make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.

Please state the actions you have taken or are planning to take:
All staff who have not attended up to date fire training are scheduled to attend fire training on 18/10/2016 and further training is due to be confirmed for November 2016

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:
A small number of doors were held open with door wedges or other items, which was not good fire safety practice.

9. Action Required:
Under Regulation 28(2)(i) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

Please state the actions you have taken or are planning to take:
All staff have been informed of the fire safety hazards related to wedging doors open. Daily checks are carried out. All wedges have been removed.

Proposed Timescale: Actioned sept 2016

Proposed Timescale: 13/09/2016

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:
Required improvements in relation to the premises included:
• signage and colours to support residents with dementia navigate around the centre
• there was some chipped paintwork and damaged floor sealant
• there was inadequate storage for equipment.

10. 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:
a)Maintenance schedule is in place to address the upgrading of all parts of the premises as required. b)Damaged floor sealent in the main dining room is currently being repaired and is awaiting to be resurfaced. c) Priority being given to the areas where there is chipped paintwork. d)Storage issues will be on the agenda for discussion at the management meeting which is scheduled to take place within the next 2 weeks. e) Signage companies are being sourced at present to provide appropriate colour coded signage to support residents with dementia

Proposed Timescale: a)ongoing jan 2017 b) 26/10/2016 c) 30/11/2016 d) march/april 2017 e) January 2017

Proposed Timescale: 30/04/2017

Outcome 13: Complaints procedures

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The complaints process was on display, however, it was not located in a prominent position and it the process was difficult to follow.

11. Action Required:
Under Regulation 34(1)(b) you are required to: Display a copy of the complaints

procedure in a prominent position in the designated centre.

Please state the actions you have taken or are planning to take:
The complaints process is presently located on a notice board at the main entrance of the centre however additional copies will be displayed in both dome areas and dining rooms with the amendments for clarification of the relevant contact people. It will identify Helen O Mahony as the complaints office, the CNM2 Anna Hickey to oversee that complaints are responded to, and the appeals office Breda Noonan can be contacted c/o Maria Goretti Nursing Home.

Proposed Timescale: 31/10/2016

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The complaints log did not detail the satisfaction, or otherwise, of the complainant with the outcome of the complaint.

12. 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:
The complaints log has been updated and will reflect complainant satisfaction.
Proposed Timescale: completed October 2016

Proposed Timescale: 31/10/2016

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The complaints policy did not identify the person responsible for overseeing the complaints process to ensure all complaints are responded to and that adequate records are maintained.

13. 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:

A CNM2 has been nominated the responsibility of overseeing the complaints process to ensure that all complaints are responded to and that adequate records are maintained.
Proposed Timescale: completed 11/10/2016

Proposed Timescale: 11/10/2016

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:
There were a number of shared bedrooms, including twin and four bedded rooms. The design and layout of some of the bedrooms presented a challenge to staff to respect the privacy and dignity of residents when providing care. For example, two residents in one of the twin bedrooms required a hoist for transfer to and from the bed. In order to access the resident in the inner bed in this bedroom with the hoist, it was necessary to move the outer bed out of the way, which was occupied by the other resident. The layout of one of the other twin bedrooms had been reconfigured resulting in the beds being moved. However, the curtains surrounding the beds remained in the original position and no longer encircled either of the beds when closed.

14. Action Required:
Under Regulation 09(3)(b) you are required to: Ensure that each resident may undertake personal activities in private.

Please state the actions you have taken or are planning to take:
The bed configuration of shared rooms will be reviewed to ensure the privacy and dignity of each resident. In addition the privacy screening has been adjusted where identified as per last inspection. Proposed timescale 8 weeks.

Proposed Timescale: 11/12/2016

Outcome 18: Suitable Staffing

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
While training in manual handling had been facilitated for staff and a significant number of staff had attended, certificates of attendance, however, had not been made available by the instructor.

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

Please state the actions you have taken or are planning to take:
Attendance certificates for manual handling have been requested in writing from the PIC to the trainer/instructor on numerous occasions and no reply has been received. We have now submitted this matter to our solicitor and awaiting an update re same.

Proposed Timescale: ongoing

Proposed Timescale: