Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	Maryfield Nursing Home
Name of provider:	West of Ireland Alzheimer Foundation
Address of centre:	Farnablake East, Athenry, Galway
Type of inspection:	Unannounced
Date of inspection:	16 November 2022
Centre ID:	OSV-0000359
Fieldwork ID:	MON-0038299

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

Maryfield Nursing Home is a designated centre that provides long term and respite care for 24 male or female residents who have dementia or a related condition. The centre is located in a rural setting approximately two kilometres from the town of Athenry and 25 kilometres from Galway city. The centre is purpose built. It is single storey and residents' accommodation is provided in 12 single and six double rooms. There is adequate sitting and dining space to accommodate all residents in comfort. A safe garden area is also available. The environment has been enhanced by the use of dementia friendly features that include signage, good levels of natural lighting and a homelike layout.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	20

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 16 November 2022	09:00hrs to 18:00hrs	Una Fitzgerald	Lead

What residents told us and what inspectors observed

Maryfield Nursing home is a dementia specific centre where residents with a diagnosis of dementia live. Throughout this one day inspection, the inspector spent time observing residents and their engagement with staff. While none of the residents met were able to tell the inspector their views on the quality of the service, in the main, the inspector observed that the residents appeared content and relaxed in their environment. Staff were observed promoting a person-centred approach to care and were observed to be kind and caring. Relatives spoken with had high praise for the care their relatives received and also for the staff that they interact with.

The atmosphere observed by the inspector was calm, welcoming and homely. The communal sitting room was occupied by residents throughout the day. Residents were observed enjoying a wide variety of social activities. There was no group activity held on the day of inspection. When this was discussed with the care staff the inspector was told that the needs of the current residents are better met through the provision of one to one activities. The communal room was a hive of activity. At one point the inspector observed one resident completing a puzzle, one resident exploring a sensory mat and one resident sitting watching daily mass that had been specifically turned on for them. The communal room was supervised by a member of staff at all times. All staff spoken with displayed knowledge of the importance of social engagement with residents. In addition, staff had excellent knowledge of the residents, including their likes and dislikes.

The majority of residents spent their day in the communal room. Residents were seen moving about the centre unrestricted. The inspector observed staff asking residents what they would like to do. The inspector observed that residents in the centre were not rushed. Residents that required assistance with mobility were actively encouraged to walk to their destination. Staff in attendance chatted openly and freely. The inspector observed staff providing residents with assistance at mealtimes. Again, residents were not rushed, staff were observed actively encouraging residents to finish their meals, to ensure they had taken adequate nutrition.

The centre had recovered from a significant outbreak of COVID-19 in April 2022 and had been through a difficult time. Despite the challenges faced, relatives and staff spoken with expressed confidence in the service and supports available to them.

Residents and their relatives had access to an independent advocacy service. The inspector observed that the complaints process was made available at the main reception notice board. However, the document was observed to be inaccessible as it was taped closed and placed at a high level out of easy reach. This was highlighted to the person in charge who committed to a review of accessibility of the complaints process.

The next two sections of the report present the findings of this inspection in relation to the capacity and capability in place in the centre, and how these arrangements impacted on the quality and safety of the service being delivered.

Capacity and capability

The inspector found that residents received a high standard of direct care that met their assessed needs. The governance and management of the centre was organised. Information requested was presented in an easily understood format. The service was audited and while the person in charge was committed to quality improvement that would enhance and improve the daily lives of the residents, progress was negatively impacted due to having insufficient management support. This is a repeated finding from the last inspection in November 2021. Action was required on the systems in place surrounding the management of fire precautions to ensure full compliance with regulatory requirements. In addition, the inspector found significant gaps in the documentation that guides staff in the provision of care. This detail is discussed in the Quality and safety section of the report.

West of Ireland Alzheimers Foundation is the registered provider of Maryfield Nursing Home. This was an unannounced risk-based inspection. On the day of inspection, there were sufficient numbers of staff on duty to attend to the direct care needs of residents. The person in charge works full time on a supervisory basis. On the day of inspection, there was a clinical nurse manager on duty. There was one registered nurse on duty who was supported by a team of health care assistants.

The person in charge was supported in the centre by a clinical nurse manager. This clinical nurse manager was allocated 22 supervisory hours per week to supervise and support the nursing and care teams and to ensure appropriate monitoring of the service. A review of the staffing rosters found that the number of nursing staff committed to in the centres statement of purpose did not reflect the number of nurses available on the roster. This meant that the clinical nurse manager was required to be redirected and allocated to work in the provision of direct nursing care. This impacted the resources available to ensure that the service was appropriately monitored. For example, the inspector found poor oversight of resident records. In addition, a number of quality improvement actions, identified through clinical and environmental audit, could not be completed.

An auditing schedule was in place. Audits had been completed in a number of key areas including, care plan audits, infection prevention and control audits, nutritional audits and monitoring of restrictive practices. The inspector found that the audits completed were analysed and that an appropriate action plan was in place to address the identified issues. However, due to the issue raised under the governance and management resources available in the centre, audits actions

identified were not always completed in a timely manner.

Staff were provided with ongoing training and development relevant to their role and responsibilities. The inspector reviewed the training records for staff and observed that, with the exception of training relating to the management of responsive behaviours, all staff had received training appropriate to their role. A review of staff files did not contain all of the information required under Schedule 2 of the regulations.

A record of complaints raised by residents and relatives was maintained in the centre. Details of communication with the complainant and their level of satisfaction with the measures put in place to resolve the issues were included.

Regulation 15: Staffing

On the day of inspection, the number and skill mix of staff was appropriate with regard to the needs of the current residents, and the size and layout of the designated centre.

Judgment: Compliant

Regulation 16: Training and staff development

The person in charge confirmed that staff had not attended training on the management of behaviour that is challenging.

Judgment: Substantially compliant

Regulation 21: Records

Records as required by the regulations were not available. For example;

- Staff files did not contain all of the information required under Schedule 2 of the regulations. Written references and evidence of accredited training was not always available.
- Gaps in the nursing documentation and resident records.

Judgment: Substantially compliant

Regulation 23: Governance and management

The provider had failed to ensure there was continuous resources in place to support the person in charge. While the inspector found that systems such as auditing were in place, the shortfall in management resources was causing a delay in timely action taken by the management to address the gaps found. For example;

- Poor monitoring of fire safety procedures. For example, no fire drills had been completed in the centre for 2022. In addition, the effectiveness of the fire safety training received by staff was not monitored
- Poor oversight of the quality of nursing documentation. For example, incomplete information in the resident's care plan and nursing documentation. Care plans were allocated to named staff. When staff were on leave, the documentation was not reviewed and updated as required.
- Inadequate oversight of records management. For example, staff files did not contain the information required under Regulation 21.
- Poor information governance. For example, the visiting policy had not been updated since April 2020

Judgment: Not compliant

Regulation 34: Complaints procedure

The inspector reviewed the complaint management system and found that it contained the detail required under Regulation 34.

Judgment: Compliant

Quality and safety

The inspector found that the residents in Maryfield nursing home were receiving a high standard of care that supported and encouraged them to actively enjoy a good quality of life. Residents were encouraged and supported by staff to maintain their personal relationships with family and friends. Visitors were welcomed in the centre. The inspector spoke with visitors and all were very complimentary of the care provided to their relatives.

The inspector found that insufficient progress had been made following the last inspection on the management of fire precautions. Staff responses in what action to take on the sounding of the fire alarm were inconsistent. In addition, no fire drill had

been completed by the management team in 2022. Therefore, the provider could not provide assurances that all staff would be aware of the procedure to be followed, or that residents could be safely evacuated, in the event of a fire.

Residents' lives had been significantly impacted by the COVID-19 pandemic. Despite these challenges, the inspector found that the care and support residents received was of a high quality and ensured that they were safe and well-supported. Residents' medical and health care needs were met. The inspector found that the needs of residents were known to the staff. While there were gaps found in the recording of resident care assessments and in care plan documentation, in the main, the inspector found that these gaps were a recording issue and not a reflection on the direct care delivered. For example, a review of wound management identified that interventions taken and regular dressing changes resulted in the healing of wounds. The daily nursing notes recorded the care that was provided.

Clinical assessments of need were completed on admission. In addition individual risks assessments were completed and this information was then used to inform the development of the care plan. The records evidenced consultations with allied health and social care professionals. General practitioners completed on-site medical reviews when required. Residents daily care was observed to be recorded.

Resident accommodation is along one corridor. Through walking around the centre, the inspector observed many residents had personalised their bedrooms and had their photographs and personal items on display. Following the last inspection, upgrade works on the overall state of repair of the premises had been completed. The centre now has three communal bathrooms with showering facilities for resident use. In addition, repair and replacement of wardrobe doors and sink surrounds had been completed. Resident personalised equipment was observed to be clean.

Residents' rights were promoted in the centre and residents were encouraged to maximise their independence with support from staff. Residents were observed to be engaged in one to one activities throughout the day. Residents had access to religious services and could access religious services daily, via video link.

Regulation 11: Visits

The registered provider had ensured that visiting arrangements were in place and were not restricted.

Judgment: Compliant

Regulation 17: Premises

The inspector was satisfied that the premises were designed and laid out to meet the needs of the current residents.

Judgment: Compliant

Regulation 28: Fire precautions

Action was required in relation to the management of fire safety which posed a risk to the safety of residents. This was evidenced by;

- A review of the record of fire drills found that drills were not scheduled at suitable intervals. The management confirmed that they had not completed any fire drill in the centre for 2022. This is a repeated non compliance.
- Some staff spoken with did not demonstrate appropriate knowledge of evacuation procedures in the event of a fire.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

The inspector found that care plans did not contain the information required to guide the care. The inspector found that residents' needs were not always appropriately assessed in a timely manner which resulted in no care plan being developed to guide care. For example; two resident files evidenced that no care plan was developed for eight weeks following their admission into the centre. The review of resident care documentation also found that care plan detail was not always accurate with the most updated information.

Judgment: Substantially compliant

Regulation 6: Health care

Residents were provided with timely access to health and social care professional services. In addition, there was good evidence that advice received was followed which had a positive impact on the resident.

Judgment: Compliant

Regulation 9: Residents' rights

Interactions between residents and staff were observed to be kind, dignified and respectful. Residents were encouraged to exercise choice and had choice in a variety of one to one activities.

Residents right to privacy was upheld. Residents were supported to maintain their individual style and appearance. For example; multiple residents had makeup applied and were wearing decorative scarves and jewellery. Residents were well presented.

Residents had access to an independent advocacy service.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Maryfield Nursing Home OSV-0000359

Inspection ID: MON-0038299

Date of inspection: 16/11/2022

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant 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 document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: All staff are in the process of completing a Course for Support Pathways for people with Non-Cognitive Symptoms of Dementia and they will receive a certificate of completion following assessment.	
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: All staff files have been reviewed and gaps in documentation have been received / requested to ensure full compliance with Schedule 2. A review of Care Plans is underway to comply with Schedule 3. Additional resources have been allocated to ensure compliance going forward.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management:	

Three fire drills have been completed since the date of inspection and all staff have received refresher training in fire prevention and emergency procedures. Oversight of fire training/drills has been included in the annual planner to ensure compliance with fire regulations.

Additional nursing resources have been sourced to ensure that nursing care plans are kept up to date, taking extended periods of staff annual leave into consideration to ensure that there are no gaps in documentation.

Gaps in staff file documentation are in the process of being rectified. Files for new members of staff will be audited by management going forward to ensure there are no gaps in documentation.

A review of the Visiting Policy is underway and this will be updated as changes occur.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Three fire drills have been undertaken including one at night when staff ratios are at their lowest. In addition, all staff have received refresher training in fire prevention & emergency procedures to be followed in the event of a fire.

Fire Drills have been included in the Annual Planner to ensure that they are undertaken at regular intervals going forward.

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
Additional resources have been secured to ensure that care plans are prepared within the allocated time frame post admission of a new resident and that Care Plans are reviewed and updated to guide the care of residents.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	28/02/2023
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Substantially Compliant	Yellow	28/02/2023
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	31/12/2022
Regulation 23(c)	The registered provider shall ensure that	Not Compliant	Orange	31/12/2022

	management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.			
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	30/11/2022
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.	Substantially Compliant	Yellow	31/12/2022
Regulation 5(3)	The person in charge shall prepare a care plan, based on the	Substantially Compliant	Yellow	31/12/2022

	assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.			