# Compliance Monitoring Inspection Report

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

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Maynooth Lodge Nursing Home</th>
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</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0004593</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Crinstown, Maynooth, Kildare.</td>
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<tr>
<td>Telephone number:</td>
<td>087 679 4601</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:flormccarthy@mail.com">flormccarthy@mail.com</a></td>
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<tr>
<td>Type of centre:</td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
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<tr>
<td>Registered provider:</td>
<td>Maynooth Lodge Nursing Home Partnership</td>
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<tr>
<td>Provider Nominee:</td>
<td>Florence McCarthy</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Sheila McKevitt</td>
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<tr>
<td>Support inspector(s):</td>
<td>None</td>
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<tr>
<td>Type of inspection:</td>
<td>Unannounced</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>25</td>
</tr>
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<td>Number of vacancies on the date of inspection:</td>
<td>54</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.

Please note the definition of the following term used in reports: responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).
Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National 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: 26 October 2016 10:00  
To: 26 October 2016 18:00

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

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Our Judgment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome 01: Statement of Purpose</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 04: Suitable Person in Charge</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 05: Documentation to be kept at a designated centre</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 07: Safeguarding and Safety</td>
<td>Non Compliant - Major</td>
</tr>
<tr>
<td>Outcome 08: Health and Safety and Risk Management</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 09: Medication Management</td>
<td>Non Compliant - Major</td>
</tr>
<tr>
<td>Outcome 11: Health and Social Care Needs</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 13: Complaints procedures</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 18: Suitable Staffing</td>
<td>Non Compliant - Major</td>
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Summary of findings from this inspection
Maynooth Lodge Nursing Home is a purpose-built, single storey residential centre registered to care for 79 residents. This was the first inspection of the centre since it was registered in March 2015.

There were 25 residents living in the centre. The person authorised to act on behalf of the provider (who will be referred to as the provider throughout this report) was available on the day of inspection. The person in charge was on leave. The inspector reviewed documentation such as nursing assessments, care plans, policies and procedures and staff files. Residents' and staff were spoken with throughout the inspection process. Residents' enjoyed living in the centre, were satisfied with the nursing and medical care they received. They spoke positively about the staff who cared for them and the variety of activities available to them to choose from.

Action plans identified on the registration inspection report (from January 2015) relating to incomplete or non availability of policies such as the health and safety and risk management, emergency plan and the complaints policy had all been addressed.
The health and social care needs of residents were being met. Residents had access to general practitioner (GP) services, and to members of the multi-disciplinary team when required. Residents' were assessed on admission and had care plans put in place where required. However, these documents were not always reviewed within the required timeframe or when changes were recommended by multi-disciplinary team members. All staff files reviewed did not contain the documents outlined in schedule 2. Staff on duty at the time of this inspection were found not to have the required garda vetting disclosure in place, the provider was informed immediately of this finding. Within 24 hours the provider informed HIQA that both staff had been taken off the roster and would not return to work until they had garda vetting disclosure in place.

The inspector was not satisfied with the skill mix of staff rostered on duty during the day. There were not enough qualified staff on duty to ensure that residents' received medications in a timely manner and to ensure an adequate level of supervision of staff.

Practices in relation to medicines management were not safe and required review. Fire records showed that fire alarms and extinguishers were serviced in line with best practice guidelines. Records were not available to reflect servicing of emergency lighting and records of fire drills required more details.

The action plans at the end of this report reflect where the regulations were not met.
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 01: Statement of Purpose**

*There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.*

**Theme:**
Governance, Leadership and Management

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

**Findings:**
A statement of purpose was submitted as part of the application to registration. It had been reviewed in March 2015 following registration of the centre. It outlined the overall aim of the centre and other details as specified in Schedule 1 of the Regulations, including the conditions of registration.

A copy was available to residents' and staff in the centre.

**Judgment:**
Compliant

**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 (PIC) was on leave during this unannounced inspection. She was deemed fit to hold the post of PIC by HIQA in January 2015. She submitted a detailed report of her nursing experience which assured HIQA she had the required level of experience in working with older people. She was contracted to work fulltime, is a
registered nurse and has completed a certificate course in further education and training and in mentorship. She is also a moving and handling instructor.

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

Findings:
The following two action plans identified on the last inspection report had been addressed;
Some of the schedule 5 policies were not yet developed and some were incomplete. The provider's insurance was not yet in place.

The inspector saw that all policies listed in schedule 5 were available for review. Although as discussed further in outcome 11 not all were being adhered to in practice.

The inspector saw that the centre had insurance in place. The certificate of insurance was on display in the centre. It expired in 2017.

Four staff files were reviewed. Documents outlined in schedule 2 were not available in the four staff files reviewed. As mentioned under outcome 7, two did not contain evidence of garda vetting disclosure on file, one of these contained only one reference and none of the 4 contained evidence that staff had up-to-date mandatory training in place.

Judgment:
Substantially Compliant

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 was not satisfied that all measures had been put in place to ensure the safety of residents as the inspector found that two staff on duty did not have a vetting disclosure in accordance with the national vetting bureau in place.

The inspector informed the provider of this finding prior to the end of the inspection and requested that the provider contact the Health Information and Quality Authority (HIQA) within 24 hours of the measures taken to ensure the safety of residents. The provider informed the inspector that both staff had been taken off duty and would remain off duty until their garda vetting disclosure was in place.

A restraint-free environment was promoted. There were no bedrails in use in the centre, alternative equipment was available such as crash mats and low, low beds. The inspector saw this equipment being used effectively. There were no residents' residing in the centre who had been identified with responsive behaviours.

The inspector was informed that the centre did not act as a pension agent for any of the 25 residents'. They encouraged residents' to manage their own petty cash and at the time of this inspection did not manage any petty cash on behalf of the residents'.

Staff spoken with said they had completed training in the detection and prevention of elder abuse. However, records were not available in staff files to confirm that this had been completed by each member of staff.

**Judgment:**
Non Compliant - Major

**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):**
The action(s) required from the previous inspection were satisfactorily implemented.
Findings:
The following two action plans identified on the last inspection report had been addressed;
There was no risk management policy in place.
A full emergency plan was not in place.

The inspector was shown a copy of the risk management policy which on review met the requirements of 26 (1). An emergency plan was in place and it outlined procedures for staff to follow in the event of an emergency. The inspector was informed their had been none since the centre had been opened.

Infection control practices observed were good with hand washing and drying facilities available and all wash hand basins and hand sanitizers available throughout the centre. However, the inspector observed that there was no wash hand basin located in the laundry.

There was adequate means of escape and fire exits were unobstructed. Floor plans identifying the nearest fire exit were on display throughout the centre.

Records reviewed on inspection showed that the fire alarm was serviced on a quarterly basis and fire safety equipment was serviced within the past year. However, there were no records available to the inspector to show whether emergency lighting had been checked on a quarterly basis.

Staff spoken with told the inspector that they had attended fire safety training on induction and were clear on what to do in the event of the fire alarm sounding. However, records to confirm they had attended this training were not available to the inspector in the absence of the person in charge. Training records to reflect attendance at annual fire training were not available in the four staff files reviewed on inspection. Records showed that a mock fire drills were practiced on average once every four months. However, the inspector observed that the records in relation to these fire drills were not detailed enough. For example, the records of each fire drill did not reflect those in attendance, response times or actions if any which needed to be actioned post the drill being practiced.

The room temperature in the communal living room and dining room was below 21 degrees during the course of the inspection and the room felt cool to the inspector. The wall mounted temperature gauge in each of these rooms were checked twice during the inspection and on all occasions the temperature gauge in each room read 19 degrees or less. There was no system in place whereby the temperature of these rooms was being monitored or audited.

Manual handling practices observed were in line with best practice. However, records to reflect when all staff last completed manual handling training were not available to the inspector and were not available in the four staff files reviewed on inspection.

The inspector requested that the last date that all staff had received mandatory fire, manual handling and protection, detection and management of elder abuse be
forwarded to the inspector.

**Judgment:**
Non Compliant - Moderate

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### Outcome 09: Medication Management
*Each resident is protected by the designated centre’s policies and procedures for medication management.*

**Theme:**
Safe care and support

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

**Findings:**
This outcome was not reviewed in full. The inspector observed medication administration and found these practices together with resident prescription practices were not in line with best practice and therefore improvements were required.

The inspector reviewed a number of the prescription and administration charts. The following issues were identified with prescription charts:

- one resident who required their medicines to be crushed prior to administration however, the prescriber had not indicated that crushing was authorised for each individual medicine on the prescription sheet.
- the dose of the drug to be administered was not clear on all signed prescriptions, for example a resident was prescribed madopar 125mg tds, under special instructions it was written 2 tabs. The nurse stated that each tablet contained 125mgs and the resident was receiving madopar 250mgs, tds. The prescription was not clear and left a risk for errors to occur.
- medications prescribed for one resident at 12:00 hours were not being administered until 17:00 hours. The inspector was informed that this had been sanctioned by a more senior member of staff and was been administered at the later time at 17:00hrs. There was no documented evidence that the prescriber had agreed to this changed administration time.
- the frequency medications to be administered were not reflected on those prescription charts reviewed.

The inspector observed medications prescribed for resident at 12:00 hours were being administered at 13:30 hours. The inspector was informed that this was due to the inspector being on site and that medication administration normally begun at 12:30 hours. However, as the nurse administering the medications was the only qualified staff member on duty, she had to stop the administration of medications to oversee to a medical emergency in the dining room.

Resident details were not completed on both the PRN and regular side of the prescription charts. For example, 4 prescription charts reviewed only had the name of...
the resident in place, the section date of birth, general practitioner name, identification of allergies were all incomplete/blank.

There was no evidence that any system was in place for reviewing and monitoring safe medication management practices.

**Judgment:**
Non Compliant - Major

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

**Findings:**
The inspector was satisfied that the healthcare needs of residents' were being met. Some improvements were required in relation to the frequency that resident assessments and care plans were reviewed and updated.

Residents had access to general practitioner (GP) services and a full range of other services was available on referral including speech and language therapy (SALT), dietetic services, physiotherapy and occupational therapy. Chiropody, dental and optical services were also provided. Psychiatry for older persons community services were also been consulted.

The inspector reviewed a sample of residents’ records and found that nursing assessments, care planning and additional clinical risk assessments were carried out on each resident on admission. These initial assessments were detailed and gave a clear picture of the residents health care status. The end of life assessment and activity assessments were particularly detailed and resident specific. Each identified need had a care plan in place. However, these assessments and care plans were not consistently reviewed on a four monthly basis and there was no written evidence that residents and/or their relatives were involved in these reviews. Nursing daily narrative notes were not directly linked to the residents care plans and a number of residents' daily narrative note did not include the time the narrative note was written. This was discussed with the staff nurse during the inspection.

Care was being provided in line with the residents' care plan and those residents' spoken
with expressed satisfaction with the level of care they received. The inspector saw that they were reviewed on a regular consistent basis by their general practitioner and by members of the multi disciplinary teams as mentioned above. However, resident care plans were not being updated to reflect the recommendations made by these visiting disciplines. This was discussed with the staff nurse during the inspection.

The nutritional policy stated that residents Malnutrition Universal Screening Tool (MUST) would be recorded on a three monthly basis, however, this was not consistently recorded in line with the policy.

The inspector observed that three residents sitting alone in their bedroom did not have their call bell within their reach. This was not in line with best practice. The inspector observed staff assisting residents in the dining room at lunch time. One staff member did not provide assistance in line with best practice and the inspector observed that clothing protectors were not discreet and were only used on those who required assistance with eating. There use required review to ensure the residents’ dignity was maintained at all times.

Judgment:
Non Compliant - Moderate

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

**Findings:**
The following action identified on the last inspection report had been addressed;
The complaints policy did not meet the requirements of the Regulations.

The inspector read the updated complaints policy which had been issued in March 2015. It now met the regulatory requirements. The staff on duty informed the inspector that to their knowledge there had been no complaints since the centre opened.

Judgment:
Compliant

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**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
The inspector was satisfied that the number of staff on duty was adequate. However, the skill mix was not adequate to ensure that the nursing care was being delivered to a high standard and to ensure that health care assistants were adequately supervised.

The inspector observed that there was only one qualified member of nurse rostered on duty 24 hours per day since week beginning 17 Oct 2016. The person nominated during the registration process to take over in the absence of the person in charge, a clinical nurse manager (CNM), although rostered to work in the PIC’s absence, the CNM was the only qualified member of staff on duty. Therefore, the CNM could not have had the time to carry out a managerial role in the PIC’s absence.

The inspector observed a lack of supervision by management and qualified staff on the floor of the nursing home. This lack of supervision meant that care being provided to residents was not always to a high standard. For example, the inspector observed three residents sitting in their bedrooms. None of the three had their nurse call bell within their reach and all three were assessed as unable to not mobilise without the assistance of staff. In addition, the manner in which one resident was assisted at lunchtime was not to a high standard. The delay in medication administration and the lack of consistent review of all residents’ assessments and care plans within a four month time frame resulted from a lack of qualified staff rostered on duty during the busy day time hours.

The inspector was informed that there was an appraisal form in place however, it had not yet been implemented. There was no evidence that formal staff appraisal had been carried out with staff since the centre opened. As mentioned under outcome 5, 4 staff files were reviewed.

The absence of a manager and the rostering of one staff nurse on duty during the busy hours of the day have contributed to the level of non compliances identified under outcomes 5, 9, 11 and 18 of this report.

Staff spoken with informed the inspector that they had attended mandatory training in fire, manual handling and protection, detection and reporting of elder abuse. However, records to reflect staff attendance at these mandatory training sessions were not available on the day of the inspection and evidence of completion were not available in
those staff files reviewed. Training records are not accurately maintained.

As evidenced in outcome 7 and outcome 5, the recruitment policy was not being implemented in practice.

Judgment:
Non Compliant - Major

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:

Sheila McKevitt
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider’s response to inspection report

**Centre name:** Maynooth Lodge Nursing Home  
**Centre ID:** OSV-0004593  
**Date of inspection:** 26/10/2016  
**Date of response:** 22/11/2016

**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 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:
Documents outlined in schedule 2 were not available in each of the 4 staff files reviewed.

1. **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

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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:
All staff files have now been reviewed and are complete. All staff files now contain all
documents as stated in schedule 2.

Proposed Timescale: 14/11/2016

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:
Two staff on duty did not have a vetting disclosure in accordance with the national
vetting bureau in place.

2. Action Required:
Under Regulation 08(1) you are required to: Take all reasonable measures to protect
residents from abuse.

Please state the actions you have taken or are planning to take:
Garda vetting for all staff is now in place. Evidence of vetting disclosure is in place in
each staff file.

Proposed Timescale: 17/11/2016

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:
Measures had not been put in place to ensure the risk associated with the heating
temperature in communal areas dropping below 21 degrees identified and measures
put in place to address this risk in a prompt manner.

3. Action Required:
Under Regulation 26(1)(a) you are required to: Ensure that the risk management policy
set out in Schedule 5 includes hazard identification and assessment of risks throughout
the designated centre.

Please state the actions you have taken or are planning to take:
All thermostats have been adjusted to account for any seasonal changes in
temperature. All thermostats have been designed to be tamperproof and therefore
cannot be adjusted by unauthorised personnel. Room temperatures are now verified by temperature gun. The provider is monitoring temperatures in all communal areas on monthly basis, a rotating random sample of bedroom temperatures are also monitored at this time and recorded.

**Proposed Timescale:** 09/11/2016  
**Theme:**  
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
There was no wash hand basin available in the laundry room.

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

**Please state the actions you have taken or are planning to take:**  
A wash hand basin has been installed in the laundry.

**Proposed Timescale:** 11/11/2016  
**Theme:**  
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
There was no records available to show that emergency lights had been checked on a quarterly basis.

5. **Action Required:**  
Under Regulation 28(1)(c)(iii) you are required to: Make adequate arrangements for testing fire equipment.

**Please state the actions you have taken or are planning to take:**  
An Emergency Light Certificate has been forwarded to the inspector. Emergency lights are serviced on a 3 monthly basis.

**Proposed Timescale:** 30/09/2016  
**Theme:**  
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in**
the following respect:
Records of fire drills required more detail. They did not reflect those in attendance, response times or actions if any which needed to be actioned post the drill being practiced.

6. Action Required:
Under Regulation 28(1)(e) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and residents are aware of the procedure to be followed in the case of fire.

Please state the actions you have taken or are planning to take:
A P.E.E.P. (Personal Emergency Evacuation Plan), was in place for each resident. While staff and resident drills were carried out, staff and resident attendance records have since been updated to reflect these practices more accurately. A further fire drill has taken place, records of those in attendance have been recorded. Response times have been recorded also, with no actions being required.

Proposed Timescale: 18/11/2016

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:
The prescription practices required review to ensure staff administering medications were enabled to do so in line with professional guidelines and best practices. The following issues require review;
• The dose of medications to be administered needs to be made clear by the prescriber.
• The frequency of medications to be prescribed needs to be made clear by the prescriber.
• Resident details were not reflected on each prescription chart reviewed.
• Medications were not being administered within one hour of either side of the time they were prescribed to be administered at.
• Medications for one resident was not being administered as prescribed.

7. 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:
1. G.P. advised of HIQA findings re lack of clarity of prescribed dosage and frequency.
2. G.P. has now given clear direction regarding frequency and dosage of medication prescription.
3. Resident details are now recorded on each Kardex. All nursing staff have been made aware of this requirement and is now implemented.
4. Systems are now in place to ensure that medications are now administered within one hour of the prescribed time.
5. Medication for the resident mentioned is now administered as prescribed.
6. Medication management systems are being audited on a monthly basis by the CNM and PIC.

**Proposed Timescale:** 18/11/2016

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There was no evidence that any system was in place for reviewing and monitoring safe medication management practices.

**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:
A medication management auditing system was in place on the day of inspection. However this was not made available to the inspector and has since been forwarded to the inspector.

Medication management systems are being audited on a monthly basis by the CNM and PIC.

**Proposed Timescale:** 18/11/2016

**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:**
Assessments and care plans were not consistently reviewed on a four monthly basis. Care plans were not being updated with recommendations made by visiting multi disciplinary team members.
Daily nursing narrative entries did not reflect the time of these entries.
Malnutrition Universal Screening Tool (MUST) was not always recorded every three months in line with the nutritional policy.
9. **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:**
A copy of 3 monthly audit of residents profile notes reviewed by PIC have been forwarded to the inspector. All Care Plans are now being assessed and reviewed, to be completed by 14th December 2016 in consultation with resident/ next of kin as appropriate. There is a schedule in place to ensure care plans are updated on a four monthly basis and on an ongoing basis to ensure they accurately reflect the residents changing needs.

Care plans will be updated to reflect recommendations made by visiting multi disciplinary team members, this will be carried out by the nurse on duty at the time of the recommendation.

We query if the Medication Management file was viewed on the date of inspection, and also if the monthly audits were viewed.

A daily monitoring system is now in place to ensure that this function has been carried out.

All daily nursing narrative entries have recording time clearly reflected.

Each resident has their MUST score recorded on a 3 monthly basis.

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**Proposed Timescale:** 18/12/2016

**Theme:**
Effective care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There was no written evidence to reflect the resident or their family's involvement in their care plan review.

10. **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:**
A more individual approach is being implemented prior to and during the next scheduled review which is due during January 2017
All careplans are currently under review in consultation with the residents and/or their next of kin.

**Proposed Timescale:** 31/01/2017

**Theme:**
Effective care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Call bells were not within reach of residents’ sitting alone in their bedroom.
The manner in which assistance was provided at lunch time did not reflect best practice.
The use of protective clothing for those receiving assistance required review.

11. **Action Required:**
Under Regulation 06(1) you are required to: Having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care for a resident, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais.

Please state the actions you have taken or are planning to take:
We are now sitting the resident within reach of their call bell when sitting out in their own room. This is monitored during hourly monitoring bedroom checks

Staff members have received training on how to discretely provide assistance during mealtimes in a dignified manner

All residents are offered the use of clothing protectors during mealtimes

**Proposed Timescale:** 17/11/2016

**Outcome 18: Suitable Staffing**

**Theme:**
Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The skill mix of staff on duty: one qualified staff nurse on duty during the busy day time hours was not adequate to ensure the nursing care needs of residents was being met to a high standard as evidence by the level of non compliance identified in this report.

12. **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:**
Unfortunately the PIC was on annual leave on the day of the inspectors visit. The provider Nominee had not provided a replacement during this absence. A replacement will be provided in future. During normal working the PIC would provide on floor backup to the R. N on duty during busy periods.

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**Proposed Timescale:** 18/11/2016

**Theme:**
Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Records were not in place to confirm when and what mandatory training each staff member had in place.

13. **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:**
We have implemented a new training matrix which provides greater clarity to the mandatory training which had already been provided.

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**Proposed Timescale:** 18/11/2016

**Theme:**
Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The level of supervision of health care assistants on the floor was not adequate.

There was no evidence that the management team were conducting any form of formal supervision with employees.

14. **Action Required:**
Under Regulation 16(1)(b) you are required to: Ensure that staff are appropriately supervised.

**Please state the actions you have taken or are planning to take:**
The team of HCA’s on the day of inspection was short one of its compliment, due to ill health. The backup HCA who would normally attend, could not fill the void on the day. Under normal circumstance the PIC would give direction.
The PIC/CNM/Nurse in Charge formally connect with staff members during hand over
reports morning and night. Direction and discussion takes place at this time to ensure staff are familiar with the changing needs of residents. This is supported by a mini handover mid morning which gives further opportunity for feedback and direction. All staff are aware of the need to inform the PIC/CNM/Nurse of any change to residents condition. Opportunities for supervision are availed of on an on going basis as the PIC/CNM/Nurse in Charge are directly involved with all staff through the course of the shift

**Proposed Timescale:** 18/11/2016