### Centre name:
Maypark House Nursing Home

### Centre ID:
OSV-000249

### Centre address:
Maypark House,
Maypark Lane,
Waterford.

### Telephone number:
051 301 848

### Email address:
info@mayparkhouse.ie

### Type of centre:
A Nursing Home as per Health (Nursing Homes) Act 1990

### Registered provider:
Maypark Lane Limited

### Provider Nominee:
Michael Dwyer Snr.

### Lead inspector:
Catherine Rose Connolly Gargan

### Support inspector(s):
Ide Cronin

### Type of inspection:
Unannounced Dementia Care Thematic Inspections

### Number of residents on the date of inspection:
30

### Number of vacancies on the date of inspection:
12
About Dementia Care Thematic Inspections

The purpose of regulation in relation to residential care of dependent Older Persons is to safeguard and ensure that the health, wellbeing and quality of life of residents is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer and more fulfilling lives. This provides assurances to the public, relatives and residents that a service meets the requirements of quality standards which are underpinned by regulations.

Thematic inspections were developed to drive quality improvement and focus on a specific aspect of care. The dementia care thematic inspection focuses on the quality of life of people with dementia and monitors the level of compliance with the regulations and standards in relation to residents with dementia. The aim of these inspections is to understand the lived experiences of people with dementia in designated centres and to promote best practice in relation to residents receiving meaningful, individualised, person centred care.
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 compliance with specific outcomes as part of a thematic inspection. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times
From: 03 March 2016 08:00  To: 03 March 2016 19:00

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

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Provider's self assessment</th>
<th>Our Judgment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome 01: Health and Social Care Needs</td>
<td>Substantially Compliant</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 02: Safeguarding and Safety</td>
<td>Substantially Compliant</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 03: Residents' Rights, Dignity and Consultation</td>
<td>Substantially Compliant</td>
<td>Non Compliant - Major</td>
</tr>
<tr>
<td>Outcome 04: Complaints procedures</td>
<td></td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 05: Suitable Staffing</td>
<td>Substantially Compliant</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 06: Safe and Suitable Premises</td>
<td>Substantially Compliant</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 08: Governance and Management</td>
<td></td>
<td>Non Compliant - Moderate</td>
</tr>
</tbody>
</table>

Summary of findings from this inspection
This inspection report sets out the findings of a thematic inspection which focused on specific outcomes relevant to dementia care in the centre. The inspection also considered notifications received and the details of unsolicited information received by the Authority referencing unsatisfactory resident care, staffing levels, provision of resources and infection prevention and control procedures in relation to soiled linen segregation. With the exception of infection prevention and control procedures, this unsolicited information was substantiated by inspectors' findings on this inspection.

This inspection also reviewed 22 actions required following the last inspection in August 2015 and found that 10 actions had been satisfactorily completed. Seven of eighteen outcomes were inspected against in full or in part on this inspection.
As part of the thematic inspection process, providers were invited to attend information seminars given by the Authority. In addition, evidence-based guidance was developed to guide the providers on best practice in dementia care and the inspection process. Prior to this inspection, the provider nominee completed the self-assessment document by comparing the service provided with the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

Residents' accommodation in the centre comprises of two floors. Residents with dementia integrated as part of the overall resident population in the centre. While the inspectors found that the provider and staff had made efforts to upgrade the premises décor to provide a therapeutic and comfortable environment for residents with dementia, further significant improvements were required. These improvements included provision of a safe external space for residents and limitations posed by a ramp in the corridor to the dining room.

In the pre-inspection self assessment document, the provider's judgement of substantial compliance concurred with the inspectors' judgement in relation to safeguarding and safety. However the provider's judgement of substantial compliance was divergent to inspectors' judgement of moderate non compliances in health and social care, staffing, and premises and major non compliance in residents' rights, dignity, consultation. Inspectors also found a moderate non compliance in relation to the outcome governance and management.

Inspectors met with residents and staff members during the inspection. They tracked the journey of three residents with dementia within the service. They observed care practices and interactions between staff and residents who had dementia using a validated observation tool. Inspectors also reviewed documentation such as care plans, medical records and staff files. Inspectors examined the relevant policies including those submitted prior to inspection.

The commentary from residents and relatives who spoke with the inspectors was generally positive about the care and support they received. However, the findings of this inspection did not support satisfactory person-centred care and communication practices on some occasions. While there was some improvement in the centre's overall level of regulatory compliance, there was repeated and new areas of non-compliance found on this inspection.

The centre's management structure did not clearly demonstrate the lines of accountability and authority on this inspection. Arrangements for the person in charge to adequately manage and oversee the delivery of care to two designated centres were not adequate. This is demonstrated in the findings and impacted negatively on the outcome of this inspection.

The provider confirmed that the maximum occupancy was revised from 42 to 30 residents due to challenges in recruitment of adequate staffing resources. While this action is acknowledged, further improvement was found to be required to ensure
effective delivery of care to residents with dementia in line with the centre's statement of purpose.

There were policies and procedures in place around safeguarding residents from abuse. All staff had completed training, and were knowledgeable about the steps they must take if they witness, suspect or were informed of any abuse taking place. There were also policies and practices in place around managing responsive and psychological behaviour, and using methods of restraint in the service. Improvement in development of care plans to inform management of behaviors that challenged was required. Some areas of medication management practice was identified for improvement on this inspection.

The Action Plan at the end of this report identifies areas where improvements are required to comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centre's for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.
Outcome 01: Health and Social Care Needs

Theme:
Safe care and support

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

Findings:
This outcome sets out the inspection findings relating to healthcare, assessments and care planning. The social care of residents with dementia is discussed and actioned in Outcome 3.

There were a total of 30 residents in the centre on the day of this inspection. Seventeen residents had been assessed as maximum dependency, seven residents had high dependency needs, five residents had medium dependency needs and one resident had low dependency needs. 11 residents had a formal diagnosis of dementia and 10 others presented with symptoms of dementia. A referral pathway was in place for residents admitted with symptoms of dementia to ensure diagnostic procedures were completed appropriately which was demonstrated. There were no residents under 65 years residing in the centre on the day of inspection.

A computerised password protected system was in use for management of residents’ documentation in the centre. There were suitable arrangements in place to meet the health and nursing needs of residents with dementia. Each resident’s needs were determined by comprehensive assessment with care plans developed based on their identified needs within 48hrs of admission. Care plans were updated in line with residents changing needs. Residents and their families, where appropriate were involved in the care planning process, including end of life care plans which reflected the wishes of residents with dementia. Care staff were involved in recording care given by them to residents by means of touch-screen pods located on each floor.

Residents had a choice of General Practitioner (GP). As some residents were from the locality, they continued to have their medical care needs met by their GP prior to their admission to the centre. Residents had access to allied healthcare professionals. A physiotherapist was employed by the provider and treated residents as part of the service provided to them. The centre also had a physiotherapy treatment room with equipment such as parallel bars for residents’ use. Some residents/relatives spoken with complimented the physiotherapy service. Many residents with complex care and mobility needs were assessed by occupational therapy services and had assistive wheelchairs to
promote their comfort and mobility needs.

Residents in the centre also had access to specialist mental health of later life services. A member of this team visited residents referred to them and reviewed other residents on a regular basis as follow-up to consultations they completed.

Inspectors focused on the experience of residents with dementia in the centre on this inspection. They tracked the journey of three residents with dementia and also reviewed specific aspects of care such as nutrition, wound care and end of life care in relation to other residents.

The Authority were notified of six incidents of pressure ulcers to residents in the centre since 01 January 2015. Three of these incidents occurred prior to admission to the centre and three incidents referenced pressure ulcers that occurred in the centre. There were no residents in the centre with pressure ulcers on the day of this inspection. Inspectors found that each resident had a risk of pressure ulcer development assessment completed on admission and regular reassessment thereafter. Many residents were provided with pressure relieving mattresses and seating. Wound care management procedures were reviewed by inspectors and were found to be satisfactory on this inspection. Prescribed dressing regimes were recorded and progress was monitored by photographic tracking procedures. Nutritional assessments were completed with supplementation provided as appropriate to optimise healing.

There were systems in place to optimise communications between the acute hospital and the centre. Copies of transfer documentation to and from hospital in residents’ files contained appropriate information about their health, medications and their specific communication needs. The person in charge or a senior nurse in the centre visited prospective residents in hospital prior to admission. This gave the resident and their family information about the centre and also ensured that the service could adequately meet their needs.

Each resident had a comprehensive nursing assessment completed on admission. The assessment process involved the use of a variety of validated tools to assess their needs for support and risk of deterioration. For example, risk of malnutrition, risk of falls, level of cognitive impairment and risk of pressure ulcer development among others. There was evidence that non-verbal residents experiencing pain had a pain assessment completed which reflected appropriate pain management procedures. Each resident had a care plan developed within 48 hours of their admission based on their assessed needs. While most care plans in place detailed the interventions necessary by staff to meet residents’ assessed needs, some care plans for behaviour that challenged and end of life care and wishes did not adequately inform person-centred care for these residents. This finding was identified on the last inspection in August 2015 and while partially addressed required further improvement.

There was evidence that residents and their family, where appropriate participated in care plan reviews.

Staff provided end of life care to residents with the support of their medical practitioner. Community palliative care services were available if required. The inspectors reviewed residents’ ‘end of life’ care plans. However, they did not adequately outline the individual
physical, psychological and spiritual needs of the residents, including their individual preferences regarding their preferred setting for delivery of care. Single rooms were available for end of life care and relatives were supported to be with residents during this time. Families were supported to host removal services in the centre for deceased residents. Staff told inspectors that they arranged a candlelit guard of honour for deceased residents on removal of their remains from the centre. Residents' religious and cultural practices were facilitated. The centre had a spacious oratory which was available to residents including their end of life services.

There were systems in place to ensure residents' nutritional needs were met, and that they did not experience poor hydration. Residents were screened for nutritional risk on admission and reviewed regularly thereafter. Residents' weights were checked on a monthly basis and more frequently if evidence of unintentional weight loss was observed. Residents were provided with a choice of hot meal at mealtimes. There was an effective system of communication between nursing and catering staff to support residents with special dietary requirements. An inspector observed the lunchtime meal and found that all opportunities were not availed of to make mealtimes in the dining room a social occasion for residents. There was limited interaction by staff with residents whilst providing assistance to them with their meal. Staff were observed to rush residents with eating, assisting more than one resident at the same time and tended not to sit with residents whilst providing assistance to them. These observations did not reflect person-centred care practices. This finding is also discussed in outcomes 3 and 5.

There were arrangements in place to review accidents and incidents within the centre, and residents were regularly assessed for risk of falls. Care plans were in place and following a fall, the risk assessments were revised and care plans were updated to include interventions to mitigate risk of further falls.

There were written operational policies advising on the ordering, prescribing, storing and administration of medicines to residents. An inspector observed medication administration on the day of inspection and noted that details of all medicines administered were recorded. However, from review of three residents’ medication documentation, the inspectors found that faxed medication prescriptions were not transferred into residents’ prescriptions within 72 hours.

Residents had access to a pharmacist of their choice and the pharmacist participated in a regular medication reviews and was available to meet with residents or advise staff where required.

Judgment:
Non Compliant - Moderate

Outcome 02: Safeguarding and Safety

Theme:
Safe care and support
Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
There were policies in place advising on managing behaviour that challenged BPSD (also known as behavioural and psychological signs and symptoms of dementia) and restrictive practices. Policies were seen to give clear instruction to guide staff practice. Inspectors were told that two residents with dementia had episodes of behaviour that challenged. Bedrails were in use for some residents. There was evidence from review of bedrail use that bedrail risk assessments were completed and their use was closely monitored. Inspectors observed efforts made to minimise bedrail use with use of low beds and foam floor mats where possible.
However, inspectors observed some areas for improvement required in the management plans for residents with behaviours that challenged. This finding was identified on the last inspection of the centre in August 2015 and was found to be partially completed on this inspection. The inspectors noted that antecedents to behaviours that challenged were known to staff but a proactive consistent approach was not evident in management documentation to mitigate incidents occurring. Behavioural intervention care plans were not consistently completed detailing antecedents and effective positive behavioural strategies to de-escalate behaviours. Staff training records given to the inspectors confirmed that all staff in the centre had received training on dementia care and management of behaviour that challenged since the last inspection.

Measures to protect residents from being harmed or suffering abuse were in place. A policy on, and procedures for the prevention, detection and response to allegations of abuse was in place in accordance with national Health Service Executive (HSE) procedures. The Safeguarding Vulnerable Persons at Risk of Abuse documents were available and accessible to staff. Staff spoken to by inspectors confirmed that they had received training on recognising abuse, and were familiar with the reporting structures in place. All staff had been trained in 2014. There were systems in place to ensure allegations of abuse were fully investigated, and that pending such investigations measures were in place to ensure the safety of residents. Staff confirmed that there were no barriers to raising issues of concern. A review of incidents since the last inspection in August 2015 confirmed that any allegations of abuse that had been reported were investigated and dealt with appropriately. Residents with whom the inspectors were able to communicate verbally said they felt safe and secure in the centre, and felt the staff were supportive and respectful.

A policy was in place for the management of residents’ personal belongings and valuables and appropriate procedures were in place to safeguard this process including the secure storage of valuables. Records of residents’ valuables were maintained. Where the centre operated as a pension agent for residents, transactions were recorded and signed and documentation was maintained in an appropriate manner.

Judgment:
Substantially Compliant
Outcome 03: Residents' Rights, Dignity and Consultation

**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:**
Residents with dementia were generally consulted with and actively participated in the organisation of the centre through regular residents' meetings. However improvements were required to ensure they received care in a dignified and person-centred way. There were no restrictions to visiting in the centre and many residents were observed spending time with family or friends in the front reception area or communal room.

There was a residents’ committee in operation. An inspector viewed the minutes of the last meeting. External advocacy services and a volunteer advocate were available in the centre. The volunteer advocate supported residents with dementia at the residents’ committee. This ensured that any issues raised for/by residents with dementia were acknowledged, responded to and recorded, including the actions taken in response to issues raised. There was evidence that an annual satisfaction survey was completed on residents’ satisfaction with the service and responses were generally positive.

Inspectors spent time observing interactions during the early morning, prior to, during and after lunch and in the afternoon. These observations took place in the communal area and dining area in the centre. Although some instances of person centred care were observed overall, it was found that care was primarily task oriented. It was also observed that many staff did not engage residents in conversation except when task related. Staff were observed to pass through the sitting room without speaking to residents even where there were obvious attempts by residents to try and talk to the staff. Although staff seemed familiar with residents' basic physical care needs and some of their family background, opportunities to chat with them about their family, previous interests or working life were not taken. Opportunities to discover how they were feeling, how their mood was emotionally or psychologically were also generally lost.

Overall observations of the quality of interactions between residents and staff in the communal area for a selected period of time indicated that the majority of interactions were of a neutral nature. For the majority of the residents in the communal area, there were no interactions with staff and most residents were left staring into space, or asleep in their chairs with no stimulation for considerable periods of time. During the lunch time period an inspector observed that there was not a sufficient number of staff present to encourage independent dining or to assist residents in a discreet and sensitive manner. An inspector observed a member of staff standing over a resident whilst assisting the resident and there was no conversation at all between the staff member and the resident. The inspector observed that residents were not given adequate time to swallow their food by staff providing assistance to them with eating. The inspector
observed that the mealtime was hurried and some staff did not communicate, engage or interact with residents at all while assisting them. The inspector observed that at one table a care staff member was assisting two residents at the same time whilst also going to another table to assist another resident whose food was going cold. These practices did not reflect a person-centred approach and did not support residents to maintain their independence, dignity and functioning. This finding is addressed and actioned in outcome 1.

There was an activities coordinator employed over a five day period and care staff took on the role of activities during the weekends. In conversation with staff, review of documentation and observation it was found that in general direct care staff considered activities not to be part of their work and so residents were dependent on the activities coordinator for meaningful occupation and engagement. The activity co-ordinator spoke with an inspector and was well informed about the residents. She understood the needs of residents with dementia and was creative in her efforts to ensure residents were provided with activities that met their interests and capabilities. However, the activity co-ordinator finished work each weekday at 17:00hrs and did not work at weekends. Inspectors found there was a varied activities programme for some residents with arts and crafts, exercise and bingo included. However, inspectors observed that meaningful occupation and recreation for some residents with dementia was limited due to their inability to participate in communal activities. A therapeutic sensory programme for residents with dementia was not available on this inspection. This was also identified on the last inspection in August 2015.

Residents were facilitated to exercise their civil, political and religious rights. Inspectors were told that residents were enabled to vote in national referenda and elections with the centre registered to enable polling. Inspectors observed that residents' choice was respected and control over their daily life was facilitated in terms of times of rising /returning to bed and whether they wished to stay in their room or spend time with others in the communal rooms. Inspectors observed that some residents were spending time in their own rooms, watching TV, or taking a nap. Other residents were seen to be spending time in the various communal areas of the centre. Newspapers and magazines were available as observed by inspectors.

There was limited signage to direct and enable residents with dementia to independently access toilets, bedrooms and communal areas.

There was a communication policy in place. However, required review as it did not comprehensively inform the communication needs of residents with dementia and/or residents with speech, vision and hearing needs. Staff informed inspectors that they made every effort to provide each resident with the freedom to exercise their choice in relation to their daily activities of living.

**Judgment:**
Non Compliant - Major

**Outcome 04: Complaints procedures**

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

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

### Findings:
A complaints process was in place to ensure the complaints of residents, their families or next of kin including those with dementia were listened to and acted upon. The process included an appeals procedure. The complaints procedure was displayed and met regulatory requirements. Some residents and relatives spoken with confirmed that they felt they could express any dissatisfaction to the staff. However, some were unsure who was responsible for dealing with complaints in the centre. Records showed that complaints made to date were investigated and on-going consultation meetings were in progress as an outcome of some complaints made. However, there was inconsistent recording of the complainants’ satisfaction regarding the outcome of their complaint.

### Judgment:
Substantially Compliant

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**Outcome 05: Suitable Staffing**

### Theme:
Workforce

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

### Findings:
Recruitment processes were reviewed on this inspection and on review of a sample of staff files these were found to meet the requirements of Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. A record was maintained of current professional registration details of nursing staff.

An action plan regarding staff training requirements from the last inspection was satisfactorily completed on this inspection. Mandatory training was in place and staff had received up to date training in fire safety, safe moving and handling and safeguarding vulnerable persons. Training to support staff professional development was also provided including restraint management training, wound care, medication management and continence promotion, dementia care and management of behaviours that challenge.

Inspectors found that given the size and lay out of the centre premises, which is over two floors and the assessed dependencies of the residents staffing levels and skill mix required review. The dependency levels provided to the inspectors on the day of...
inspection indicated that there were 17 residents assessed as maximum dependency, seven as high dependency, five as medium dependency and one resident as low dependency. Although, inspectors found that staff were familiar with residents needs, current staffing levels and skill mix was not sufficient to meet the social and supervision needs of residents. 80% of residents had high and maximum dependency needs and required the assistance of two staff with most or all of their activities of daily living.

The provider advised the Authority on 04 March 2016 that he had reduced the centre’s occupancy levels to a maximum of 30 residents until staffing shortages were resolved to ensure the needs of current residents were met. Recruitment of staff was under way and although posing challenges, interviews were planned. However, the findings of this inspection confirmed further review of staffing was required in the interim.

Inspectors were told by residents and staff and they also observed that healthcare staff were busy and at times could not meet residents' needs in a timely and person centred manner. As outlined under Outcome 3 the observations of the quality of interactions between residents and staff in the communal area for a selected period of time indicated that the majority of interactions were of a neutral nature. During the observation period, there were no interactions with staff for the majority of the residents in the communal area and most residents were not engaged or asleep in their chairs without stimulation for considerable periods of time.

There was insufficient staff available to assist residents with eating their lunchtime meal on the day of inspection. Inspectors observed that there was limited supervision by staff in the communal sitting area during periods throughout the day of inspection.

Systems of communication were in place to support staff with providing safe and appropriate care. There were handovers each day to ensure good communication and continuity of care from one shift to the next. Staff nurses completed walk-around handovers to each other followed by a handover to healthcare workers. An inspector attended the handover to care staff on the day of inspection. This handover was informative regarding any changes residents’ needs and additional care procedures to be completed.

The inspectors saw records of regular meetings between nursing management at which operational and staffing issues were discussed. In discussions with staff, they confirmed that they were supported to carry out their work by the providers and the person in charge. The inspectors found staff to be well informed and knowledgeable regarding their roles, responsibilities and the residents’ needs and life histories.

**Judgment:**
Non Compliant - Moderate

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### Outcome 06: Safe and Suitable Premises

**Theme:**
Effective care and support

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

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

**Findings:**
Residents with dementia integrated with the other residents in the centre. Since the last inspection in August 2015, improvements made to the environment positively impacted on the quality of life for residents in the centre. However, inspectors found that further improvement is required to provide a comfortable and therapeutic environment for all residents and particularly residents with dementia. Areas requiring improvement included provision of independent access to a suitable and safe external space, the location of a sluice off a residents’ toilet, ramped access to the dining room and a large frosted glass panel in a communal toilet door.

The centre is a two-storey period building which has been extended. The building is set at the end of a long avenue off the road and is located on a site along a river. Car parking is provided to the front of the centre. Garden areas were not accessible and were generally overgrown. A small narrow veranda was located to the front of the centre. However, it did not provide a safe accessible outdoor space which residents with dementia could access independently due to risks of leaving the centre unaccompanied. The main entrance led directly into a large foyer. Access to the first floor was provided by means of a stairs and a lift. Some residents favoured the foyer area to sit in. Comfortable seating and occasional tables were available to meet their needs.

The dining room provided a spacious and bright area for residents to dine in. However, was accessible via a ramp which was carpeted. Communal sitting accommodation comprised of two rooms one on each floor in the centre. Inspectors were advised that this room is sometimes used by residents to meet visitors or to rest quietly in.

Most residents rested in the main sitting room which was bright and decorated in a traditional style. A large screen television was available to support ease of viewing for residents with visual deficits. The layout and dimensions of the bedrooms met the needs of residents in terms of adequate personal storage space, access for assistive equipment such as hoists and wheelchairs, privacy and dignity. The inspectors saw that some residents personalised their bedrooms.

The environment in the centre was brightly painted and the many large windows provided good natural lighting access to the centre. The provider had maintained many of the original features of the house such as the tiled floors in the foyer. There was some use of signage to support residents with dementia, however this area needed improvement. Familiar curtain designs, pictures and photographs of local scenes and traditional items displayed along corridors and in communal rooms supported the comfort of residents with dementia.

The centre was visibly clean. Hand hygiene dispensers were located at intervals throughout the centre and staff were observed to carry out hand hygiene procedures as appropriate. Personal protective equipment (disposable gloves and aprons) were stored in the staff office on the first floor. Staff were observed coming up from the ground floor for these items. This practice should be reviewed to ensure infection prevention and
control best practice can be assured at all times.

Infection control practices were satisfactory in general and additional precautions had been taken when required for specific infection risks. However, information received by the Authority prior to this inspection and a review of the complaint log demonstrated dissatisfaction with segregation of soiled clothing from residents' other clothing. This is discussed and actioned in outcome 7. Inspectors reviewed the procedures in place on the day of inspection and confirmed that recent improvements had ensured that residents clothing was correctly segregated. Most staff had attended training in infection prevention and control.

All fire exit doors had break box-keys attached. The nurse in charge of each shift carried a master key in the event that the keys were inadvertently mislaid or removed. Although a smoking room was available, no residents in the centre smoked. Three members of staff as referenced by the staff training matrix given to inspectors had not completed fire safety training. This is discussed and actioned in outcome 5. All fire exits were free of obstruction on the day of inspection.

Judgment:
Non Compliant - Moderate

Outcome 08: Governance and Management

Theme:
Governance, Leadership and Management

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

Findings:
The findings of this inspection supported improvements required in the governance and management structure to ensure the needs of residents were met. The provider reduced the maximum occupancy in the centre from 42 to 30 residents in response to challenges with recruiting sufficient staffing resources.

There was an arrangement in place where a senior staff nurse had responsibility for co-coordinating the day to day operation of the centre to support the person in charge to manage two designated centres in the service. However, inspectors found on this inspection that lines of management accountability were unclear regarding overall decision-making and responsibility for the delivery of services to residents.

The current management structure in the centre did not clearly indicate who was in charge and/or who was accountable for the service provided to residents. The findings in relation to staffing and oversight of the delivery of care indicated that this arrangement was not satisfactory on the last inspection of the centre in August 2015.
Inspectors' findings on this inspection regarding the lack of sufficient staff, the management and supervision of care delivered to residents and care plans to meet residents' needs indicated that improvements were required in the oversight of care and resources provided.

An annual report referencing a review of the quality and safety of care as required by regulation 23 had been prepared by the provider for 2015.

**Judgment:**
Non Compliant - Moderate

**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:**

Catherine Rose Connolly Gargan
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 01: Health and Social Care Needs

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Care plans for behaviour that challenged and end of life care and wishes did not consistently inform person-centred care for residents.

1. Action Required:
Under Regulation 05(3) you are required to: Prepare a care plan, based on the assessment referred to in Regulation 5(2), for a resident no later than 48 hours after

1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Please state the actions you have taken or are planning to take: We have added challenging behaviour and end of life specifically to our care plan audit and will discuss and further train our nurses at our next nurses meeting.

**Proposed Timescale:** 30/05/2016  
**Theme:**  
Safe care and support  

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:  
Staff were observed to rush residents with eating, assisting more than one resident at the same time and tended to not sit with residents whilst providing assistance to them.

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

Please state the actions you have taken or are planning to take:  
ALL staff will be retrained in communication skills and managing a positive dining room experience for our residents. We will also add communication specifically to our appraisal form which will give staff a clear pathway to improve their skills.

Proposed Timescale: Immediate for dining room experience. 1st June 2016 for appraisals

**Proposed Timescale:** 01/06/2016  
**Theme:**  
Safe care and support  

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:  
Faxed medication prescriptions were not transferred into residents’ prescriptions within 72 hours and as such medications were not administered from a valid prescription.

3. 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:  
We are tightening our communication between nurses to ensure all are aware when a medication sheet needs to be signed by the GP. Medication competencies will also be a
part of the nursing appraisal. We will raise the issue at the next staff meeting also.

Proposed Timescale: Immediate for the communication of information. 1st June 2016 for the appraisals.

**Proposed Timescale: 01/06/2016**

### Outcome 02: Safeguarding and Safety

**Theme:**
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Antecedents to behaviours that challenged were known to staff but a proactive consistent approach was not evident in management documentation to mitigate incidents occurring. Behavioural intervention care plans were not consistently completed detailing antecedents and effective positive behavioural strategies to de-escalate behaviours.

**4. Action Required:**
Under Regulation 07(2) you are required to: Manage and respond to behaviour that is challenging or poses a risk to the resident concerned or to other persons, in so far as possible, in a manner that is not restrictive.

Please state the actions you have taken or are planning to take:
We have already commenced a behaviour log for any resident who exhibits behaviour which may challenge and this can be completed by any member of staff who witnesses the behaviour. This will be reviewed monthly or as necessary to try and identify triggers which could de-escalate any situations where challenging behaviour is an issue. Triggers identified will be discussed with staff and individual care plans will be put in place with actions to de-escalate situations. We will record and use these de-escalation techniques for future residents and training of staff at regular staff meetings.


**Proposed Timescale: 01/05/2016**

### Outcome 03: Residents' Rights, Dignity and Consultation

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

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The communication policy available did not adequately inform the communication needs of residents with dementia, including speech, hearing and vision.
5. **Action Required:**
Under Regulation 04(1) you are required to: Prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.

**Please state the actions you have taken or are planning to take:**
The communication policy has already been updated and communication has also been added to the dementia policy. These policies will be placed in the staff communication book and also added to the agenda of the next staff meeting. The 10 rules of communication with people with dementia will be displayed on the staff notice board.

**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:**
Provision of activities to meet the capabilities and interests of residents with dementia unable to participate in the communal day-to-day programmes was limited.

6. **Action Required:**
Under Regulation 09(2)(b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests and capacities.

**Please state the actions you have taken or are planning to take:**
The activities co-ordinator (who has been formally Sonas trained and uses the techniques to document activities) has now grouped residents to work with their different levels of ability. She has commenced sensory therapy for those who are unable to take part in some of the daily activities. We have also been keeping a log of different activities we have tried with each resident to allow us to audit their likes and dislikes.

**Proposed Timescale:** 01/06/2016

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

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The communication needs of residents were not adequately addressed by staff.

7. **Action Required:**
Under Regulation 10(1) you are required to: Ensure that each resident, who has communication difficulties may communicate freely, having regard to his or her wellbeing, safety and health and that of other residents in the designated centre.
Please state the actions you have taken or are planning to take:
Staff will be required to undergo further communication training and will have communication as a part of their appraisal, which will have timescales for improvement if necessary – this will raise the importance of communication in the home

Proposed Timescale: 01/06/2016

Outcome 04: Complaints procedures

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was inconsistent recording of the complainants’ satisfaction regarding the outcome of their complaint.

8. 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:
Previously some complaints were recorded in the family communication section of the care plan as families were not at the time identifying the issues as complaints. From now on all discussions about residents with families that raise issues will be recorded as complaints. Complaints will be audited quarterly by the PIC

Proposed Timescale: 30/04/2016

Outcome 05: Suitable Staffing

Theme:
Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors found that given the size and layout of the centre premises, which is over two floors and the assessed dependencies of the residents staffing levels and skill mix required review

9. 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:
There has been a full review of staffing levels and skill mix. We have made every effort to recruit to our nursing posts. We have now recruited 2 full time PIN'ed nurses and 1 part time PIN'ed nurse. Interviews continue for more relief nurses staff. This will ensure we have 2 nurses on each shift when resident numbers increase.

**Proposed Timescale:** 31/05/2016

**Outcome 06: Safe and Suitable Premises**

**Theme:**
Effective care and support

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

Areas requiring improvement included
- provision of independent access to a suitable and safe external space,
- inappropriate location of a sluice off a residents' toilet,
- ramped access to the dining room
- a large frosted glass panel in a communal toilet door.

10. **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:

We have already sought advice with regard to the garden space and hope to have plans in place within the month.

We do have building restraints at Maypark as the building is a listed property. We have asked an architect to identify ways of accessing the sluice without entering the bathroom and this is ongoing.

The ramp access has never been raised as a problem at any inspection or registration and in fact has never caused any problem for our residents – there are no recorded incidents/accidents involving the ramp. We have had architects and engineers look at the ramp and there is very little that can be done as the floor levels of room off the ramp would require steps to access and of course this would not be safe for our residents. We will ensure we add the ramp to our risk assessments.

The toilet doors have been further covered so that the residents privacy and dignity will be maintained.

**Proposed Timescale:** 01/10/2016

**Outcome 08: Governance and Management**

**Theme:**
Governance, Leadership and Management
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The centre was not adequately resources in terms of adequate staffing to ensure the effective delivery of care in accordance with the statement of purpose.

11. **Action Required:**
Under Regulation 23(a) you are required to: Ensure the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.

Please state the actions you have taken or are planning to take:
There is a new staffing structure for the home to ensure adequate supervision and improve the delivery of care. Until we meet our staffing levels we have agreed to maintain our resident numbers at 30.

**Proposed Timescale:** 01/05/2016

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The management structure in place did not clearly identify the lines of authority and accountability, specifies roles, and detail responsibilities for all areas of service provision.

12. **Action Required:**
Under Regulation 23(b) you are required to: Put in place a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

Please state the actions you have taken or are planning to take:
As stated above we have introduced a new staffing structure to reflect the accountability and responsibilities of the home. There will be a PIC based full time at Maypark – the current senior nurse - NF30 will be sent to HIQA on 22nd April 2016. Post to commence 2nd May 2016.
There will also be a PIC recruited full time at Rockshire Care Centre. An Operations Manager will oversee the governance of both centres.

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