

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Catherine McAuley House
Centre ID:	OSV-0000125
Centre address:	Beaumont Woods, Beaumont, Dublin 9.
Telephone number:	01 837 9186
Email address:	divillyh@eircom.net
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Sisters of Mercy
Provider Nominee:	Anne Doyle
Lead inspector:	Sheila McKeivitt
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	24
Number of vacancies on the date of inspection:	9

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 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 inform a registration renewal decision. This monitoring inspection was announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 10 September 2014 09:30 To: 10 September 2014 18:30

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

Outcome 01: Statement of Purpose
Outcome 02: Governance and Management
Outcome 03: Information for residents
Outcome 04: Suitable Person in Charge
Outcome 05: Documentation to be kept at a designated centre
Outcome 06: Absence of the Person in charge
Outcome 07: Safeguarding and Safety
Outcome 08: Health and Safety and Risk Management
Outcome 09: Medication Management
Outcome 10: Notification of Incidents
Outcome 11: Health and Social Care Needs
Outcome 12: Safe and Suitable Premises
Outcome 13: Complaints procedures
Outcome 14: End of Life Care
Outcome 15: Food and Nutrition
Outcome 16: Residents' Rights, Dignity and Consultation
Outcome 17: Residents' clothing and personal property and possessions
Outcome 18: Suitable Staffing

Summary of findings from this inspection

This inspection was announced following an application by the provider to renew the registration of the centre. As part of the inspection, the inspector met with residents and staff. The inspector observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files.

Prior to the inspection, the inspector reviewed written evidence from a suitably qualified person confirming the building meets all the statutory requirements of the fire and planning authorities in relation to the use of the building as residential centre for older people. All documents submitted by the nominated person on behalf of the provider, for the purposes of application to register were found to be satisfactory.

The centre is registered to accommodate 35 residents' and there were 24 residents on the day of inspection with two in hospital, leaving nine vacant beds.

The provider and the person in charge were found to be operating in compliance with the conditions of registration and in compliance with fourteen of the eighteen outcomes inspected against. The inspector confirmed that the nominated person on behalf of the provider had fully addressed the eight non compliant outcomes from the last monitoring inspection which took place on 04 February 2014.

The inspector found that the governance structure remained robust. The management team had addressed non-compliances from the last inspection relating to the statement of purpose, contracts of care, fire records and fire training, policies, staffing levels and premises.

The four non compliances not met on this inspection related to residents not having been involved in a practice fire drill. Medications were not being administered in accordance with best practice and professional guidelines. Policies in relation to food and nutrition and end of life care not reflecting current practice and residents records/care plans not accurately reflecting interdisciplinary team members recommendations and/or care being given.

The action plans at the end of this report reflect these non-compliances.

Section 41(1)(c) of the Health Act 2007. 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.

Outcome 01: Statement of Purpose

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

Theme:

Governance, Leadership and Management

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

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

Findings:

The statement of purpose had been reviewed on 08 August 2014. It included a statement of the aims, objectives and ethos of the designated centre and a statement reflecting the facilities and services provided for residents. It now contained all of the information required by Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Staff spoken with were familiar with its content and the inspector was satisfied that it provided a clear and accurate reflection of the facilities and service provided.

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):

No actions were required from the previous inspection.

Findings:

There were sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose. There had been no change to the management structure since the application to vary was issued to the centre in April 2014. A clearly defined

management structure that identified the lines of authority and accountability remained in place. Robust management systems ensured that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored. These systems included reviewing and monitoring the quality and safety of care and the quality of life of residents.

Improvements had been brought about as a result of some monitoring practices. For example, continuous monitoring of the use of restraint had led to alternatives to restraint being tried and tested and had led to no form of restraint being used in the centre.

There was evidence of consultation with residents and their representatives. For example, the inspector saw evidence that residents had recently been consulted with about their quality of life and provision of food and nutrition. However, all questionnaires issued to residents' had not been returned to date and therefore final analysis had not been completed.

Judgment:
Compliant

Outcome 03: Information for residents

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

Theme:
Governance, Leadership and Management

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

Findings:
There was a guide to the centre available to residents, a copy of which was submitted and reviewed prior to this inspection. It included a summary of services and facilities provided, outlined the terms and conditions of a residents stay, the complaints procedure and arrangements for visitors to the centre. There was a copy available to residents' living in the centre.

The contract of care had been reviewed since the last inspection. Each resident now had a written contract agreed on admission which included details of the care and welfare and services provided. Each contract also included details of the fees charged to the resident each week and outlined any additional fees that may be added for services that the resident may request or require.

Judgment:
Compliant

Outcome 04: Suitable Person in Charge

The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The centre was managed by a suitably qualified and experienced nurse with authority, accountability and responsibility for the provision of the service. She demonstrated a good level of clinical knowledge and knowledge of the regulations and her legislative responsibilities. She worked full-time and was supported in her role by the provider and a clinical nurse manager.

The clinical nurse manager also worked full-time and demonstrated good clinical knowledge of all residents. She took over the running of the centre in the absence of the person in charge and was found to be pro-active in promoting evidence-based practice.

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:

All records outlined in schedule 2, 3, 4 and 5 were available for review.

Overall, the inspector found records were kept secure and were easily retrievable. Residents could access their records if they wished. There was a policy in place which reflected practice in relation to retention of records in the centre. That is, that all records were retained for a minimum of seven years.

Following up from the last inspection, the inspector noted that fluid balance charts were now totalled by the staff nurse on night duty and residents who sustained a head injury now had neurological observations recorded post the incident/accident.

The centre-specific policies outlined in schedule 5 reflected the centre's practices. The protection of residents from elder abuse and the fire policy had been updated and implemented since the last inspection. Policies, procedures and practices were reviewed at a minimum every three years to ensure the changing needs of residents were met.

The inspector reviewed insurance documents which showed the centre was adequately insured against injury to residents and other risks were insured against, including loss or damage to a resident's property. The directory of residents contained all the required details of each resident including the date, time, cause and place of those who had died.

Three staff files reviewed contained all documents outlined in schedule 2.

Judgment:
Compliant

Outcome 06: Absence of the Person in charge

The Chief Inspector is notified of the proposed absence of the person in charge from the designated 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 had been no period to date where the person in charge was absent for 28 days or more. The inspector was satisfied that suitable arrangements were in place to cover any prolonged period of her absence. Her deputy, the clinical nurse manager took over in her absence. For example, the inspector reviewed the staff roster and saw that the clinical nurse manager was rostered to cover when the person in charge was on leave.

The management team were aware of the legal requirement to notify the Authority of any period of leave of 28 days or more, one month prior to expected absence of the person in charge and in the case of an emergency absence within 3 days of its occurrence and within 3 days of person in charge's return.

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):

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

Findings:

Measures were in place to protect residents from being harmed or suffering any form of abuse.

The policy and procedures in place for, the prevention, detection and response to abuse had been updated since the last inspection. It now included guidance for staff in the event the person in charge was named in any allegations of abuse and included contact details for the local elder abuse social worker and advocacy service.

Residents spoken with told the inspector they felt safe in the centre. The inspector saw that all main entry/exit doors were kept secure and reception desk was manned during the day. There was a visitor's sign in book at the main entrance.

The inspector saw evidence that all staff had up-to-date training in relation to the prevention, detection and response to abuse. Staff spoken with had a good, clear understanding of what constitutes abuse and knew what to do in the event of an allegation, suspicion or disclosure of abuse, including who to report any incidents to. Their knowledge reflected that outlined in the updated policy and procedure.

There were systems in place to safeguard residents' money. It was covered by a clearly outlined policy. There was a policy on, and procedures in place, for managing behaviour that may be challenging. However, there were no residents displaying such behaviour at the time of inspection.

There was a policy on, and procedures in place, for the use of restraint. However, as mentioned under outcome 2, the centre was a restraint free environment.

Judgment:

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):

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

Findings:

The health and safety of residents, visitors and staff was promoted and protected. However, some improvements in residents understanding of the procedure to follow in the event of fire were required.

The centre had a risk management policy, an emergency plan and an up-to-date health and safety statement in place. The risk register was comprehensive. It now identified potential risks and specific measures put in place to reduce the level of risk. Infection control practices were good with hand washing and drying facilities available by each wash hand basin and hand sanitizers available throughout the centre. The emergency plan had been updated since the last inspection and now gave clear guidance on what to do in the event of all types of emergencies.

Prior to this inspection the Authority had received written confirmation from a competent person stating that all the requirements of the statutory fire authority were complied with. The inspector saw that there was adequate means of escape and fire exits were unobstructed. Records reviewed on inspection showed that the fire alarm was serviced on a quarterly basis and fire safety equipment and emergency lighting was serviced on an annual basis. All staff had recently completed fire training which included the entire building. Records reviewed showed that this training included practicing a mock fire drill twice each year. Although there was a floor plan showing the nearest fire exit displayed behind each residents' bedroom door and in corridors throughout the centre. Residents and staff stated that residents had not been involved in a mock fire drill and residents were not clear on the course of action to follow in the event of a fire.

Manual handling practices observed were in line with best practice and records reviewed showed all staff had up-to-date training in place.

Judgment:

Non Compliant - Moderate

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:

Medication management required review. The written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents had been updated to reflect current practices. The policy now stated that individual orders for the crushing of medications were required and that two staff signatures were required when a telephone order was taken in an emergency situation.

The practices in relation to the ordering, prescribing and storing of medicines reflected practice. However, medication administration practices did not reflect the centres policy nor did they reflect An Bord Altranais agus Cnáimhseachais na hÉireann "Guidance to Nurses and Midwives on Medication Management" (July 2007).

The inspector saw that a number of residents' were not been administered medications as prescribed by their General Practitioner (GP) and the nurse was not entering a reason as to why the medication was not been administered or had written "sleeping" and had not signed the administration chart. For example, one resident was prescribed medication at 22.00hrs daily. On the medication administration signature sheet, on 01/09/14 and 04/09/14 the nurse had written "sleeping" and had not signed the entry. There was no indication that the medication was given at a later time. Another resident was prescribed medication each day at 18.00hrs. However, for 29/08/14, 30/08/14 and 31/08/14 there was no nurses signature in place to indicate that the medication had been administered, the signature section was blank with no reason entered to indicate why the medication had not been administered as prescribed.

The system in place for reviewing and monitoring safe medication management practices were being reviewed by the clinical nurse manager. Currently, the pharmacy supplying medications to the centre and the clinical nurse manager were completing two separate audits on medication management practices. However, neither were identifying the above errors in practice as the audit tools being used were not capturing all aspects of the medication management policy. The clinical nurse manager had identified this and had sourced a more comprehensive audit tool which appeared to include all areas of the medication management policy.

Judgment:

Non Compliant - Major

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:

Clear and concise records of all incidents occurring in the centre were maintained and made available for review.

The inspector found that all notifiable incidents had been notified to the Chief Inspector within three days. Quarterly reports had been provided to the authority to notify the Chief Inspector of any incident which did not involve personal injury to a resident.

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:

Each resident's wellbeing and welfare was maintained by a high standard of evidence-based nursing care.

The inspector saw evidence that residents received appropriate medical and allied health care without delay. Residents were seen by their GP on a frequent basis and had their medications reviewed every three months.

Each resident had an assessment in place which was updated every three months. The inspector reviewed two residents' files and saw that each identified need had a care plan in place. However, as mentioned later in this report under Outcome 14 and 15, the residents care plan did not always reflect the care recommended by visiting inter

disciplinary team members or the care been provided by staff. There was evidence that residents' were involved in their assessment and care plan.

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):

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

Findings:

The newly constructed extension and the original building were now joined as one centre which included an adequate amount of private and communal space to care for 35 residents.

There were 35 single en suite bedrooms; therefore, each resident had an adequate amount of private space available to them. There were a number of communal rooms accessible to residents. These included a large activities room, a sitting room, a large bright oratory, visitors room, a therapy room, small quiet areas off the corridors and a residents library. A treatment room was also available for use by interdisciplinary team members visiting residents in the centre. The staff area contained separate changing facilities for kitchen and care staff and a staff rest room.

There was a large bathroom which contained an assisted bath. There were now an adequate number of communal toilets located throughout the centre. Alterations had taken place since the last inspection in February 2014. Two communal wheelchair accessible toilets (one for residents and one for visitors) had been developed near the large activities room and other communal rooms.

Residents had access to an enclosed courtyard and an enclosed garden both of which were safe and secure.

Judgment:

Compliant

Outcome 13: Complaints procedures

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

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

Complaints were well managed. There was a complaints policy in place which met the legislative requirements and was clearly outlined in the statement of purpose and the residents guide. The process was clear, accessible to all residents and displayed in prominent places throughout the centre.

The person in charge was the nominated person to deal with all complaints. The inspector reviewed records of complaints received since the last inspection (of which there were few). All complaints had been fully investigated with clear concise records kept including the residents level of satisfaction with the outcome of the complaint. Residents and relatives who provided written feedback stated that they had never had a reason to complain.

Judgment:

Compliant

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 policies and practice in place ensured that each resident received care at the end of their life which met their physical, emotional, social, psychological and spiritual needs and respected their privacy, dignity and autonomy.

The management team had recently completed a full review of end of life care provided to residents and as a result introduced some positive changes. For example, the availability of overnight accommodation to the dying residents family and the development of a centre specific sympathy card. However, policies in place for end-of-life care had not been updated to reflect these positive changes in end of life care. The

centre had also joined the hospice friendly hospitals programme to assist them in continuing to meet the best standards in end of life care. The centre had access to a local palliative care team and there was no delay in seeking their expert advice.

The inspector reviewed the file of one resident who died in the centre. The resident's end of life preferences were recorded and there was an end of life care plan in place. However, it did not outline the exact care to be given and therefore was not specific enough to guide staff. For example, it stated to re-position and provide oral hygiene regularly. It did not reflect the frequency that this care was to be given. Although, the re-positioning chart showed that the resident was been re-positioned every two to three hours and was given oral care every four hours.

Residents could choose their preferred place of death. All religious and cultural practices were facilitated by staff with the support of the pastoral care leader. Respect was shown for the remains of a deceased resident and arrangements for the removal of remains occurred in consultation with deceased resident's family.

Staff training on palliative care/end of life had been sought and dates booked for all staff and volunteer sisters to attend.

Judgment:

Non Compliant - Minor

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 in place for the monitoring and documentation of nutritional intake. However, it did not reflect new practices put in place. Processes had been reviewed and new practices had been put in place to ensure residents did not experience poor nutrition and hydration. For example, residents' who required assistance at mealtime were now served their meal on a red tray. This reminded staff that they could not serve a meal to the resident unless they were free to assist the resident. Also, a system had been introduced where all residents who had been assessed and identified as having an issue with their weight had it monitored more frequently than once per calendar month.

Residents had access to fresh drinking water at all times. Residents stated that the food provided met their needs and overall they received a good variety and choice in sufficient quantities at each meal time. However, the starter on the lunch menu

displayed on each table in the dining room did not reflect that displayed on the board on entry to the dining room. Meals and snacks were available at times suitable to residents. The inspector saw that the special dietary requirements of each resident were addressed.

Food appeared to be properly prepared, cooked and served, and appeared wholesome and nutritious.

The inspector saw evidence that all residents' had been reviewed by a dietician. However, the inspector observed that nutritional supplements recommended by the dietician were not been administered to the resident, although they were prescribed by the resident's GP. For example, the dietician had reviewed a resident, recommended a nutritional supplement of 200ml volume be prescribed and administered. The residents GP had prescribed the supplement. However, there was no evidence that the supplement was been administered as prescribed. It was not recorded on the resident's fluid balance chart and the supplement had not been signed as given on the medication administration sheet for three consecutive days. The inspector noted there was no record of why the supplement had not been administered, the section was left blank.

Also, recommendations made by the dietician and care been provided by care staff were not reflected in the residents food and nutritional care plan. For example, the two residents care plans reviewed did not refer to the supplement prescribed or the frequency care staff were recording the residents' weight.

Judgment:

Non Compliant - Moderate

Outcome 16: Residents' Rights, Dignity and Consultation

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

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

Residents were consulted with and participated in how the centre was run.

Feedback was sought from them, both verbal and written and this information was used to inform practice. Residents had access to independent advocacy services, volunteers and sister companions who visit on a daily basis from the local convent.

Routines, practices and facilities maximised residents' independence. Residents were facilitated to exercise their civil, political, religious rights and were enabled to make informed decisions about the management of their care through the provision of appropriate information. They had a choice to attend Mass and a number of structured religious prayer meetings each day.

There was group and one to one recreation activities scheduled daily to meet the needs of residents. The new refurbishment had led to a quite library space, large recreational room and a therapy room been made available for residents use. The large bright therapy room was in the process of been furnished.

There were no restrictions on visitors expect at a residents' request. The inspector met with some visitors and saw that residents could receive their visitors in the private visitors lounge which contained facilities to make hot beverages.

Residents confirmed that they received care in a dignified way that respected their privacy at all times. Staff were aware of the different communication needs of residents and there were systems in place to meet the diverse needs of all residents. Each resident s' communication needs were reflected in their assessment and care plan.

The centre was part of the local community particularly Beaumont hospital which could be accessed via the grounds of the centre and the convent which was next door.

Residents had access to radio, television, newspapers, information on local events, etc. All residents had access to wireless internet and a private telephone in their bedroom.

Judgment:
Compliant

Outcome 17: Residents' clothing and personal property and possessions
Adequate space is provided for residents' personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.

Theme:
Person-centred care and support

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

Findings:
There was a policy on residents' personal property and possessions. The inspector saw that a record of each resident's personal property was recorded on admission. Residents' informed the inspector that they maintained control of their personal belongings and they had an adequate amount of storage space available to them including lockable storage in their personal bedroom.

Residents' personal laundry was done on site and residents told the inspector that good systems were in place to ensure that residents' clothes were returned to them within a short time frame.

Judgment:
Compliant

Outcome 18: Suitable Staffing

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

Theme:
Workforce

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

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

Findings:

There were sufficient numbers of staff with the right skills, qualifications and experience to meet the assessed needs of 26 residents.

There was an actual and planned staff rota. The inspector saw that there was a minimum of one staff nurse on duty at all times and the numbers of staff rostered during the day and night took into account the statement of purpose and size and layout of the building. The roster showed that all new staff were supported by long term staff members with similar qualifications. Residents spoken with confirmed that staffing levels were good, stating they never had to wait long for their call bell to be answered or their requested needs to be met.

Records reviewed confirmed that all staff had mandatory education and training in place. The clinical nurse manager provided care staff with in-house education on a variety of topics, such as, continence promotion, hand hygiene and updated policies. This practice enabled staff to provide care that reflects contemporary evidence based practice. Staff spoken with told the inspector their learning and development needs were being met and they demonstrated a good knowledge of policies and procedures relating to the general welfare and protection of residents.

A review of three staff files confirmed that effective recruitment procedures were in place, all three files contained the required documents outlined in Schedule 2, including evidence of up-to-date registration with the relevant professional body for staff nurses. The inspector was informed that the centre were in the process of recruiting new staff to ensure they could meet the needs of 35 residents'.

There were two volunteers currently working in the centre, both had been Garda vetted and had their roles and responsibilities clearly set out in a written agreement.

Judgment:
Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Sheila McKeivitt
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	Catherine McAuley House
Centre ID:	OSV-0000125
Date of inspection:	10/09/2014
Date of response:	10/10/2014

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 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:

Residents had not been involved in a practiced fire drill to date and were unaware of the procedure to follow in the event of a fire.

Action Required:

Under Regulation 28(1)(e) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the

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

designated centre and residents are aware of the procedure to be followed in the case of fire.

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

We promote the health and safety of our residents, staff and visitors at all times. Fire training is conducted twice yearly which includes the practice of a mock fire drill. The most recent fire drill took place on the 16th and 25th September 2014. A mock fire drill was practiced with residents and staff in various scenarios during this training. A detailed written report of the training practices conducted is documented in the Fire Register.

Further mock fire drill sessions are scheduled to take place involving staff and residents over the next few weeks and are planned and co-ordinated by Person in Charge and Health and Safety Officer.

All our residents are made aware of our Health and Safety Policy and Fire Procedures at monthly residents meetings. An action plan outlining the procedures to be followed in the event of a fire occurring is placed in each resident's room.

An Audit is undertaken by the Person in Charge following each fire drill practice and the outcome is communicated to residents and staff. Any issues identified are dealt with and adjustments if required made to the fire drill practice.

Our Fire Policy and Procedure is updated to reflect the positive changes regarding fire safety training and increased awareness and promotion of health and safety for residents and staff.

Proposed Timescale: 31/10/2014

Outcome 09: Medication Management

Theme:

Safe care and support

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

Medications were not been administered as prescribed or in line with An Bord Altranais agus Cnáimhseachais na hÉireann "Guidance to Nurses and Midwives on Medication Management, July 2007.

Action Required:

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

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

We have introduced a more specific Medication Administration Report Sheet. This sheet has clearly outlined codes as to the reason why a medication was not administered to a resident. These reasons are reflected in resident's Care Plan, discussed at staff handover report each day and an action plan put in place. This ensures that residents are administered their medications as prescribed by their General Practitioner.

Guidelines from the document "The Principles of good practice in medication reconciliation" (HIQA May 2014) have been incorporated into our medication management policy. All our nurses are familiar with these guidelines and are committed to improving the overall medication management process in line with An Bord Altranais 'Guidance to Nurses and Midwives on Medication Management, July 2007.

A more comprehensive system is now in place to review and monitor the safe medication management practice in the Nursing Home.

This new audit tool is designed to capture all aspects of the medication management policy. An audit is completed weekly by Clinical Nurse Manager and findings relayed to Director of Nursing. A report on the findings of the audit is communicated to Board of Management at monthly meeting by Director of Nursing.

Staff Nurses are required to attend training in "Best Practice in Medication Management for Older People" which has been booked for 14th October and 13th January. This training will ensure nurses medication management skills are updated and will assist in their professional development in line with best evidence based practice in Medication Management Practices.

Nurses are also required to complete the online HSEland Medication Management Programme each year. A record stating that this programme has been completed is maintained in staff files.

Our Medication Management Policy is updated to reflect all these changes and the contents communicated to all staff nurses in the Nursing Home.

Proposed Timescale: 30/11/2014

Outcome 14: End of Life Care

Theme:

Person-centred care and support

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

The end of life policy did not reflect the care and comfort provided together with the physical, emotional, social, psychological and spiritual needs of the residents'.

Action Required:

Under Regulation 13(1)(c) you are required to: Inform the family and friends of the resident approaching end of life of the resident's condition, with the resident's consent. Permit them to be with the resident and provide suitable facilities for them.

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

All residents wishes are now recorded in an end of life support and care form which we have introduced in the Home. The End of Life Policy has been reviewed and updated to reflect the positive changes that have been introduced in the provision of care for our residents at end of life. As residents condition deteriorates family/next of kin are notified of the approach of end of life and a meeting is arranged with their GP.

Residents expressed wishes and consent are documented in their End of Life Care Plan. We have a family room available for overnight accommodation if required by family. A mobile altar containing crucifix, candle and prayers is placed in a resident's room at end of life. This helps create a calm and peaceful atmosphere in the room at this time for resident, family and friends.

A sympathy card is currently being developed and will be specific to the Nursing Home and provided to relatives/next of kin following the death as an expression of our sympathies.

All staff have attended Palliative Care training which was conducted by the Hospice in recent weeks.

Proposed Timescale: 30/11/2014

Theme:

Person-centred care and support

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

End of life care specific to the resident was not clearly outlined in the resident's end of life care plan.

Action Required:

Under Regulation 13(1)(a) you are required to: Provide appropriate care and comfort to a resident approaching end of life, which addresses the physical, emotional, social, psychological and spiritual needs of the resident concerned.

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

A person centred End of Life Care Plan is commenced for each resident as they approach end of life. This documentation is now more specific on all aspects of care being given to the resident and provides guidance for staff in the delivery of care. The daily observation charts reflect the care provided at regular intervals and this information is linked to the Care Plan and signed by staff nurse at the end of the shift. Any changes in residents condition are reflected in the Care Plan which is reviewed daily by the staff nurse.

Audits are conducted by CNM and Person in Charge and findings are relayed to staff and any learning outcome is communicated to all staff at daily report and staff meetings.

The End of Life Policy is updated to reflect this practice.

Proposed Timescale: 30/11/2014

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:

The choice of food available was not reflected on all documents. The board outside the dining room did not display the correct choice of soup available.

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:

Residents are offered a choice of menu each day. The menu of the day is displayed on the dining table and also written on a board at the entrance to the dining room.

Both menus reflect the actual food that is served on the day at each meal.

Residents are asked to provide comments in a feedback form made available to them at the entrance to dining room. An audit of these comments by the person in charge will help guide us to improve our quality of food and service for our residents and therefore improve their overall dining experience in our Nursing Home.

All catering and Healthcare staff receive regular training in all aspects of food and nutrition.

Regular audits are completed by Person in Charge to ensure that any issues in choice and quality of food for residents are identified and improved.

Our Nutrition Policy is updated to reflect these positive changes.

Proposed Timescale: 30/11/2014

Theme:

Person-centred care and support

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

Dietary supplements recommended by dietetic staff and prescribed by medical practitioners were not being administered by nurses to residents.

Action Required:

Under Regulation 18(1)(c)(iii) you are required to: Provide each resident with adequate quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietetic staff, based on nutritional assessment in accordance with the individual care plan of the resident concerned.

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

All residents who have been reviewed by the dietician and are recommended to have nutritional supplements will have them prescribed by the GP and documented in their kardex.

These supplements are administered to residents by the staff nurse as per 'Guidance to Nurses and Midwives on Medication Management, July 2007'.

Nutritional supplements that are given to residents are also recorded in the residents daily fluid balance chart. This chart is signed by the staff nurse at the end of each shift and audited weekly by CNM.

The updated and more specific Medication Administration Record introduced in the Nursing Home will show a record of all supplements administered and also a clear reason if a supplement has not been administered to a resident will be documented. An audit using the newly developed more comprehensive audit tool is completed weekly by CNM. Results of this audit are relayed to staff and to Board of Management by Director of Nursing and any action required as an outcome of the audit will be addressed in a prompt manner.

The Medication Management Policy is updated to reflect these positive changes.

Proposed Timescale: 30/11/2014**Theme:**

Person-centred care and support

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

Residents who had food and nutritional care plans in place did not reflect recommendations made by the dietician or the care being provided.

Action Required:

Under Regulation 18(1)(c)(iii) you are required to: Provide each resident with adequate quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietetic staff, based on nutritional assessment in accordance with the individual care plan of the resident concerned.

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

All residents on admission have a nutritional assessment completed and based on this assessment a person centred nutritional care plan is initiated incorporating residents food preferences. Following a dietetic review of the residents all the recommendations that are made are incorporated into their nutritional care plan including their care pathway and frequency of weights.

Catering staff are informed of the dietary needs for all new admissions and this is reviewed on a daily basis and all changes to dietary plan is communicated to catering staff and documented on the notice board in the kitchen.

A review of all residents who are on nutritional supplements is currently underway by GP.

An audit using an audit tool specific to the use of dietary supplements for residents is completed monthly by CNM. The outcome is reported to Person in Charge who addresses any issues arising who also informs the Board of Management of the results of the audit and any action taken if required.

Our Nutritional Policy is updated to reflect all of the positive changes in the nursing home regarding nutritional needs of our residents.

Proposed Timescale: 30/11/2014