Health Information and Quality Authority
Social Services Inspectorate

Inspection report
Designated centres for older people

Centre name:	The Marlay Nursing Home
Centre ID:	108
Centre Address:	Kellystown Road Rathfarnham Dublin 16
Telephone number:	01-4994444
Fax number:	01-4994445
Email address:	sue.cameron@themarlay.com
Type of centre:	☒ **Private** ☐ **Voluntary** ☐ **Public**
Registered provider:	Brehon Care Ltd
Person in charge:	Colette Clabby
Date of inspection:	19 and 20 January 2011
Time inspection took place:	**19 Jan Start:** 08:30 hrs **Completion:** 17:30 hrs **20 Jan Start:** 08:10 hrs **Completion:** 17:00 hrs
Lead inspector:	Angela Ring
Support inspector:	Eileen Kelly
Type of inspection:	☒ **Registration** ☐ **Scheduled** ☒ **Announced** ☐ **Unannounced**

About inspection

The purpose of inspection is to gather evidence on which to make judgments about the fitness of the registered provider and to report on the quality of the service. This is to ensure that providers are complying with the requirements and conditions of their registration and meet the standards; that they have systems in place to both safeguard the welfare of service users and to provide information and evidence of good and poor practice.

In assessing the overall quality of the service provided, inspectors examine how well the provider has met the requirements of the Health Act 2007, 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* under the following topics:

1. Governance and leadership: how well the centre is organised.
2. The quality of the service.
3. How well the healthcare needs of residents are met.
4. Premises and equipment: appropriateness and adequacy.
5. Communication: information provided to residents, relatives and staff.
6. Staffing: the recruitment, supervision and competence of staff.

This report summarises the findings of the inspection under some or all of these topics, highlighting areas of good practice as well as areas where improvements were required as follows:

Evidence of good practice – this means that an acceptable standard was reached and the provider demonstrated a culture of review and improvement and aimed to drive forward best practice.

Some improvements required – this means that practice was generally satisfactory but there were areas that need attention.

Significant improvements required – this means that unacceptable practice was found.

The report also identifies minor issues, where applicable, to which the provider should give consideration to enhance the quality of the service.

Registration inspections are one element of a process to assess whether providers are fit and legally permitted to provide a service. The registration of a designated centre is for three years. After that the provider must make an application for registration renewal at least six months before the expiration date of the current registration. New providers must make an application for first time registration 6 months prior to the time the provider wishes to commence.

In controlling entry to service provision, the Chief Inspector of Social Services is fulfilling an important regulatory duty under section 40 of the Health Act 2007. Part of this duty is a statutory discretion to refuse registration if the Chief Inspector is not satisfied about a provider's fitness to provide services, or the fitness of any other person involved in the management of a centre.

The registration inspection is one element for the Chief Inspector to consider in making a proposal to the provider in respect of registration. Other elements of the process designed to assess the provider's fitness include the information provided in the application to register, the Fit Person self-assessment and the Fit Person interviews. Together these elements are used to assess the provider's understanding of, and capacity to, comply with the requirements of the Regulations and the Standards. Following assessment of these elements, a recommendation will be made to the Chief Inspector and the formal legal process for registration will proceed. As a result, this report does not outline a final decision in respect of registration.

The report is available to residents, relatives, providers of services and members of the public, and is published on our website www.hiqa.ie.

About the centre

Description of services and premises

The Marlay Nursing Home is a purpose-built three-storey building with capacity for 124 residents made up of four units. Grange Unit is on the ground floor which has 32 places and is used for long-term, convalescence and respite care. Whitechurch is on the first floor and is divided into two units (White Church one and two) with 46 places for long-term care. Threerock is on the second floor which is divided into two units (Threerock one and two), with capacity for 46 places for long-term care. Most of the residents in Threerock one have dementia although it is not considered to be a dementia specific unit.
All of the residents were over 65 years and several had varying degrees of dementia. There were no residents admitted for respite or convalescence on the days of inspection.

Each bedroom is a single room with en suite facilities including a shower. In addition to the accommodation, facilities include a main kitchen, oratory, library, smoking room, laundry, visitors' toilet, staff facilities and four assisted bathrooms. There is a bright reception area with comfortable armchairs, couches and a piano. Each floor has a day room, dining room, sluice room, nurses' station and treatment room. The building has four sets of stairs, two passenger lifts servicing all floors and one service lift.

There is an enclosed courtyard on the ground floor with seating and raised beds. Parking is available at the front and rear of the centre.

Location

The Marlay Nursing Home is located near Taylors Rock in Rathfarnham just off the M50 in Dublin.

Date centre was first established:	2007
Number of residents on the date of inspection	121 + 2 in hospital
Number of vacancies on the date of inspection	1

Dependency level of current residents	**Max**	**High**	**Medium**	**Low**
Number of residents	25	51	27	18

Management structure

The Provider is Brehon Care Ltd and Sue Cameron, the Director of Operations, is the person named to represent the Provider. The Person in Charge, Colette Clabby, reports to Sue Cameron, who in turn reports to the Board of Directors. There is a Clinical Nurse Manager 1 (CNM1) on each unit who is supported by the Clinical Nurse Manager 2

(CNM2), and both report to the Person in Charge. The nurses and care assistants report to the CNM1 responsible for the unit they work on. The maintenance person reports to the Director of Operations, the housekeeping staff report to the housekeeping manager who also reports to the Director of Operations. The catering staff report to the Kitchen Manager who reports to the Director of Operations. The accounts and administrative staff report to the Director of Finance who also reports to the Provider.

Staff designation	Person in Charge	Nurses	Care staff	Catering staff	Cleaning and laundry staff	Admin staff	Other staff
Number of staff on duty on day of inspection	1	9	22	11	9	2	8*

*other staff include Director of Operations, Financial Director, Human Resource Manager, Maintenance Manager, three activity coordinators and a receptionist.

Summary of findings from this inspection

This was an announced registration inspection and the third to be carried out by the Health Information and Quality Authority (the Authority). The provider had applied for registration under the Health Act, 2007 and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2009. As part of the registration process, the provider and person in charge have to satisfy the Chief Inspector of Social Services that they are fit to provide the service and that the service will comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

Inspectors carried out fit-person interviews with the person in charge and the provider, the fit-person self assessment document was completed in advance of this visit. All of this information was reviewed by inspectors, in addition to the information provided in the registration application form and supporting documents. Inspectors met with residents and relatives and reviewed documentation as part of the inspection process.

Inspectors found that improvements had been made since the previous inspections and the completion of the fit-person entry programme. The person in charge and her team had developed centre-specific policies which guided staff practice, improvements had been made in care planning, strong management structures were in place and staff had received training on several aspects of caring for older people.

Inspectors found that this centre was well run. Residents and their relatives spoke highly of the managers and of the ethos of care. Inspectors found that residents' health needs were well monitored and there was good access to peripatetic services.

There were good risk management procedures in place and there was evidence of a quality assurance programme. However, there was potential for poor outcomes for some residents who were using bedrails and there was a lack of supervision for vulnerable residents in communal areas.

The Authority received information prior to the inspection, that some parts of the centre were cold on occasion and there was a lack of supervision in the day rooms. This information was considered during the inspection.

Inspectors also followed up on actions from the previous inspection in April 2010. These actions related to making the care planning process more person centred, ensuring staff files complied with Regulations and continuing to review staffing levels.

There were some areas for improvement identified by inspectors which are outlined in action plans at the end of the report. These included the use of restraint, reviewing residents who have frequent falls, further development of care planning, providing an increased range of activities for people with dementia, increasing opportunities for residents to participate in running the centre, ensuring all staff providing direct care to residents had access to relevant resident information, ensuring staff files fully comply with Regulations and reviewing the staffing levels to ensure that residents were adequately supervised in communal areas.

Comments by residents and relatives

Inspectors received 18 completed questionnaires from residents and their relatives prior to the inspection and on the day, inspectors also spent time chatting with residents and their relatives.

The vast majority of the feedback was positive, with one resident describing the centre as “the best in the country”. Residents said they were very happy and felt they could make choices in their daily routines. They all agreed that their health needs were met and described the staff as kind and attentive.

Both residents and relatives said they felt safe and were aware to whom they would speak if they had a concern. Relatives said they were kept well informed of their family member’s condition, and were always made feel welcome. They all agreed that the centre was clean and well maintained and there was high quality of food served.

A small number of relatives told inspectors that they were concerned about the supervision of one of the day rooms where several residents had dementia. Inspectors considered this information during the inspection.

Overall findings

1. Governance: how well the centre is organised

Outcome: The centre is well organised and managed and complies with the requirements of the Health Act 2007, the Regulations and standards.

Good governance involves the effective and efficient deployment of resources in accordance with the stated purpose and function of the centre. Governance includes setting clear direction for the service, a commitment to continual improvement and having a system in place to effectively assess and manage risk.

Evidence of good practice

The provider and person in charge worked full-time and were very committed to providing high quality care to residents. They demonstrated a good understanding of their responsibilities as outlined in the Health Act 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) 2009 (as amended) and *National Quality Standards for Residential Care Settings for Older People in Ireland*. They had worked on the fit-person entry programme in consultation with their nursing management team - it was completed to a high standard and identified goals for further improvements in areas such as advocacy, communication and care planning.

The deputising arrangements were appropriate. The person in charge told inspectors that there was a senior member of the nursing management team on call in the evenings and at weekends. Members of the nursing management team deputised in the absence of the person in charge.

Inspectors found that the person in charge and CNM2 were committed to continuous quality improvement. Inspectors reviewed monthly audits completed on falls, use of psychotropic drugs and sedatives, incidents and the use of restraint. The CNM2 explained to inspectors that he used this information to determine trends and to highlight areas for improvement such as falls prevention strategies. During the fit-person interview, the provider assured inspectors that there was a contingency budget in place for unforeseen circumstances that required significant expenditure.

Inspectors found that the statement of purpose and Residents' Guide were available to the residents. They clearly outlined the ethos of care, detailed the services provided and complied with the requirements in the Regulations. Inspectors found that the service provided reflected the statement of purpose. Inspectors spoke with the financial director and found that residents' finances were not managed at the centre. Inspectors reviewed the contract of care and found that it complied with the Regulations and contained the additional fees to be paid by residents such as hairdressing and physiotherapy. There was an up-to-date insurance certificate.

The provider informed inspectors that she developed the safety statement as she had experience and training in safety legislation. Inspectors reviewed the statement and found that it identified environmental risks, risk ratings and named the person responsible for managing each risk. There was a comprehensive, centre-specific emergency plan in place with details of evacuation procedures and relevant contact numbers. There was also an emergency kit with supplies for evacuation such as torches, spare batteries, high visibility vests and two way radios.

Risk was well managed and had improved since the initial inspection in November 2009. There was a centre-specific risk management policy which addressed the regulatory requirements including the procedures to follow in the event of assault, aggression and violence and self harm. Inspectors reviewed the minutes of the risk management task force recently set up which consisted of the provider, person in charge, CNM2, maintenance personnel, housekeeping manager and kitchen manager. There was evidence of the environmental and clinical risks discussed and evidence of measures being put in place to reduce the identified risks. While speaking to staff, inspectors found that they had a good knowledge of safety and risk management.

Inspectors found that the procedures in place for preventing, detecting and responding to fire were satisfactory. Staff were aware of the procedures to follow in the event of fire and said they attended regular fire drills. There were records to indicate that there were recent checks of fire alarms and fire equipment. Inspectors received written confirmation from a competent person that all requirements of the statutory fire authority were complied with. There were records to indicate that all of the staff had attended recent training on fire prevention and procedures.

Inspectors spoke with staff and found they had a good knowledge of the procedures to follow in the case of alleged elder abuse. There were records to indicate they had all attended training on the prevention, detection and response to elder abuse and there was a centre-specific policy in place. During the fit-person interviews, the provider and person in charge demonstrated a good awareness of the procedures to follow in the case of alleged abuse of residents.

Inspectors viewed the complaints log and found that it contained a number of complaints, all of which were addressed in a timely manner by the person in charge. The complaints policy complied with the requirements in the Regulations and it was displayed in a prominent place. Staff were aware of the complaints procedure and had received training on complaints management and the relevant policy. The person in charge told inspectors that she welcomed complaints and comments from residents and saw them as opportunities for learning and service development. There was an initial lack of clarity of the independent appeals process, however this was clarified shortly after the inspection and a new complaints procedure was developed and submitted to the Authority.

The directory of residents was updated to include the recent transfers of residents to hospital and all other relevant details as outlined in the Regulations.

Some improvements required

Inspectors found that there were a small number of residents who had had a number of falls in the previous months. There was no comprehensive multi-disciplinary review to devise a plan to reduce the number of falls for these residents. Inspectors saw evidence that nursing staff had put some falls prevention strategies in place for some of these residents, such as moving them to a bedroom closer to the nurses' station for increased supervision and reviewing a resident's footwear. However despite these measures, residents continued to fall.

2. Quality of the service

Outcome: Residents receive a good standard of service, appropriate treatment and are treated with courtesy and respect.

A quality service is one where residents are protected from harm or abuse, where practice is person-centred, where rights are protected, where residents are enabled to play an active part in the centre and where management, staff and residents work together towards continuous improvement.

Evidence of good practice

Inspectors found that there was a relaxed atmosphere during the day. Residents told inspectors that there was flexibility in the daily routine and they could decide when to get up and go to bed. They said that staff were aware of their need for privacy and knocked on their bedroom doors and waited for a response prior to opening the door. Inspectors observed this to be the case.

Staff demonstrated a good knowledge and understanding of each resident's likes, routines and preferences. All of the staff spoken to said they enjoyed their work and believed that there was a high quality of care provided to the residents.

Residents' spiritual needs were met. Mass took place five days a week, it was celebrated by one of the residents who was a priest. Residents who did not wish to attend the oratory could watch Mass which was broadcast on the television. Inspectors found that some residents were from different religions and their spiritual needs were also met and appropriate services were provided.

There was a schedule of activities on offer each day. Inspectors met with two of the activity coordinators who explained that there were a range of things for residents to do and they were always trialling new activities to ensure variety. Inspectors saw residents participating in singing and music, reading newspapers, playing bingo and taking part in a quiz. Other activities included bowling ball games, karaoke, pet therapy and poetry. Inspectors found that additional activities were being trialled following feedback from the residents' council which resulted in the establishment of a knitting group and walking group. Residents told inspectors that there was enough for them to do during the day and they enjoyed the activities available. Care assistants told inspectors that they were also involved in providing activities for residents and inspectors observed this to be the case.

Inspectors observed most residents having their meals in the main dining room on each floor and others told inspectors that they had chosen to dine in their bedrooms. Inspectors observed staff providing meals in residents' bedrooms which were well presented and hot. Inspectors observed staff providing discreet, respectful assistance to more dependent residents. There was a good choice of food available with three main courses available. The food was freshly cooked, hot and nutritious and special diets were available as required. The tables were nicely set in all dining rooms and there was a friendly convivial atmosphere during mealtimes, with some residents enjoying a glass of wine with their

lunch. Residents told inspectors that they looked forward to their meals and the quality of food was excellent.

Inspectors visited the kitchen and spoke with the kitchen manager who was also the head chef. He demonstrated a good awareness of each resident's dietary needs and preferences. Inspectors found that he took great pride in providing a high quality dining experience to residents. Inspectors found there was a plentiful supply of food with fresh fruit, vegetables, fish and meat delivered daily. Inspectors reviewed records that showed the catering staff had received training in food hygiene to ensure that best practice was adhered to when serving food to residents. Inspectors found that the provider commissioned an independent company to carry out regular food safety audits - inspectors reviewed these audits which showed there was a high level of compliance with food safety guidelines.

Some improvements required

Inspectors found that improvements were required in the provision of opportunities for meaningful engagement for residents with dementia. Most of the activities were group sessions and could be too overwhelming for residents with dementia. Inspectors found that there was a need for specialised dementia specific activities for residents which were tailored to suit their individual needs and based on their previous likes and interests. The provider and person in charge acknowledged this during the inspection and explained that they had plans to address this area in the near future.

There was a monthly meeting which was co-chaired by the person in charge and a resident and residents were invited to it. Inspectors read the minutes and found that there was evidence of residents making suggestions and change occurring as a result. New carpets and curtains had been purchased for some areas and suggestions had been made for celebrating the upcoming Bealtaine festival in May.

This meeting was usually attended by the more independent residents who were cognitively intact. Inspectors found that there were limited opportunities for consultation with other residents and they had few opportunities to participate in the running of the centre.

Inspectors found that there were limited opportunities for residents to access local community services and to maintain social contacts in their community. Inspectors met with some residents who occasionally went out with family members, but this was not the case for the majority of residents.

3. Healthcare needs

Outcome: Residents' healthcare needs are met.

Healthcare is integral to meeting individual's needs. It requires that residents' health, personal and social care needs are assessed and reviewed on an ongoing basis, within a care planning process, that is person centred. Emphasis is firmly placed on health promotion, independence and meaningful activity.

Evidence of good practice

Inspectors found that residents' health needs were well met. There were good links maintained with the general practitioner (GP) practices in the local area and there was a medical officer on site two days a week. A review of the residents' medical files showed that residents' were reviewed every three months by their GP and the pharmacist on some occasions. Residents told inspectors that the staff contacted the doctor when necessary and they were satisfied that their healthcare needs were met. Inspectors met with a GP who regularly attends the centre and he explained that he and his colleagues were in the process of reviewing residents' medication to reduce the use of psychotropic medication.

Residents' health was well monitored; inspectors reviewed a sample of residents' files and found that their weight, blood pressure and pulse rate were recorded regularly and nursing staff told inspectors that abnormalities were reported to the GP promptly. Inspectors reviewed a small number of residents with wounds such as leg ulcers and found that there were good records maintained of the treatment and progress of the wound.

There was good access to peripatetic services - nursing staff told inspectors that they had access to physiotherapy and occupational therapy services, at an extra cost to the resident. There was also evidence of residents receiving specialist services such as speech and language therapy, dietetics, chiropody, dental and optician when required and at no extra cost.

Inspectors found that there were no residents receiving end-of-life care on the days of inspection. However, they reviewed the procedures and facilities in place for end-of-life care for residents. There was a centre-specific policy and the person in charge told inspectors that they access the local palliative care team if required. There was information on the resuscitation status of some residents in their medical notes.

The medication policy was reviewed by inspectors who found that it contained the procedures for prescribing, administering, recording and storing of medication. The prescription and administration records were clear and updated to record the most recent administration of medication. Inspectors accompanied a nurse during the medication round and observed her practice. They found that it complied with best practice as she identified and assessed the resident, checked the prescription, explained what each tablet was to the resident and gained their consent, waited while the resident swallowed the medication, and then signed the medication as administered. Inspectors observed the staff

promoting residents' independence by guiding their hand to their mouth to self administer their own medication. Inspectors looked at the controlled drugs register and found that that the stocks were checked at the end of each shift.

Inspectors reviewed the care planning process in place which is based on an electronic system and found it to be thorough. Inspectors reviewed a sample of care plans and found that there was a comprehensive pre-admission assessment completed on all residents requiring long-term care to assess their needs and determine their suitability to move to the centre. There was then a comprehensive assessment carried out on each resident on admission and a three monthly assessment was completed following admission. Risk assessments were completed for pressures ulcers, risk of falls, pain, depression, cognitive decline and malnutrition. The daily narrative notes for each resident were detailed and descriptive and related to the problems identified in the care plans.

There were care plans developed on residents' preferred daily and night routine which gave valuable information to staff on the residents' likes and routines. This was an improvement since the initial inspection in November 2009 where there was limited personal information on residents' likes, dislikes and preferred routines. The person in charge told inspectors that she and the CNM2 held meetings with residents and their relatives to discuss the care plan. Inspectors saw evidence that this was the case when speaking to relatives and reviewing care plans.

Inspectors found that there was evidence of good staff response to residents with behaviours that challenge. Staff had received training on best practice in this area and there was a centre-specific policy in place. Inspectors saw records being maintained of residents' behaviour to monitor for potential antecedents to behaviour and potential alleviating factors. Inspectors observed staff using a variety of techniques to de-escalate situations where residents were showing signs of behaviour that challenged such as singing their favourite tune or simply giving the resident space. The GP told inspectors that links have been made with the department of psychiatry of old age in a nearby hospital and there was evidence of a consultant reviewing residents with behaviours that challenge and suggesting different treatment plans.

Some improvements required

As already explained, care plans were based on an electronic system which was password protected and only accessible to the nursing staff. Therefore residents were unable to see and contribute to their care plans. This also resulted in care assistants being unable to access and contribute to residents' care plans. While discussing this issue with the provider, she stated that there were plans in place to ensure that all relevant staff had access to resident information in the near future. She also explained that residents were invited to attend a care plan review meeting which gave them an opportunity to review their care plan, but this had not happened for all residents and their families as yet.

Significant improvements required

Inspectors found that improvements were required in the use of restraint and this had been identified at the initial inspection in November 2009. There was a high use of bedrails. While speaking with staff, inspectors found that there was a lack of awareness of the dangers associated with the use of bedrails. The restraint policy indicated that bedrails were not to be used for residents who could get over them and this had not been implemented in practice. Inspectors saw evidence of bedrails continuing to be used for three residents who had got out of bed and over them in the past. Inspectors found that there was a lack of reassessment of the use of restraint following the decision to use it. There was however documentary evidence of residents being checked every half hour at night for safety reasons.

4. Premises and equipment: appropriateness and adequacy

Outcome: The residential care setting provides premises and equipment that are safe, secure and suitable.

A good physical environment is one that enhances the quality of life for residents and is a pleasant place to live. It meets residents' individual and collective needs in a comfortable and homely way, and is accessible, safe, clean and well-maintained. Equipment is provided in response to the assessed needs of each of the residents and maintained appropriately.

Evidence of good practice

The centre was clean and well maintained throughout. There were day-rooms on each floor, all of which were used by residents and chairs were strategically positioned in small groups to encourage conversation.

Inspectors visited some bedrooms with residents' permission and found that residents were encouraged to bring in their personal possessions and there was adequate storage for their belongings with a locked cupboard for valuables.

Inspectors found there was an adequate amount of equipment such as hoists, pressure relieving mattresses and mobility aids available to meet residents' needs. Inspectors reviewed the records of servicing to electric beds, hoists and lifts. There were maintenance reports on each floor to record any items which required repair. Inspectors met with the maintenance personnel who explained the procedures he followed and safety checks he carried out to ensure that potential areas of risk are identified and dealt with promptly. He explained that he carried out regular environmental tours around the premises to identify areas of potential risk and areas requiring maintenance and health and safety audits were completed on a quarterly basis. There was documentary evidence of weekly checks being completed on call bells, lights and wheelchairs. There was adequate storage for equipment such as hoists.

There was a clean and well equipped staff room, staff locker rooms, staff changing room and shower rooms. Inspectors found that the laundry was clean, well ventilated, well organised and had industrial sized machines. There was adequate room for storage and segregation of soiled clothing. Inspectors spoke with a staff member who worked full-time in the laundry - he explained the procedures he followed to ensure that clothing was laundered appropriately and returned to residents. Residents told inspectors that their clothes were well looked after and were returned promptly following laundering.

Inspectors found that waste was well managed and clinical waste and soiled laundry were placed in separate bins for safety and hygiene purposes. There were hand gels, gloves and aprons available to staff to use for infection control purposes. Inspectors met with a cleaner who explained the procedures he followed to ensure that a high standard of cleanliness was maintained. Inspectors observed that all cleaning chemicals were locked in

a press at all times. There were separate changing rooms and toilets for catering and clinical staff to prevent the risk of cross contamination.

As stated in the summary, the Authority received information of concern related to the room temperature feeling cold on occasion. Inspectors found that there was evidence that the heating system was reviewed following the complaint and regular temperature checks being recorded as a result. Inspectors found the room temperature to be satisfactory.

There was a secure courtyard area on the ground floor with seating and plants. Residents, relatives and staff told inspectors that it was mostly used in warm weather.

5. Communication: information provided to residents, relatives and staff

Outcome: Information is relevant, clear and up to date for residents.

Information is accessible, accurate, and appropriate to residents' and staff needs. Feedback is actively sought from residents and relatives and this informs future planning and service provision. Information is recorded and maintained in accordance with legal requirements and best practice and is communicated to staff on a need to know basis to ensure residents' privacy is respected.

Evidence of good practice

Inspectors found that there were regular meetings with the management team and the staff which helped to ensure that there was an effective communication system in place. Staff said they were kept informed of all aspects of the running of the centre and of any changes that occurred. Minutes of meetings were available to staff on the computer on each floor.

Inspectors found that records were stored in a secure space to ensure confidentiality. There was a sign-in book at reception which kept a record of all visitors. There was a suggestion box available at reception so that residents, staff and relatives could make comments in private if they wished and a residents' notice board with information on activities, external advocacy services, fire, and complaints procedures.

Inspectors found that the policies and procedures were centre specific, updated and comprehensive. They were divided into different sections to make them more user friendly for staff. There was a framework in place to record the date of implementation and review of policies and the person responsible for approving the policy. The CNM2 explained that with the assistance of a private company, over 100 policies had been developed. Staff had been divided into teams and each team was involved in developing and reviewing a policy. The CNM2 stated that this process gave staff a greater awareness and understanding of the process of developing a policy and of the content required. Staff told inspectors that policies are discussed with them at 12 noon each day with a new policy discussed each week. Inspectors saw this training in practice and found that it gave staff an opportunity for learning and clarifying issues.

Residents told inspectors that they had access to telephones and newspapers, and inspectors saw newspapers and other reading material were readily available to residents. Inspectors observed the staff communicating effectively with residents with dementia and residents with communication problems.

Some improvements required

Inspectors found that there was no internal advocacy service for residents. However, the provider told inspectors that she was trying to access an advocacy service for residents via national organisations. There was documentary evidence of this in recent minutes of meetings.

6. Staff: the recruitment, supervision and competence of staff

Outcome: Staff are competent and recruited in sufficient numbers to meet residents' needs

Staff numbers and skill-mix are determined by the size and complexity of the service and there should be sufficient competent staff on duty, both day and night, to meet the needs of residents. Robust recruitment and selection procedures ensure the appointment of suitably qualified and experienced staff. Staff are supported in their work by ongoing training and supervision.

Evidence of good practice

Residents told inspectors that there were adequate staffing levels on duty. Inspectors found that call bells were answered promptly and residents said they were never left waiting for long periods when they required assistance. There was a good skill-mix of staff with at least three nurses on duty most days on each floor. The staff explained that they attended a morning report and this informed their plan of work for the day. All staff spoken to said they enjoyed their work and had been given several opportunities for further training and development.

The person in charge explained to inspectors that she determined staffing levels by assessing the dependency levels of residents. Inspectors found that there was evidence of increased staffing levels following requests by staff on one unit, to ensure residents' needs were met.

Inspectors reviewed the recruitment policy which addressed all of the procedures to be followed in recruitment, induction, supervision and appraisal of staff. There were job descriptions developed for each staff member. Inspectors reviewed a sample of staff files and found that they contained evidence of Garda Síochána vetting, nurses' registration with their professional body, pre employment history, identification and three references. The person in charge explained to inspectors that there was an induction programme for nursing and care staff where each member of staff received an induction folder. Inspectors saw evidence of a yearly performance appraisal where staff goals and training needs were identified in staff files.

Inspectors found that all of the care staff had completed FETAC (Further Education Training Awards Council) Level 4 or 5 training which gave them the skills and knowledge to provide high quality, evidenced based care to residents.

There were records to indicate that staff received training in manual handling, prevention and detection of elder abuse and fire prevention and detection. Inspectors found that staff had also received training on issues such as best practice in infection control, behaviours that challenge, ethics and medication management. There were also several planned training programmes for staff including an education session on their legal responsibilities in terms of documentation and consent.

The provider told inspectors that dementia care was one of the main areas of interest and focus for staff development and training in the year ahead.

Some improvements required

As stated at the start of the report, some relatives stated that there was an occasional lack of supervision in one of the day rooms where there were several residents with dementia. Inspectors spent time in this area and found this to be the case, especially in the morning when personal care was being delivered. Some staff told inspectors that they believed the unit would benefit from an additional staff being employed to supervise these residents as they were at risk of falling and of displaying behaviours that challenge.

On review of staff files, staff gave a self declaration for their medical and physical fitness. Inspectors found that this was not sufficient as there was no evidence that it was impractical for them to provide evidence of physical or mental fitness as required in the Regulations.

Closing the visit

At the close of the inspection visit a feedback meeting was held with the provider, person in charge and CNM2 to report on the inspectors' findings, which highlighted both good practice and where improvements were needed.

Acknowledgements

The inspectors wish to acknowledge the cooperation and assistance of the residents, relatives, provider and staff during the inspection.

Report compiled by:

Angela Ring

Inspector of Social Services
Social Services Inspectorate
Health Information and Quality Authority

24 January 2011

Chronology of previous HIQA inspections	
Date of previous inspection	**Type of inspection:**
24 and 25 November 2009	☐ Registration ☒ Scheduled ☐ Follow up inspection ☒ Announced ☐ Unannounced
14 April 2010	☐ Registration ☐ Scheduled ☒ Follow up inspection ☐ Announced ☒ Unannounced

Health Information and Quality Authority
Social Services Inspectorate

Action Plan

Provider's response to inspection report*

Centre:	The Marlay Nursing Home
Centre ID:	108
Date of inspection:	19 and 20 January 2011
Date of response:	24 February 2011

Requirements

These requirements set out what the registered provider must do to meet the Health Act 2007, 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*.

1. The provider has failed to comply with a regulatory requirement in the following respect: There was no comprehensive multidisciplinary review of residents who had multiple falls.	
Action required: Put arrangements in place for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents.	
Reference: Health Act, 2007 Regulation 31: Risk Management Procedures Standard 26: Health and Safety	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**

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

Provider's response: The Marlay has a centre-specific evidenced based policy on the Prevention and Management of Falls. A root cause analysis is now being introduced for every serious or untoward incident or adverse event involving residents. The recently established Multidisciplinary Risk Management Task Force which meets monthly is the forum where both clinical, including falls and non clinical risk management audits are reviewed and acted upon.	1 month and ongoing

2. The provider has failed to comply with a regulatory requirement in the following respect: Staff did not use evidenced based nursing practice in the use of restraint.	
Action required: Put procedures in place to ensure that staff use evidenced based nursing practice in the use of restraint.	
Reference: Health Act, 2007 Regulation 6: General Welfare and Protection Standard 21: Responding to Behaviour that is Challenging	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The Marlay has an evidenced based policy on restraint management. As a result of the inspection which highlighted the fact that the policy was not been adhered to in relation to three residents, all residents will be currently reassessed, in addition to their routine ongoing reassessments. Staff will be monitored to ensure their compliance with the policy.	1 month and ongoing

3. The provider failed to comply with a regulatory requirement in the following respect: There were limited activities and opportunities for meaningful engagement for dependent residents and residents with dementia.
Action required: Put procedures in place to ensure that all residents have opportunities to participate in activities appropriate to his or her interests and capacities.

Reference: Health Act, 2007 Regulation 6: General Welfare and Protection Standard18: Routines and Expectations	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: As outlined in the report different activities are continually being tested and feedback sought from the residents. Two members of the care team have undertaken training in Sonas© which is a therapy recommended for residents with dementia and Sonas© sessions are currently being introduced. Pet therapy and hand massage is also provided on an individual basis for residents. Story telling is also an activity which is enjoyed by our residents irrespective of their dependency level. We will continue to research suitable activities for our more dependent residents.	1 month and ongoing

4. The person in charge has failed to comply with a regulatory requirement in the following respect: There were limited opportunities for residents to partake in the development of their care plan.	
Action required: Ensure that residents' needs are set out in an individual care plan developed and agreed with each resident.	
Reference: Health Act, 2007 Regulation 8: Assessment and Care Plan Standard 11: The Resident's Care Plan	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: As outlined in the body of the report there has been an improvement in our care planning process. Care plans are developed with the resident/care representative but going forward we will introduce a system where residents will be shown a print out of the plan as agreed with them.	2 months

5. The provider has failed to comply with a regulatory requirement in the following respect:

There were limited arrangements in place for residents' consultation and participation in the organisation of the centre.

Action required:

Put arrangements in place to facilitate, insofar as is reasonably practical, consultation and participation in the organisation of the designated centre.

Reference:

Health Act, 2007
Regulation 10: Residents' Rights, Dignity and Consultation
Standard 2: Consultation and Participation

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The resident's council is the formal forum for residents to partake in the organisation of the centre with topics being raised and addressed by residents and the DON. The meetings are attended by approx 25 residents of varying degrees of dependency. An Advocacy representative from Age Action has committed to attending the next meeting with a view to enhancing our advocacy skills. On a day-to-day basis there is a relaxed open two-way communication process between residents/relatives and staff/management which facilitates taking on board residents comments and suggestions.	1 month and ongoing

6. The person in charge has failed to comply with a regulatory requirement in the following respect:

There was insufficient evidence of supervision in one of the day rooms where there a number of residents with dementia who displayed behaviours that challenged.

Action required:

Ensure that at all times the numbers of staff and skill-mix of staff are appropriate to the assessed needs of residents, and the size and layout of the designated centre.

Reference:

Health Act, 2007
Regulation 16: Staffing
Standard 23: Staffing Levels and Qualifications

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: The day room in question is now supervised more closely in the early morning which was the time highlighted as at risk.	Immediately

7. The provider has failed to comply with a regulatory requirement in the following respect: Staff files did not adequately comply with the Regulations, staff signed a self declaration for medical fitness instead of providing a physical and mental fitness from a qualified practitioner.	
Action required: Put plans in place to ensure that staff files contain all of the requirements in Schedule 2 of the Regulations.	
Reference: Health Act, 2007 Regulation 18: Recruitment Standard 22: Recruitment	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: All new staff will now be required to have a medical prior to commencing employment with The Marlay. Existing staff who have signed self declarations of fitness have been instructed to provide a physical and mental fitness from a qualified practitioner.	3 months

Recommendations

These recommendations are taken from the best practice described in *the National Quality Standards for Residential Care Settings for Older People in Ireland* and the registered provider should consider them as a way of improving the service.

Standard	Best practice recommendations
Standard 5: Civil, Political and Religious Rights	Provide an independent advocacy service for residents.
Standard 11: The Resident's Care Plan	Put planned procedures in place to ensure that all staff providing direct resident care have access to relevant resident information.
Standard 20: Maintaining Social Contacts	Provide increased opportunities for residents to maintain links and involvement with their local community groups are maintained in accordance with residents' preferences and with appropriate protective measures.

Any comments the provider may wish to make:

Provider's response:

We would like to take this opportunity to thank the inspectors for their objective assessment of our service. The report accurately reflects the continuous improvement we are constantly working towards.

Provider's name: Sue Cameron
Date: 21 February 2011