

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Stella Maris Nursing Home
Centre ID:	OSV-0000105
Centre address:	Baylough, Athlone, Westmeath.
Telephone number:	090 649 2162
Email address:	stellamaris1@eircom.net
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Clare McNally
Provider Nominee:	Clare McNally
Lead inspector:	Catherine Rose Connolly Gargan
Support inspector(s):	Mary O'Donnell. Una Fitzgerald
Type of inspection	Unannounced Dementia Care Thematic Inspections
Number of residents on the date of inspection:	24
Number of vacancies on the date of inspection:	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.

Please note the definition of the following term used in reports:
responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National 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 1 day(s).

The inspection took place over the following dates and times

From: 08 March 2017 08:50 To: 08 March 2017 16:00

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

Outcome	Provider's self assessment	Our Judgment
Outcome 01: Health and Social Care Needs	Substantially Compliant	Non Compliant - Moderate
Outcome 02: Safeguarding and Safety	Substantially Compliant	Compliant
Outcome 03: Residents' Rights, Dignity and Consultation	Substantially Compliant	Compliant
Outcome 04: Complaints procedures	Substantially Compliant	Compliant
Outcome 05: Suitable Staffing	Substantially Compliant	Compliant
Outcome 06: Safe and Suitable Premises	Substantially Compliant	Non Compliant - Moderate
Outcome 07: Health and Safety and Risk Management		Substantially Compliant
Outcome 08: Governance and Management		Compliant

Summary of findings from this inspection

This inspection was carried out to review the care and welfare of residents with dementia. The inspectors also monitored the action plans from the previous two inspections which were carried out in January and March 2016. The inspection in March 2016 focused specifically on the arrangements in place with respect to fire precautions. Twelve of the thirteen action plans arising from the two inspections had been completed and the action plan relating to consultation with residents when reviewing care plans is repeated in this report.

As part of the inspection, inspectors met with residents and staff members.

Inspectors observed practices and reviewed documentation such as care plans, medical records, fire safety records, accident logs, policies and procedures and staff files. The inspectors also reviewed the self assessment questionnaire which the provider completed in 2016 and found that the action plans to achieve compliance had been progressed or completed. The self assessment judgments and the inspection judgments are set out in the table above.

The inspectors were satisfied that residents with dementia receive a quality service. There was evidence of a substantial level of compliance, in a range of areas, with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Standards for Residential Care Settings for Older People in Ireland (2016).

Inspectors found that the health and safety of residents and staff was promoted and protected. Fire procedures were robust. Recruitment practices and staff files met the requirements of the regulations. All staff and volunteers were Garda vetted.

The centre was managed by a suitably qualified and experienced nurse who was accountable and responsible for providing a high standard of care to residents.

The health needs of residents were met to a high standard. Residents had access to general practitioner (GP) services, to a range of other health services and evidence-based nursing care was provided. Care, nursing and ancillary staff were well informed and were observed to have friendly relationships with residents. Staff who spoke with the inspectors could convey a comprehensive understanding of individual residents' wishes and preferences. Quality of life and well being was promoted by supporting residents to actively engage in the wider community and by encouraging residents to remain stimulated by actively engaging in social activity. There was a varied programme of activities overseen by a nominated person on a daily basis and all staff had a role in meeting the social and emotional needs of resident.

The allocation of staff at mealtimes required review to ensure that staff were present to supervise and assist residents while eating. Some improvement was required to ensure that intake output records were appropriately completed.

On the previous inspection the water in the taps was too hot and posed a risk to residents. On this inspection the water in the taps was cold and took a long time to heat up. The provider had plans to install a new plumbing system in April 2017. Following the inspection she confirmed that she had contacted the contractor to expedite plans and the installation work is due to begin on the 14 March 2017.

These matters are discussed further in the body of the report and the actions required are included in the action plan which identifies the areas where improvements are required to comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland 2016.

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

Outcome 01: Health and Social Care Needs

Theme:

Safe care and support

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

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

Findings:

The healthcare needs of residents with dementia were met to a good standard. Inspectors found that there were suitable arrangements in place to meet the health and nursing needs of residents with dementia. Comprehensive assessments were carried out and care plans were developed to inform care to be provided. While all residents' needs were informed by a care plan two residents whose files were examined were non insulin dependent diabetics and they did not have a care plan to guide staff in relation to the management of their diabetes. Assessments of need and development of care plans was done within 48 hours of each resident's admission and were reviewed accordingly thereafter.

The centre catered for residents with a range of healthcare needs including nine residents with a diagnosis of dementia and one resident with symptoms of dementia. Inspectors focused on the experience of residents with dementia living in the centre. They tracked the journey of a sample of residents and reviewed specific aspects of other residents' care such as safeguarding, nutrition, pressure area and end-of-life.

There were arrangements in place for communication regarding residents with dementia between the acute hospital and the centre. The person in charge told inspectors that most residents were admitted from hospital and she or her deputy visited prospective residents prior to their admission to the centre. Pre-admission documentation was retained as required. Prospective residents and their families were welcomed into the centre to view the facilities and discuss the services provided before making a decision to live in the centre. This gave residents and their families information about the centre and also ensured them that the service could adequately meet their needs.

Common Summary Assessments (CSARs) documentation which details pre-admission assessments undertaken by the multidisciplinary team for residents admitted under the 'Fair Deal' scheme were not routinely obtained for residents admitted from the hospital setting for long-term care. However, this information was reviewed as part of their pre-admission assessment completed by the person in charge or her deputy. The files of

residents' admitted from hospital held their hospital discharge documentation. The centre was not currently using communication passports to support residents with dementia to access services outside the centre but provided a detailed account of their individual preferences, dislikes and strategies to prevent or to support their physical and psychological symptoms of dementia (BPSD) if necessary.

There was evidence that residents received timely access to health care services including support to attend out-patient appointments. The person in charge confirmed that a number of local GPs were attending to the needs of residents in the centre, giving residents a choice of general practitioner. Residents' documentation reviewed by the inspector confirmed they had access to GP care including out-of-hours medical care. Residents from the locality were facilitated to retain the services of the GP they attended prior to their admission to the centre. Residents had good access to allied healthcare professionals. Physiotherapy and occupational therapy specialists attended the centre routinely every two weeks and more often if necessary. These services supported staff with risk of fall, post fall reviews, mobility and seating assessments. One resident told an inspector that she was provided with a tailor-made footstool to promote her comfort while she was seated. Dietetic, speech and language therapy, dental, ophthalmology and chiropody services were also available to residents as necessary. Members of the community psychiatry of older age team attended residents in the centre. This service supported GPs and staff with the care of residents experiencing BPSD. Positive health and wellbeing was promoted for residents, with regular exercise as part of their activation programme, physiotherapy reviews, regular occupational therapy, an annual influenza vaccination programme, regular vital sign monitoring and medication reviews by their GPs. Residents in the centre had access to palliative care services for support with management of their pain and for symptom management during end-of-life care as necessary. A suitable pain assessment tool was available for residents with dementia.

A care plan was developed for each resident within 48 hours of admission based on their assessed needs. Care plans contained the required information to guide staff with caring for each resident. Care plans were informed by comprehensive assessment and the application of validated tools to determine each resident's risk of malnutrition, falls, level of cognitive function and skin integrity among others. Care plans in place were informative and person-centred. However, there was opportunity for improvement to ensure that specific details were included in personal hygiene care plans and diabetic care plans to facilitate a consistent approach by staff. Parameter values were not consistently stated in some care plans regarding the amount of fluids residents should be supported to consume over 24 hours and the acceptable blood glucose parameters for residents with diabetes. Residents' care plans were updated routinely on a three to four monthly basis and thereafter to reflect their changing care needs. While inspectors were told that this process was completed in consultation with residents or family members where appropriate, residents' documentation did confirm that this was consistently done. This finding was also identified on the inspection completed in January 2016. Inspectors found that all staff spoken with were knowledgeable regarding residents' likes, dislikes and care needs. A communication policy document was available to inform residents' communication needs including residents with dementia. Equipment was provided to support residents with communication needs such as 'talking mats' and one resident wore a hearing aid.

Staff provided end-of-life care to residents with the support of their GP and community palliative care services as necessary. No residents were in receipt of end-of-life or palliative care services at the time of this inspection. Inspectors reviewed a sample of end-of-life care plans and found that they outlined residents' individual preferences regarding their physical, psychological and spiritual care. Residents' individual wishes regarding the place for receipt of their end-of-life care were also recorded. Residents receiving end-of-life care were accommodated in single bedrooms where possible, to enhance their end-of-life comfort and privacy. Relatives of residents were facilitated to stay overnight with residents receiving end-of-life care if they wished. Staff outlined how residents' religious and cultural practices were met. Members of the local clergy from the various religious faiths were available to provide pastoral and spiritual support to residents as necessary.

There were care procedures in place to prevent residents developing pressure related skin injuries. Each resident had their risk of developing pressure related skin injury assessed. Pressure relieving mattresses, cushions and repositioning schedules were in use to mitigate risk of skin breakdown. There was a very low incidence of pressure wounds developing in the centre and one resident had a pressure ulcer that developed in the centre on the day of this inspection. Tissue viability specialist services were available to support staff with management of any residents' wounds that were deteriorating or slow to heal. There were arrangements and policy documentation to meet the woundcare needs of residents in the centre as necessary including procedures in place to photograph wounds for the purpose of monitoring progress.

There were systems in place to ensure residents' nutritional needs were met and that they did not experience dehydration. Residents were screened for nutritional risk on admission and reviewed regularly thereafter. Residents' weights were checked routinely on a monthly basis and more frequently. There was room for improvement to ensure weights were consistently recorded on a more frequent basis for residents who experienced unintentional weight loss and the completion of food intake and output charts. One intake chart viewed had no entries after 16:30hrs and another which showed a total fluid intake of 280mls in 24 hour period, did not accurately reflect the residents fluid intake on the day in question. Inspectors saw that residents had a choice of hot meal. The chef confirmed that alternatives were also available to the menu available each day if residents did not like the dishes on offer. Staff reminded residents with dementia of the menu available at mealtimes so they were provided with the food they liked to eat. The chef was aware of and discussed individual residents' food preferences, dislikes and routines. There were arrangements in place for communication of residents' dietary needs between nursing and catering staff to support residents with special dietary requirements. Residents on specialised diets such as diabetic, fortified and modified consistency diets and thickened fluids received their correct diets and fluid consistencies. Residents received discreet assistance from staff with eating where necessary. Residents spoken with commented positively on the food provided to them. A variety of drinks were made available to residents at mealtimes and inspectors observed that some residents also enjoyed refreshments outside of scheduled mealtimes. Inspectors were told that staff were trained to administer subcutaneous fluids to residents to treat dehydration if necessary, to avoid unnecessary hospital admissions.

There were arrangements in place to record and review accidents and incidents

involving residents in the centre. Residents were assessed on admission and regularly thereafter to ensure their risk of falls was minimised. The physiotherapist and occupational therapist were involved in this process. There was a low incidence of resident falls resulting in serious injury. There was sufficient evidence of appropriate action taken to review fall incidences and leaning was implemented. Fall incidents were trended taking account of location, times of incidents and repeat falls. Equipment was used to protect residents at risk of falling from injury such as hip protectors, low-level beds, foam floor mats and sensor alarms.

Residents were protected by safe medicines management practices and procedures. There was a written operational policy informing ordering, prescribing, storing and administration of medicines to residents. Practices in relation to prescribing and medicine reviews met with the legislation and regulatory requirements. Nursing staff were observed administering medicines to residents and practices reflected professional guidelines. In the self-assessment information, the person in charge identified a plan to have a pharmacist that met residents' satisfaction, if unable to continue to receive their medicines from the pharmacy they attended pre-admission. Inspectors observed that this action was in progress and a notice was displayed to inform residents that the pharmacist was available to discuss their medicines with them if they wished. Systems were in place for recording and managing medication errors. Appropriate storage and checking procedures were in place for medicines controlled under misuse of drugs legislation and medicines requiring refrigerated storage.

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:

Measures were in place to protect residents from harm or suffering abuse and to respond to allegations, disclosures and suspicions of abuse. There were robust systems in place to safeguard residents' money. Restraint was rarely used and when employed it in line with national guidelines. Staff adopted a positive, person centred approach towards the management of behaviours that challenge.

Additional equipment such as low level beds and sensor alarms had been purchased to reduce the need for bedrails. Consequently bedrail usage was very low and alternatives were trailed before bed rails were used. Only two residents had bedrails in place for safety reasons and appropriate risk assessments had been carried out. Care plans were in place to monitor the use of bedrails.

The inspector found that appropriate measures were in place to protect residents from being harmed or abused. All staff had received training on identifying and responding to elder abuse in 2016. There was a policy in place which gave guidance to staff on the assessment, reporting and investigation of any allegation of abuse. The person in charge and staff who spoke with the inspectors demonstrated sufficient knowledge of the different forms of elder abuse and all were clear on reporting procedures. There were no allegations of abuse being currently investigated.

There were robust systems in place to safeguard residents' money. The person in charge was an agent for one resident and she lodged the resident's pension to a separate interest earning account. All transactions were documented and witnessed.

Because of their underlying condition some residents showed behavioural and psychological signs of dementia (BPSD). Two residents who were tracked had been appropriately assessed to determine any underlying cause and the behaviours were monitored using the ABC (antecedent, behaviour and consequences) chart. Person centred care plans were put in place and reviewed regularly. Staff spoken with by inspectors were familiar with appropriate interventions for individual residents. During the inspection staff approached residents in a sensitive and appropriate manner and the residents responded positively to the techniques used by staff. Residents were also referred for assessment by mental health of later life services. Some residents were prescribed antipsychotic or mood altering medications to treat an underlying condition. The inspector found that the use of PRN (a medicine only taken as the need arises) medications was carefully monitored and used as a last resort when other person centred interventions had failed. No residents were receiving PRN psychotropic medications at the time of this inspection.

Judgment:

Compliant

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

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

Findings:

The ethos of the service upheld the rights and dignity for each resident. The nursing assessment included an evaluation of each resident's functional capacity for each activity of daily living and their social needs. Staff optimised opportunities to engage with residents and provide positive connective interactions. The daily routine was organised to suit the residents. Rosary was an important aspect of daily life and activities available to residents, including those with advanced dementia reflected the capacities and

interests of each resident.

The centre did not have an activity co-ordinator but a health care assistant was rostered to provide recreation and engaging activities for residents on a daily basis. Training had been provided to support staff to provide meaningful activities for residents. Group activities were organised such as exercise classes, music sessions, card games and painting. Residents who spoke with inspectors were satisfied with activities that were arranged. Staff created opportunities for one-to-one activities, for residents who were unable or unwilling to participate in groups. Staff were creative in offering stimulation to residents with advanced dementia. Sensory knitted mitts with baubles and bells, crochet cushions with flowers and fabric photos were created by staff for residents. Doll therapy was used therapeutically for one of the residents who was case tracked.

A 'Key to Me' document containing information about each resident's history, hobbies and preferences was used to inform the planning of activities. Staff had worked with family members to create a 'life story' book for each resident who had dementia. This project was being extended to include other residents. The inspector found that all residents' files examined held a 'life story' and/or a 'key to me' booklet which provided valuable information for staff to reminisce and engage in a person centred way with residents. Inspectors identified some institutional practices. For example residents who have breakfast in the dining room ate their meal from a tray. The practice of having set days for weekly showers was also discussed at the feedback meeting.

Inspectors spent two hours observing staff interactions with residents, including residents with dementia. These periods of observations took place in the dining room and day room and the vast majority of interactions were rated as positive task orientated care. Inspectors also observed positive connective interactions between staff and residents who had dementia. Staff who spoke with the inspector attributed this to the relationships they had with the residents and the training they had received.

There was evidence that resident with dementia received care in a dignified manner that respected his or her privacy. Staff were observed knocking on residents' bedroom doors before entering, and drawing the curtain in the bedroom when providing personal care. There were no restrictions on visiting times and there were facilities to enable residents to receive visitors in private.

There was evidence that residents with dementia were consulted about how the centre is run, and the services that are provided. Residents and staff confirmed that they were offered choice about all aspects of their day. Residents' meetings were held every two months, but residents were also routinely consulted about important decisions and they selected the paint colours when the centre was decorated.

The centre had developed a number of methods of maintaining residents' links with their local communities. Residents were supported to attend events in the community. Some of the residents were members of the community choir and residents also attended the local Alzheimers café. A number of residents attended local day-care services. One resident told inspectors that he attended events in the community most days and goes home on alternative weekends. Inspectors met a resident who decided to take a taxi to the local hairdresser. Daily and local newspapers were provided for residents.

Residents were facilitated to exercise their civil, political and religious rights. There was evidence that residents' right to refuse treatment or care interventions was respected, and that residents were facilitated to vote in the centre or in the local polling station. A SAGE advocate was available to residents and she attended the residents meetings.

Judgment:
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:
There were policies and procedures for the management of complaints, including details of the appeals process. A summary of the complaints' process was displayed in a prominent area and was also outlined in the Residents' Guide document. It was displayed in a flowchart format, which was accessible to residents, relatives and visitors. The person in charge had progressed an action plan when she completed the self-assessment questionnaire to ensure that prospective residents are made aware of the complaints policy prior to admission. Inspectors found that that this information had been given to a recently admitted resident prior to their admission.

The person in charge was the person nominated to deal with complaints. Records indicated that complaints were minimal, the last being in Jan 2017. All of the information required by the Regulations was appropriately recorded, including the satisfaction of the complainant with the outcome of the complaint. Evidence of learning was also recorded. Residents said that they would not hesitate to make a complaint if they had one. The centre had also identified a second person to ensure that all complaints are appropriately recorded and responded to. It was confirmed to inspectors that complaints are audited on a monthly basis.

Judgment:
Compliant

Outcome 05: Suitable Staffing

Theme:
Workforce

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

No actions were required from the previous inspection.

Findings:

Inspectors were satisfied that there was sufficient staff on duty to meet the needs of residents. Nursing staff had up-to-date registration with An Bord Altranais agus Cnáimhseachais na hÉireann in place. Inspectors reviewed the roster which reflected the staff on duty on the day of inspection. Resident dependency was assessed using a recognised dependency scale and the staffing rotas were adjusted accordingly. Staff leave rates were low and arrangements in place to cover planned and unplanned leave were appropriate. The majority of staff were long standing employees at the centre. A new nurse due to begin working in the centre, had been recruited to replace a nurse who was due to retire at the end of March 2017.

Residents spoken with confirmed that there were staff available at all times to meet their needs and spoke positively about the staffing team and the care they provided. Inspectors found that the deployment of staff to supervise residents during meal times required review. This finding is actioned in outcome 1. Some residents had swallowing problems and inspectors observed that there were prolonged periods when there was no staff presence in the dining room when some residents were eating their meals.

The person in charge and the assistant director of nursing had both completed post graduate programmes in gerontology and dementia and demonstrated a commitment to their continuous professional development and implementing their learning.

The person in charge carried out an annual performance review with each staff member and promoted professional development for staff. The person in charge maintained a matrix record to ensure that all staff attended mandatory training and refresher training. Detailed records were maintained of attendance and course content. All staff had attended mandatory training such as fire safety, safe moving and handling and safeguarding. Training was tailored to meet residents' needs. Staff told the inspector they had received a broad range of training which included caring for residents with dementia, responsive behaviours, infection prevention and control and activity provision.

The person in charge told inspectors that one volunteer attended the centre and provided very valuable social activities which the residents enjoyed and appreciated. The volunteer had been vetted appropriate to their role and their roles and responsibilities were set out in a written agreement. This action had been progressed since the self-assessment questionnaire was completed. The provider representative/person in charge confirmed that all staff working in the centre had satisfactory An Garda Síochána vetting.

Judgment:

Compliant

Outcome 06: Safe and Suitable Premises

Theme:

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

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

Findings:

On the inspection in January 2016 the arrangements for segregation of clean and dirty linen required improvement. This action plans had been satisfactorily completed. Inspectors noted that a strip had been applied to the floor to demarcate the areas for clean and soiled linen. The laundry skip which was appropriately positioned in the laundry area held three sections for segregating various types of laundry. A folding table was used to organise clean laundry and each resident had a shelf section for their laundry. With a few exceptions, the items of clothing examined were marked with the resident's initials.

In March 2016 an inspector found that hot water was above recommended temperatures at the point of contact and posed a risk of scald to residents. The provider completed the action plan and installed thermostatic control devices on five water tanks. However on this inspection when inspectors tested the water temperature in hot tap outlets in a number of bedrooms and bathrooms, the water was found to be cold. The person in charge acknowledged that the hot water had a distance to travel and took a long time to warm up. The plan to address this was to install a new plumbing system in April 2017. The day following the inspection the provider confirmed in writing that the installation of the new plumbing system would begin on the 14 March 2017.

The centre was not purpose built and the provider had installed a passenger lift, refurbished the rooms and reduced occupancy levels in order to meet residents' individual and collective needs in a comfortable and homely way in accordance with the regulations and standards.

There was suitable and sufficient space for storage of equipment and limited but adequate space in the laundry and sluice room. Inspectors observed that additional shelving was necessary in the sluice room for the storage of equipment. In addition some paints used by residents for artwork were inappropriately stored on a shelf in the sluice room. This finding is actioned under outcome 7. Overall there was a good level of cleanliness and hygiene maintained in the centre and there were measures in place to prevent and control infection.

Nurse call alert bells and appropriate assistive equipment was provided to meet residents' needs such as hoists, seating, specialised beds and mattresses. Inspectors viewed the servicing and maintenance records for equipment and found they were up-to-date. Appropriate arrangements were in place for the disposal of clinical and general waste.

Inspectors found that the premises were well maintained and nicely decorated. The communal areas such as the dining room and the day room had a variety of comfortable furnishings and were domestic in nature. The inspector saw that signage using pictures and text were placed at eye level on the doors to communal rooms and other key areas.

Toilet doors had been painted a yellow colour to assist residents to identify them.

Contrasting colours were also evident in the toilet on the first floor.

There was no glare from highly polished floors. A variety of carpet and matt flooring was used throughout and non slip flooring was used in bathrooms and toilets. Handrails and grab rails were provided where required in circulating areas and in toilets and bathrooms.

Bedroom accommodation for residents comprises seven single and six twin bedrooms. All the bedrooms had a wash-hand-basin. Six single and six twin bedrooms had an en suite toilet and wash hand basin and one single room and a twin room had full ensure facilities with a wheelchair accessible shower. There are three additional assisted shower rooms with toilets, one on the first floor and two on the ground floor. There was also a smaller toilet on the first floor. There was no bath available for residents to use should that be a resident's choice.

All bedrooms had a call bell fitted within close proximity to their beds and many of the residents had clocks and calendars in their bedrooms. Bedrooms were spacious enough to accommodate personal equipment and assistive devices required by existing residents. Residents had a locked facility for safe storage of their personal valuables in their rooms. Residents were encouraged to personalise their rooms and many had photographs and other personal belongings in their bedrooms. Heat, lighting and ventilation were adequate and the temperature of the building met requirements in bedrooms and communal areas where residents rested during the day.

Staff had made progress towards creating a dementia friendly environment. Examples of this included unique identifiers or pictures on bedroom doors to help residents to identify their bedroom. The use of edible, herbs in the dining room. Art projects which the residents had created were on display. A reminiscence project 'Athlone Old and New' created a tasteful display of old photographs of various parts of the town along with modern photographs depicting more recent developments. Further improvements were discussed with the inspectors, such as the further use of signage to support way-finding. Inspectors observed that residents would benefit from the installation of additional shelving in some bedrooms to display ornaments, books and other private possessions.

There is a large decking area and a small garden to the rear of the centre. An area adjacent to the garden was being developed to create additional outdoor space for residents. The person in charge had identified the provision of raised flower-beds and additional seating in the action plan when completing the pre-inspection self-assessment. Inspectors noted that the frame for the raised beds had been created and a passenger lift had been installed to facilitate access from the decking area. Inspectors noted that the door leading to the decking area was controlled by a key pad. This meant that residents with memory impairment could not readily access an outdoor area if they wished.

Judgment:

Non Compliant - Moderate

Outcome 07: Health and Safety and Risk Management

Theme:

Safe care and support

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

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

Findings:

The health and safety of residents, staff and visitors was promoted and protected. The centre had comprehensive policies relating to health and safety. The provider has addressed all actions in the action plan in relation to fire safety found on the inspection carried out in March 2016. The high temperature of hot water at the point of resident contact as found on the last inspection was also addressed. The provider representative advised the inspectors following the inspection that a new water pumping system was scheduled for installation on 14 March 2017.

A safety statement dated 2015 was available for the centre and required updating for 2017. The risk management policies as required by regulation 26 were in place. The risk management policy informed practices in relation to residents at risk of self-harm, violence and aggression, abuse and unexplained absence and were demonstrated in practice. The centre maintained a risk register setting out hazards identified in the centre and the control measures in place to minimise associated risk. There was evidence that this register was reviewed and updated as necessary. Clinical risks such as residents using restraint and bedrail and smoking among others were identified with appropriate controls in place. For example, residents who smoked were risk assessed, appropriately supervised and a safety apron was available in the smoker's room on ground floor. Health and safety issues and risks were discussed at management meetings and remedial actions completed.

All incidents and accidents involving residents, staff and visitors were logged. They were reviewed and addressed by the provider representative/person in charge. There was evidence of learning from any serious incidents involving residents with corrective actions and controls implemented to prevent recurrence.

Overall, the provider took a proactive approach to fire safety management. Actions from previous inspections had been addressed. Fire exits were free of any obstruction and were checked on a daily basis to ensure evacuation of residents, staff and visitors was not hindered in the event of an emergency. Measures were implemented since inspection in March 2016 to ensure residents with reduced mobility could exit safely. All residents had evacuation risk assessments completed and documented. Fire safety management checking procedures were in place and no gaps were observed in these records. Servicing of the fire panel, alarm, emergency lighting, directional signage and smoke/heat sensor equipment had been completed. Documentation reviewed confirmed they were in working order. Equipment including fire extinguishers and fire blankets were available at various points throughout the centre. Fire evacuation drills were completed at regular intervals and reflected testing of day and night-time resources and conditions to ensure residents could be safely evacuated in an emergency. Fire

evacuation procedures were displayed in prominent locations for residents and visitors, including in high traffic areas and in residents' bedrooms. Staff spoken with by inspectors had a good knowledge of what to do in the event of the fire alarm sounding. Fire safety training was completed by all staff, as confirmed by the staff training records and staff spoken with by an inspector.

The centre was visibly clean. Hand hygiene facilities were located throughout the premises. An infection control policy informed procedures for management of communicable infection and infection outbreak to guide and inform staff. Staff attended training on infection prevention and control. Inspectors observed that additional shelving was necessary in the sluice room for the storage of equipment. In addition some paints used by residents for artwork were inappropriately stored on a shelf in the sluice room.

Judgment:
Substantially Compliant

Outcome 08: Governance and Management

Theme:
Governance, Leadership and Management

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

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

Findings:

There were sufficient resources in place to ensure the effective delivery of care as described in the centre's statement of purpose. There were sufficient resources to ensure residents' comfort and access to equipment to assist them with their activities of daily living. Resources were made available to progress the action plans identified in the self assessment questionnaire and to facilitate ongoing staff development.

There was a clearly defined management structure that identified lines of accountability and reporting relationships. Residents, relatives and staff were familiar with same. There was a board of five members; including the person in charge who was also the person nominated to represent the provider, who oversaw the governance of the centre. Residents, relatives and staff were supportive of management and confirmed that they were present in the centre on a regular and consistent basis.

There were management systems in place to ensure that the service provided was safe and appropriate. A schedule of audits was undertaken in 2016. Audits on medication were carried out by the person in charge and the pharmacist. Other audits were undertaken including care plans and staff files. The audit reports included action plans to inform service improvements.

The annual review in respect of the quality and safety of care of residents had been completed. This included consultation with residents and relatives.

There was evidence of consultation with residents and their representatives on a daily basis and in a formal resident and relative forum. Nurses described other opportunities for consultation when staff were engaged in reviewing and assessing the changing needs of residents and care planning process. A resident satisfaction survey which elicited with a 30% response rate. It indicated high levels of satisfaction with the service provided. Inspectors were told that a satisfaction survey was recently issued to the relatives of residents which had not yet been returned.

Judgment:
Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	Stella Maris Nursing Home
Centre ID:	OSV-0000105
Date of inspection:	08/03/2017
Date of response:	27/03/2017

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 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:

Two residents did not have a care plan in place to inform the actions staff should complete for managing their diabetes.

Parameter values were not consistently stated in some care plans stating the minimum amount of fluids residents at risk of dehydration should be supported to consume over 24 hours and the acceptable blood glucose parameters for residents with diabetes.

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

1. 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:

Care plans are being updated in consultation with GP's to include these parameters where required.

Proposed Timescale: 07/04/2017

Theme:

Safe care and support

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

While inspectors were told that care plans were completed and reviewed in consultation with residents or family members and a tick box was provided to indicate that consultation had taken place this was not consistently done.

2. Action Required:

Under Regulation 05(5) you are required to: Make the care plan, or revised care plan, prepared under Regulation 5 available to the resident concerned and, with the consent of that resident or where the person-in-charge considers it appropriate, to his or her family.

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

Nursing staff will be more vigilant in this area and ensure that the box is ticked showing that care plans including reviews have been discussed with the resident or their family. This will also be dated and nursing staff will document on the care plan or review who it was completed in consultation with.

Proposed Timescale: 07/04/2017

Theme:

Safe care and support

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

Care plans for some residents' personal hygiene needs lacked sufficient detail to guide staff to provide consistent person centred care.

Improvement was required to ensure weights were consistently recorded on a more frequent basis for residents who experienced unintentional weight loss.

3. Action Required:

Under Regulation 05(1) you are required to: Arrange to meet the needs of each resident when these have been assessed in accordance with Regulation 5(2).

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

Care plans are being updated to have more specific details regarding residents personal hygiene needs.

Residents weights are recorded weekly following indication from the Mini Nutritional Assessment tool (MNA)

Proposed Timescale: 07/04/2017

Theme:

Safe care and support

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

The deployment of staff to supervise residents during meal times requires review. Some residents had swallowing problems and inspectors observed that there were prolonged periods when there was no staff presence in the dining room when residents had their main meal.

4. Action Required:

Under Regulation 18(3) you are required to: Ensure that an adequate number of staff are available to assist residents at meals and when other refreshments are served.

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

A staff member is designated to remain in the dining room during meal times to ensure optimum supervision is maintained at all times.

Proposed Timescale: 27/03/2017

Outcome 06: Safe and Suitable Premises

Theme:

Effective care and support

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

When inspectors tested the water temperature in a number of bedrooms and bathrooms the water was found to be cold.

5. Action Required:

Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

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

The building is currently having a new plumbing system installed.

Proposed Timescale: 07/04/2017

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:

Additional storage space was needed in the sluice room.

Some art material used by residents were in appropriately stored on a shelf in the sluice room.

6. Action Required:

Under Regulation 27 you are required to: Ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.

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

All art supplies, which were placed here in error, have been removed from the sluice room. Art facilitator and staff have been made aware of same.

An additional shelf has been installed.

Proposed Timescale: 27/03/2017