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## The Marlay Nursing Home, Kellystown Road, Rathfarnham, Dublin 16

Item Type	report
Authors	Rafferty, Nuala;Ewings, Leone
Citation	Nuala Rafferty, Leone Ewings, 'The Marlay Nursing Home, Kellystown Road, Rathfarnham, Dublin 16', [report], Health Information and Quality Authority, 2017-01-06, Older People Inspection Report, Compliance Monitoring Inspection report Designated Centres under Health Act 2007, as amended
Publisher	Health Information and Quality Authority
Rights	Y
Download date	2026-03-11 04:36:37
Link to Item	<a href="https://hdl.handle.net/20.500.14765/80664">https://hdl.handle.net/20.500.14765/80664</a>

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	The Marlay Nursing Home
<b>Centre ID:</b>	OSV-0000108
<b>Centre address:</b>	Kellystown Road, Rathfarnham, Dublin 16.
<b>Telephone number:</b>	01 499 4444
<b>Email address:</b>	reception@themarlay.com
<b>Type of centre:</b>	A Nursing Home as per Health (Nursing Homes) Act 1990
<b>Registered provider:</b>	Brehon Care
<b>Provider Nominee:</b>	Paul Davis
<b>Lead inspector:</b>	Nuala Rafferty
<b>Support inspector(s):</b>	Leone Ewings
<b>Type of inspection</b>	Unannounced Dementia Care Thematic Inspections
<b>Number of residents on the date of inspection:</b>	123
<b>Number of vacancies on the date of inspection:</b>	1

## **About Dementia Care Thematic Inspections**

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor compliance with specific outcomes as part of a thematic inspection. This monitoring inspection was un-announced and took place over 2 day(s).

**The inspection took place over the following dates and times**

From:	To:
12 July 2016 09:00	12 July 2016 19:00
13 July 2016 09:00	13 July 2016 17:30

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

<b>Outcome</b>	<b>Provider's self assessment</b>	<b>Our Judgment</b>
Outcome 05: Documentation to be kept at a designated centre		Substantially Compliant
Outcome 01: Health and Social Care Needs	Non Compliant - Moderate	Non Compliant - Moderate
Outcome 02: Safeguarding and Safety	Substantially Compliant	Substantially Compliant
Outcome 03: Residents' Rights, Dignity and Consultation	Substantially Compliant	Substantially Compliant
Outcome 04: Complaints procedures	Not applicable	Non Compliant - Moderate
Outcome 05: Suitable Staffing	Compliance demonstrated	Non Compliant - Moderate
Outcome 06: Safe and Suitable Premises	Substantially Compliant	Compliant
Outcome 08: Governance and Management		Substantially Compliant
Outcome 11: Information for residents		Non Compliant - Moderate

**Summary of findings from this inspection**

This inspection report sets out the findings of a thematic inspection which focused on six specific outcomes relevant to dementia care. The purpose of this inspection was to determine what life was like for residents with dementia living in the centre. The inspection monitored progress on the actions required arising following the last registration inspection carried out on 6 November 2013. The inspection also considered information received by HIQA in the form of notifications and other

relevant information. The provider had completed a self-assessment tool on dementia care in 2016 and had assessed the compliance level of the centre as follows: Compliant in Outcome 5: Substantially compliant in Outcomes 2,3 and 6 and Moderately Non compliant in Outcome 1. The provider had not assessed their compliance with the complaints procedures as this was not included in the self assessment tool sent to the provider. The findings of this inspection are broadly in agreement with the provider's assessment with the exception of staffing which was found to be moderately non compliant and premises which was found to be compliant.

Inspectors found a good standard of nursing care was delivered to residents in an atmosphere of respect and cordiality. Safe and appropriate levels of supervision were in place to maintain residents' safety in a low key unobtrusive manner during this inspection. Improvements to clinical care, supervision of staff and competence development for all staff was required.

The Action Plan at the end of this report identifies other areas where improvements are required to comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centre's for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland. These also include improvements to contracts of care, consultation with relatives, medication management and care planning processes.

**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 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):**

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

**Findings:**

Records set out in Part 6 of the Regulations were available and kept in a secure place. The Statement of Purpose and Residents' Guide were complete and available.

The directory of residents was reviewed and was complete and up to date with records of admissions, discharges and transfers maintained.

Some of the records required under Schedule 4 of the Regulations were reviewed including appropriate staff rosters, accident and incidents, nursing and medical records. Planned rosters were in place in all units and an actual working rota was maintained. All of the operational policies and procedures as required by Schedule 5 of the Regulations were available, were reviewed on a regular basis and within the three month timeframe as required by the regulations.

It was found that some policies in place were not fully implemented in practice. These included the policies on medication management, restraint and safeguarding. These are further referenced under outcomes 7 and 9.

Other policies also required revision to ensure they gave sufficient guidance to staff, reflected current best practice and the regulations. These include policies on complaints and restraint.

**Judgment:**

Substantially Compliant

## ***Outcome 01: Health and Social Care Needs***

### **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 evidence that the well being and welfare of residents was being maintained through the provision of a good standard of nursing medical and social care.

Residents had access to GP services. There were records of access to specialist and allied health care services to meet the care needs of residents such as opticians, dentists and chiropody services.

Evidence of access to medical and allied health professionals was found with documented visits, assessments and recommendations by dietician speech and language therapists, physiotherapist and occupational therapist reviews.

Samples of clinical documentation including nursing and medical records were reviewed. These showed that all recent admissions to the centre were assessed prior to admission. The pre admission assessment was generally conducted by the person in charge who looked at both the health and social needs of the potential resident.

Transfer of information within and between the centre and other healthcare providers was good. Discharge letters for those who had spent time in acute hospital and letters from consultants detailing findings after clinic appointments were maintained.

The arrangements to meet residents' assessed needs were set out in individual care plans and each resident file reviewed had a care plan completed. A number of core risk assessment tools to check for risk of deterioration were also completed and assessments were in place for most identified needs.

A number of care plans referred to family involvement in the care planning process, where family were consulted for decision making or to seek and give information relating to the resident.

However, it was found that assessments and care plans were not in place for all identified needs. Examples included wounds and management of oedema. This was noted in particular where residents were losing weight but it could not be determined whether the weight loss was due to the effectiveness of diuretics (medicine prescribed to reduce fluid retained by the body and causing oedema) or due to loss of muscle or body fat. It was further noted that clinical monitoring by the nursing team to assess the effectiveness of medical interventions to reduce oedema and maintain normal body weight was not in place, for example, limb and urine measurement.

Where care plans were in place, they were not specific enough to guide staff and manage the needs identified, examples included: In a sample of nutrition care plans, it was noted that they did not always include reference to the frequency of weight or intake monitoring, food fortification or type of diet required.

Wound assessments were not in place for every wound and care plans did not always refer to how frequently the dressings should be changed. Where care plans stated the type of dressing to be used, they were not always followed. It was noted that in the case of one wound, the dressing in use was a highly absorbent type used when there is a lot of fluid coming from the wound, yet this wound was dry.

Plans in place to manage risks associated with a slow pulse rate directed staff to withhold prescribed medicines used to slow or regularise the heart rate if the pulse was below 60 beats per minute. Although the plan directed staff to monitor the pulse rate daily it did not guide them on how frequently the blood toxicity levels should be monitored or when/ in what circumstances the resident should be referred for GP or specialist consultant review. A blood sample was taken to check the levels of the medication being used to regularise the heart rate in the bloodstream in May 2016. The results were not recorded in the care plan. On review of several other locations on the computerised record such as: nurse progress notes and medical notes they could not be located. A hard copy was also not available. However, an entry in the nurse progress notes the day after the blood sample was sent indicated that a nurse had informed the family of the blood test results which indicated they had been received or notified to the nursing team.

End-of-life or palliative care plans did not include reference to expressed wishes or efforts made to capture residents' wishes for religious or spiritual preference or to facilitate supports for place of death or funeral arrangements.

A system to make sure healthcare plans reflected the care delivered and were amended in response to changes in residents' health was in place. Although in general care plans reflected the care delivered, further improvements were required. The checks in place, although regular, did not consider the effectiveness of the plans to make sure they were detailed enough to maintain or improve a resident's health. The daily nursing progress notes did not always refer to changes in health care plans or changes to treatments or recommendations made by clinicians to give a clear and accurate picture of residents' overall health. It was also found that most although not all care plans were generic in nature and were not person centred.

Inspectors found that there were written operational policies in place in the centre relating to the ordering, prescribing, storage, and administration of medicines to residents.

Medicines were supplied to the centre by a retail pharmacy business in a monitored dosage system that consisted of pouches of medication on a roll. Medicines were stored securely in the centre in medication trolleys or within locked storage cupboards. A secure fridge was available to store all medicines and prescribed nutritional supplements that required refrigeration, and temperatures were checked and recorded on a daily basis. Controlled drugs were stored securely within a locked metal cabinet, and balances of all controlled drugs were recorded in the controlled drugs register. Nursing staff checked and documented the balances of all controlled drugs twice daily at the change of shift. Nursing staff were familiar with the procedure for disposing of unused or out of date medicines.

Inspectors observed nursing staff administering medicines to residents during the evening administration rounds on one of the units. The nurse knew the residents well, and was familiar with the residents' individual medication requirements. Inspectors observed that the nurses took time to ensure each resident was comfortable before

administering their prescribed medicines in a person centred manner. Nurses were observed to use alcohol hand gels appropriately throughout the process. Medication administration practices were found to adhere to current professional guidelines.

Medication audits were conducted in the centre and inspectors reviewed a sample of those audits. It was noted that these audits were conducted by the external pharmacist, who supplied medicines to the centre, and did not include nursing or medical inputs. These audits only covered some aspects of good medication management practices. The audits looked at aspects such as: storage, labelling, administration records controlled medicines and temperature controls on medicine refrigeration.

Medication errors were appropriately recorded and action plans associated with follow up on these medication errors included appropriate feedback to staff.

It was noted however, that the duration of medication administration was outside recommended guidance for early morning medicines at specific times. There were several reasons for this including respecting resident's choice for waking and length of staff handover in the mornings. It was also noted that the actual times medicines were administered by the nursing staff was not accurately recorded where this differed from the time the medicine was prescribed for administration.

This was discussed with the management team and measures to address this including review of the times for administration was required.

Measures to ensure medication was administered within an appropriate timeframe were implemented on the second day of inspection and the administration of medicines was completed in a timelier manner.

However, the documentation of care and administration of medicines was not sufficiently accurate or complete to determine that a high standard of evidence based nursing care was being delivered at all times to all residents to fully meet their personal social and healthcare care needs.

**Judgment:**

Non Compliant - Moderate

***Outcome 02: Safeguarding and Safety***

**Theme:**

Safe care and support

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

No actions were required from the previous inspection.

**Findings:**

Staff who spoke with inspectors were knowledgeable regarding what constituted abuse and how to respond to suspicions or any allegation of abuse. Measures including policies to protect residents from being harmed or suffering abuse were in place and residents spoken with confirmed they felt safe and some knew who they would speak too if they were concerned. Relatives also confirmed that they did not have any concerns for the

safety of their loved ones. There was a positive approach to the management of behaviours and psychological symptoms associated with dementia. Staff spoken to by the inspectors confirmed that they had received recent training on recognising abuse, and were familiar with the reporting structures in place. There were systems in place to ensure allegations of abuse were fully investigated, and that pending such investigations measures were in place to ensure the safety of residents. Inspectors viewed a report of a recent investigation into an allegation of abuse and found it had been appropriately investigated. The report also reflected satisfaction of the family and complainant on the outcome and management of the complaint. However, the investigation did not fully follow the centre's safeguarding policy in that the investigation team did not include an impartial assessor or reference inclusion of a social worker for support or access to expertise.

The inspectors reviewed the system in place to manage residents' money and found that reasonable measures were in place and implemented to ensure resident's finances were fully safeguarded. But it was noted that some improvements to procedures were required to ensure transparency and security such as separation of monies held for safekeeping in private property accounts.

A review of the use of restraint found that there was a reduction in the use of bed rails throughout the centre although bed rails were still in place for some residents. A culture of promoting a restraint free environment with an increase in the use of alternative safety measures such as bed alarms, roll out mats and low- low beds was being established.

Evidence of alternatives considered or trialled was available and a clear rationale for use of bed rails was referenced in risk assessments or in associated care plans.

A policy to guide staff on the use of restraint was in place. The policy was reviewed and implemented in 2015. It references the current Department of Health National Policy but it was found that the policy was not being fully implemented in that:

- The policy clearly states that restraints should not be used in response to a risk of falls unless the risk of falling is immediate. The inspector found that bed rails were in place for all residents who had pressure relieving mattress systems or mattress overlays on their beds. A total of 19 were in place at the time of inspection. In conversation with CNM's they clarified that these mattresses were the rationale for use of the bed rails, to prevent residents from falling from their beds due to the increased height.

- A record of opportunity for motion and exercise for 10 minutes in every two hour period as required under section 7.14 of the policy was not in place for any resident.

**Judgment:**

Substantially Compliant

***Outcome 03: Residents' Rights, Dignity and Consultation***

**Theme:**

Person-centred care and support

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

No actions were required from the previous inspection.

**Findings:**

Overall residents' rights, privacy and dignity was respected with personal care delivered in their own bedroom or in bathrooms with privacy locks and the right to receive visitor's in private.

There were no restrictions to visiting in the centre and some residents were observed spending time with family or friends reading newspapers or chatting in their bedrooms.

Choice was respected and residents were asked if they wished to attend Mass or exercise programmes, control over their daily life was also facilitated in terms of times of rising /returning to bed and whether they wished to stay in their room or spend time with others in the communal rooms. The right to vote in national referenda and elections was facilitated with the centre registered to enable polling.

Staff were observed to interact with residents in a warm and personal manner, using touch eye contact and calm reassuring tones of voice to engage with those who became anxious restless or agitated.

Information on the day's events and activities was prominently displayed in the centre. Two activities coordinators delivered the programme which included both group and one to one activities. Inspectors were told that one to one time was scheduled for residents with more severe dementia or cognitive impairment or who would not participate in the group activities, and that this time was used for sensory stimulation such as providing hand massages. Other dementia relevant activities were included in the programme such as reminiscence and sensory stimulation. Residents life stories were collated by staff who were aware of them and inspectors were told they would be used to inform reviews of the programme going forward.

Access to the community was facilitated through occasional trips to places such as Dun Laoghaire Pier: Marley Park sensory garden and Rathfarnham Castle. Inspectors were told these were only held during the summer and dependent on the weather.

All communal areas were supervised and apart from short periods at least one staff member was present to ensure resident safety.

Inspectors observed an activity co-ordinator holding poetry and singing sessions with a group of residents, some of whom joined in and appeared to be enjoying themselves. A bunch of herbs for sensory reminiscence was on the table.

Residents and Relatives who spoke to inspectors were generally very satisfied with the care provided. All said that staff were respectful and kind and nothing was too much trouble. All said they felt safe and trusted staff to look after them well. Some did say that there were times when staff were under pressure and did not always have time to respond promptly to requests or were rushed. This was identified as an issue particularly during the morning. Some residents said they were bored with the repetition of the films shown which they said were old 1950's movies and the quality was not great. They also said that they really enjoyed the music recitals occasionally held which were great fun.

Evidence that residents were given an opportunity to be involved and included in decisions about the life of the centre was found A meeting was held generally every three months where residents were consulted about future activities or outings. Minutes of these meetings were viewed and included discussions on past outings and events. At the most recent meeting one resident gave a talk on the 1916 Rising and Padraig Pearse. The meetings also combine an element of fun and relaxation with soft drinks

served a sing song and a best dressed attendee competition. An opportunity for suggestions for ideas on outings or activities or any questions was noted but none were made.

But it was found that opportunities for residents' relatives, advocates or next of kin to be involved or consulted about the running centre were not provided.

There were systems in place to ensure residents' nutritional needs were met, and that they did not experience poor hydration. Residents' weights were checked on a monthly basis, and where required, daily intake charts were in place to monitor food or fluid intake.

Menus were available and all residents were offered choice at each meal. The inspectors observed residents having their lunch in the dining room, where a choice of meals was offered. All staff sat beside the resident to whom they were giving assistance and were noted to patiently and gently encourage the resident throughout their meal. Assistance was discreet good humoured and punctuated with lots of smiles. Independence was promoted and residents were encouraged to eat their meal at their own pace by themselves with minimal assistance to improve and maintain their functional capacity. However, although the dining experience for residents was generally good it was noted that there was quite a lot of background noise created by staff when bringing meals to residents and clearing tables. This included staff calling across the room to check if everyone had their meal, to ask for assistance or other general queries. A lot of noise was created when staff were scraping food from plates and gathering cutlery left by residents after their meal as this took place in close proximity to other residents who were still having their meal. This did not facilitate or respect the rights of residents to an appropriate enjoyable and relaxing dining experience.

**Judgment:**

Substantially Compliant

***Outcome 04: Complaints procedures***

**Theme:**

Person-centred care and support

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

No actions were required from the previous inspection.

**Findings:**

Policies and procedures were in place for the management of complaints. Residents were aware of the process which was displayed.

On review of the record of complaints there was evidence that complaints were documented, investigated and outcomes recorded. Complainants were notified of the outcomes and a review was conducted to ascertain the satisfaction of the complainant further to issues being resolved. But not all complaints made were recorded. Inspectors were aware that complaints had been made related to fees charged for additional

services. This was confirmed by the provider nominee who had met with the complainants but records of the management, outcome or whether the complainants were satisfied or not were not kept.

All nominated persons as required by the regulations were in place to ensure the process was adhered too. But inspectors found that the appeals process was not sufficiently effective as it was not completely independent.

The nominated person to deal with complaints was the person in charge. The second nominated person to audit the process and ensure appropriate responses to and recording of complaints was the Director of Operations. The independent adjudicator to whom appeals were to be made was the Provider Nominee. However the process did not include an external independent person for appeals or review.

**Judgment:**

Non Compliant - Moderate

***Outcome 05: Suitable Staffing***

**Theme:**

Workforce

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

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

**Findings:**

Suitable and sufficient staffing and skill mix were found to be in place to deliver a good standard of care to the current resident profile.

The staff rota was checked and found to be maintained with all staff that worked in the centre identified.

Systems were in place to provide relief cover for planned and unplanned leave. Actual and planned rosters were in place.

Regular staff gave notice on their availability to provide cover for unforeseen absences. Then gaps were filled on rota's from this 'bank' of internal relief staff. Although agency staff were still used this was not extensive.

A specific staff allocation system was in place that identified the staff for each area on every floor in the centre. All staff were aware of the system which was implemented in full. The system also identified staff supervision of communal areas throughout the day.

A system was in place to supervise the standard of care being delivered to residents.

This included a clinical nurse management (CNM) team who provided supervision and support to frontline nursing and care staff. A clinical nurse manager was assigned to each floor of the centre and management cover was provided at weekends and on night duty. But it was noted that improvements to the monitoring of care delivery was required. Inspectors found that some aspects of care were not delivered in a timely manner and recording of care delivery was not always fully completed. These included medication administration and recording of food and fluid intake and repositioning charts. Although most of these records were being completed many were recorded at the same time and not at the time the intervention had actually occurred.

Mandatory training was in place for all staff on safeguarding, moving and handling and fire safety.

Training in areas such as wound care: hand hygiene: dementia awareness and responsive behaviours also formed part of the core training for staff on an ongoing basis. Inspectors found that staff were being provided with training on a regular basis in many areas of skill development to meet residents needs, but some gaps were identified. Additional training appropriate to the roles and responsibilities of each staff member was required. Further training in areas including, but not limited to the following was required to ensure staff were competent and confident to carry out their duties in relation to care assessment and planning, recording care interventions, clinical decision making on factors influencing use and provision of pressure relieving mattress systems.

There was a lack of clarity on the specific role and responsibilities of each staff grade in relation to clinical decision making on the use of pressure relieving mattress systems. For instance, some pressure relieving mattresses (PRM) were not set at the correct setting where weight was an indicator for same.

In conversations with nurses, CNM's and housekeeping staff it was found that the decision to provide a resident with a PRM was made by the ADON or PIC, on clinical review of a resident's overall condition, in conjunction with the CNM or key nurse. However, once the decision was made to provide the PRM, the type of mattress and level of setting was left with the housekeeping team who were contacted to bring the mattress from the storage area. The housekeeping team leave the mattress in the bedroom for staff to place on the bed and decide on the setting. However, where staff indicate they are not confident to do this the housekeeping team do it for them. It was found that the nursing and healthcare staff believed it was the role of the housekeeping team to set up the PRM's at all times. Inspectors noted that the CNM's and nurses did not consider that they had a clinical responsibility for decision making in this regard. It was further noted that the decision making on the types of PRM's purchased by the centre were based on cost and not, necessarily, on the basis of clinical needs.

The system in place in the centre, to purchase, store, and respond to a request for a pressure relieving mattress needed to be reviewed and aligned with the clinical decision to use the mattress. Appropriate training was required for each staff person involved, linked to their role and responsibility. This was discussed with the senior management team at the close of inspection.

It was also noted that a competence development programme would benefit all staff going forward which should be linked to a formal staff appraisal and development review plan.

**Judgment:**

Non Compliant - Moderate

***Outcome 06: Safe and Suitable Premises***

**Theme:**

Effective care and support

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

No actions were required from the previous inspection.

**Findings:**

The premises were found to meet the needs of the residents at the time of the inspection. The centre was found to be well maintained, warm, comfortably and tastefully furnished and visually clean. All walkways were clear and uncluttered to ensure resident safety when mobilising. Suitable and sufficient communal space such as a large sitting room and dining room were available on each floor. A separate quiet room which was used for religious ceremonies or meetings was also available on the ground floor.

There were 124 single bedrooms all with full en-suite across three floors in the centre which was purpose built. All of the bedrooms were personalised to reflect residents' individual wishes with pictures photograph's and mementos. Some also contained items of furniture with sentimental value such as armchairs dressing tables and other occasional furniture.

The premises and grounds were clean and well maintained. Grab rails and hand rails were installed where required. There was a functioning call bell system in place within the centre, and hoists and pressure relieving mattresses were in working order, with records available to indicate servicing at appropriate intervals.

A small enclosed paved landscaped patio was available for resident's use. Although the grounds were landscaped and well maintained they were not secure and there was no garden area available and directly accessible to residents.

Evidence of improvements to appropriate signage and cueing to support freedom of movement for residents with dementia was also found. Picture cueing on bedrooms, bathrooms and toilet areas were in place. Colour cueing was also used with the colours of bathroom/toilet doors and grab rails and toilet seats contrasting with bedroom doors and wall colours on the third floor but this had not fully extended to the rest of the centre at the time of the inspection.

**Judgment:**

Compliant

***Outcome 08: Governance and Management*****Theme:**

Governance, Leadership and Management

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

No actions were required from the previous inspection.

**Findings:**

A clearly defined management structure that identified the lines of authority and accountability was in place.

The provider nominee was formerly the finance director and works full time in the centre. The former provider nominee remains working in the centre on a part time basis

as operational director to support the person in charge. Accountability and responsibility for all clinical decision making and determination of suitability for admission to the centre lies with the person in charge and the operational director. They are also responsible for oversight and monitoring of the safety and quality of care delivered to residents. The provider nominee is responsible for administrative, financial and strategic decisions.

Governance systems were in place. The Person in charge was also supported by an Assistant Director of Nursing (ADON) who was on leave at the time of this inspection. A clinical nurse management (CNM) team provided a good level of supervision and support to frontline nursing and care staff. A clinical nurse manager was assigned to each floor of the centre and management cover was provided at weekends and on night duty. Systems were in place to monitor quality and safety of care in place and data was being collated on a monthly basis on key performance indicators (KPI's) of clinical care such as; falls; pressure injuries; medication errors and nutrition management.

A risk management meeting took place monthly to discuss clinical and non clinical risks. These meetings were attended by the person in charge, operations director, assistant director of nursing (ADON) and the CNM's on duty. At the meeting the team reviewed the data collated on the KPI's. Inspectors read a sample of the monthly meetings minutes.

The minutes of the meetings were brief and consisted of a general summary of the discussion or decision taken. Some analysis of KPI's was included, such as: accidents and incidents and falls. Although brief the team identified issues arising from the data such as forms not being fully completed therefore some accidents being incorrectly logged as non specific. The data from falls showed that falls had increased and some residents were falling frequently. In both these areas the need to initiate practice changes were documented. However, the information in the minutes did not indicate a full analysis of the KPI's had taken place to identify all actions or measures to be undertaken, learning derived or review to be conducted. For example data on accidents showed a number of bruises and skin tears had occurred. The CNM team were directed to investigate all reported incidents of skin tears. However, the minutes did not reflect whether a review of the skin tears already recorded was or should be conducted; a review of the incidence of bruising was not referenced. Although the management team were collecting information on clinical care indicators the process was not yet complete. A quality assurance programme to continuously review and monitor the quality and safety of care was not fully established through a complete audit cycle. Some of the audits viewed included some learning and actions required to improve practice although they did not always include the actions taken to address the problem identified, when the action was implemented or reviewed to determine effectiveness. This was discussed with the PIC during the inspection process.

It was also noted that audits were conducted on aspects of medication management practices. However, evidence that these audits were rigorous enough to address issues arising from poor administration practices was not available. This is referenced under outcome 1. Inspectors findings detailed under relevant outcomes in this report highlighted the need to improve the level of care monitoring and to develop competence and skills in nursing and care teams in order to meet the future needs of the service. A performance appraisal system to implement skill development and training to meet the needs of the current and future resident profile was required. There was a need to identify and fill gaps in skills and expertise such as; leadership and supervision, gerontology, auditing and analysis. Inspectors found that skill development would also

be of benefit to the senior management team.

An annual review of safety and quality of care was in place. A report on the review was available. The report identified key performance indicators such as; staff recruitment, retention and training; complaints analysis and service developments. Although other quality care indicators were referenced to indicate the standard of and safety and quality of service being delivered; the report did not reference or include a consultation process with residents or relatives or inform whether and how their views informed the day to day running or development of the service.

**Judgment:**

Substantially Compliant

***Outcome 11: Information for residents***

**Theme:**

Governance, Leadership and Management

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

No actions were required from the previous inspection.

**Findings:**

Information in the form of concerns was received by HIQA relating to additional fees being charged to all residents. Inspectors reviewed the contract of care to determine the validity of these concerns. The inspectors found that residents had an agreed written contract which deals with the resident's care and welfare. The contract, as provided on inspection for review, included all details of the services to be provided for that resident and the fees to be charged. This included a list of facilities and services provided including care provision, laundry, meals, and housekeeping.

Services offered in the centre which incurred additional fees were listed. Additional fees were stated to be imposed to all residents for activities, a laboratory service and a medical doctor service. The Marlay Doctor Service was separate to the general practitioner service provided for under the medical card scheme. In the case of the Marlay Doctor Service, these costs were in addition to those covered for residents who had a medical card and could avail of the out of hours doctors service in the area. The activities fee applied whether or not the resident availed of them. The laboratory transport fee was ascribed as falling due to an alleged requirement by HIQA, which is not the case. The contract did not include an element of choice for those residents who did not wish to avail of these services. This was discussed in full with the provider nominee during the inspection. The provider nominee confirmed the additional charges were mandatory and that he was not in a position to offer residents an opportunity to opt out of paying for these additional services even if not availed of.

**Judgment:**

Non Compliant - Moderate

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## Closing the Visit

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

### **Acknowledgements**

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

### ***Report Compiled by:***

Nuala Rafferty  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority

## Health Information and Quality Authority Regulation Directorate

### Action Plan



### Provider's response to inspection report<sup>1</sup>

<b>Centre name:</b>	The Marlay Nursing Home
<b>Centre ID:</b>	OSV-0000108
<b>Date of inspection:</b>	12/07/2016
<b>Date of response:</b>	01/11/2016

### 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 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:

Some policies did not reflect the regulations current best practice or guidance issued by the Health Service Executive or gave sufficient guidance to staff.

#### 1. 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

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

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 policies highlighted by the inspectors in the report will be reviewed to reflect best practice and that they sufficiently guide staff in their practice. All policies will continue to be reviewed and updated as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and where necessary will be reviewed and updated in accordance with best practice.

In order that staff read and understand the policies, a weekly agenda for policy reading is in place.

**Proposed Timescale:** 31/12/2016

**Outcome 01: Health and Social Care Needs**

**Theme:**

Safe care and support

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

Assessment and care planning were not specific enough to direct the care to be delivered or guide staff on the appropriate use of interventions to consistently manage the identified need

**2. Action Required:**

Under Regulation 05(3) you are required to: Prepare a care plan, based on the assessment referred to in Regulation 5(2), for a resident no later than 48 hours after that resident's admission to the designated centre.

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

Further training for Nurses in the Care Planning process which will incorporate assessment of identified needs specific to the individual resident, the interventions required and evaluating the effectiveness of the interventions. Following training, random auditing of the process will take place monthly to monitor compliance.

**Proposed Timescale:** 31/05/2017

**Theme:**

Safe care and support

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

Evidence that all care plans were fully reviewed for effectiveness as residents needs changed and records of residents current overall condition as required by the regulations were not available

**3. Action Required:**

Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.

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

As outlined in Action Plan 2; Further Care Planning training and auditing is currently being planned which will cover the formal review process which includes consultation with residents and where appropriate the resident's family in a way that is appropriate to their understanding.

**Proposed Timescale:** 31/05/2017**Theme:**

Safe care and support

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

The documentation of care and administration of medicines was not sufficiently accurate or complete to determine that a high standard of evidence based nursing care was being delivered at all times to all residents to fully meet their personal social and healthcare care needs.

**4. Action Required:**

Under Regulation 06(1) you are required to: Having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care for a resident, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais.

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

Further medication management training will be given to all the nurses by the pharmacist which will then be followed by competency assessments and any gaps identified will be addressed with further training.

**Proposed Timescale:** 31/01/2017**Theme:**

Safe care and support

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

The duration of medication administration on the first day of inspection was outside recommended guidance for early morning medicines at specific times and the actual times medicines were administered by the nursing staff was not accurately recorded where this differed from the time the medicine was prescribed.

**5. Action Required:**

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

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

The proposed medication training will address these issues. In addition, we have reviewed our operational practices for first thing in the morning which has resulted in the medication round starting and finishing within the recommended timeframes.

**Proposed Timescale:** 31/01/2017

**Outcome 02: Safeguarding and Safety****Theme:**

Safe care and support

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

Policies in place for safeguarding vulnerable adults and use of restraint were not being fully implemented in the centre.

**6. Action Required:**

Under Regulation 04(1) you are required to: Prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.

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

A review of our current practice with regards to use of bedrails is currently being carried out. Following this review any bedrails that are in place which are not in line with our policy and DOH guidelines will be removed and alternative methods applied to keep the resident safe in bed will be deployed.

**Proposed Timescale:** 31/01/2017

**Theme:**

Safe care and support

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

Evidence that restraints in use were in line with current Department of Health guidance was not available. A record of opportunity for motion and exercise for 10 minutes in every two hour period was not in place for any resident for whom bed rails were in place.

**7. Action Required:**

Under Regulation 07(3) you are required to: Ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.

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

As above in Action Planned 6; A review of our current practice is currently taking place and following this review, bedrails will only be used in accordance with national policy.

**Proposed Timescale:** 31/01/2017

**Outcome 03: Residents' Rights, Dignity and Consultation**

**Theme:**

Person-centred care and support

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

The level of noise created by staff during lunch did not facilitate the rights of residents to an appropriate enjoyable and relaxing dining experience.

**8. Action Required:**

Under Regulation 09(3)(e) you are required to: Ensure that each resident can exercise their civil, political and religious rights.

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

Staff were made aware that the inspectors found the dining experience for residents at lunchtime noisy. Since this was brought to their attention they have been mindful of keeping the noise level down during mealtimes. This will continue to be monitored by the catering dept. and care staff.

**Proposed Timescale:** 12/07/2016

**Outcome 04: Complaints procedures**

**Theme:**

Person-centred care and support

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

A record of all complaints was not being maintained.

**9. Action Required:**

Under Regulation 34(2) you are required to: Fully and properly record all complaints and the results of any investigations into the matters complained of and any actions taken on foot of a complaint are and ensure such records are in addition to and distinct from a resident's individual care plan.

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

A satisfactory response was not submitted by the provider in relation to this action plan. The Authority has taken the decision not to publish this action plan and is considering further regulatory action in relation to this issue.

**Proposed Timescale:**

**Theme:**

Person-centred care and support

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

The complaints process did not include an external independent person as part of an effective appeals process.

**10. Action Required:**

Under Regulation 34(1) you are required to: Provide an accessible and effective complaints procedure which includes an appeals procedure.

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

In order to meet our obligations under Regulation 34(1) we have in place a nominated person who is not involved in the matter the subject of the complaint to deal with complaints(C). We have also nominated a person other than the person nominated in (C) to be part of our appeals procedure.

**Proposed Timescale:** 31/08/2016

**Outcome 05: Suitable Staffing**

**Theme:**

Workforce

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

Further training appropriate to the roles and responsibilities of each staff member was required in areas including, but not limited to the following was required: care assessment and planning, recording care interventions, clinical decision making on factors influencing use and provision of pressure relieving mattress systems.

**11. 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:**

As outlined in 2 Action plan; Further training in the Care Planning process is planned. The responsibility and clinical decision making on factors influencing the use of pressure relieving mattress systems rests solely with the Clinical Managers. Once a decision is

made Housekeeping are contacted to provide the system specified and the Nurses are responsible to set the system up and to continue to monitor the system. This has been made clear to all our staff. Training will be given to Nurses that require it in setting up and monitoring the systems.

**Proposed Timescale:** 31/05/2017

**Theme:**  
Workforce

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

A review of the supervision systems in place was required to ensure timely provision and recording of care interventions.

**12. Action Required:**

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

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

A review of the supervision systems is taking place. Reference was made to medication documentation and this will be addressed in the training. Training for care staff in the timely provision and recording of care interventions is planned.

**Proposed Timescale:** 31/05/2017

## **Outcome 08: Governance and Management**

**Theme:**  
Governance, Leadership and Management

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

Governance systems in place were not yet fully established or effective to ensure; effective monitoring processes including a complete audit cycle that contributes to the quality and safety of care in a meaningful way

Governance processes that monitors and develops all required staff skills and competence to meet the full needs of current and future resident profile was not in place.

**13. Action Required:**

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

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

Further training in Auditing for key staff is planned. In addition the PIC is currently

undertaking a Leadership and Supervision course for Directors of Nursing and the Assistant Director of Nursing is currently doing a Masters in Dementia Care. Modules in this cover the skills required to meet the complex profiles of our current and future residents. 24 of our staff have completed Dementia Training accredited to the University of Stirling and a further 8 are currently being trained. In addition all staff are encouraged and supported to undertake further studies which will enhance their practice.

Proposed Timescale: Auditing training February 2017

**Proposed Timescale:** 28/02/2017

**Theme:**

Governance, Leadership and Management

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

The Annual review of quality and safety of care did not include a formal consultation process with residents or their families.

**14. Action Required:**

Under Regulation 23(e) you are required to: Prepare the review referred to in regulation 23(1)(d) in consultation with residents and their families.

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

The 2016 Annual review will be presented at the next Residents Forum in Oct and residents will be consulted on the review going forward. Families will be given the opportunity to consult at the resident's review meeting going forward.

**Proposed Timescale:** 31/03/2017

**Theme:**

Governance, Leadership and Management

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

The contract of care included details of additional fees that were stated to be imposed for services including social activities, The Marlay Doctor Service and a laboratory transport service. The contract did not include an opt out or choice provision not to pay if the resident chose not to avail of these services.

**15. Action Required:**

Under Regulation 24(2)(d) you are required to: Ensure the agreement referred to in regulation 24 (1) includes details of any other service which the resident may choose to avail of but which is not included in the Nursing Homes Support Scheme or which the resident is not entitled to under any other health entitlement.

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

A satisfactory response was not submitted by the provider in relation to this action plan. The Authority has taken the decision not to publish this action plan and is considering further regulatory action in relation to this issue.

**Proposed Timescale:**