

# eDeposit Ireland

## Our Lady's Manor Nursing Home, Dublin Road, Edgeworthstown, Longford.

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Authors	Connolly Gargan, Catherine Rose
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**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Our Lady's Manor Nursing Home
<b>Centre ID:</b>	ORG-0000081
<b>Centre address:</b>	Dublin Road, Edgeworthstown, Longford.
<b>Telephone number:</b>	043 667 1007
<b>Email address:</b>	phil@newbrooknursing.ie
<b>Type of centre:</b>	A Nursing Home as per Health (Nursing Homes) Act 1990
<b>Registered provider:</b>	Lady Edgeworth Nursing Home Limited
<b>Provider Nominee:</b>	Philip Darcy
<b>Person in charge:</b>	Paula Gavagan
<b>Lead inspector:</b>	Catherine Rose Connolly Gargan
<b>Support inspector(s):</b>	None
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	55
<b>Number of vacancies on the date of inspection:</b>	6

## **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 judgements 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 Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.**

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

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

From: 12 March 2014 11:30 To: 12 March 2014 19:00

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

Outcome 01: Statement of Purpose
Outcome 03: Suitable Person in Charge
Outcome 04: Records and documentation to be kept at a designated centre
Outcome 06: Safeguarding and Safety
Outcome 07: Health and Safety and Risk Management
Outcome 08: Medication Management
Outcome 11: Health and Social Care Needs
Outcome 12: Safe and Suitable Premises
Outcome 14: End of Life Care
Outcome 17: Residents clothing and personal property and possessions
Outcome 18: Suitable Staffing

**Summary of findings from this inspection**

This was the ninth inspection of the centre by the Authority, was unannounced and took place over one day. The inspector reviewed progress with completion of the action plan from the last inspection of the centre on 30 July 2013 in addition to review of information received by the Authority in respect of the governance arrangements in the centre. The details of the information received were discussed with the provider and the person in charge on the day of inspection who confirmed that the governance procedures were as stated in the centre's Statement of Purpose. The inspector found no evidence to support the content of the information received on this inspection. The inspector also met with the newly appointed person in charge as part of the Authority's assessment of fitness. The newly appointed person in charge is Paula Gavagan. The inspector found that she was knowledgeable and met all the requirements of the legislation for the person in charge role. Areas reviewed on this inspection included delivery of care, medication management and administration, staffing, end of life care, provision of activities, risk management and fire safety in addition to documentation in support of same. During the inspection the inspector met with residents and staff members.

The inspectors found that eight actions were complete and three were partially

completed to varying degrees from the inspection in July 2013. Actions partially completed have been restated in the action plan at the end of this report in addition to new areas requiring improvement identified on this inspection. Actions partially completed included aspects of care documentation and maintenance of the external ground surfaces. New areas requiring improvement on this inspection and included in the action plan at the end of this report were medication management procedures and practices in relation to prescription of medications in 'crushed' format and advisory documentation. Completion of window replacement work was required. Supervision of residents in the centre while others were engaged in outings required review. Staff mandatory training was not complete including fire safety, moving and handling and elder abuse recognition and prevention training. There was more detail required in care records that outlined dementia care needs to ensure staff could provide care in an informed way and the daily progress records did not always describe the range of care provided. Behavioural support planning for some residents with challenging behaviour also required improvement.

The Action Plan at the end of this report identifies improvements that must be made to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009(as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.

**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 2009 (as amended) 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:**  
 Leadership, Governance and Management

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

**Findings:**  
 There was a written statement of purpose for Our Lady’s Manor Nursing Home which consisted of a statement of the aims, objectives and ethos of the centre, detailed the facilities and services provided for residents and contained information in relation to the matters listed in schedule 1 of the Regulations. A copy of the statement of purpose was forwarded to the Authority. It was updated on the 24 February 2014 to include the details of a newly appointed person in charge, Ms Paula Gavagan. The provider was aware of the need to keep the document under review and notify the Chief Inspector in writing before changes could be made which would affect the purpose and function of the centre.

**Judgement:**

Compliant

**Outcome 03: Suitable Person in Charge**

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

**Theme:**

Leadership, Governance and Management

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

No actions were required from the previous inspection.

**Findings:**

The person in charge of the centre is Paula Gavagan. She was appointed in this role on 20 January 2014. She is a registered general nurse with Bord Altranais agus Cnáimhseachais na hÉireann. She has completed a postgraduate gerontology course and has three years experience in her previous role as person in charge of a designated centre for older people. .

The required notification of change of person in charge and required associated documentation was received by the Authority as appropriate. The person in charge was engaged in the governance, operational management and administration of the centre on a consistent and full-time basis. There was adequate evidence of positive developments made since she commenced in her role in January 2014 to support clinical practice including care plan documentation review with an aim of promoting enhanced person-centred care. The provider was supportive of the person in charge and collectively, they demonstrated awareness of their responsibilities in respect of the implementation of the regulations and standards. The person in charge was knowledgeable about each individual resident's needs and their individual choices. During this inspection the person in charge demonstrated that she had good knowledge of the Regulations, the Authority's Standards and her responsibilities as person in charge of the centre.

The person in charge is supported in her role by a clinical nurse manager and a team of nursing staff, care assistants, catering administrative and ancillary staff. The group clinical practice co-ordinator also attends the centre one day per week or more often to support development and implementation of new initiatives. The administrative systems were well established and documentation was accessible, information easy to retrieve and managed with appropriate attention to security. The inspector was satisfied from the findings of the inspection that the arrangements in place enabled the person in charge to undertake her role and responsibilities effectively.

**Judgement:**

Compliant

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**Outcome 04: Records and documentation to be kept at a designated centre**

*The records listed in Part 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) 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 2009 (as amended).*

**Theme:**

Leadership, Governance and Management

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

No actions were required from the previous inspection.

**Findings:**

Daily progress notes were completed by nurses and in most cases were detailed and described the range of care provided as informed by the individual care plans. However, the standard of this documentation varied and some did not reflect care plans in place or fully describe what care had been provided during the day and night. Therefore, positive outcomes for residents sought by means of care interventions prescribed in the care plans were not fully appraised.

**Judgement:**

Non Compliant - Moderate

**Outcome 06: 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.*

**Theme:**

Safe Care and Support

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

No actions were required from the previous inspection.

**Findings:**

The inspector found that measures were in place to protect residents from being harmed or suffering abuse. Residents had access to a lockable facility in their bedroom for safekeeping of personal belongings if they wished.

The centre had a policy and procedure in place for the management of abuse situations. Staff were familiar with how to report concerns and staff training records confirmed that training was provided for staff and refresher training had commenced for 2014. .

Residents told the inspector that they felt safe in the centre and that staff responded to meeting their needs for assistance promptly and were patient and gentle with them. The inspector observed staff-resident interactions and found these to be supportive and responsive to the residents' needs. Call bells were answered promptly.

The centre has an electronic controlled access procedure on all external doors to protect residents and staff. Residents were safeguarded by the security arrangements as access by visitors to the centre was controlled through one entry point which was monitored by a receptionist, located in the reception lobby Monday to Friday until 17:00hrs each day. On her departure, the front door to the centre was secured and was monitored by CCTV by means of a display monitor located in the nurses station. This ensured staff could have sight of persons seeking entry before granting same. Members of the local community attended services in the centre church including funeral services for residents and non-residents. While residents could attend the church at will, access by members of the public to the centre was also controlled at this point to ensure residents' right to privacy was not breached. There was a visitors' book at the entrance to the centre to record all persons entering and exiting the centre. While completion of this book was monitored during office hours by the centre's receptionist from Monday to Friday, its completion was not monitored at other times.

Review of staff training records confirmed that 19 staff had not attended elder abuse recognition refresher training in the past two years. This finding does not ensure that all residents in the centre are adequately protected. However, refresher training was scheduled for March 25, April 01, 05, 07, 23, and 28 2014.

**Judgement:**

Non Compliant - Moderate

***Outcome 07: 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:**

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

**Findings:**

The centre had a risk management and health and safety statement in place that had been reviewed within the last twelve months. A staff Health and Safety representative was nominated by staff. Two days training were provided for the centre's health and safety representative. Risk management was a standing item on the agenda of the monthly governance meetings in the centre.

There were four residents identified in the risk register as being at increased risk in this area and monitoring procedures were in place as a control in mitigating this potential

risk. A missing person drill had been undertaken. Residents had an assessment in place that identified their potential risk of leaving the centre unaccompanied. Each resident had a profile document completed which included their photograph and key information to assist the emergency services with their timely recovery if necessary. Vulnerable residents identified as being at risk of leaving the centre unaccompanied were enabled to go outside accompanied by staff.

Risk assessments were completed for residents who smoked, use of restraint, the use of hazardous substances, the management of clinical waste and infection control. These assessments were current and reviewed regularly. As the centre comprised of three floor lift access was in place in addition to a staircase between each floor. Staircases were risk assessed and the top and last steps of each staircase were coloured red to alert users to impending change in level. In addition the top of each staircase had a stair-gate fitted. Use of the centre's transport was also risk assessed. Controls were identified including the presence of the Activity Co-ordinator to supervise. To improve safety, the pick-up point for the centre's bus was changed to outside the dining room as there was no through traffic there and the surface was recently upgraded. The inspector observed the residents entering the bus which was parked outside the dining room to facilitate this activity.

The surface of the drive into the centre was uneven and posed a risk of trip or fall to residents and visitors who chose to walk on it. A deep hole was noted in the drive surface between the front door of the centre and the walled garden. This was identified in the risk register since 25 April 2013 but remained unresolved. The provider advised that re-surfacing of this drive in and around the reception area of the centre was scheduled to be done imminently. The re-surfacing work would address the deep hole in the surface close to the front door and also include traffic calming measures. Although in place, speed restriction signage required improvement to ensure unobstructed visibility to drivers entering the site.

The fire safety arrangements were reviewed and satisfactory arrangements were in place. The inspector found that staff were aware of the procedures to follow in the event of the fire alarm sounding. Nearest exits were clearly stated and fire action signs were displayed at regular intervals throughout the building to guide staff and residents who were able in an emergency. Fire training had been revised to include a realistic evacuation exercise. A list of residents, their dependencies and requirements should the centre need to be evacuated was available. Fire drills were carried out at frequent intervals and simulated at varied times of the day and night. There were comments on the response to fire drills, staff who attended and times of drills. Review of the staff training records referenced that ten staff were overdue for annual refresher fire training since February 2014. However, fire training was scheduled for March 12 and April 04 2014. Fire alert and fire fighting equipment was serviced regularly. A checking schedule of fire preventative and safety procedures was routinely completed.

The inspector noted that there were a small number of incidents where some residents sustained injuries during assisted transfer procedures over the past year. A root-cause analysis process was introduced which also reviewed learning required from a staff training needs perspective. Issues highlighted as a result were being addressed through an quality improvement action plan process A review of the centre's training record

confirmed that four members of staff did not have evidence of having completed two yearly moving and handling refresher training, one of which was the centre's physiotherapist. Additional moving and handling training was scheduled for March 31, April 08 and April 11 2014.

**Judgement:**

Non Compliant - Moderate

**Outcome 08: Medication Management**

*Each resident is protected by the designated centres policies and procedures for medication management.*

**Theme:**

Safe Care and Support

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

No actions were required from the previous inspection.

**Findings:**

The centre's staff training records referenced that ten out of the twelve nursing staff had attended refresher medication management training in 2013. The inspector carried out a review of medication prescription and administration records belonging to residents in the centre. Discontinued medications were signed and dated by the residents' GP and maximum doses of 'as required' (PRN) medications were stated. Residents who were allergic to individual medications had the medication concerned clearly stated and highlighted on a yellow background on their medication prescription sheets.

Some residents with swallowing deficits were administered their medications in crushed format. However, prescription of individual medications to be administered in crushed format was not made. There was no reference guide available to advise staff of medications where crushing was contraindicated or medications that could not be administered together as crushed preparations.

The inspector observed two faxed prescriptions dated 06 March 2014 that were not prescribed on the medication prescriptions sheets as advised by the centre's medication policy - within 72 hours. Medications were been administered from a hospital prescription dated 26 February 2014 for another resident. The staff nurse administering medications advised the inspector that she was expecting the residents' GP into the centre in the evening of the inspection to complete these prescriptions.

The times of medication administration did not match the prescription sheets as the 24hour clock was used on one and not on the other.

**Judgement:**

Non Compliant - Moderate

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**Outcome 11: Health and Social Care Needs**

*Each residents wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each residents 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:**

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

**Findings:**

There were 55 residents accommodated over three floors on the day of inspection, one of which was in hospital. Their assessed dependency levels were 18 residents with maximum care needs, 12 with high dependency needs, 11 with medium dependency needs and 14 with low dependency needs. The centre had two residents in receipt of respite care. Residents in receipt of long term care had a variety of age related conditions, some of which were complex.

The person in charge confirmed to the inspector that none of the residents had pressure related skin breakdown. All residents were assessed and those identified as being 'at risk' had a variety of pressure relieving equipment including mattresses and cushions incorporated into their care to mitigate potential risk.

Some residents had dementia care and mental health support needs. Comprehensive assessment of needs included mental well-being. Each resident had a mood and behaviour pattern, cognitive and emotional status, mental health and anxiety/depression assessments. While these assessments informed deficits requiring care, improvement was required to ensure residents exhibiting challenging behaviours had behavioural supports in place such as identification of triggers and strategies that worked identified to inform interventions to take to modify or avoid these episodes. Seven residents were identified in the risk register as exhibiting behaviours that challenged. The community mental health services provided specialist support for residents who had needs in this area. The inspector found that while the level of some residents' confusion was outlined there was inadequate information detailing how this impacted on their quality of daily life. Information such as who the resident still recognised, what functions or activities could still be undertaken independently or where assistance was needed which would guide staff practice was not clearly documented in each case. However, while not always documented, the inspector observed staff guiding, reminding and orientating residents with memory deficits to ensure they were involved in the daily life of the centre and were afforded opportunities to participate where able. This area was the

subject of an action plan developed from findings during the inspection carried out on the 30 July 2013 and is repeated in the action plan at the end of this report.

The inspector found that residents had good access to allied health professionals. A physiotherapist was employed by the group and provided consistent rehabilitative care and assessment post falls. Many residents spoken with spoke positively about the physiotherapy service provided. In addition residents had various items of specialist assistive equipment supplied, which they were assessed for to promote their independence and safety. An occupational therapist assessed residents needs as required, some residents had assistive chairs. The inspector was informed that when a resident required an assistive chair they were afforded opportunity to trial a variety of suitable chairs and make a choice on the one they preferred. Residents dietary risk of malnutrition assessment was reviewed weekly using an accredited tool. The provider employed the services of a dietician on a contract basis to ensure improved and timely accessibility for all residents but especially those at increased risk of dietary imbalance. Staff maintained food diaries for residents with weight loss while the referral process was underway. In addition, staff had received instruction on food fortification, food and fluid consistency modification to meet the needs of residents with evidence of weight loss and swallowing difficulties. There was evidence of assessment by speech and language therapy services and recommendations were translated in practice. Residents had access to GP services and there was evidence of regular review and as required.

Each resident had a care plan informed by comprehensive assessment procedures. Each care plan was in a folder which also contained relevant information including contract of care, record of personal possessions and records of documented consent by residents or their families to various procedures including photography. While plans of care were very personalised, they tended to be very detailed and as such could present difficulties for the reader in eliciting what care actions should be completed to meet each resident's needs. While there was evidence of regular care plan reviews, details of the areas of the care plan revised were not clear. Daily progress notes were completed by nurses and in most cases were detailed and described the range of care provided as informed by the individual care plans. However, the standard of this documentation varied and some did not reflect care plans in place or fully describe what care had been provided during the day and night. Therefore, positive outcomes for residents sought by means of care interventions prescribed in the care plans were not fully appraised. This finding was the subject of an action plan developed from findings during inspection on 30 July 2013 and is repeated in the action plan at the end of this report.

There was a comfortable and happy atmosphere in the centre, on the day of inspection, many residents chose to watch horse racing from Cheltenham in one of the communal sitting rooms on the ground floor while others chatted together in another sitting room. Some residents went on an outing on the centre's mini-bus accompanied by an activity co-ordinator. While a member of staff remained to supervise residents in the sitting rooms, the inspector saw that this presented challenges with ensuring each area was adequately supervised. Each resident's interests was assessed and their level of participation in the activities on offer was recorded. Key to me documentation was completed for residents and formed the foundation of a recreational/activity daily plan for them. The inspector noted that residents who had capacity were very involved in this process and their wishes and goals for themselves were ascertained and respected.

Residents told the inspector that they enjoyed the activities arranged for them and that they could choose whether they wanted to participate or not. The inspector observed that residents' individual documented activity programme plan could be improved by identification of the actual activity that the resident planned to attend as opposed to entering 'activities of the day'. This would assure the person in charge that the individual resident's activity programme referenced an activity that satisfied the interest and capability of each resident. Residents with dementia care needs were encouraged to participate in a sensory based accredited programme provided.

**Judgement:**

Non Compliant - Moderate

**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. There is appropriate equipment for use by residents or staff which is maintained in good working order.*

**Theme:**

Effective Care and Support

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

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

**Findings:**

Our Lady's Manor Nursing Home has been extended and modified over the years to improve the facilities available for residents. In 2010 and 2011 a major refurbishment programme was undertaken and this work is now fully complete. The centre interior provides a spacious and comfortable environment for residents. Residents are accommodated over three floors. The reception and main communal space is located on the ground floor. The basement and upper floors can be accessed by stairs or by means of a spacious passenger lift. The provider and person in charge told the inspector of their plans to redesigned a large twin room on the first floor to a sitting room to improve the communal facilities for residents accommodated there who may not wish to access the communal area on the ground floor. An area off the reception that was part of the original internal building was been refurbished to provide additional communal space for residents including an area where they could avail of quiet time or meet their visitors in private. This work was managed so as not to impact on the residents' safety or quality of life.

A walled vegetable and flower garden was available to residents who wished to go there. Paths were in place throughout. There was also a recently cultivated garden which was enclosed for use by vulnerable residents. Seating was available at intervals around this garden.

The floor space in the residents' bedrooms varied however, each met size requirements

outlined in the Authority's Standards and where provided en suite facilities were spacious and contained a toilet, shower and wash-hand basin. A married couple shared a large bedroom which was also fitted with additional furniture, some of which belonged to the couple. Assistive aids such as handrails throughout the building and were in contrasting colours to assist residents with visual problems. The layout of two twin bedrooms had been reviewed and was used to accommodate one resident in each however, the unused beds remained in the rooms which prevented the additional space being realised or enjoyed.

A window replacement project was under way as some existing window frames were draughty. The inspector noted that many of the new windows were in place but some were not completed as surrounding masonry was still visible and some window boards were not re-fitted. Unused electric heaters were fitted in some bedrooms in the older part of the building. The person in charge told the inspector they were already identified for removal.

The décor in the centre was noted to be of a good standard. Surface re-painting was completed in most areas and the centre was visibly clean throughout, hand hygiene facilities were provided and used appropriately by staff. This was the subject of an action plan developed from findings during inspection in July 2013. Bedroom doors, walls and corridors were painted in contrasting colours to assist residents who experienced difficulties finding their accommodation. This action afforded residents greater autonomy and increased independence. The centre was very clean and well organised throughout. Most residents rooms were personalised with photographs and ornaments and in some cases items of the residents' own furniture.

The surfaces of the external drive into the centre and the ground surface around the reception required attention as there were multiple uneven areas and a large hole in the surfaces which posed a risk of fall to residents and others. This area had also been the subject an action plan developed from findings during inspection on 30 July 2013. The provider told the inspector on this inspection that resurfacing of this area was scheduled to commence imminently. This finding is discussed further in Outcome 7.

**Judgement:**

Non Compliant - Moderate

***Outcome 14: End of Life Care***

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

**Theme:**

Person-centred care and support

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

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

**Findings:**

The inspector reviewed the end of life policy which was reviewed and approved by the new person in charge on the 17 February 2014. The policy also informs on last offices, property of the deceased and post mortem procedures. There were no residents in receipt of end of life care on the day of this inspection. The most recent resident death in the centre was discussed and the information related was satisfactory. The centre provides accommodation and refreshments for relatives of residents at the end stage of their lives to facilitate residents to have their families with them at this time.

Deceased residents are removed to the centre's church and are facilitated to have their funeral there if they wish. Sandwiches and refreshments are provided for mourners who travel long distances and prior to travelling long distances to meet the internment wishes of some residents. As part of the improvements since the inspection in July 2013, a newly formatted care plan template has been developed to ascertain and record residents' wishes for their end of life care. The inspector observed that this was in progress and residents end of life wishes were being recorded. This area was the subject of an action plan developed from findings during inspection in July 2013. The centre have also adopted the Hospital Friendly Hospice symbol displayed to inform of the death or impending death of a resident. End of life training for staff was scheduled for May 29, June 10 and July 10 2014.

Palliative care services were available to residents in the centre and members of the team attended residents as required including those who had chronic pain. The person in charge confirmed that this service was of a good standard and resident referrals were met with prompt review by the team.

**Judgement:**

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:**

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

**Findings:**

The inspector found that residents had adequate space to store their clothes and personal belongings. A record of each resident's property was completed and the inspector noted that this was updated every six months. The centre does not have a laundry on-site and clothing is sent for laundering to one of the other centres owned by the company. Residents spoken with told the inspector that their clothing was managed to their satisfaction. Items of residents clothing viewed by the inspector had the residents identification on them. Loss of items residents' clothing was the subject of an

action plan developed from findings during inspection in July 2013 and while these complaints were resolved to the satisfaction of the residents concerned, this area requires close monitoring to prevent reoccurrence.

**Judgement:**

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.*

**Theme:**

Workforce

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

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

**Findings:**

The inspector found evidence to support conclusion that generally numbers and skill mix of staff were appropriate to the assessed needs of residents and the size and layout of the centre. However, review of the supervision arrangements for the communal areas when the activity co-ordinator goes on outings with residents required review. While the majority of residents were satisfied with watching the horse racing from Cheltenham, the staff member was supervising two communal areas and should more than one resident require assistance, this would have posed significant challenges for the staff member concerned.

The majority of care staff had Further Education and Training Awards (FETAC) Level 5 training due mainly to care staff being recruited were required to have this qualification and staff employed for some time were facilitated to attend this training. The person in charge ensured that staff had adequate training appropriate to their roles. A proposed training schedule was in place to facilitate staff to refresh and improve their theoretical knowledge and skills including infection control, continence care, nutrition, falls management, wound care, palliative and end of life care. Some staff had not attended mandatory training including moving and handling, elder abuse and fire safety however, there was training scheduled for each in the short term. The inspector was told that training was ongoing and that there was a commitment from the company to ensure that staff had opportunities to develop and extend their skills. The company has a practice co-ordinator who was on-site for part of the inspection and feedback. She provides training and support to staff and the person in charge. The staff team were observed to be committed to providing a good service to the residents in their care. They were also observed to be responsive and effective in meeting residents' needs. Residents spoken with spoke highly of the staff in the centre and felt they cared about

them.

The inspector reviewed the staff rota which reflected the staff on duty over the 24 hour period. The day-time allocation included two nurses in addition to the person in charge and the clinical nurse manager. The person in charge and clinical nurse manager also worked on the weekends to ensure widespread senior clinical support for staff in the centre. Staff were deployed over each floor in accordance with the needs of residents. At night there were two nurses and three carers on duty with a nurse and a carer allocated to each floor. The care team was supported by an administrator, catering staff, cleaning and two activity staff. Residents told the inspector that they felt that there was sufficient staff available to provide care for them and said that call bells were answered promptly when they required help.

**Judgement:**

Non Compliant - Moderate

## **Closing the Visit**

At the close of the inspection a feedback meeting was held to report on the inspection findings, which highlighted both good practice and where improvements were required.

### **Acknowledgements**

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

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

Catherine Rose Connolly Gargan  
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>	Our Lady's Manor Nursing Home
<b>Centre ID:</b>	ORG-0000081
<b>Date of inspection:</b>	12/03/2014
<b>Date of response:</b>	27/06/2014

### Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure Compliance with Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.

#### Outcome 04: Records and documentation to be kept at a designated centre

**Theme:**

Leadership, Governance and Management

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

However, the standard of daily nursing progress notes varied and some did not reflect care plans in place or fully describe what care had been provided during the day and night. Therefore, positive outcomes for residents sought by means of care interventions prescribed in the care plans were not fully appraised.

**Action Required:**

Under Regulation 25 (1) (b) you are required to: Complete, and maintain in a safe and accessible place, an adequate nursing record of each residents health and condition and treatment given, on a daily basis, signed and dated by the nurse on duty in accordance with any relevant professional guidelines.

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

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

The PIC will review and improve the current documentation and care plans. Nurses have attended care plan training since inspection on 11/06/2014. The PIC will introduce a new Holistic Care Plan. The PIC will support and educate nurses in this area.

A computerised system is planned for Our Lady's Manor Nursing Home next year.

**Proposed Timescale:** 30/09/2014

### **Outcome 06: Safeguarding and Safety**

**Theme:**

Safe Care and Support

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

While completion of the visitors' book was monitored during office hours by the centre's receptionist from Monday to Friday, its completion was not monitored at other times.

**Action Required:**

Under Regulation 6 (1) (a) you are required to: Put in place all reasonable measures to protect each resident from all forms of abuse.

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

The Nurse in Charge will monitor and take responsibility of the visitors' book after receptionist core hours and at weekends.

The front door will be secured daily at 17:00 as is the current practice. Visitors will ring the bell to gain entry each evening after 17:00 and throughout the weekend. The nurse in charge will ensure the visitors' book is completed and the PIC will check same.

The CCTV camera is in operation and will be monitored by the nurse in charge.

**Proposed Timescale:** 27/06/2014

**Theme:**

Safe Care and Support

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

Review of staff training records confirmed that 19 staff had not attended elder abuse recognition refresher training in the past two years.

**Action Required:**

Under Regulation 6 (2) (a) you are required to: Make all necessary arrangements, by training staff or by other measures, aimed at preventing residents being harmed or suffering abuse or being placed at risk of harm or abuse.

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

The PIC has a training plan in place and elder abuse training and policy education is

mandatory. All staff who have attended training are evident on the Centre's training matrix. Any new staff will attend Elder abuse training as part of Induction.

Elder abuse training completed on the 21/03/2014, 24/03/2014, 25/03/2014, 31/03/2014, 05/04/2014, 07/04/2014, 11/04/2014 and 06/05/2014 by PIC.

**Proposed Timescale:** 31/08/2014

### **Outcome 07: 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:**

The surface of the drive into the centre was uneven and posed a risk of trip or fall to residents and visitors who chose to walk on it. Although in place, speed restriction signage required improvement to ensure unobstructed visibility to drivers entering the site. A deep hole was noted in the drive surface between the front door of the centre and the walled garden.

**Action Required:**

Under Regulation 31 (4) (a) you are required to: Take all reasonable measures to prevent accidents to any person in the designated centre and in the grounds of the designated centre.

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

All external work is currently in progress (resurfacing, kerbing etc) and will be completed by 30/09/2014.

A new speed restriction sign will be installed so as to promote resident safety and reduce any risks.

**Proposed Timescale:** 30/09/2014

**Theme:**

Safe Care and Support

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

Review of the centre's training record confirmed that four members of staff did not have evidence of having completed two yearly moving and handling refresher training, one of which was the centre's physiotherapist.

**Action Required:**

Under Regulation 31 (4) (f) you are required to: Provide training for staff in the moving and handling of residents.

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

Moving and Handling training took place on the 31/03/2014, 08/04/2014, 11/04/2014 and 09/06/2014. Two staff are due to receive training and this will be completed by the 15/07/2014.

The Centre's Physio had completed training on the 22/11/2013. His certificate is now available at the Centre.

The Physiotherapist has commenced "Falls Training" sessions for staff to attend at the Centre on the 14/04/2014 and 23/06/2014 and further training planned.

All new staff in the future will attend training on induction prior to working at the Centre.

**Proposed Timescale:** 31/08/2014

**Theme:**

Safe Care and Support

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

Review of the staff training records referenced that ten staff were overdue for annual refresher fire prevention training since February 2014.

**Action Required:**

Under Regulation 32 (1) (d) you are required to: Provide suitable training for staff in fire prevention.

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

The PIC has organised fire training dates in order to comply with this action. Training has been carried out on the following dates 12/03/2014, 04/04/2014, 10/04/2014 and 06/06/2014. Further training is scheduled for the 03/07/2014. All staff will have completed fire training by the 03/07/2014.

**Proposed Timescale:** 03/07/2014

**Outcome 08: Medication Management**

**Theme:**

Safe Care and Support

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

Prescription of individual medications to be administered in crushed format was not made. There was no reference guide available to advise staff of medications where crushing was contraindicated or medications that could not be administered together as crushed preparations.

The contents of two faxed prescriptions dated 06 March 2014 were not prescribed on the medication prescription sheets as advised by the centre's medication policy - within

72 hours. Medications were been administered from a hospital prescription dated 26 February 2014 for another resident.

The times of medication administration did not match the prescription sheets as the 24hour clock was used on one and not on the other.

**Action Required:**

Under Regulation 33 (1) you are required to: Put in place appropriate and suitable practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents and ensure that staff are familiar with such policies and procedures.

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

The PIC will review and improve all current practices and policies in relation to Medication Management and in particular Medication that is given in a crushed format. The PIC will work closely with the pharmacist (education and training) and GP to improve this practice.

The PIC and the CNM has reviewed the practice of faxed prescriptions. All prescription sheets will be signed by the residents' GP within seventy two hours of receipt of fax. Completed on the 01/07/2014.

The drug administration charts have been reviewed and updated to reflect the same administration times. Completed on the 01/07/2014.

**Proposed Timescale:** 31/08/2014

**Outcome 11: Health and Social Care Needs**

**Theme:**

Effective Care and Support

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

While assessments of residents with behavioural management issues informed deficits requiring care, improvement was required to ensure residents exhibiting challenging behaviours had behavioural supports in place such as identification of triggers and strategies that worked identified to inform interventions to take to modify or avoid these episodes.

The inspector found that while the level of some residents' confusion was outlined there was inadequate information detailing how this impacted on their quality of daily life. Information such as who the resident still recognised, what functions or activities could still be undertaken independently or where assistance was needed which would guide staff practice was not clearly documented in each case.

**Action Required:**

Under Regulation 8 (1) you are required to: Set out each resident's needs in an individual care plan developed and agreed with the resident.

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

The PIC and CNM will review all documentation in relation to residents with challenging behaviour and improve the current level of information to ensure clarity and enhance good practices of care in this area.

The PIC will review all residents in the Centre with dementia and will implement an appropriate dementia mapping tool after that review.

**Proposed Timescale:** 30/09/2014

**Theme:**

Effective Care and Support

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

While plans of care were very personalised, some tended to be very detailed and as such could present difficulties for the reader in eliciting what care actions should be completed to meet each resident's needs.

**Action Required:**

Under Regulation 8 (1) you are required to: Set out each resident's needs in an individual care plan developed and agreed with the resident.

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

The PIC will review the current care plan practice, documentation and system in place and where necessary introduce a new holistic approach. The PIC will ensure the documentation is more user friendly in order to ensure clarity for all reading care plans and meet all residents' needs.

**Proposed Timescale:** 30/09/2014

**Theme:**

Effective Care and Support

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

While there was evidence of regular care plan reviews, details of the areas of the care plan revised were not clear.

**Action Required:**

Under Regulation 8 (2) (b) you are required to: Keep each residents care plan under formal review as required by the residents changing needs or circumstances and no less frequent than at 3-monthly intervals.

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

The PIC will examine this current system to ensure that care plans are reviewed and evidence of any revision to the Care Plan is documented.

**Proposed Timescale:** 30/09/2014

**Outcome 12: Safe and Suitable Premises**

**Theme:**

Effective Care and Support

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

Many of the new windows were in place but some were not completed as surrounding masonry was still visible and some window boards were not re-fitted. Unused electric heaters were fitted in some bedrooms in the older part of the building.

**Action Required:**

Under Regulation 19 (3) (b) you are required to: Ensure the premises are of sound construction and kept in a good state of repair externally and internally.

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

Window replacement programme has commenced and painting/decorating of rooms to compliment same.

Electric heaters are being removed as part of this refurbishment.

**Proposed Timescale:** 30/09/2014

**Theme:**

Effective Care and Support

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

The surfaces of the external drive into the centre and the ground surface around the reception required attention as there were multiple uneven areas and a large hole in the surfaces which posed a risk of fall to residents and others.

**Action Required:**

Under Regulation 19 (3) (o) you are required to: Provide and maintain external grounds which are suitable for, and safe for use by residents.

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

Extensive outdoor refurbishment is in progress which will address all of the issues highlighted by the Inspector.

**Proposed Timescale:** 30/09/2014

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**Outcome 18: Suitable Staffing****Theme:**

Workforce

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

One staff member was supervising two communal areas in the absence of the activity co-ordinator and should more than one resident require assistance, this would have posed significant challenges for the staff member concerned.

**Action Required:**

Under Regulation 16 (1) you are required to: Ensure that the numbers and skill mix of staff are appropriate to the assessed needs of residents, and the size and layout of the designated centre.

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

The PIC will review and audit the current activities in progress at the Centre.

The PIC will ensure that suitable staff levels are in place to maintain the health, safety and welfare of all residents. The PIC will also review the allocation of staff in the Centre and monitor the delivery of the activities programme. The CNM is supervising the delivery of the activities programme.

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**Proposed Timescale:** 30/08/2014**Theme:**

Workforce

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

Some staff had not attended mandatory training including moving and handling, elder abuse and fire prevention training.

**Action Required:**

Under Regulation 17 (1) you are required to: Provide staff members with access to education and training to enable them to provide care in accordance with contemporary evidence based practice.

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

The PIC will ensure that all existing staff are up to date with training and all future staff will attend same on induction.

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**Proposed Timescale:** 31/08/2014