Health Information and Quality Authority
Regulation Directorate

Compliance Monitoring Inspection report
Designated Centres under Health Act 2007, as amended

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	Maynooth Community Care Unit
Centre ID:	OSV-0000516
Centre address:	Leinster Street, Maynooth, Kildare.
Telephone number:	01 610 6351
Email address:	catherine.dempsey2@hse.ie
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Catherine Dempsey
Lead inspector:	Sheila McKevitt
Support inspector(s):	Shane Walsh
Type of inspection	Unannounced
Number of residents on the date of inspection:	34
Number of vacancies on the date of inspection:	8

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 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:	To:
23 March 2017 09:00	23 March 2017 17:00

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

Outcome	Our Judgment
Outcome 02: Governance and Management	Non Compliant - Major
Outcome 05: Documentation to be kept at a designated centre	Non Compliant - Major
Outcome 07: Safeguarding and Safety	Non Compliant - Moderate
Outcome 08: Health and Safety and Risk Management	Non Compliant - Major
Outcome 09: Medication Management	Compliant
Outcome 11: Health and Social Care Needs	Compliant
Outcome 12: Safe and Suitable Premises	Non Compliant - Major
Outcome 14: End of Life Care	Compliant
Outcome 17: Residents' clothing and personal property and possessions	Compliant
Outcome 18: Suitable Staffing	Non Compliant - Moderate

Summary of findings from this inspection

The purpose of this inspection was to follow-up on the action plans identified on the registration renewal inspection in January 2015. During that inspection 18 outcomes were inspected against and the provider was found to be in non compliance with 10 outcomes.

Inspectors found that four of these 10 outcomes were now in compliance, two remained unchanged as moderate non compliant, one had moved from substantially compliant to moderate non compliant and four had moved from moderate to major non compliant.

The outcomes where improvements had occurred included health and social care needs, end of life care, medication management, residents' clothing and personal property and possessions. All of which are the responsibility of the director of nursing as outlined in the Health Act 2007. Residents spoken with confirmed to inspectors that the standard of care they received was good. They praised staff.

The outcomes which had increased in the level of non compliance included governance and management, documentation to be kept in the designated centre, safe and safeguarding, health and safety and risk management, premises and staffing.

There had been a changed of provider representative in January 2017 and a change in person in charge in early February 2017. However arrangements for regular consistent communication for 2017 were not evident. The frequency of auditing was ad hoc and no annual review had been completed in the centre. Fire drills were not been completed with staff and a number had not completed fire training for some period of time. The use of bed rails as a form of restraint was not in accordance with the National policy and there use had increased. No changes had been made to the premises to improve the amount of private space made available to residents occupying multi-occupancy bedrooms. Although staffing had improved since the last inspection vacancies remained unfilled for some period of time and staff did not have refresher elder abuse training completed.

The provider was requested to attend HIQA Dublin office to discuss this report.

The action plans at the end of this report reflect where mandatory improvements are required.

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:
This outcome had increased from moderate to major non compliance. The governance of the centre was not strong. There had been a complete change to the management team in early 2017. The evidence on inspection supported the view that the provider's representative and the person in charge were not carrying out their roles and responsibilities in line with their legislative requirements. A greater knowledge of the Health Act 2007 was required.

The Authority had been notified of a change of representative on behalf of the provider in January 2017 and of a change in the person in charge in February 2017. The relevant documentation had been received for both personnel. Inspectors conducted a fit person's interview with the person in charge on this inspection however the representative on behalf of the provider was on leave and had yet to complete a fit person's interview.

On inspection, inspectors were informed that an assistant director of nursing named on the current registration certificate as a person participating in management had retired in October 2016. HIQA had not been informed of this change as required by the regulations. The employees name remained on the certificate of registration on display in the centre. Inspectors requested the management team to complete the required paperwork and submit it to the registration office in Cork without further delay. The completed notification had not been received at the time of writing the report.

Inspectors reviewed minutes of meetings which the director of nursing had with the assistant director of nursing and clinical nurse managers. On the previous inspection it was noted that these meetings were not taking place. While these meetings were now taking place on a three monthly basis, there was no agenda for these meetings; the

minutes recorded were vague with no evidence of actions required or those responsible for addressing these actions. Therefore, it was not clear if issues such as the lack of alternatives to using bedrails had been brought to the attention of the person in charge.

The wider management team for area CH07 older persons services which included the Head of Social Care, the Manager for Older Persons, the newly appointed providers representative and the directors of nursing from the six long term stay centres met on a regular, consistent basis. The minutes of the last meeting held on the 26 January 2017 were not available for review, however inspectors were shown the agenda for the meeting which covered a range of management issues.

Inspectors were informed that the new provider representative had visited the centre on commencing in her role on the 23 January 2017. However there had been no meetings to date between the new provider representative, person in charge and assistant director of nursing. The meeting schedule for March was cancelled and the next meeting was scheduled for April 2017. This meant that there was no evidence to show if issues, such as vacant staff posts entered in the escalated risk assessment on 03 January 2017 were being addressed, by whom or when. Meetings for the remaining of 2017 were not scheduled to date. In addition, inspectors were informed that there was no dietician available to them since December 2016 and there was no recorded plan of action to address this vacancy.

The person in charge informed inspectors that she had no budgetary control. Therefore she had to apply to one department within CH07 for funding to train staff and another to purchase equipment. As evidence in this report this had resulted in staff not receiving the required training in a timely manner and appropriate equipment not being purchased.

The standard of auditing required improvement. As stated in response to the previous action plan, staff had commenced the completion of nursing metrics which were to inform the annual review. Inspectors saw evidence that these matrix were covering areas such as falls, restraint, environment, discharge planning, medicine management, nursing documentation and pressure ulcer management. They were being completed on three to six monthly basis and not monthly as stated in the providers response. The summary of these reports showed the percentage of compliance with the audit. For those, audits that had less then a 100% compliance it was not consistently clear what actions if any were recommended to ensure 100% compliance was achieved in the next audit. It was therefore not evident if these audits were leading to any improvements in practice where improvements were required.

Inspectors were informed that no annual review had been completed in the centre for 2014, 2015 or 2016.

Judgment:
Non Compliant - Major

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

Findings:
This outcome had moved from moderate to major non compliance. Inspectors found that the restraint policy had not been updated since the last inspection. It was last updated in 2010.

The emergency plan as stated and actioned under outcome 8 did not reflect practices in the centre.

The staff training and development policy was not being implemented.

Judgment:
Non Compliant - Major

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

Findings:
The outstanding action was not implemented.

Inspectors reviewed the records of restraint in use, primarily in relation to the use of

bed rails. Over 50% of residents in the centre were using one or two bedrails. Inspectors reviewed a sample of files for residents using bed rails and found that each resident had an assessment carried out by a staff nurse on the use of bed rails as a restraint. This was reviewed in most cases within a four month period, however some were noted not to be reviewed for six months.

In the sample of bed rail assessments reviewed inspectors noted in some cases the resident was recorded to have requested bed rails, in others the assessment stated alternatives to bed rails had not been trailed. However it was not clear as to why alternatives were not trialled prior to bed rails being used. On further discussion with staff it became evident that there were few alternatives to bed rails available for staff to trial with residents prior to using bed rails. For example, staff had access to a small number of sensor and bed alarm mats and one crash mat. They had no access to alternative equipment such as bed wedges or low beds. Inspectors found that the centre required improvement in moving towards National Policy 2011 'Towards a Restraint Free Environment in Nursing Homes'.

Twenty six staff had not received refresher elder abuse training within two years, a target set by the provider. Inspectors found that staff spoken with during the course of the inspection had a clear understanding of the different types of abuse and their responsibility in line with the centres policy to report it. Residents told inspectors they felt safe living on in the centre and there were no reports of alleged abuse.

Judgment:
Non Compliant - Moderate

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

Theme:
Safe care and support

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

Findings:
This outcome had moved from moderate to major non compliance. The action required from the previous inspection in the centre was followed up on and had been implemented.

Inspectors reviewed the fire safety procedures and documentation in place in the centre. The procedure to be followed in the instance of a fire was displayed in a prominent position at the nurses' station in each of the two units. The procedure outlined what steps staff were to follow, the direction to evacuate and where the assembly points were located. Inspectors found that this information matched what was detailed in the fire

policy, which had been reviewed in March 2017. Fire exits in the centre were well displayed and fire fighting equipment was available throughout the two units. Records detailed that the fire alarm and emergency lighting had been serviced on a quarterly basis. Inspectors were informed that the fire fighting equipment was being serviced on the day of the inspection. Inspectors spoke to a number of staff and they were knowledgeable around their role in the event of a fire. However inspectors were informed that fire drills were not routinely practiced, that drills used to occur, but they had not taken place in the centre in over a year. The person in charge explained that two talks to staff on the fire procedure had taken place in 2015 however these were not full drills.

On the last inspection it was found that some staff did not have up to date training in fire safety. Inspectors found that this was still the case. Training records detailed that ten staff did not have up to date training in fire safety.

There was no centre specific emergency plan in place for the centre. The inspectors reviewed the emergency plan on file and found that it was for the wider HSE Mid-Leinster region and did not outline plans in place specific to the centre in the event of an emergency.

Inspectors reviewed the safety statement for the centre. The statement outlined the responsibilities HSE in relation to the health and safety of any occupants in the building. The inspectors reviewed the risk policy which was not centre specific, but it did detail risk identification, evaluation and recording. The policy had no date of review or issue on it so the inspectors were unable to tell when the policy had last been reviewed. There was a risk register attached to the policy which had identified risks in the centre on a monthly basis, yet identified risks were not being assigned to a single person as was stated in the risk policy.

Judgment:
Non Compliant - Major

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

Findings:
There was an improvement in medicine management since the last inspection. Inspectors reviewed a sample of prescription charts. Prescriptions for p.r.n. medicines (a medicine only taken as the need arises) specified the conditions under which the medication was to be administered.

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

Findings:
Improvements had occurred under this outcome. A sample of residents documents were reviewed from both units.

Inspectors found that residents had a comprehensive assessment completed on admission. Each need identified on assessment had a care plan in place. The care plans reviewed were detailed enough to direct the care the resident required to meet their need. They were person centred and it was evident from their content that the resident or/and their families were involved in their development. They were person centred.

Judgment:
Compliant

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:
This outcome had moved from moderate to major non compliance. Inspectors found

that no changes had been made to the multi-occupancy bedrooms since the last inspection. Inspectors were told that their was no plan in place to address the issues posed by these multi-occupancy bedrooms.

The person in charge told inspectors that six of the 42 beds had been closed to admissions for over one year. However the six beds, wardrobes, bedside lockers, bedside tables and chairs remained in these multi-occupancy bedrooms. No efforts had been made to remove this furniture and increase the amount of private space available to residents still occupying beds in these multi-occupancy bedrooms. When discussed with the person in charge, inspectors were informed that there was no place available to store unused furniture. The person in charge stated to date there was no known plan for reconfiguring these multi-occupancy bedrooms.

A number of bathrooms in both units did not have hand rails in place beside the shower, toilet and wash-hand basin.

Judgment:
Non Compliant - Major

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

Findings:
Improvements had occurred under this outcome. A sample of residents end of life documents were reviewed.

Inspectors saw there was a multidisciplinary approach to completing end of life treatment plans. It was evident that the resident and/or their next of kin was involved in these decisions which were signed, dated by all involved and reviewed within the past year.

Each resident had their end of life preferences/likes either in their end of life assessment or in their end of life care plan and where a resident did not wish to engage in discussions relating to their end of life this was documented. These documents were updated on a four monthly basis by staff nurses.

There was a dedicated unoccupied room available in the event of a resident approaching end of life into which their bed would be transferred. A sofa bed was in place to accommodate relatives, together with a small discreet kitchenette.

Judgment:
Compliant

Outcome 17: Residents' clothing and personal property and possessions
Adequate space is provided for residents' personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.

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:
A log book was held on both units in the centre for the recording of residents' valuables. Inspectors reviewed a random sample of the records of residents' valuable possessions and found that they were being recorded for each resident reviewed.

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

Findings:
Staffing levels and skill mix was adequate to meet the needs of residents on the day of this inspection.

The newly appointed person in charge informed inspectors that they had been short

staffed in 2016 and that they still had job vacancies. Although the centre was registered to care for a maximum of 42 residents, there were only 36 beds opened, six were closed for over a year due to a lack of staff. Even with six beds closed there was still not enough staff employed to cover leave. Between the first of January 2017 and the 19 March 2017, 172 nursing hours were covered by agency staff nurses and 145 hours were covered by health service executive staff nurses doing overtime. This practice did not promote continuity of care.

An extra health care assistant had been rostered to work from 17:00 to 23:00 post the last inspection. Inspectors were informed that having this extra staff member on duty insured residents' sitting in the main sitting room in the evening were supervised.

All staff had up to date manual handling training in place. As mentioned under outcome 7 and 8 a high number of staff had not completed refresher elder abuse training within the past two years and ten staff had not completed mandatory annual fire training.

A formal appraisal system which was due to be introduced in May 2015 had not been implemented. Senior managers confirmed they had not received any training on the new performance management process and therefore it had not been implemented.

Judgment:
Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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Action Plan

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Provider's response to inspection report[1]

Centre name:	Maynooth Community Care Unit
Centre ID:	OSV-0000516
Date of inspection:	23/03/2017
Date of response:	19/04/2017

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:
No annual review of the service had been completed in the centre for 2014, 2015 or 2016.

1. Action Required:
Under Regulation 23(d) you are required to: Ensure there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that

[1] The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.

such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.

Please state the actions you have taken or are planning to take:
The annual Review for 2016 is currently being undertaken, this report will be completed to view by June 15th 2017

Proposed Timescale: 15/06/2017

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The standard of auditing being completed was not detailed enough to ensure that the service provided was safe, appropriate, consistent and effectively monitored.

The provider representative and person in charge were not meeting on a regular, consistent basis to discuss governance issues within this centre.

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:
Since the 1st March 2017 the overall Metric's are being compiled on a two monthly basis.
The 10 standards measured in March 2017 (Medication management including storage and custody, MDA drugs, medication prescription and administration, Care planning, Pressure ulcers, Falls and Environment) have been reviewed and an action plan has been put in place for each area where compliance has been recorded as less than 100%. A person responsible for each action requiring improvement has been identified. A timescale of 3 weeks has been set for the implementation of the required improvement.
The following plan has been implemented to ensure robust communication and governance within the centre:
• From the 1st April monthly Management team meetings are taking place in the centre with the Provider Nominee, the Person in charge (PIC), Assistant Director of Nursing (ADON) and Business Manager. The schedule of meetings had been forwarded to the Person in Charge and administration in the unit in February 2017. A HSE Standard Agenda has been agreed for the monthly team meetings and minutes of each meeting will be kept in the centre to ensure records are kept of the meetings
• Ward meetings will be held every 8 weeks with CNM and staff in attendance. Minutes of each meeting will be kept in the centre to ensure records are kept of the meetings. Clinical and operational challenges are discussed and collaborate, problem focussed solutions are sought. Risks are escalated to PIC and service provider as required
• Joint Long Stay meetings (LSU) with each of the seven units in CHO 7 will be held

every 6 weeks in Oak House, Millennium Park, Naas with the Provider Nominee, Managers of Older Persons, Person in Charge from each unit, the Quality and Risk Manager, and Finance in attendance in order to share information and to strengthen communication, between all the residential units in CHO 7. A HSE Standard Agenda has been agreed for the joint LSU meetings and minutes of each meeting will be kept in the centre to ensure records are kept of the meetings

• Multi-disciplinary team meeting are held quarterly in the centre. The Director of nursing/A/ADON, Physiotherapist, Occupational therapist, ward CNM and Activities staff member will attend. Minutes of each meeting will be kept in the centre to ensure records are kept of the meetings

• Centre Health and Safety meeting held 3 times yearly. Fire officer, maintenance representative, safety representative, business manager, administrative staff member, CNM, A/ADON/DON will attend and minutes of each meeting will be kept in the centre to ensure records are kept of the meetings. These meetings ensure that the centre is a safe environment for residents, visitors and staff with safe systems of work in operation. Risk assessments and control measures are discussed. Risks that require additional resources are escalated to senior HSE management.

• Social Care, Quality and Risk meeting are held quarterly in Oak House, Millennium Park. The Head of Social Care, Provider Nominee, Managers of Older Persons, Persons in Charge from each centre, the Quality and Risk Manager and Business manager of the seven units in CHO7 will attend. The purpose of the meeting is to ensure each risk assessment that has been submitted by services within social care, including the residential units has been discussed and an outcome determined in line with, HSE quality and risk policy. These meetings also include representatives from disability services within social care and the dates for these meetings have been provided to all stakeholders at the beginning of 2017. Minutes of each meeting will be kept in the centre to ensure records are kept of the meetings

Proposed Timescale: 17/04/2017

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider representative and person in charge did not demonstrate clear knowledge of their individual roles under the Health Act 2007 as evidenced in this report.

HIQA have not received the relevant paperwork in relation to the retirement of an assistant director of nursing.

The person in charge did not have sufficient autonomy to manage the centre.

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

Please state the actions you have taken or are planning to take:
The Provider Nominee will undertake to ensure that, both the Person in Charge and the Provider Nominee will be informed of their individual roles within the centre, by reviewing the Health regulations 2013 in addition to, the relevant sections of the Health Act 2007 with the Person in Charge. This will be completed by 29th April 2017. A clear reviewed management structure and organisational chart has been put in place in the centre since the HIQA inspection in March 2017.

Documentation has been submitted to HIQA in relation to the retirement of the ADON.

A review of the autonomy of the Persons in Charge role within the units in CHO 7 will be undertaken with the Head of Social Care and HSE management by 31st May 2017. This review will consist of collaboration with Finance, to explore the possibility of allocating a budget that can be managed directly by the Person in Charge for aspects of care provision such as, the purchase of equipment required for the safety of residents, and the training needs of the staff within the centre.

Proposed Timescale: 30/04/2017

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:
Inspectors found that the restraint policy had not been updated since the last inspection. It was last updated in 2010.

4. Action Required:
Under Regulation 04(3) you are required to: Review the policies and procedures referred to in regulation 4(1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.

Please state the actions you have taken or are planning to take:
A review of the restraint policy in the centre has been undertaken in line with, the national restraint policy. Equipment to provide alternatives to restraint is being sourced by the Director of Nursing and ADON in the centre. A review of all existing restraints currently in use will be completed, and a trial of alternatives will take place. The outcome of this trial will determine the equipment required to minimise the use of restraints within the centre and will be completed by 30th June 2017.

Proposed Timescale: 30/06/2017

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The staff training and development policy was not being implemented in practice.

5. Action Required:
Under Regulation 04(1) you are required to: Prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.

Please state the actions you have taken or are planning to take:
The Centre is working to ensure that all mandatory training is completed as per schedule. All staff who did not receive fire training in 2015 will be trained by May 31st 2017. All staff will be trained in Safeguarding Vulnerable Adults by 30th June 2017. As of 2nd May 2017, 8 nurses remain to be retrained in CPR and are being prioritised by HSE trainers outside the centre.

Professional Supervision Training Programme is being implemented by the HSE. The HSE will begin a national training programme in relation to this in October 2017. Applications for places on the training programme have been submitted by the Centre in order to, ensure that management have the training needed to complete this requirement.

Proposed Timescale: 31/12/2017

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:
Alternatives to restraints were not being consistently trailed, thus the use of restraint was not in line with national policy.

6. 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:
A review of the restraint policy in the centre has been undertaken in line with the national restraint policy. Equipment to provide alternatives to restraint is being sourced by the Director of Nursing and ADON in the centre. A review of all existing restraints currently in use will be completed, and a trial of alternatives will take place. The outcome of this trial will determine the equipment required to minimise the use of restraints within the centre and will be completed by 30th June 2017.

Proposed Timescale: 30/06/2017

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:
The risk register did not state who was the responsible person for carrying out actions to control the risks identified.

7. 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:
A new Risk Register has been completed for the centre with the Quality and Risk manager, the Person on Charge and ADON. A new HSE Quality and Risk Policy has been launched and will be adapted to suit the needs of the Centre.

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:
There was no centre specific emergency plan in place in the centre.

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

Please state the actions you have taken or are planning to take:
The Emergency Evacuation Plan has been reviewed and has been amended to ensure it is centre specific in addition to, reflecting current HSE guidelines.

Proposed Timescale: 19/04/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
No fire drills were being carried out in the centre.

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:
Two fire drills have been completed by nursing management in April 2017 and will be repeated in September 2017. Two night duty drills will be carried out by nursing management in April 2017 and September 2017.
Further regular fire drills have been scheduled on a six monthly basis. All personnel working in the centre are aware of the procedure to be followed in the case of fire.

Proposed Timescale: 30/09/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Ten staff in the centre had not got up to date fire training in place.

10. Action Required:
Under Regulation 28(1)(d) you are required to: Make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.

Please state the actions you have taken or are planning to take:
The staff identified who have not received up to to date fire training in 2016, will have undertaken training by 31st May 2017. The remaining staff will have received their 2017 fire training with the fire officer completed by December 2017.
In addition, two fire drills have been completed by nursing management in April 2017 and will be repeated in September 2017.
Also, two night duty drills will be carried out by nursing management in April 2017 and September 2017.

Proposed Timescale: 30/09/2017

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:
Multi occupancy rooms did not meet the needs of all residents.

There was no plan in place on how this was going to be addressed.

A number of bathrooms in both units did not have hand rails in place beside the shower, toilet and wash-hand basin.

11. 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:
A Feasibility study has been undertaken for the centre to explore the cost and value of reconfiguring the premises, which is now at stage two of the pre planning stage. A plan for the centre will be in place 30th September 2017. Beds not in use in the four bedded area will be removed by the 6th May 2017.

A functional review of the bathrooms will be completed by 30th April 2017 by the Occupational Therapist and all necessary equipment will be put in place by 30th June 2017.

Proposed Timescale: 30/06/2017

Outcome 18: Suitable Staffing

Theme:
Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Vacant posts were not been filled once they became vacant.
There was a high use of agency and overtime staffing hours to cover leave while posts remained vacant.

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:
A National recruitment campaign is under way. All vacant posts have been approved by the Chief Officer and submitted to the National Recruitment Service for progression. This is continue to be reviewed on a monthly basis at our Joint Long Stay Unit

Meetings (LSU) with each of the seven units in CHO 7, which are held six weekly in Oak House, Millennium Park, Naas. The attendees at these meetings include the Provider Nominee, Managers of Older Persons, Person in Charge from each unit, the Quality and Risk Manager, Business Managers and Finance.

Proposed Timescale: 30/10/2017

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was no system of staff appraisal in place.

13. 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:
Professional Supervision Training Programme is being implemented by the HSE Nationally in Oct 2017. Applications have been submitted by the Centre to avail of this training for all managers within the unit in order to, complete this requirement.

Clinical supervision is provided by 1.5 clinical nurse manager's level 2, and 1.5 clinical nurse manager's level 1 at ward level. 1WTE DON and 1WTE ADON support all staff and provide clinical supervision in the centre.

Proposed Timescale: 31/12/2017