### Centre name:
Maypark House Nursing Home

### Centre ID:
OSV-0000249

### Centre address:
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:
Sonia McCague

### Support inspector(s):
Sheila Doyle; Una Fitzgerald

### Type of inspection:
Unannounced

### Number of residents on the date of inspection:
26

### Number of vacancies on the date of inspection:
16
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).
This inspection report sets out the findings of a monitoring inspection, the purpose of which was following receipt of unsolicited information. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times
From: 02 March 2017 09:38  
To: 02 March 2017 18:50

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 02: Governance and Management</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 03: Information for residents</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 05: Documentation to be kept at a designated centre</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 07: Safeguarding and Safety</td>
<td>Non Compliant - Moderate</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 - Moderate</td>
</tr>
<tr>
<td>Outcome 10: Notification of Incidents</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 11: Health and Social Care Needs</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 12: Safe and Suitable Premises</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 13: Complaints procedures</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 14: End of Life Care</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 15: Food and Nutrition</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 16: Residents’ Rights, Dignity and Consultation</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 18: Suitable Staffing</td>
<td>Non Compliant - Moderate</td>
</tr>
</tbody>
</table>

Summary of findings from this inspection
This unannounced inspection was triggered following receipt of unsolicited information by the Health Information and Quality Authority (HIQA) that outlined concerns in relation to the standards of care, staffing levels and arrangements, communications and end of life care.

The matters arising from the previous inspection were followed up and the application to renew the registration of the centre for 42 residents was also considered.

On arrival to the centre, inspectors met with the deputising person in charge and other persons participating in the management of the centre who were informed of the purpose of the inspection.
Inspectors met and spoke with residents and staff during this inspection. Residents who spoke with inspectors expressed satisfaction with the care and services provided and were complimentary of the staff group and care received.

While systems were in place to review and monitor the care and outcomes for residents, with some actions from the previous inspection in July 2016 being addressed, all regulatory requirements had not been fully addressed for compliance at this time.

Significant non-compliances were found within Outcome 2 Governance and Management with evidence that the management arrangements were not sufficiently robust to assure the quality and safety of the service on a consistent basis. As a result of the inspection findings and issues highlighted within the unsolicited information received, a provider led investigation was requested by inspectors. The investigation was to be completed within two weeks as relevant information was not available on enquiry from management and from a review of the records maintained and available.

Other areas for improvement were needed with moderate non-compliances found across nine of the 14 outcomes inspected as outlined in the table above. The challenge of recruiting adequate competent staff to meet the needs of 42 residents was an on-going issue.

The findings and improvements required are discussed within the body of this report and set out in the action plan at the end for response.
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 Standards for Residential Care Settings for Older People in Ireland.

Outcome 02: Governance and Management

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

Theme:
Governance, Leadership and Management

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

Findings:
A governance structure and reporting mechanisms were reported as in place for this centre and a clearly defined management structure was outlined in the Statement of Purpose.

A management structure was in place including arrangements for the absence of the person in charge since August 2016. However, the evidence found in this inspection did not demonstrate that the governance and management arrangements were sufficient to ensure the effective delivery of care in accordance with the statement of purpose.

Staff responsibility and accountability for practice and service delivery was also in need of improvement to ensure all areas of care provision were suitably governed and managed in accordance with the aims and objectives of the statement of purpose.

The staff resources and roster for the month of February 2017 was reviewed by inspectors. It showed the person deputising in the absence of the person in charge worked four days per week and did not work on a full-time basis, which was confirmed by staff. The roster also showed that persons participating in management worked from Monday to Friday and not on weekends or nights. Inspectors confirmed that up to eight staff worked night duty mainly. The roster for February 2017 showed that two out of the four nurses rostered and four care staff worked night duty shifts only. Inspectors were told by the deputising person in charge that the rotation of staff from nights to days may not suit all staff but this arrangement was recently discussed by managers for improvement. The need to review and improve the supervision and oversight of all staff including those on nights full-time required improvement to ensure the delivery of care was safe, appropriate and monitored on a consistent basis. Inspectors concluded that the staffing levels, arrangements and resources available at the time of inspection did
not support an application to accommodate 42 residents and therefore required review, despite the planned return of the person in charge on 6 March 2017.

Improvement was required in relation to the lines of authority, reporting arrangements and recording practices. Inspectors found evidence during the course of this inspection that the management arrangements were not sufficiently robust to assure the quality and safety of the service delivered. Inspectors found evidence that the supervision, monitoring and review of residents care and staff practices needed improvement. For example, staff had not maintained contemporaneous records and had reported on resident outcomes six hours in advance of their shift ending and up to 10 hours after a significant event that involved emergency response services. Staff involved had not reported or completed a comprehensive record of their findings, response or actions taken following a significant incident and event.

Improvement was required in relation to the recording and management of assessment details, incidents, staff response and communications. Assessments and clinical care did not consistently accord with evidence based practice, were incomplete and not maintained in accordance with the centre’s policies or protocols as described by management. Records reviewed showed a lack of an appropriate and timely response to clinical assessments, observations and symptoms described and noted by members of the staff team. Gaps in records were found in relation to monitoring and reporting of clinical observations, monitoring of food and fluid intake and relevant information required and known following a significant incident and change in a resident’s condition. There did not appear to be a system in place to monitor staff practice, acts or omissions and procedures carried out to identify areas for improvement, as previously reported. Inspectors concluded that the practice and service delivered by staff was not sufficiently governed to ensure the service provided was safe, appropriate, consistent and effectively monitored.

The arrangements for the review of incidents within the centre required improvement. There was insufficient evidence found to demonstrate sufficient or robust arrangements available for the identification, recording, investigation and learning from serious incidents or adverse events involving residents.

Management acknowledged the findings and told inspectors they would review the staff rostering, practices, monitoring and supervision arrangements to bring about improvements.

Systems were described and in place to review and monitor aspects of the quality of care. An annual review of the quality and safety of care delivered to residents for 2016 was completed that informed the service plan being implemented in 2017, for example staff training was identified.

There was evidence of consultation with residents and their representatives on a daily basis and in a formal resident and relative forum. Other opportunities for consultation were afforded when staff were engaged in reviewing and assessing the changing needs of residents and care planning process. A resident satisfaction survey had been completed since the previous inspection. However, the response was poor and not well represented by residents. Inspectors were told that a survey was recently issued to the
relatives of residents which had not yet been returned.

The information outlined within the statement of purpose and in the contract of care in relation to the terms and conditions of a resident's stay required review. Additional charges applied to all residents for laundry and in the event that property remained in storage after their departure or discharge required review and clarification. Further information and clarity in this regard was requested from the provider.

Judgment:
Non Compliant - Moderate

### Outcome 03: Information for residents

**A guide in respect of the centre is available to residents. Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.**

**Theme:**
Governance, Leadership and Management

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

**Findings:**
Inspectors read the residents guide and noted that it met the requirements of the regulations.

Inspectors read a sample of completed contracts and saw that they met the requirements of the regulations. They included details of the services to be provided and the fees to be charged.

**Judgment:**
Compliant

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

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

**Theme:**
Governance, Leadership and Management

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

**Findings:**
Records listed in Schedules 2, 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People), Regulations 2013 (as amended) were available and a sample of records was reviewed by the inspector. These included records relating to fire safety, staff recruitment, previous and existing residents' care, as well as the centre's directory of residents, residents guide, complaints register and statement of purpose. Improvement was required in relation to the maintenance of records associated with fire safety drills, which is discussed further in outcome 8.

While records required under regulation 21 were available, not all records were and in those inspected some improvements were required as follows:

- a sufficient and complete record of the name, address and telephone number of the resident’s next of kin or of any person authorised to act on their behalf was not sufficiently maintained as required in schedule 3(3)(b)
- a comprehensive nursing record of all communications in relation to each resident by the nurse on duty in accordance with any relevant professional guidelines had not been sufficiently maintained as required in schedule 3(4)(c)

Records of the food provided for residents required improvement to ensure sufficient detail was included to enable any person inspecting the record to determine whether the diet is satisfactory in relation to nutrition and otherwise, and of any special diets prepared for individual residents.

A sample of staff files was also reviewed. While most were found to be compliant with the regulations, it was noted that there were some gaps in documentation in relation to the requirement for a satisfactory history of any gaps in employment for all members of staff.

A record of visitors and the directory of residents were available and maintained in the centre, as required.

The centre's insurance cover was current and a certificate of insurance was available.

The inspectors also reviewed operating policies and procedures for the centre, as required by Schedule 5 of the regulations. All policies listed in Schedule 5 were available, including those on the health and safety of residents, staff and visitors, risk management, medication management, end-of-life care, admissions, communications, management of complaints and the prevention, detection and response to abuse. Of these policies, some were not sufficiently implemented in practice such as risk management, medication management, and admission of residents, communications and end of life care. The policy and practice in relation to the creation of, access to, retention of and destruction of records required review and improvement in line with best practice, the regulations and professional standards.

**Judgment:**
Non Compliant - Moderate
**Outcome 07: Safeguarding and Safety**

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

**Theme:**
Safe care and support

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

**Findings:**
Inspectors found that measures were in place to protect residents from harm or suffering abuse and to respond to allegations, disclosures and suspicions of abuse. However the use of restraint was not in line with national guidelines and required improvement to safeguard residents.

Improvement was required around the use of bedrails. Risk assessments had been completed. However the care to be provided to residents while bedrails were in use was not documented in the care plan. There was limited evidence that consent was given by residents. In addition there was no evidence that safety checks were completed when bed rails were in use, in line with national guidelines.

Additional equipment such as low beds and sensor alarms had been purchased to reduce the need for bedrails.

Staff had received training on identifying and responding to elder abuse. There was a policy in place which gave guidance to staff on the assessment, reporting and investigation of any allegation of abuse. The person in charge and staff who spoke with inspectors displayed sufficient knowledge of the different forms of elder abuse and all were clear on reporting procedures.

Inspectors were satisfied that residents were provided with support that promoted a positive approach to responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). Staff had received specific training and although not currently required by any residents. Staff told the inspector that detailed care plans would be developed including identifying possible triggers and appropriate interventions. Inspectors saw that regular advice and support was available from the psychiatric services.

Small amounts of money were managed for some residents at their request. Inspectors were satisfied that this was managed in a safe and transparent way, guided by a policy. Frequent checks of the balances were carried out to ensure that they were correct.
**Judgment:**
Non Compliant - Moderate

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**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

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

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**Findings:**
The centre had policies and procedures relating to health and safety that included a health and safety statement, a risk management policy and supporting operating procedures to include items set out in Regulation 26(1). Health and safety audits had been completed by staff and management, and risk assessments carried out had been reviewed and rated.

While a system for the identification of operational hazards and management of risk was in place, the hazards and risks found by inspectors on this inspection had not been identified or assessed within the recent assessments reviewed and audits carried out.

Inspectors identified the following risks that required assessment by the provider:
- electrical leads seen draped from the top of residents’ wardrobes to a socket attached to the top of a curtain screen that was connected to a television (TV) below on a table. The table and TV obstructed access to the wardrobes where residents clothes were seen stored and the wardrobe doors in this bedroom did not open easily
- while some radiators and pipes along corridors were encased, others in bedrooms were not and were very hot to touch posing a risk to residents
- the water temperature in some bedrooms was too hot for safe use
- a fire exit via a resident’s bedroom on the first floor had not been risk assessed to ensure suitable arrangements and consent were in place for its intended purpose
- the identified fire exit from the ground floor dining room had a step down on exiting the room into a garden. Five residents using modified wheelchairs dined in this room
- oxygen cylinders were stored along the corridor into the chapel.

A good standard of cleanliness was observed in the centre. Staff had access to hand washing and sanitiser facilities on corridors, and was seen using these facilities between resident contact. Inspectors found that actions required from the previous inspection relating to infection control had been addressed to include the provision of an additional sluice on the first floor which contained a bed pan washer, sluice sink, hand washing facilities and pedal bins for clinical and ordinary waste. However, further improvements were required to prevent infection and promote control of healthcare associated infections. For example, the storage of a clean linen on a trolley, open packets of
incontinence pads and cleaning equipment such as mops and buckets seen in this sluice room required review. While the provision of a clinical waste bin and personal protective equipment was available on one floor it was not seen on the ground floor within close proximity to a resident identified with an infection and care interventions that required the management of clinical waste material. An infection control policy with supporting protocols was available but it required review in accordance with the safety statement protocols for implementation in practice.

Arrangements, equipment and practices were in place to promote fire safety and to enable staff to respond in the event of an emergency. The fire alarm system was serviced recently and fire safety equipment was serviced on an annual basis. Fire evacuation procedures and exits were prominently displayed throughout the building.

Fire safety and response equipment such as extinguishers, hose reels, fire blankets and ‘sleds’ (a ski pad to transport a resident on in an emergency) was provided. Fire exits were identifiable by obvious signage and exits examined were unobstructed to enable means of escape. However, the fire exit through a resident’s bedroom on the first floor and from the dining room on the ground floor beneath required review, risk rating to ensure they were fit for purpose, readily available and sufficient to facilitate the escape of all residents accommodated in the compartment or area as outlined above.

Staff were trained in fire safety and those who spoke with the inspectors confirmed this. A personal emergency evacuation plan (PEEP) for each resident that identified the resident’s mobility levels and requirements for assistance in the event of an emergency evacuation was available. Four fire drills had been carried out since the previous inspection that included relevant information such as the staff involved, location, time and duration. However, some improvement was required as some drills completed had not included a simulated fire drill using the ‘sled’ that may be required by up to 10 residents in the PEEP. In addition, the fire evacuation drills carried out since the previous inspection had occurred between 10am and 3pm and an evacuation simulating evening or night time conditions and staffing levels had not been completed. One of the escape routes seen led into a rear garden. Staff spoken with were unsure if there were external lights or directional signage to an end point or safe area from this exit and none were visible from the exit door. Staff told inspectors they had not walked the external staircase as an escape route and some staff had not completed a drill using an evacuation sled required.

Judgment:
Non Compliant - Moderate

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

Theme:
Safe care and support

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

**Findings:**
Some improvement was required to ensure that each resident is protected by the
designated centre’s policies and procedures for medicine management.

Inspectors reviewed a sample of prescription and administration records and noted that
some improvement was required to reduce the risk of medicine error. Some residents
required medicine as and when required (PRN). However the maximum dose that could
safely be administered in a 24 hour period was not consistently recorded. This practice
was not in line with the centre’s own written operational policies relating to the ordering,
prescribing, storing and administration of medicines to residents.

Some residents required their medicines to be crushed prior to administration and a
general authorisation to crush was identified on the front of the prescription record.
However, the medicines were not consistently documented as requiring crushing.

On the previous two inspections it was found that faxed medicine prescriptions were not
transferred into residents’ prescriptions within 72 hours in line with the policy. This
meant that the medicines were not administered from a valid prescription. Medicines
were not transcribed and checked in accordance with the centre's policy and
professional standards. Nine medicines were administered in the absence of a fax or
original prescription in the centre and had been recorded as administered for 10 days in
the absence of an original signed/prescription.

Inspectors noted that the other actions required from the previous inspection relating to
medicine management had been addressed. Inspectors did not see the medicine trolley
left unattended when in use on the day of inspection. The nurse administering the
medicines was familiar with their use. Pain charts were in use as required.

Residents had access to the services of the pharmacist of their choice and the
pharmacist was available to meet with residents if required. Records showed that all
nursing staff had attended medicine management training.

**Judgment:**
Non Compliant - Moderate

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**Outcome 10: Notification of Incidents**
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

**Theme:**
Safe care and support

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.
Findings:
Inspectors were satisfied that a record of accidents occurring in the designated centre was maintained and, where required, notified to the Chief Inspector.

The person in charge was aware of the legal requirement to notify the Chief Inspector regarding incidents and accidents. To date all notifiable incidents had been notified to the Chief Inspector as required.

The inspector saw that details of each accident were recorded together with actions taken. The person in charge had developed a monitoring system and all accidents were analysed for the purposes of learning.

Judgment:
Compliant

Outcome 11: Health and Social Care Needs
Each resident’s wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident’s assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

Theme:
Effective care and support

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

Findings:
Inspectors found that resident’s wellbeing and welfare was maintained with access to nursing, medical and allied healthcare professionals. However as at the previous inspections, some gaps were identified in the assessment and care planning process, and in the daily progress documentation. The standard of documentation by some staff was not consistently maintained in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais.

An admission policy was available that included the requirement to complete a pre-admission assessment of all residents. However, the policy had not been implemented in full and a pre-admission assessment had not been completed for the most recent resident admitted to the centre.

Inspectors reviewed a sample of care plans and saw that improvement had occurred. They were person centred and for the most part set out the interventions required to meet the assessed needs. Inspectors reviewed the management of clinical issues such
as wound care, diabetic care and dementia care. While they were generally complete, it was noted that some were not specific enough to inform practice. For example the wound care plan did not specify how often the dressing was to be changed.

In addition inspectors noted that there was limited evidence that residents or relatives were consulted regarding care plan reviews. The contact details of relatives or significant others was not recorded in the comprehensive assessment in one resident’s file reviewed.

Weight management is discussed in more detail under outcome 15.

Residents had access to GP services and out-of-hours medical cover was provided. A full range of other services was available in house including speech and language therapy (SALT), occupational therapy and dietetic services. Physiotherapy was available in the centre. Chiropody, dental and optical services were also provided. Inspectors reviewed residents’ records and found that residents had been referred to these services and results of appointments were written up in the residents’ notes.

**Judgment:**
Non Compliant - Moderate

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**Outcome 12: Safe and Suitable Premises**

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

**Theme:**
Effective care and support

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

**Findings:**
The centre is registered for a maximum capacity of 42 residents and residents’ accommodation is on the ground and first floor. The centre comprises of 25 single bedrooms, five with full en-suite facilities, seven twin bedrooms, two with en-suite facilities and a three bedded room that was vacant at this time.

Some actions required under this outcome following the last inspection have not been carried out. Access to appropriate garden space has been discussed at previous inspections. The management had informed HIQA that an appropriate area had been identified and the work was due completion at the end of March 2017. The area was marked out but no work had begun. The inspector was informed by the PIC that the...
General Manager is in charge of this area and she is unaware of the date for the work to be completed.

In a previous report the ramp leading to the dining room was identified as an issue under Outcome 8. The Manual Handling instructor/physiotherapist told inspectors she had carried out a risk assessment and provided instructions to all care staff on safe techniques when assisting residents to access the dining room. Residents who mobilise independently had also been risk assessed.

Corridors and door entrances were wide and spacious to facilitate modified, support or bulky equipment and aids seen used and required by residents.

An action with respect to the location of an appropriate sluice room on corridor D had been addressed. However on the day of inspection the inspector noted that the new sluice room was also being utilised as a place of storage for clean laundry, incontinence wear and the storage of mop buckets. Storage arrangement required review as these items were being inappropriately stored. There was no option to lock the first floor sluice door.

Overall, the design and layout of the centre were in line with the statement of purpose. Inside the building was kept in a good state of repair. The centre was clean and homely. There was adequate private and communal accommodation for residents, including space for residents to receive visitors in private. There is a large welcoming reception area. The centre has a separate sitting room and dining space that can meet the needs of the residents. There were handrails on both sides of the corridors and an operating lift between floors that could accommodate a stretcher. There was a magnetic rail across the bottom of the stairs which restricted residents from using the stairs and a wooden gate at the top of both stairs. The inspectors discussed this with the management staff who agreed to carry out a comprehensive risk assessment.

All bedrooms viewed were individualised with personal belongings and photos. The bedrooms are primarily spread across four corridors A-D. Corridor D has en-suite bathrooms and each bathroom had grab-rails. One twin room inspected was noted to have cables hanging over the residents' wardrobe connecting it to the television. The television was placed in front of the residents' wardrobe restricting access.

The bedrooms on Corridor C were fitted with a hand basin facility. There are two toilets at the end of the corridor that are not of adequate size to provide assistance to a resident. The person deputising for the person in charge informed the inspectors that residents are assessed for suitability prior to being admitted to this corridor. The rooms inspected along this corridor were all well maintained. They had been freshly painted. Each room inspected had a working call bell. Remote control powered beds were in place and in good repair. Each room has access to a lockable press for the safe keeping of personal items. It was noted that the lock on the bedroom doors had been sealed with paint. Therefore, the option for residents to lock there bedroom was not available to promote choice, privacy and dignity.

The running water in the bedrooms on corridor C was too hot for the inspector to leave her hand under. There is a risk of scalding. It was also noted that some radiators were
too hot to hold and did not have a guard, and that internal pipes were exposed and also very hot when touched.

The assisted bathroom on the ground floor Corridor B was of large size fitted with a wheelchair accessible shower and a bath. An inspector noted that there was no hot water from the taps at the time of inspection.

On the day of inspection there was a power outage in the area. The management team were able to inform the inspectors of the plan of action should it not be restored within a two hour timeframe.

Judgment:
Non Compliant - Moderate

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 inspectors saw that there were policies, procedures and systems in place for the management of complaints.

The complaints procedure was displayed in the reception area of the centre, and residents who communicated with the inspectors were aware of the process and identified the person with whom they would communicate with if they had an issue of concern.

The operations manager was deputising in the absence of the person in charge and was responsible for the management of complaints. Staff said they were open to receiving complaints.

A log of complaints was maintained and reviewed by inspectors. There were three complaints logged since the previous inspection which were recorded as resolved to the satisfaction of the complainant addressing the previous findings. Inspectors were also informed that a further complaint had been received and a meeting with the complainant was held the previous day. The nature and details of the complaint and meeting had not yet been logged. Inspectors were informed that the complaint was to be investigated in line with the centres policy.

Judgment:
Outcome 14: End of Life Care
Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.

Theme:
Person-centred care and support

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

Findings:
A policy and operational procedures for end of life were available to guide staff and inform care practices. At the time of inspection, inspectors were informed that none of the residents were approaching the end of life.

Inspectors were told by staff that the involvement of a multi-disciplinary approach to treatment and care that included a palliative care team was available but not required by any of the current residents at this time.

In the sample of resident's files reviewed, inspectors found that medical decisions regarding care and treatment decisions at the end of life were not consistently assessed, discussed or recorded for all residents on or following admission. The primary contact person was also omitted in a file examined, therefore the arrangements in place required improvement to ensure each resident or their relative had been given the opportunity to outline their wishes regarding end of life such as a preference as to his or her location, for example a preference to return home, for a private room or funeral service within the centre as referenced in the contract of care. The inspectors discussed the number of deaths within the past four months and were told by management that they will carry out an audit of the end of life care that was provided to residents to inform improvements.

Staff outlined how religious and cultural practices were facilitated within the centre. Caring for a resident at end of life was regarded by staff as an essential part of the care service provided. Choices were offered and facilities were available to support residents and families, as required. Most residents had a single bedroom and two twin rooms were occupied at this time with other room vacancies. Facilities available to families or next of kin included a visitor's room and parlour.

A spacious and suitably maintained chapel facility was available within the centre and used by residents for prayer and reflection on a daily basis and for mass on a weekly basis. It had suitable equipment and religious artefacts available that respected residents’ cultural and religious background. Residents told inspectors their religious needs were met by the local priest who visited weekly and on religious occasions. For example, they had received blessed ashes from the priest on the previous day (Ash
Judgment:
Non Compliant - Moderate

Outcome 15: Food and Nutrition
Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.

Theme:
Person-centred care and support

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

Findings:
Inspectors were satisfied that each resident was provided with food and drinks at times and in quantities adequate for his/her needs. Food was properly prepared, cooked and served, and was wholesome and nutritious. Assistance was offered to residents in a discreet and sensitive manner.

Validated nutrition assessment tools were used to identify residents at potential risk of malnutrition or dehydration on admission and were regularly reviewed thereafter. Weights were also recorded on a monthly basis or more frequently if required. Inspectors noted that some gaps were evident in fluid balance records and this is included under Outcome 5.

Records showed that some residents had been referred for dietetic and speech and language reviews. The treatment plan for the residents was recorded in the residents’ files.

Inspectors visited the kitchen and saw that it was clean and organised. Inspectors reviewed the menus and saw that adequate choices were available at each meal. Residents requiring modified consistency diets had the same choices available to them.

Snacks and refreshments were available at all times. Residents spoke very highly of the catering staff and the foods served.

Judgment:
Compliant

Outcome 16: Residents’ Rights, Dignity and Consultation
Residents are consulted with and participate in the organisation of the centre. Each resident’s privacy and dignity is respected, including receiving
Theme:
Person-centred care and support

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

Findings:
Inspectors were satisfied that residents were consulted about how the centre was run and were enabled to make choices about how to live their lives.

Inspectors were satisfied that each resident’s privacy and dignity was respected. Staff were observed knocking on bedroom, toilet and bathroom doors and waiting for permission to enter. Locking mechanisms are discussed under Outcome 12.

Residents’ civil and religious rights were respected. Residents confirmed that they had been offered the opportunity to vote. In-house polling was available. Mass took place on a weekly basis. The person in charge said that residents from all religious denominations were supported to practice their religious beliefs.

A residents’ committee had been established and regular meetings were held. Inspectors read some of the minutes and saw that when residents had made some recommendations these had been acted upon. For example, some residents felt they were too long waiting for breakfast and rosters were reviewed to address this.

Residents had access to independent advocacy services. Daily records showed that residents, including those who were unable or chose not to attend group sessions were provided with social stimulation on a daily basis.

Each resident has opportunities to participate in meaningful activities and the activity programme was based on residents’ assessed interests and capabilities. Music and bingo were firm favourites. Daily records were maintained of residents’ participation in the various activities.

Residents were seen enjoying various activities during the inspection. A movie afternoon with ice cream and drinks was underway and discussions had taken place as to which movie they should watch. Unfortunately a power outage changed that plan.

Judgment:
Compliant

Outcome 18: Suitable Staffing
There are appropriate staff numbers and skill mix to meet the assessed needs
of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

Theme:
Workforce

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

Findings:
Inspectors did not find sufficient evidence that there were appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre.

There was a recruitment policy in place. Inspectors reviewed a sample of staff files and found that some were not complete. For example three of four files reviewed did not contain a satisfactory history of any gaps in employment as required by the regulations. Action required in relation to this is included under Outcome 5.

Several volunteers and outsourced service providers attended the centre and provided very valuable social activities and services which the residents said they thoroughly enjoyed and appreciated. They had been vetted appropriate to their role. Their roles and responsibilities were set out in writing.

The deputising person in charge gave assurances that garda vetting was in place for all staff.

Inspectors reviewed the roster which reflected the staff on duty. Up to date registration numbers were in place for nursing staff. Professional development for staff was promoted. Staff told the inspectors they had received a broad range of training which included continence care, infection control, responsive behaviours and basic life support. However, gaps in the provision of manual handling training were found. In addition, training in relation to the recording of clinical practice and medication management was required based on the inspection findings.

Actions required from the previous inspection were still ongoing. At that time it was identified that the provider had difficulty recruiting nurses and had given an undertaken to keep the occupancy levels below 30 until the full complement of staff was in place. This was still the case. Staff supervision and the arrangement of skill mix on duty at all times required review to ensure staff with appropriate training, qualifications and experience were available to maintain residents' needs and numbers.

Inspectors found following a review of the roster and meeting with staff and residents
that the levels and skill mix of staff at the time of inspection were sufficient to meet the needs of the 26 residents. However, inspectors were not assured that staffing levels would be suitable and sufficient to meet the needs of residents if the occupancy levels were above 30.

Other areas requiring review included the need to review the system in place regarding the length of time staff spent on night duty and supervision arrangements for that shift, as outlined in outcome 2.

**Judgment:**
Non Compliant - Moderate

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**Closing the Visit**

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

**Acknowledgements**

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

*Report Compiled by:*

Sonia McCague  
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 02: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The governance and management arrangements, processes and controls in place were insufficient to ensure the effective delivery of care in accordance with the statement of purpose.

The staffing levels and whole time equivalent resources available at the time of inspection did not support an application to accommodate 42 residents and therefore

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
required review, despite the planned return of the person in charge on 6 March 2017.

1. **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:**
At present we have 27 residents, the staffing levels of the home are regularly assessed and adjusted to meet the needs of these residents. The staffing levels will be increased when resident numbers go above 30 or if the resident’s dependency levels warrants it. We are currently recruiting staff nurses, the shortage of nurses nationally is an issue and at present we have recruited two relief nurses. We have also recruited two full time care assistants to ensure appropriate cover is maintained.

**Proposed Timescale:** 27/03/2017

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The management arrangements were not sufficiently robust to assure the service was safe, appropriate, consistent and effectively monitored to ensure the quality and safety of the service.

Arrangements for the supervision, monitoring and review of residents care and staff practice were inadequate.

Governance arrangements required improvement to ensure the delivery of care was safe, appropriate and monitored on a consistent basis to deliver quality care standards. The staff roster showed that persons participating in management worked from Monday to Friday and not at weekends or at night. The roster and staff confirmed that a number of staff (up to eight) mainly worked night duty. The roster for February 2017 showed that two out of the four nurses available and four care staff worked night duty shifts only.

The arrangements for the recording and review of incidents within the centre required improvement. Gaps were found in the recording and management of assessment details, incidents, staff response and communications.

Assessments and clinical care did not consistently accord with evidence based practice, were incomplete and not maintained in accordance with the centre’s policies or protocols described by management.

A system to monitor staff practice, acts or omissions and/or and procedures carried out following a significant incident and change in a resident’s condition required improvement.
Some records reviewed showed a lack of an appropriate and timely response to clinical assessments, management of observations and symptoms described and noted by members of the staff team.

The information outlined within the statement of purpose and in the contract of care in relation to the terms and conditions of a resident's stay such as charges applied to all residents for laundry and in the event that property remained in storage after their departure or discharge required review and clarification.

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

Please state the actions you have taken or are planning to take:
At present the Director of Nursing works full time hours across four days this includes two 8.00-20.00 shifts to ensure evening supervision and contact with the night staff. The Director of Nursing has worked one night shift since the inspection to assess staff competency levels at night. The Senior Nurse Manager is to commence a 15.00-22.00 shift to provide more supervision at night time. The Director of Nursing will also provide weekend cover where possible without compromising the supervision required during weekdays.
All Staff Nurses and care assistants are to commence a night duty rotation. The Staff nurses will be rotated first, all staff nurses will have to complete a night duty rotation over a period of two weeks at least once every three months. The care staff rotation will rotate the current night carers onto days over a period of one to two weeks at least once every three months. A different group of day staff will be rotated every quarter. This will have commenced by 1-5-2017
Future incidents in the home such as unexpected deaths or cardiac arrest will be reviewed by the Director of Nursing, a meeting will then be held with all staff involved to facilitate learning and identify areas for improvement. A Clinical Incident Debriefing S.O.P. is being developed and will be discussed at the next staff nurse meeting on 30-3-2017.
In relation to documentation the named nurse system is currently in place. All aspects of documentation will be audited by the DON and SNM this will include assessments, care plans, daily reports, observations and the continuity of care surrounding changes in resident’s condition. All staff nurses will have an appraisal and the areas of improvement will be highlighted. If retraining is required this will be provided. A timeframe for improvement will be given, if there are further episodes of poor documentation, assessment and clinical procedure disciplinary action will be taken. These appraisals will commence 24-4-2017.

The information outlined within the statement of purpose and in the contract of care in relation to charges applied to all residents for laundry and in the event that property remained in storage after their departure or discharge has been reviewed and amended. These changes have been submitted to the inspector for review.

Proposed Timescale: 08/05/2017
# 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:**
Policies such as risk management, medication management, and admission of residents, communications and end of life care required review and implementation in practice.

The policy and practice in relation to the creation of, access to, retention of and destruction of records required review and improvement in line with best practice, the regulations and professional guidance standards.

### 3. 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:
All necessary policies will be reviewed by the DON and the Operations Manager, this will be discussed at the Staff Nurse meeting on 30-3-2017. Ongoing auditing of practices and monitoring of care will identify if these policies are implemented effectively. At present our system for filing resident documents is being reviewed and the responsibility for maintaining this is allocated to the named nurse this will be monitored by the DON and SNM.

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**Proposed Timescale:** 28/04/2017

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Three of four files reviewed did not contain a satisfactory history of any gaps in employment.

Improvements in the maintenance of records was required to ensure:
- a sufficient and complete record of the name, address and telephone number of the resident’s next of kin or of any person authorised to act on their behalf was sufficiently maintained as required in schedule 3(3)(b)
- a comprehensive nursing record of all communications in relation to each resident by the nurse on duty in accordance with any relevant professional guidelines as required in schedule 3(4)(c)

Records of the food provided for residents required improvement to ensure sufficient detail was included to enable any person inspecting the record to determine whether the diet is satisfactory in relation to nutrition and otherwise, and of any special diets prepared for individual residents.
4. **Action Required:**
Under Regulation 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

**Please state the actions you have taken or are planning to take:**
Policies and procedures relating to the admission of a resident will be reviewed as previously mentioned. Within 72 hours of admission the Senior Nurse Manager or in her absence the Director of Nursing will review all admission documentation, assessments and care plans to ensure they are appropriately documented. The daily report is currently documented by staff nurses once a day. If there is a change in a residents condition the staff nurse will be required to enter into the daily report the care they have provided at regular intervals to ensure a safe standard of care has been delivered while maintaining communication and continuity of care. This again will be introduced at the next staff nurse meeting and a case study given as an example.
In relation to care staff documentation of dietary and fluid intake a care staff meeting is to be held on the 28-3-2017 frequency and content of their documentation will be highlighted, timeframes for improvements will be given. A third touch screen will be put in place to facilitate timely documentation of care. A policy in relation to care staff recording of care procedures will be put in place.

**Proposed Timescale:** 21/04/2017

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**Outcome 07: Safeguarding and Safety**

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Care to be provided to residents while bedrails were in use was not documented in the care plan.

There was no evidence that safety checks were completed when in use, in line with national guidelines.

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

**Please state the actions you have taken or are planning to take:**
Restraint care plans will be audited by the SNM within 2/52, this will also be an area of focus in the Staff Nurse appraisals.

Changes and improvements required with the restraint/release documentation will be covered in the care staff meeting, the additional touch screen will also aid
improvements. Care staff appraisals will be undertaken with a focus in this area. Failure of care staff to meet these documentation standards will result in disciplinary action.

**Proposed Timescale:** 02/06/2017

**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:

Inspectors identified the following risks that required assessment by the provider:
- electrical leads seen draped from the top of residents’ wardrobes to a socket attached to the top of a curtain screen that was connected to a television (TV) below on a table. The table and TV obstructed access to the wardrobes where residents clothes were seen stored and the wardrobe doors in this bedroom did not open easily
- while some radiators and pipes along corridors were encased, others in bedrooms were not and were very hot to touch posing a risk to residents
- the water temperature in some bedrooms was too hot for safe use
- a fire exit via a resident’s bedroom on the first floor had not been risk assessed to ensure suitable arrangements and consent were in place for its intended purpose
- the identified fire exit from the ground floor dining room had a step down on exiting the room into a garden. Five residents using modified wheelchairs dined in this room
- oxygen cylinders were stored along the corridor into the chapel.

The fire exit through a resident’s bedroom on the first floor and from the dining room on the ground floor beneath required review, risk rating to ensure they were fit for purpose, readily available and sufficient to facilitate the escape of all residents accommodated in the compartment or area.

6. **Action Required:**

Under Regulation 26(1)(b) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the risks identified.

**Please state the actions you have taken or are planning to take:**

The electrical leads and the obstruction created by a table and TV in a bedroom will be rectified by our maintenance man, the wardrobe doors will also be fixed.

The temperature of the radiators has been reviewed and adjusted at the thermostat. The temperature will then only be adjusted according to the residents preference. The pipes along the corridors and in bedrooms will be encased.

The water temperature in the bedrooms was addressed when the temperature of the thermostat was adjusted.

A risk assessment will be completed for the fire exit in the identified bedroom and consent for its use will be obtained from the resident.

The fire exit leading from the dining room has a step down this will be addressed with
the commencement of the garden. This will also be included in the above-mentioned risk assessment. Arrangements have been made to remove unused oxygen cylinders stored in the chapel corridor.

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

Improvements were required to prevent infection and promote control of healthcare associated infections.

The storage of a clean linen on a trolley, open packets of incontinence pads and cleaning equipment such as mops and buckets seen in this sluice room required review.

The provision of a clinical waste bin and personal protective equipment on the ground floor within close proximity to a resident identified with an infection required review.

The infection control policy with supporting protocols required review in accordance with the safety statement protocols for implementation in practice.

**7. 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:**

Linen trolleys are no longer stored in sluice rooms, storage areas have been identified and staff have been informed. Incontinence pads stored in sluice rooms have been removed and staff informed that they should never be stored there, these incontinence pads can be stored in resident’s rooms and in toilets. Suitable storage will be provided for the incontinence wear in the main downstairs bathroom. Alternative storage for mops and buckets has been identified and they are no longer stored in sluice rooms. A clinical waste bin has been put in place in the sluice room near to the resident with an infection along with the appropriate P.P.E. All staff have been made aware of this and our Infection Control Policy will be discussed at the next staff meeting. Infection Control training has commenced for staff who are out of date.

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**The Registered Provider is failing to comply with a regulatory requirement in**
the following respect:
One of the escape routes led into a rear garden. Staff spoken with were unsure if there were external lights or directional signage to an end point or safe area from this exit and none were visible from the exit door.

8. Action Required:
Under Regulation 28(1)(b) you are required to: Provide adequate means of escape, including emergency lighting.

Please state the actions you have taken or are planning to take:
Emergency lighting is in place over the rear fire exit door and along the side of the building. Appropriate signage will be put in place directing staff and residents to an assembly point. This information will be included in all fire drills going forward.

Proposed Timescale: 30/04/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Improvement was required in the fire drill procedures completed as they had not included a simulated fire drill using the ‘sled’ that may be required by up to 10 residents in the PEEP.

The fire evacuation drills carried out since the previous inspection had occurred between 10am and 3pm and an evacuation simulating evening or night time conditions and staffing levels had not been completed.

Some staff told inspectors they had not walked the external staircase as an escape route or completed a drill using an evacuation sled required by up to 10 residents in the PEEP.

9. 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 number of fire drills have taken place where the evacuation sled had been used. This will now be incorporated into all fire drills.
A fire drill including a table top evacuation has taken place with staff on night duty on 18-3-2017. One fire drill will take place each month with night staff and these fire drills will include simulation with the evacuation sleds.

The Fire Officer and the Director of Nursing have now walked the external staircase, all staff nurses will have the opportunity to do this.
Proposed Timescale: 21/04/2017

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:
For medicines to be given as and when required (PRN), the maximum dose that could safely be administered in a 24 hour period was not consistently recorded.

Medicines to be crushed prior to administration were not consistently documented this way.

Medicines were not administered from a valid prescription. Medicines were not transcribed and checked in accordance with the centre's policy and professional standards.

Nine medicines were administered in the absence of a fax or original prescription in the centre and had been recorded as administered for 10 days in the absence of an original prescription.

10. 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:
There have been issues in the past with getting GP’s to specify the maximum doses for PRN’s within a 24 hour period, it is the Staff Nurses responsibility then to seek clarification and to document this accordingly. This again will be highlighted at the staff nurse meeting and will be monitored through auditing.
Crushed medication forms have been reviewed for all residents who require it and signed by the GP’s and the Pharmacist. We are currently looking at new prescription records that would allow a more accurate documentation of this. Developments for this prescription record has commenced. Procedures will also be changed to ensure that when a new medication is commenced that this is also reviewed by both the GP and Pharmacist that it can be crushed prior to administering.

Insufficient transcription, checking of transcription and lack of necessary prescriptions will require rectifying through auditing and appraisals. The issues surrounding this will again be highlighted in the next staff meeting and improvements will be monitored by the DON and SNM.
Proposed Timescale: 26/05/2017

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:
There was limited evidence that residents or relatives were consulted regarding care plan reviews.

11. 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:
Resident/family meetings have recommenced this will ensure a greater involvement with care planning which will in turn ensure more individualised person centred care is delivered.

Proposed Timescale: 30/06/2017

Theme: Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some care plans were not specific enough to inform practice.

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

Please state the actions you have taken or are planning to take:
As previously mentioned all care plans are to be audited by the Director of Nursing, the findings of these audits will be highlighted in the Staff nurse meetings and carried forward into the appraisals. Family and resident involvement will improve care planning also.

Proposed Timescale: 30/06/2017
Theme: Effective care and support
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The standard of documentation was not consistently maintained by some staff in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais.

Gaps were identified in the assessment and care planning process, and in the daily progress documentation.

13. 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:
A recent incident of poor documentation following an unexpected death was thoroughly investigated, disciplinary actions are to follow in relation to this. As previously identified going forward staff nurses will document on a resident at regular intervals if a change in condition has occurred so as to ensure safe and consistent care is provided. Assessments and care planning again will be monitored improved upon through auditing and appraisals of staff in consultation with the families, residents and named carers.

Proposed Timescale: 30/03/2017

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

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Appropriate secure outdoor space was not yet commenced or available.

Storage arrangement required review as items were being inappropriately stored in a sluice room such as clean laundry and mop buckets.

The toilet facilities in one wing were not suitable for residents who are not fully independent with mobility.

A supply of hot water was not available in a downstairs bathroom

Hot water, radiators and pipes in some parts carried a potential risk of scalding.

There was no option to lock the first floor sluice door.
14. **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:**
Work has commenced on the secure garden.

As mentioned above alternative storage areas have been identified for linen, incontinence wear and mops.

Residents are assessed prior to admission and suitable rooms are identified for them, residents who require hoist transfers would not be placed in these bedrooms.

The hot water in the downstairs bathroom and the radiators have been addressed when the temperature of the thermostat was reviewed. Exposed pipes are to be encased.

A keypad has been installed on the door of the first floor sluice.

**Proposed Timescale:** 30/06/2017

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**Outcome 14: End of Life Care**

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

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Inspectors discussed the number of deaths within the past four months and were told by management that they will carry out an audit of the end of life care that was provided to residents to inform improvements.

15. **Action Required:**
Under Regulation 13(2) you are required to: Following the death of a resident make appropriate arrangements, in accordance with that resident’s wishes in so far as they are known and are reasonably practical.

**Please state the actions you have taken or are planning to take:**
An audit will be undertaken by the Director of Nursing in relation to the End of Life Care provided to all residents who have passed away within the last 6 months this will be done in line with the Quarterly NF 39. If areas in need of improvement are identified these will be implemented in the home and the necessary policies and procedures updated. This will then be communicated to all staff in a meeting.

**Proposed Timescale:** 30/05/2017

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

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Decisions regarding care and treatment decisions at the end of life were not consistently assessed, discussed or recorded for all residents on or following admission.

The arrangements in place required improvement to ensure each resident or their relative had been given the opportunity to outline their wishes regarding end of life such as a preference as to their location, for example a preference to return home, for a private room or funeral service/facilities within the centre as referenced in the contract of care.

16. **Action Required:**
Under Regulation 13(1)(a) you are required to: Provide appropriate care and comfort to a resident approaching end of life, which addresses the physical, emotional, social, psychological and spiritual needs of the resident concerned.

**Please state the actions you have taken or are planning to take:**
End of life care plans will be discussed with residents/families at the family meetings or when a change in condition occurs. A family meeting will be held within the first two weeks of admission and every three months thereafter

**Proposed Timescale:** 30/06/2017

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Outcome 18: Suitable Staffing

**Theme:**
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all staff had attended mandatory training.

Gaps in the provision of manual handling training for staff were found.

Training in relation to the recording of clinical practice and medication management was required based on the inspection findings.

17. **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:**
All mandatory training is currently being scheduled, manual handling training has commenced with the distribution of the information booklet and questionnaire prior to the practical sessions.
**Proposed Timescale:** 30/06/2017  
**Theme:** Workforce  

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**  
The supervision of staff required improvement.

**18. 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:**  
As previously mentioned both the Director of Nursing and Senior Staff Nurse hours have been reviewed to ensure more evening and weekend supervision. The rotation of staff from night duty onto days will also improve the overall supervision.

**Proposed Timescale:** 01/05/2017