### Health Information and Quality Authority

**Regulation Directorate**

**Compliance Monitoring Inspection report**

**Designated Centres under Health Act 2007, as amended**

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Dean Maxwell Community Nursing Unit</th>
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</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000665</td>
</tr>
<tr>
<td>Centre address:</td>
<td>The Valley, Roscrea, Tipperary.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>0505 21572/21389</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:brona.brophy@hse.ie">brona.brophy@hse.ie</a></td>
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<tr>
<td>Registered provider:</td>
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<tr>
<td>Provider Nominee:</td>
<td>Maria Bridgeman</td>
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<tr>
<td>Lead inspector:</td>
<td>Mary Costelloe</td>
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<tr>
<td>Support inspector(s):</td>
<td>Michelle O'Connor</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>26</td>
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<tr>
<td>Number of vacancies on the date of inspection:</td>
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About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

▪ Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
▪ Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider’s compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

▪ to monitor compliance with regulations and standards
▪ to carry out thematic inspections in respect of specific outcomes
▪ following a change in circumstances; for example, following a notification to the Health Information and Quality Authority’s Regulation Directorate that a provider has appointed a new person in charge
▪ arising from a number of events including information affecting the safety or wellbeing of residents.

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.
Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

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

The inspection took place over the following dates and times
From: 12 January 2016 09:00  To: 12 January 2016 19:30

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

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<td>Outcome 08: Health and Safety and Risk Management</td>
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<td>Outcome 09: Medication Management</td>
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<td>Outcome 11: Health and Social Care Needs</td>
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<td>Outcome 12: Safe and Suitable Premises</td>
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<td>Outcome 13: Complaints procedures</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 18: Suitable Staffing</td>
<td>Non Compliant - Moderate</td>
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Summary of findings from this inspection
This report sets out the findings of a monitoring inspection, which took place to monitor ongoing regulatory compliance. This inspection was unannounced and took place on one day. As part of the inspection the inspectors met with residents, the person in charge, staff, business manager and volunteers. The inspectors observed practices and reviewed documentation such as care plans, medical records, health and safety records, complaint logs, policies and procedures and staff files.

On the day of inspection, the inspectors were satisfied that the residents were cared for in a safe environment and that their nursing and healthcare needs were being met. The inspectors observed sufficient staffing and skill mix on duty during the day and night time but had some concerns regarding the levels in the evening time. This is discussed further under Outcome 18 Staffing.

The quality of residents’ lives was enhanced by the provision of a choice of interesting things for them to do during the day and an ethos of respect and dignity for both residents and staff was evident.
The person in charge and staff demonstrated a comprehensive knowledge of residents’ needs, their likes, dislikes and preferences. Staff and residents knew each other well, referring to each other by first names. Residents were observed to be relaxed and comfortable when conversing with staff.

The collective feedback from residents was one of satisfaction with the service and care provided.

The building was warm and comfortable but as outlined in previous inspection reports the design and layout of parts of the existing building did not meet the needs of all residents or comply with the requirements of the Regulations, as evidenced by the inadequate bath/shower facilities and lack of storage space for equipment. This is discussed further under Outcome 12 Premises.

The inspectors noted that other improvements were required to meet the Regulations in terms of reviewing the quality and safety of care, restraint management, medication management, nursing documentation, staff training, recording, emergency plan and complaints management.

There were 19 non compliances to be addressed including one major and seven moderate non compliances, these areas for improvement are contained in the Action Plan at the end of this report.
Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

Outcome 02: Governance and Management
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.

Theme:
Governance, Leadership and Management

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

Findings:
The provider had established a clear management structure, and the roles of managers and staff were clearly set out and understood. The former clinical nurse manager CNM 2 held the post of person in charge since November 2015 on an interim basis. The business manager informed the inspectors that the HSE were in the process of trying to recruit a new fulltime person in charge and CNM. Supports were in place to assist the person in charge deliver a good quality service. These supports included a risk advisor, infection prevention and control manager, business manager and senior operations manager. The management team were in regular contact. There were established regular meetings of persons in charge to discuss issues of concern and to share learning. Formal management meetings took place on a regular basis.

The inspector was satisfied that there was a full time person in charge with the appropriate experience and qualifications for the role. Deputising arrangements were in place in the absence of the person in charge. There was an on call out of hours system in place.

There were systems in place to review some aspects of the safety and quality of care. Audits/reviews had been carried out in relation to infection control, medication management and risk management protocols, however, where there were non compliances recorded there was no corrective action/reviews documented. While the person in charge told inspectors that there had been a review of incidents and accidents, the results were not available and there was no evidence that improvements had been brought about as a result of the audits. The person in charge told inspectors that she was currently in the process of improving and extending the audit systems.

Judgment:
Non Compliant - Moderate
Outcome 04: Suitable Person in Charge
The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:
Governance, Leadership and Management

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

Findings:
The person in charge was a registered nurse with the required experience in the area of nursing older people. She had been recently employed in the post, she worked full time. She had previously worked as the CNM2 for several years. She was on-call at weekends and out of hours.

The person in charge was knowledgeable regarding the Regulations, the Standards and her statutory responsibilities.

Suitable interim arrangements were in place in the absence of the person in charge. A senior nurse deputised in the absence of the person in charge and supervised the delivery of care. The operations manager told inspectors that the HSE were actively recruiting for a CNM2 who will deputise in the absence of the person in charge.

Judgment:
Compliant

Outcome 05: Documentation to be kept at a designated centre
The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:
Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.
Findings:
Inspectors reviewed staff training records and noted that while mandatory training records were up to date there was no evidence of other recent training haven taken place. Nursing staff spoken to informed inspectors of some recent training undertaken and of other training planned but this was not recorded. Recently recruited staff spoken with confirmed that they had received induction training however, there were no records available to confirm this. In the absence of comprehensive training records, inspectors were unable to assess if appropriate training had been undertaken by all staff. The person in charge told inspectors that she was in the process of drafting a training plan for 2016.

Judgment:
Non Compliant - Moderate

Outcome 07: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe care and support

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

Findings:
The inspector found that while measures were in place to protect residents from being harmed or abused, some staff required training and others required refresher training. The documentation to support the management of restraint was not in line with national policy.

The inspector reviewed the policies on responding to allegations of elder abuse and prevention, detection and response to elder abuse. Staff spoken to confirmed that they had received training in relation to the prevention and detection of elder abuse and were knowledgeable regarding their responsibilities in this area. Training records reviewed indicated that most staff had received training but refresher training had not taken place in recent years, some staff and volunteers had not recent training. The person in charge advised inspectors that the policy was currently being updated and training for 'Train the trainer' had commenced and was due to be rolled out to all staff in the coming months. One staff member spoken to told inspectors that she had recently attended a training and information day on the new policy.

The inspectors were satisfied that residents’ finances were managed in a clear and transparent manner. There was a policy in place on the management of residents' personal property. Small amounts of money were kept for safekeeping on behalf of
some residents. All money was securely stored. Individual balance sheets were maintained for each resident and all transactions were clearly recorded and signed by two staff members. Receipts were kept for all purchases and expenditure.

The inspectors reviewed the policies on responding to behaviours that challenge and use of restraint. The policy on behaviours that challenged outlined guidance and directions to staff as to how they should respond and strategies for dealing with behaviours that challenged.

The policy on restraint was based on the national policy 'Towards a restraint free environment' and included clear directions on the use of restrictive procedures including risk assessment and ensuring that the least restrictive intervention was used for the shortest period possible. There were nine residents using bed rails at the time of inspection.

While staff tried to promote a restraint free environment the documentation to support the management of restraint was not in line with the centres own policy or national policy on the use of restraint. Risk assessments completed were not in line with policies. There was no evidence that alternatives had been tried or considered or of the risks involved in using the restraint. There was no evidence of multidisciplinary input into the decision to use the restraint measure and there was no clear rationale documented for its use. There were no care plans in place to guide staff on the use of bedrails, however, staff did carry out regular checks on residents using bedrails and these checks were recorded.

Inspectors were satisfied that the policy on behaviours that challenged was being implemented. Inspectors reviewed the file of a resident who presented with behaviours that challenged and noted that it included clear guidance for staff as to how to manage and deescalate situations. All episodes were recorded on an ABC chart in line with policy.

Staff spoken with and training records reviewed indicated that only seven staff members had received training on restraint management in 2012 and most staff had not received training in managing behaviour that challenges. Inspectors noted that policies mentioned under this outcome were only signed by a small number of staff as having read and understood them.

Judgment:
Non Compliant - Moderate

Outcome 08: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Safe care and support
Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
While the provider had systems in place to protect the health and safety of residents, staff and visitors, the emergency plan required updating.

There was a health and safety statement available. An inspector reviewed the risk register and found that it had been regularly reviewed and updated following the last inspection. All risks specifically mentioned in the Regulations such as assault, accidental injury, aggression and violence and self harm were included.

The inspectors noted that there were two versions of the emergency plan in place, both of which included out of date information such as identified arrangements in place locally for alternative accommodation in the event of the building having to be evacuated were now closed.

Training records reviewed indicated that all staff members had received up-to-date training in moving and handling. Staff spoken to confirmed that they had received training. The inspector observed good practice in relation to moving and handling of residents during the inspection.

The inspectors reviewed the fire policies and procedures. Records indicated that all fire fighting equipment had been serviced in February 2015 and the fire alarm was serviced on a quarterly basis. The last fire alarm service took place on 25 November 2015. Systems were in place for regular testing of the fire alarm, daily and weekly fire safety checks and these checks were being recorded. All staff spoken with stated they had received fire safety training and were confident in knowing what to do in the event of fire, training records reviewed confirmed that training had taken place. Records reviewed indicated that fire drills took place regularly, the last drill took place in September 2015.

The inspectors were unable to view the incident/accident report log. The person in charge told inspectors that when an incident form is completed, it is sent to the risk advisor who completes a quarterly analysis. The person in charge did not keep copies. The person in charge stated that she in turn receives a copy of the analysis but this was not available during the inspection. There was no evidence at the time of inspection that arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents were adequate.

The inspector noted that infection control practices were robust. There were comprehensive infection control policies in place relating to infection prevention and control. Hand sanitising dispensing units were located at the front entrance and throughout the building. Staff were observed to be vigilant in their use. All staff had received training in infection control and hand washing techniques. Recent audits reviewed by the inspector indicated good compliance.

Judgment:
Non Compliant - Moderate
Outcome 09: Medication Management
Each resident is protected by the designated centre’s policies and procedures for medication management.

Theme:
Safe care and support

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

Findings:
The inspectors noted that while the policies and procedures for medication management were generally safe some improvements were required particularly in relation to prescribing and training.

An inspector reviewed the medication management policy which was found to be comprehensive, and gave detailed, clear guidance on areas such as administration, prescribing, storage, disposal, crushing, "as required" (PRN) medications, medications requiring strict controls and medication errors.

An inspector spoke with a nurse on duty regarding medication management issues. The nurse demonstrated her competence and knowledge when outlining procedures and practices on medication management.

The inspector reviewed a sample of medication prescribing and administration sheets. All medications were regularly reviewed by the general practitioners (GP), however, nursing staff were crushing some medications that were not individually prescribed as such.

Medications requiring strict controls were appropriately stored and managed. The inspector saw that these were stored in a double locked cupboard in the clinical room. Records indicated that they were counted and signed by two nurses at change of each shift in accordance with the centre’s medication policy. Secure refrigerated storage was provided for medications that required specific temperature control. The temperature of the refrigerator was monitored and recorded on a daily basis. The opening date of some medications such as eye drops was not recorded which posed a risk of using out of date medications.

Systems were in place for recording of medication errors and the ordering, receipt and return of medications to the pharmacy. Nursing staff were familiar with these. An inspector reviewed a recent medication error report involving the prescribing and administration of a medication to which a resident was allergic to. The inspector noted that while the allergy status was recorded on the front of the prescription/administration chart, it was recorded in the same colour ink as all other information, this posed a risk to residents in that the allergy status was not clearly highlighted.
A detailed medication management audit was carried out in June 2015 by the pharmacist. Nursing staff confirmed that the result of the audit had been discussed with them and improvements brought about as a result.

Nursing staff spoken with told inspectors that they had not received recent medication management training updates and training records reviewed indicated that only three nurses had training in 2013. This non compliance is included under Outcome18 Suitable staffing.

**Judgment:**
Non Compliant - Moderate

### Outcome 11: Health and Social Care Needs

Each resident’s wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident’s assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

**Theme:**
Effective care and support

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

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

**Findings:**

The inspectors found that residents’ overall healthcare needs were met and they had access to appropriate medical and allied healthcare services and each resident had opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The inspectors followed up on issues highlighted at the last inspection and while they noted that some had been addressed, there were still some inconsistencies in the nursing documentation.

All residents had access to GP services. There was an out-of-hours general practitioner (GP) service available. The inspectors reviewed a sample of files and found that GPs reviewed residents on a regular basis.

A full range of other services were available including speech and language therapy (SALT), physiotherapy, occupational therapy (OT), dietetic services and psychiatry of later life. Chiropody services were also provided. The inspector reviewed residents’ records and found that residents had been referred to these services and results of appointments were written up in the residents’ notes.

The inspectors reviewed a number of residents’ files including the files of residents with superficial wounds, restraint measures in place, at high risk of falls, at risk of developing
pressure ulcers, nutritionally at risk, presenting with behaviours that challenge and with specific medical conditions. See Outcome 7 in relation to restraint and management of challenging behaviour.

Comprehensive nursing assessments were in place for all residents. A range of risk assessments were completed for residents including risk of developing pressure ulcers, falls risk, nutritional assessment, dependency and manual handling.

The inspectors noted that care plans were generally in place for all identified issues. Care plans guided care and were person centered. While nursing staff spoken with confirmed that there was regular and ongoing communication with relatives regarding residents care, evidence of consultation with the resident/relative in relation to development and review of care plans was seldom documented.

Inspectors were satisfied that wounds were being well managed. There were adequate up to date wound assessments and wound care plans in place.

The inspectors were satisfied that weight changes were closely monitored. All residents were nutritionally assessed using a validated assessment tool. All residents were weighed monthly. Nursing staff told the inspector that if there was a change in a resident’s weight, nursing staff would reassess the resident, inform the GP and referrals would be made to the dietician and speech and language therapy (SALT). Files reviewed by the inspector confirmed this to be the case. Nutritional supplements were administered as prescribed.

Inspectors noted some inconsistencies in the nursing documentation.
- Risk assessments were not always up to date.
- Care plans were not in place for the use of bed rails.
- The three monthly reassessment of care plans was not always informative and up to date.
- Recommendations from allied health professionals referred to in some care plans were sometimes difficult to find.
- Information such as monthly weight records were recorded in a separate log book, some residents files were not regularly updated with the relevant information.
- Some care plans did not provide clear guidance for staff for example there was no guidance for staff on the care of a catheter.

Staff and volunteers continued to provide meaningful and interesting activities for residents. There were two activity coordinators employed, both had completed a range of training specific to their role. The weekly and daily activities schedule was displayed. The inspectors observed residents enjoying a variety of activities during the inspection including light exercises, quiz, knitting and discussing the daily newspaper headlines. Many of the residents actively partook and residents informed the inspector that they enjoyed the variety of activities taking place; particularly music sessions and the exercise programme. Other activities included imagination gym, cookery, gardening, art, bingo, health promotion talks and Sonas programme (therapeutic programme specifically for residents with Alzheimer disease). Mass was celebrated weekly in the centre and the daily local church services were relayed by video link to the television in the 'snug' dayroom. Residents spoken with told inspectors how they enjoyed being able to join in
the local church ceremonies. Day service users joined the residents for some activities during the week days, residents enjoyed the social interaction and getting local news.

Judgment:
Non Compliant - Moderate

Outcome 12: Safe and Suitable Premises
The location, design and layout of the centre is suitable for its stated purpose and meets residents’ individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:
Effective care and support

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

Findings:
Inspectors found the centre to be warm and comfortable with a variety of communal day spaces available to residents. The person in charge confirmed that the centre was operating within the procedures outlined in the statement of purpose for the management of the single rooms as requested by the Authority and that all residents assessed as requiring the use of a hoist were not accommodated in single rooms.

The inspectors noted that there was one bathroom with a specialised bath for use by residents in the centre, however, the bath was out of order since June 2015. There was no other bath available and no separate shower facilities for ten residents occupying single bedrooms. The person in charge advised the inspectors that these residents used the showers located in the en suite shower rooms of other residents. Residents did not have a choice of bath or shower and lack of adequate showering facilities impacted on the privacy and dignity of residents.

Inspectors noted that there was inadequate space for the storage of equipment. Staff spoken with confirmed that this was an on going issue as there was no separate storage available to store equipment such as specialised chairs, wheelchairs, walking frames and hoists when not in use. The activities room/arts and craft room which was also being used as a hairdressing room was disorganised and cluttered with equipment. This impacted on the space available to residents to partake in activities and did not provide a relaxing, comfortable environment.

The person in charge advised the inspectors that a new specialised bath had been secured and was due to be installed within two weeks. The business manager confirmed this and told inspectors that plans were being considered to provide additional assisted
shower facilities, hairdressing room and separate storage for equipment.

There was inadequate ventilation provided to the external laundry room as there was no openable window. The person in charge confirmed that this issue had been brought to the attention of management in the HSE.

The water dispenser unit located in the dining room was found to be defective, rusted, and leaking.

**Judgment:**
Non Compliant - Major

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**Outcome 13: Complaints procedures**
*The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.*

**Theme:**
Person-centred care and support

**Outstanding requirement(s) from previous inspection(s):**
Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**
The inspectors found that improvements were required to complaints management.

Inspectors reviewed the complaints policy and noted that it required updating in order to reflect the changes to the nominated complaints officer and person responsible for dealing with appeals.

The complaints procedure was not displayed in a prominent position and also required updating to reflect the changes to the nominated complaints officer and person responsible for dealing with appeals.

Inspectors were informed that there were no recent written complaints but reviewed some verbal complaints that were recorded. Inspectors noted that there was insufficient detail documented such as no date of complaint, the investigation process was not fully explained and the outcome was not always clear. There was no evidence that the complainant was satisfied or not with the outcome.

The person in charge told inspectors that a new template to record all complaints was being developed which will assist/prompt staff to record the required information.

**Judgment:**
Substantially Compliant
### Outcome 18: Suitable Staffing

There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

<table>
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<th>Theme: Workforce</th>
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### Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

### Findings:

On the day of inspection, there was an adequate ratio of staff to residents on duty during the daytime, however, the inspectors had some concerns regarding staffing levels in the evening time. On the day of inspection there were four nurses and three multi-task assistants providing direct resident care on duty during the daytime; two nurses and two multi-task attendants providing direct resident care on duty in the evening time from 17.00 to 23.00 and one nurse and two multi-task attendants on duty at night time 23.00 to 08.30. The person in charge was also on duty during the day time. Staff rotas reviewed by the inspectors indicated that these were the usual arrangements, however, the nurse in charge in the absence of the person in charge was not clearly identified.

The person in charge and staff spoken with all mentioned the increasing dependency of many residents, there were 15 residents assessed as being of high dependency at the time of inspection. The inspectors had concerns regarding staffing levels in the evening time given that two nurses were involved in administering the evening medication rounds, some high dependency residents wished to go to bed and required the assistance of two staff while other residents required supervision in the day areas during this time period.

The inspector was satisfied that safe recruitment processes were in place. There was a comprehensive recruitment policy in place based on the requirements of the Regulations. Staff files were found to contain all the required documentation as required by the Regulations. Garda Síochána vetting was in place for all staff. Nursing registration numbers were available and up-to-date for all staff nurses.

A number of volunteers attended and assisted residents with a variety of activities in the centre. Inspectors reviewed a sample of files and found that volunteers had their roles and responsibilities clearly set out however, inspectors noted that there was no evidence of Garda Síochána vetting for one.

Inspectors reviewed staff training records and noted that while mandatory training
records were up to date there was no evidence of other recent training haven taken place. Nursing staff spoken to informed inspectors of some recent training undertaken and of other training planned but this was not recorded. Recently recruited staff spoken with confirmed that they had received induction training however, there were no records available to confirm this. In the absence of comprehensive training records, inspectors were unable to assess if appropriate training had been given to all staff. The person in charge told inspectors that she was in the process of drafting a training plan for 2016. Staff training and training records are actioned under Outcomes 4, 7 and 9.

**Judgment:**
Non Compliant - Moderate

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**Closing the Visit**

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

**Acknowledgements**

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

**Report Compiled by:**

Mary Costelloe  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority
Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider’s response to inspection report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Dean Maxwell Community Nursing Unit</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000665</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>12/01/2016</td>
</tr>
<tr>
<td>Date of response:</td>
<td>15/02/2016</td>
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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 02: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Where reviews had been carried out and non compliances recorded there was no corrective action/review documented. While the person in charge told inspectors that there had been a review of incidents and accidents, the results were not available and there was no evidence that improvements had been brought about as a result of the audits.

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

**Please state the actions you have taken or are planning to take:**
As per Regulation 23(c):

- Systems are being put in place to ensure the delivery of safe, consistent and effective care.
- A Quality Improvement Plan will ensure that where there were non compliances recorded, corrective action / reviews will be actioned and documented
- An audit schedule will be developed with corrective actions taken in response to non compliances

**Proposed Timescale:** 30/06/2016

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**Outcome 05: Documentation to be kept at a designated centre**

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Staff training records were incomplete and there were no records of induction training received by staff.

**2. Action Required:**
Under Regulation 21(1) you are required to: 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.

**Please state the actions you have taken or are planning to take:**
As per regulation 21 (1):

- Staff training records are currently being reviewed and updated.
- In particular, a comprehensive training excel sheet will be updated with recent training undertaken by staff recorded. An assessment of the training plan for 2015 will inform the actions required for training required by staff for 2016.
- All induction training records will be recorded on staff files.

**Proposed Timescale:** 30/06/2016

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**Outcome 07: Safeguarding and Safety**

**Theme:**
Safe care and support
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The documentation to support the management of restraint was not in line with the centres own policy or national policy on the use of restraint. Risk assessments completed were not in line with policies. There was no evidence that alternatives had been tried or considered or of the risks involved in using the restraint. There was no evidence of multidisciplinary input into the decision to use the restraint measure and there was no clear rationale documented for its use.

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

Please state the actions you have taken or are planning to take:
As per Regulation 07(3):

• Staff training for a refresher course on the National Restraint Policy (DoH) will be scheduled supported by the Continuing Nursing and Midwifery function (CNME). The policy on restraint will be given to all staff and when read they will sign for same.

• Staff refresher training on MAPA is further scheduled for 2016. Over 50% of staff have received recent MAPA training. Staff will sign the Policy on Behaviours that Challenge.

• The assessment, intervention and care planning document (DML) has been introduced to the unit in line with the National Restraint Policy, this assesses the use of restraint. The document is completed in conjunction with the resident and or their family acting as their advocate. The policy on restraint will be given to all staff and when read will sign for same. A lead person has been appointed to audit all care plans on a quarterly basis.

• Risk assessments will be aligned with national policy on the use of restraint. MDT input to alternatives that have been tried or considered, and any risks involved will be recorded. Careplans will be developed to guide staff on the use of bedrails.

• A Multidisciplinary approach will continue to be used with regards restraint in the future and will be documented. Guidance and support from the GP’s and all relevant allied healthcare workers will be requested.

Proposed Timescale: 31/03/2016

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Most staff had not received training in managing behaviour that challenges and many staff had not received training on the management of restraint. Inspectors noted that policies mentioned under this outcome were only signed by a small number of staff as having read and understood them.

4. **Action Required:**
Under Regulation 07(1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.

**Please state the actions you have taken or are planning to take:**
As per Regulation 07(1):

- A training needs analysis is being completed for 2016 using feedback from staff.
- The requirements will be supported by the CNME and other trainers such as MAPA and CPR leads within the service.
- Staff refresher training on MAPA is scheduled for 2016.
- Policy on Behaviours that Challenge will be given to all staff and when read they will sign same

**Proposed Timescale:** 31/03/2016

**Theme:**
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Training records reviewed indicated that most staff had received training but training had not taken place in recent years, some staff and volunteers had not recent training.

5. **Action Required:**
Under Regulation 08(2) you are required to: Ensure staff are trained in the detection and prevention of and responses to abuse.

**Please state the actions you have taken or are planning to take:**
As per Regulation 08(2):
- Staff training on the Safeguarding Vulnerable Persons at Risk of Abuse National Policy and Procedure will be rolled out to all staff on a phased basis during 2016.
- Two Staff Nurses have had training and a “Train the Trainer” plan is being actioned in 2016. The Policies are available to staff and will be read and signed immediately.

**Proposed Timescale:** 30/06/2016
**Outcome 08: 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:**
There were two versions of the emergency plan in place both of which included out of date information.

**6. Action Required:**
Under Regulation 26(2) you are required to: Ensure that there is a plan in place for responding to major incidents likely to cause death or injury, serious disruption to essential services or damage to property.

**Please state the actions you have taken or are planning to take:**
As per Regulation 26(2):
• The Emergency plan has been reviewed, updated and has been amended to respond appropriately to major incidents.

**Proposed Timescale:** 15/02/2016

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Records relating the identification, recording, investigation and learning from serious incidents or adverse events involving residents were not available during the inspection.

**7. Action Required:**
Under Regulation 26(1)(d) you are required to: Ensure that the risk management policy set out in Schedule 5 includes arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents.

**Please state the actions you have taken or are planning to take:**
As per Regulation 26(1)(d):

• A system will be put in place for the identification, recording, investigation and learning from serious incidents or adverse events involving residents are required. This will be supported by the QRPS advisor.
• The results will be communicated to staff.
• Learning notices will be issued to the unit and wider organisation if necessary for learning purposes as appropriate.
• The PIC is ensuring that discussions/feedback with staff and learning by staff is documented.
**Proposed Timescale: 30/04/2016**

**Outcome 09: Medication Management**

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Nursing staff were crushing some medications that were not individually prescribed as such.

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

**Please state the actions you have taken or are planning to take:**
As per Regulation 29(5):

- Each Nurse is required to ensure that all medicinal products are administered in accordance with the directions of the prescriber and in accordance with any advice provided by resident’s pharmacist regarding the appropriate use of the product.
- Medications requiring crushing will be individually prescribed by the GPs
- An audit of the Drug Kardex has been completed to ensure adherence to policy
- Allergy status has been highlighted clearly on Kardex.
- Nursing staff were requested to complete an NMBI e learning Medication management course and to issue the certificate to management within the month.
- The CNME, have been requested to facilitate dates on Medication Management which includes the Scope of Practice. Dates have been secured for February/March.
- The Medication Management Policy will be given to all staff and when read they will sign for same

**Proposed Timescale: 31/03/2016**

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The opening date of some medications such as eye drops was not recorded which posed a risk of using out of date medications.

**9. Action Required:**
Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident’s pharmacist regarding the appropriate use of the product.
Please state the actions you have taken or are planning to take:
As per Regulation 29(5):

• The opening date of medications, such as eye drops are now recorded.

Proposed Timescale: 15/02/2016

Outcome 11: Health and Social Care Needs

Theme:
Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
- Risk assessments were not always up to date.
- The three monthly reassessment of care plans was not always informative and up to date.
- Information such as monthly weight records were recorded in a separate log book, some residents files were not regularly updated with the relevant information.

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

Please state the actions you have taken or are planning to take:
As per Regulation 05(4):
• An audit of the DML Care Planning System is being completed and all quality improvements auctioned. Fortnightly meetings being held to review progress.
• Risk Assessments will be reviewed, updated and kept up to date.
• 3 monthly assessments will be undertaken,
• Care plans will be completed and kept up to date.

Proposed Timescale: 31/03/2016

Theme:
Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
- Care plans were not in place for the use of bed rails.
- Some care plans did not provide clear guidance for staff for example there was no guidance for staff on the care of a catheter.

11. 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:
As per Regulation 05(3):

• The Nursing staff will 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. Residents now have a separate care plan for the assessment of bed rails using the assessment document as per National Policy.
• Individualised assessments will have a care plan in accordance to the interventions required e.g. catheter care.

Proposed Timescale: 29/02/2016
Theme:
Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Evidence of consultation with the resident/relative in relation to development and review of care plans was seldom documented.

12. 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:
As per Regulation 05(5):

• Each Resident /relative is consulted in development of the care plan. The care plan when agreed and will be signed by resident/relative and this will be documented and any appropriate corrective actions will be undertaken.
• Care plans will be audited 3 monthly.

Proposed Timescale: 31/03/2016

Outcome 12: Safe and Suitable Premises
Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in

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the following respect:
The there was one bathroom with a specialised bath for use by residents in the centre, however, the bath was out of order since June 2015. There was no other bath available and no separate shower facilities for ten residents occupying single bedrooms. Residents did not have a choice of bath or shower and lack of adequate showering facilities impacted on the privacy and dignity of residents.

There was inadequate space for the storage of equipment.

The activities room/arts and craft room which was also being used as a hairdressing room was disorganised and cluttered with equipment. This impacted on the space available to residents to partake in activities and did not provide a relaxing, comfortable environment.

There was inadequate ventilation provided to the external laundry room as there was no openable window.

The water dispenser unit located in the dining room was found to be defective, rusted, and leaking.

13. 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:
As per Regulation 17(2):

• Through the Capital Plan 2016 – 2021 for Services for Older People funding to be made available for refurbishment works to the Unit - value of €100k. This is part of the overall control development plan for North Tipperary.
• Specialised bath has been installed and commissioned
• A new water dispenser has been installed.
• Storage space, ventilation and the activity centre will be considered as part of the refurbishment plan

Proposed Timescale: 31/12/2016

Outcome 13: Complaints procedures

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The complaints procedure was not displayed in a prominent position.

14. Action Required:
Under Regulation 34(1)(b) you are required to: Display a copy of the complaints procedure in a prominent position in the designated centre.

**Please state the actions you have taken or are planning to take:**
As per Regulation 34(1)(b):

- A copy of the complaints procedure is on view in the front hall.
- All staff were given a copy of the Complaints Policy and signed same when read.

**Proposed Timescale:** 15/02/2016

**Theme:**
Person-centred care and support

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

There was insufficient detail documented such as no date of complaint, the investigation process was not fully explained and the outcome was not always clear. There was no evidence that the complainant was satisfied or not with the outcome.

**15. Action Required:**
Under Regulation 34(1)(f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.

**Please state the actions you have taken or are planning to take:**
As per Regulation 34(1)(f):

- The person in charge will keep a comprehensive record of all complaints including investigations and outcomes as per complaints policy.
- At present all complaints are being collated and discussed with Senior Management.

**Proposed Timescale:** 30/03/2016

**Theme:**
Person-centred care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The complaints policy and procedure required updating in order to reflect the changes to the nominated complaints officer and person responsible for dealing with appeals.

**16. Action Required:**
Under Regulation 34(1) you are required to: Provide an accessible and effective complaints procedure which includes an appeals procedure.
Please state the actions you have taken or are planning to take:
As per Regulation 34(1):

- The complaints procedure has been updated to reflect the changes to the nominated complaints officer and person responsible for dealing with appeals.
- The complaints procedure and complaints officer are available to the public.

**Proposed Timescale:** 31/03/2016

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**Outcome 18: Suitable Staffing**

**Theme:**
Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Inspectors had some concerns regarding staffing levels in the evening time given that two nurses were involved in administering the evening medication rounds, some high dependency residents wished to go to bed and required the assistance of two staff while other residents required supervision in the day areas during this time period.

**17. Action Required:**
Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

**Please state the actions you have taken or are planning to take:**
As per Regulation 15(1):
- Current rosters and tasks will be reviewed to ensure, staff and skill mix is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.
- Ongoing recruitment of staff to the unit

**Proposed Timescale:** 31/03/2016

**Theme:**
Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Training records reviewed and nursing staff spoken with indicated that many had not received recent medication management training updates.

**18. Action Required:**
Under Regulation 16(1)(a) you are required to: Ensure that staff have access to appropriate training.
Please state the actions you have taken or are planning to take:
As per Regulation 16(1)(a):

- A training need analysis has commenced for 2016
- Medication management training is being organised, training to take place during February and March, 2016
- All nurses have been requested to access to medication management training on-line and issue the certificate of completion to PIC within the month.

Proposed Timescale: 31/03/2016

Theme: Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was no evidence of Garda Síochána vetting on one volunteer file reviewed.

19. Action Required:
Under Regulation 30(c) you are required to: Provide a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 for people involved on a voluntary basis with the designated centre.

Please state the actions you have taken or are planning to take:
As per Regulation 30 (c):

- All volunteers’ files will be reviewed to ensure they are compliant with vetting regulations as per regulations.

Proposed Timescale: 31/03/2016