

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Dean Maxwell Community Nursing Unit
<b>Centre ID:</b>	OSV-0000665
<b>Centre address:</b>	The Valley, Roscrea, Tipperary.
<b>Telephone number:</b>	050 521 389
<b>Email address:</b>	catherine.lanphier@hse.ie
<b>Type of centre:</b>	The Health Service Executive
<b>Registered provider:</b>	Health Service Executive
<b>Lead inspector:</b>	Mary Costelloe
<b>Support inspector(s):</b>	Brid McGoldrick; Catherine Sweeney
<b>Type of inspection</b>	Unannounced Dementia Care Thematic Inspections
<b>Number of residents on the date of inspection:</b>	24
<b>Number of vacancies on the date of inspection:</b>	3

## **About Dementia Care Thematic Inspections**

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

Thematic inspections were developed to drive quality improvement and focus on a specific aspect of care. The dementia care thematic inspection focuses on the quality of life of people with dementia and monitors the level of compliance with the regulations and standards in relation to residents with dementia. The aim of these inspections is to understand the lived experiences of people with dementia in designated centres and to promote best practice in relation to residents receiving meaningful, individualised, person centred care.

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:
09 April 2019 09:30	09 April 2019 19:00
09 April 2019 09:30	09 April 2019 19:00
09 April 2019 09:30	09 April 2019 19:00

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

<b>Outcome</b>	<b>Provider's self assessment</b>	<b>Our Judgment</b>
Outcome 01: Health and Social Care Needs	Compliance demonstrated	Non Compliant - Major
Outcome 02: Safeguarding and Safety	Compliance demonstrated	Non Compliant - Moderate
Outcome 03: Residents' Rights, Dignity and Consultation	Substantially Compliant	Non Compliant - Moderate
Outcome 04: Complaints procedures	Compliance demonstrated	Non Compliant - Moderate
Outcome 05: Suitable Staffing	Compliance demonstrated	Non Compliant - Moderate
Outcome 06: Safe and Suitable Premises	Compliance demonstrated	Non Compliant - Moderate
Outcome 07: Health and Safety and Risk Management	Not applicable	Non Compliant - Moderate
Outcome 08: Governance and Management	Not applicable	Non Compliant - Major

**Summary of findings from this inspection**

This inspection report sets out the findings of a thematic inspection which focused on specific outcomes relevant to dementia care, inspectors also reviewed health and safety and risk management, governance and management, and followed up on issues to be addressed from previous inspections.

The location of this designated centre allowed residents to maintain links with the local community due to it's proximity to the local church and town centre. Residents had regular interaction with day care service users. Residents commented that they

enjoyed the interaction and receiving local news from the day care service users. The overall atmosphere was homely.

However, inspectors found that there were inadequate governance and leadership systems and poor oversight arrangements in place to ensure that the service provided to residents was safe, appropriate, consistent and met regulatory requirements. There continued to be repeated regulatory non-compliances from the previous inspections dated January 2017 and July 2018. There was a breach of Condition 8 of registration whereby the Health Service Executive (HSE) had failed to implement its own compliance plans which they had submitted to the Office of the Chief Inspector.

There were repeated regulatory non-compliances in relation to, management of restraint, fire safety, risk management, complaints management, infection control, nursing documentation, access to healthcare, premises and residents rights' dignity and consultation. Additional issues of risk identified on this inspection related to storage of records containing personal identifiable information.

Following this inspection, a meeting was held with senior managers representing the HSE to discuss the poor inspection findings and repeated regulatory non-compliances. A verbal commitment was given by senior managers to come into compliance.

While this centre does not currently have a dementia specific unit, the inspectors focused on the care of residents with dementia during this inspection. Eleven residents were either formally diagnosed or had suspected Alzheimer's disease or dementia. The inspectors met with residents and staff members during the inspection. The inspectors tracked the journey of a number of residents within the service, observed care practices and interactions between staff and residents using a validated observation tool (called QUIS). The inspectors also reviewed nursing documentation including care plans, as well as medical records, staff files, training records and relevant policies.

Residents were observed to be relaxed and comfortable in the company of staff. Inspectors noted that staff assisting residents were caring and sensitive. The collective feedback from residents was one of satisfaction with the care provided.

The building was secure and residents had access to enclosed garden areas which were easily accessible.

Staffing levels and skill- mix required review to ensure that residents assessed needs could be met, to ensure that the social care needs of residents were met and to ensure adequate resources were provided to cleaning and decontamination of equipment and premises.

These areas for improvement are discussed in the body of the report and included the action plan at the end of the report.

**Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.**

***Outcome 01: Health and Social Care Needs***

**Theme:**

Safe care and support

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

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

**Findings:**

The inspectors found that improvements were still required to ensure that residents' overall healthcare and social care needs were met and to ensure that they had timely access to appropriate medical and allied healthcare services. While some residents had opportunities to participate in activities, improvements were required to ensure that all residents were provided with appropriate activities suitable to their interests, preferences and assessed needs. This is discussed further under Outcome 3: Residents rights, dignity and consultation. Improvements were still required to nursing documentation, care planning and assessment.

There were 24 residents accommodated on the day of the inspection, 14 residents were assessed as having high dependency needs and 10 assessed as low dependency needs.

Residents had access to general practitioner (GP) services of their choice and could retain their own GP if they so wished. There was an out-of-hours GP service available. The inspector reviewed a sample of files and found that GPs reviewed residents on a regular basis. The inspectors noted that medications were also regularly reviewed.

Residents had access to a range of allied health services including speech and language therapy (SALT), occupational therapy (OT), dietetic services and psychiatry of later life. Chiropody and optical services were also provided. The inspectors reviewed residents' records and found that residents had been referred to these services ; however, recommendations were not always updated in residents' files and communicated to all staff. Recommendations to be followed, such as to increase fluids or to fortify diet, were not implemented in practice.

There was still inadequate access to physiotherapy services. There was no inhouse physiotherapy service provided and there were long delays in accessing services in the local health centre. Some residents assessed by nursing staff as requiring a

physiotherapy review had not been reviewed while others had not been referred to the service. One resident who had sustained a fall in centre and who was recently hospitalised for investigations following the fall was assessed as requiring assessment by a physiotherapist, however this had not been provided.

The person in charge advised the inspectors that the pre-admission assessments continued to consider if the centre would be able to meet the needs of prospective residents. When considering admissions to the nursing home, she would consider if the residents needs would be met in that environment.

Improvements were required to care planning and assessments, with many inconsistencies were noted in the nursing documentation. Inspectors reviewed a sample of residents' files and noted the following:

- There were no risk assessments completed in one resident's file.
- Some risk assessments had not been fully completed.
- Some risk assessments had been inappropriately completed.
- Some risk assessments were not up to date.
- Pain assessments were not recorded.
- There were no care plans in place to correspond with some assessed risks.
- Recommendations from allied health professionals were not always reflected in care plans.
- Care plans did not always reflect the current care needs of residents.
- Some care plans were vague and did not provide adequate guidance for staff.
- Social care plans were still not in place for all residents.
- Information regarding residents' likes and dislikes, 'key to me' were not always completed.
- The resuscitation status of some residents was unclear.
- There were inconsistencies in the recording of consultation with GPs regarding the resuscitation status of some residents.

The inspectors were satisfied that residents' weight changes were closely monitored. All residents were nutritionally assessed using a validated assessment tool. All residents were weighed regularly. Nursing staff told the inspector that if there was a change in a resident's weight, nursing staff would reassess the resident, inform the GP and referrals would be made to the dietician and speech and language therapy (SALT). While files reviewed by the inspectors confirmed this to be the case, care plans were not always updated to reflect these recommendations and some staff were not aware of recommended changes to some residents' diets.

Each resident had a choice of where to eat their meals and staff were observed to assist residents who required help in a sensitive and discreet manner. The chef on duty was observed speaking with residents to ensure that residents were satisfied with their meals. Inspectors noted that the overall dining experience could be enhanced by improving and providing more pleasant table settings, allowing residents the choice to pour their own sauces and not clearing away plates while residents were still dining. There was a three week menu cycle in use which offered choice at each meal sitting; however, the menus had not been reviewed by a dietitian to ensure that the calorific

value was satisfactory to meet residents assessed needs.

The inspectors noted that there was a low level of falls in the centre. The inspectors reviewed the files of residents who had recently fallen and noted that the falls risk assessments and care plans had not been updated post falls. Nursing recommendations to refer a resident to physiotherapy for mobility assessment and exercise plan had not happened. Low-low beds and crash mats were in use for some residents. Residents at risk of developing contractures did not have a plan in place.

There was a reported low incidence of wound development and the inspectors saw that the risk of same was assessed regularly. There were no residents with pressure ulcers at the time of inspection. While preventative interventions, including pressure relieving equipment, were in use,, care plans did not provide guidance for staff regarding preventative interventions or the use of pressure relieving equipment in use for individual residents. Staff informed inspectors that they had access to support from the tissue viability nurse as required. Inspectors reviewed the file of resident with a wound and noted that improvements were required to the nursing documentation. Documentation was found to be disjointed and disorderly. Wound assessments had not been updated at the change of each dressing, and there was no specific wound care plan in place. Wound assessments indicated that the wound had not progressed and there was no evidence of referral to the tissue viability nurse or general practitioner.

While inspectors were satisfied that caring for a resident at end of life was regarded as an integral part of the care service provided in centre, improvements were required to the nursing documentation to support and guide the care of residents. Staff provided end- of- life care to residents with the support of their GP and the homecare palliative team. There were two dedicated single palliative care rooms with kitchenette and dayroom available. Religious sacraments were available to all residents as desired. Families were facilitated to stay overnight and were provided with refreshments and food. Some care plans reviewed outlined the individual wishes of residents and their families including residents' preferences regarding their preferred setting for delivery of care while others lacked information and guidance for staff. The resuscitation status of some residents was unclear and there were inconsistencies in the recording of consultation with GPs regarding the resuscitation status of some residents.

Inspectors did not specifically inspect under the medication management outcome, however, some issues of concern were noted during the inspection that required attention. Two medication errors were noted that had not been recorded as errors or investigated. Nursing staff continued to administer medications from pharmacy labels in place of an original signed prescription. This issue had been highlighted in an audit carried out by the HSE chief pharmacist in June 2018 and had still not been addressed. Some nursing staff spoken with were not aware of the audit findings. These issues were brought to the attention of the person in charge and nursing staff.

**Judgment:**

Non Compliant - Major

## ***Outcome 02: Safeguarding and Safety***

### **Theme:**

Safe care and support

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

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

### **Findings:**

Inspectors found that there were measures in place to protect residents from being harmed or suffering abuse; however, issues identified at two previous inspections in relation to documentation to support the use of restraints had still not been addressed.

There were seven residents using bed- rails at the time of inspection. Assessments and care plans in relation to the use of restraint were inconsistent and lacked sufficient detail to direct safe care. Some risk assessments completed did not specify what alternatives had been tried or considered and they did not include a clear rationale for the use of the bedrail. Care plans were not always in place to guide staff in care of residents using bedrails.

Psychotropic medications were prescribed on an 'as required' (PRN) basis for a number of residents and were administered by nursing staff. However, records were not always maintained to indicate the rationale for administration of these medications, what other interventions had been tried to manage the behaviour and the effect and outcome for the resident following the administration of the medicine contrary to the restraint policy guidance.

The person in charge had completed a safeguarding training course and all staff in the centre had completed up- to- date training in safeguarding.

The person in charge informed the inspectors that the centre acted as a pension agent for at least four residents. The person in charge confirmed that the management of residents finances was in line with the HSE policy and protocol. Residents had access to their finances in the centre and all incoming and outgoing transactions are logged.

The person in charge confirmed that Garda Síochana (police) vetting was in place for all staff. A sample of staff files reviewed confirmed this to be the case.

### **Judgment:**

Non Compliant - Moderate



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

**Theme:**

Person-centred care and support

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

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

**Findings:**

The inspectors had concerns that the privacy and dignity of residents was negatively impacted upon due to the use of a baby monitoring camera unit located in a shared bedroom space. Inspectors had further concerns in relation to the inappropriate storage of confidential records which contained personal identifiable information relating to residents. Further improvements were still required to ensure that all residents including residents with dementia or a cognitive impairment were offered a choice and range of appropriate recreational and stimulating activities in line with their assessed needs. Further improvements were required to ensure that residents were consulted with about how the centre was run and planned.

The inspectors had concerns that the use of a monitoring camera was intrusive as it was used in a bedroom to monitor a resident, in an area where an individual would have a reasonable expectation of privacy. There was no assessment or justification for its use documented in any of the resident's care plans. Staff confirmed that the camera was used to monitor the resident who was at high risk of falling. They advised that this resident required one- to- one supervision and staffing levels in the centre did not facilitate this supervision at night time.

It was of serious concern that records containing personal identifiable information relating to residents were stored inappropriately in an open bin in an unsecured rear yard area. This issue of concern was raised with the person in charge and a member of HSE management team, who undertook to have a full investigation and review carried out in relation to this incident and to have it addressed as a data protection breach. This investigation is to be submitted to the Office of the Chief Inspector.

Residents' committee meetings were held infrequently. There were two meetings held since the previous inspection, in July 2018 and January 2019. The meetings were attended by some family members and minutes of the meetings were recorded. The person in charge advised that families had been verbally informed of the meetings but notice of meetings had not been displayed. There was signage in the day room advising that residents' committee meetings were held every second Sunday and the annual review on the quality and safety of care indicated that meetings were held on a

quarterly basis but this was not happening in practice.

The person in charge confirmed that representatives of SAGE national advocacy group had visited the centre and spoken with residents regarding their service.

Residents were treated with respect. The inspectors heard staff addressing residents by their preferred names and speaking in a clear, respectful and courteous manner. Staff paid particular attention to residents' appearance, dress and personal hygiene and were observed to be caring towards the residents. The hairdresser visited regularly and many residents availed of the service. Residents spoken with were complimentary of staff and the care provided.

Bedroom and bathroom doors were closed and screening curtains were in place in shared bedrooms when personal care was being delivered. Staff were observed to knock and wait before entering bedrooms.

Residents' religious and political rights were facilitated. Mass was celebrated weekly in the centre and the daily local church services were relayed by video link to the television in the 'snug' dayroom. Arrangements were in place for residents of varying religious beliefs. Many residents spoken with stated that they enjoyed partaking in religious ceremonies. Residents were facilitated to vote and staff confirmed that some residents had voted in-house in the recent elections.

There was an open visiting policy in place. However, there was no separate private space available if residents wished to meet visitors in private. The person in charge advised that plans were being considered to address this issue.

Residents had access to information and news, daily and weekly local newspapers, the weekly parish newsletter, notice boards, radio, television and Wi-Fi were available.

Improvements were required to ensure that all residents were offered a choice of appropriate recreational and stimulating activities based on each residents assessed social care needs, preferences, capabilities, interests and past activities. As discussed under Outcome 1: Health and social care needs, the social care needs of all residents were not assessed and therefore, individualised care plans and activity programmes were not in place to reflect those assessments.

There was a staff member who was assigned to the day care unit who facilitated and coordinated activities on a daily basis. The inspector observed some residents and day care attendees enjoy a range of activities during the inspection including newspaper reading and discussion, light chair exercise session and quiz. Other activities that took place regularly included arts and crafts, music sessions, bingo, storey telling and sing a longs. Some staff members had recently completed training in 'Fit for life' (exercise training programme for older people). Other staff had completed Sonas training (therapeutic programme specifically for residents with Alzheimer's disease) however, staff informed the inspectors that it was difficult to organise Sonas sessions which required two staff members due to lack of staff resources. There was no activity schedule in place for residents who wished to remain in their bedrooms or for those who did not wish to partake in the main group activities facilitated by the day care staff.

As part of the inspection, the inspectors spent periods of time observing staff interactions with residents. The inspectors used a validated observational tool (the quality of interactions schedule, or QUIS) to rate and record at five minute intervals the quality of interactions between staff and residents in the communal areas. The scores for the quality of interactions are +2(positive connective care), +1 (task orientated care, 0 (neutral care), -1 (protective and controlling), -2 (institutional, controlling care). The observations took place for a total of one hour during of the inspection day. An overview of the observations is provided below:

The inspectors found that social interaction between staff and residents was person-centred and respectful. Staff were seen to spend one-to-one time sitting with residents with dementia within the dayroom setting. Residents were observed to enjoy their interactions with staff. Inspectors observed staff giving kind and supportive care.

**Judgment:**

Non Compliant - Moderate

***Outcome 04: Complaints procedures***

**Theme:**

Person-centred care and support

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

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

**Findings:**

Further improvements were still required to the oversight and management of complaints. Some issues identified during previous inspections had still not been addressed.

There was a comprehensive complaints policy in place which clearly outlined the duties and responsibilities of staff and the complaints procedure was displayed as required by the regulations.

The inspectors reviewed the complaints log and noted that two complaints had been logged, one in 2016 and another in 2018. The person in charge stated that both complaints had been investigated and that the complainants were satisfied with the outcome; however, the details of the investigation by management, or complainants satisfaction or not with the outcomes were not recorded.

A complaint regarding lack of physiotherapy services had been made through the 'your service, your say' complaints process but had not been logged in the centre's complaints log. Inspectors received some complaints from residents during the inspection regarding inadequate heating in recent weeks but the person in charge advised that she had not

been made aware of these complaints.

**Judgment:**

Non Compliant - Moderate

***Outcome 05: Suitable Staffing***

**Theme:**

Workforce

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

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

**Findings:**

Inspectors found that staff delivered care in a respectful manner. However, staffing levels and skill- mix required review to ensure that residents' assessed needs could be met, to ensure that the social care needs of residents were met and to ensure adequate resources were provided to cleaning and decontamination of equipment and premises as discussed under Outcome 1: Health and social care, Outcome 3: Residents' rights, dignity and consultation and Outcome 7: Health and safety and risk management.

On the day of inspection there were 24 residents living in the centre. There were 14 residents assessed as high dependency and 10 were assessed as low dependency. A day care service was also provided which catered for up to 15 service users from Monday to Friday. Residents shared the dayroom and dining room facilities with the day care service users. Inspectors noted positive interaction between day care service users and residents of the designated centre.

Multi-task attendants (MTAs) were rostered to deliver health and social care and also carry out cleaning, laundry and catering duties. MTA's reported that they could be rostered for more than one role in a day. For example, an MTA could start the day with catering duties and move to cleaning duties in the afternoon.

Inspectors observed that staff were attentive to residents' needs throughout the day. Person-centred and respectful interactions were observed between staff and residents. However, MTAs delivering direct care to residents did not have access to care plans and therefore could not refer to them to inform residents' care.

On the day of inspection there were three nurses and three multi-task assistants providing direct resident care on duty during the daytime; two nurses and two multi-task attendants providing direct resident care on duty in the evening time from 17.00 to 22.30 and one nurse and two multi-task attendants on duty at night time from 22.30 to 08.00. There was a full-time person in charge who was supported in her role by the clinical nurse manager (CNM), both normally worked Monday to Friday. The CNM also worked some weekends to supervise the delivery of care.

There was no actual and planned roster specific to staff in the designated centre. There was an integrated roster which included staff for both the designated centre and day care service. The lack of clarity in relation to staff allocation negatively impacted the quality of care received by residents of the designated centre.

A review of staffing provided on night duty required review as the findings on this inspection was that a baby monitoring camera device was being used to monitor a resident in lieu of additional staffing.

A number of staff files were reviewed on the day of inspection. All files contained the information required as per Schedule 2 of the regulations. There was an induction programme for newly-recruited staff and records of induction training were now maintained on staff files. While staff files contained all the required information, inspectors found them disorganised and difficult to review. Garda vetting was in place for all staff files reviewed. Performance appraisals were not completed for any staff. Inspectors were informed that there was a plan in place to provide managers with training in performance management, however, there was no timeline identified for this process.

Inspectors reviewed the training matrix and found that all mandatory training was up-to-date. This included training in fire safety, moving and handling and safeguarding vulnerable persons. The training matrix was difficult to analyse as the layout was haphazard and disjointed. The person in charge informed inspectors that there was a plan in place to improve the layout of the training matrix. Nursing staff required further training and supervision in relation to care planning and assessment as evidenced by the many inconsistencies noted in the nursing documentation. This has been discussed in detail under Outcome1: Health and social care needs. Training was also required on infection prevention and control and medication management. MTAs required training specific to cleaning and decontamination practices as well as the equipment in use in the centre.

The assessed needs of the residents did not appear to be in line with the needs of residents observed by the inspectors on the day of inspection. Inspectors observed that many residents required a high level of nursing care and staff spoken with confirmed this to be the case. For example, there were residents who required palliative care, diabetic care, management of feeding pumps and residents at high risk of falls. The lack of accurate assessments was of concern to inspectors as these assessments are used to inform the planning and allocation of resources. The person in charge undertook to review the dependency needs of all residents.

Supervision and mentoring was required to bring the centre into compliance with regulations and to improve quality and safety for residents. Copies of the Act, regulations and standards were not readily available to all staff.

The person in charge confirmed that there are no volunteers working within the centre.

**Judgment:**

Non Compliant - Moderate

## ***Outcome 06: Safe and Suitable Premises***

### **Theme:**

Effective care and support

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

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

### **Findings:**

The inspectors noted that while painting and redecoration had been carried out to a number of shared bedrooms since the previous inspection, all issues identified in the previous report had not been addressed. Further works were required in order to fully comply with the requirements of Regulations. For example, there was still inadequate storage for equipment, no private visitors' space and parts of the building required maintenance and redecorating.

The centre was single storey. There was a variety of communal day spaces including day rooms, dining room, oratory and front reception area. The communal areas had a variety of comfortable furnishings and were domestic in nature.

Bedroom accommodation was provided in 15 single bedrooms and six twin bedrooms. The twin bedrooms had en- suite- toilet and shower facilities. The single bedrooms were small in size. The person in charge confirmed that the centre continued to operate within the procedures outlined in the statement of purpose for the management of the small sized single rooms as requested by the Office of Chief Inspector and residents assessed as requiring the use of a hoist were not accommodated in these rooms.

Residents were encouraged to personalise their rooms and many had photographs and other personal belongings in their bedrooms. Some bedrooms had a picture of residents' choice on their door, the aim of these were to provide visual cues for people to recognise their own bedroom. There was a sign with a word and a picture for bathrooms to assist residents find their way more easily.

There was still inadequate space for the storage of equipment. There was no separate storage available to store equipment such as specialised chairs, wheelchairs, walking frames and hoists when not in use.

There was no private visitors' space available should residents wish to meet visitors' in private. The person in charge advised that plans were being considered to address this issue but there was no date scheduled for commencement of this work.

The inspectors noted that four of the shared bedrooms had been repainted, redecorated and new light fittings provided. However, some bedrooms and other areas of the building still required maintenance and redecorating. On day one of the inspection, the outdoor smoking gazebo was maintained in an unclean, unkept condition and required thorough cleaning. The furniture cushions provided were torn and dirty. The pipe work to many of the toilet and bathroom areas were rusted and the wall surfaces, particularly at the rear of wash hand basins, were worn, defective and not readily cleanable. Some mechanical extract ventilation fans in bathrooms showed obvious lack of regular cleaning and some were not in working order.

Residents had access to two secure enclosed garden areas which provided with safe ground surfaces. The garden areas were easily accessible, doors to the garden areas were open and residents could access them independently; however, inspectors noted a number of potential risks to residents in the garden area, these are discussed under Outcome 7: Health and safety and risk management.

Residents had access to equipment that promoted their independence and comfort. There was an appropriate level of assistive equipment, such as specialist chairs, wheelchairs, walking aids, hoists, specialist mattresses, pressure relieving cushions and beds to meet residents' needs. The inspectors saw that hoists were recently serviced however, up-to-date service records for all other equipment was not made available during the inspection.

Inspectors noted that the heating radiators in some areas of the building had been turned off and some residents had complained of inadequate heating over the past number of weeks. There were no systems in place to oversee or monitor the temperature of individual rooms to ensure suitable heating for residents.

**Judgment:**

Non Compliant - Moderate

***Outcome 07: Health and Safety and Risk 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:**

Inspectors noted that issues identified during the last inspection had not been satisfactorily addressed. Further improvements were still required in relation to fire safety management, risk management and infection control.

There were policies and procedures in place in relation to fire safety. There was

evidence of regular fire safety checks being carried out and all staff had received on-going fire safety training. The servicing of the fire alarm system and fire equipment was up-to-date. Regular fire drills had been carried out and documented and drills had been carried out simulating night time staffing levels. However, records maintained did not include the number of residents in a full compartment evacuation drill and therefore still did not provide assurance that staff could evacuate residents safely and in a timely manner in the event of fire, particularly at night time.

There was still no fire extinguisher provided in or near the designated smoking area. Cleaning chemicals were still stored in unlabelled containers. These issues continued to pose a risk to residents, staff and visitors.

During the course of the inspection, inspectors noted a number of risks in the enclosed garden areas which posed a risk to resident safety. Risks included loose and hanging cables and wires, hose pipes on the ground and unsecured garden tools. These risks were brought to the attention of the person in charge, who arranged to have them addressed during the course of the day.

Inspectors noted that procedures consistent with the standards for the prevention and control of healthcare-associated infections were not always implemented. For example, cleaning duties were fragmented and carried out by multi-task attendants, laundry personnel and general operative. The multi-task attendant assigned to cleaning duties was also involved in providing care to residents in the mornings. There was a lack of supervised cleaning and decontamination processes taking place. Some equipment used by residents was not clean for example, shower chairs. The floor to the dining room was heavily stained in parts. Cobwebs were noted to ceiling velux window areas. There were large accumulations of dust noted in the mechanical extract fans in some bathrooms. Gaps were noted in cleaning checklist records, there were no records of cleaning in some areas of the centre for several days on the week prior to the inspection. Defective wall surfaces and pipe work in some bathrooms, rusted assistive toilet frames and rusted wheels to some shower equipment did not facilitate proper cleaning and decontamination of these areas.

There was inadequate guidance, training and education provided to staff on the use sluice room equipment. These issues were discussed with senior management who undertook to have a comprehensive infection control review and assessment carried out by an infection control specialist. The report of this assessment is to be forwarded to the Office of the Chief Inspector.

**Judgment:**

Non Compliant - Moderate

***Outcome 08: Governance and Management***

**Theme:**

Governance, Leadership and Management



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

No actions were required from the previous inspection.

**Findings:**

Governance and leadership arrangements required review to ensure that management systems in place effectively monitored the totality of the service to ensure it was safe, appropriate, consistent and met regulatory requirements. There continued to be repeated regulatory non-compliances from the previous inspections dated January 2017 and July 2018 and a breach of Condition 8 of registration.

The absence of an effective system of governance and leadership was evidenced by:

- Inconsistencies in nursing documentation, care planning and assessments.
- Failure to ensure that all residents had timely access to allied health-care.
- Inadequate oversight of fire safety management, risk management and complaints management.
- Failure to ensure compliance with the national policy on the use of restraint.
- Failure to ensure and uphold residents rights' to privacy and dignity.
- Failure to ensure that adequate staff were rostered at night time to meet the assessed needs of residents.
- Failure to ensure that adequate resources were provided to the implementation, oversight and monitoring of environmental cleaning systems and infection prevention and control practices.
- Failure to ensure that adequate resources were provided to the implementation of an appropriate and suitable activities programme.
- Inadequate oversight of the storage and retention of residents' records containing personal identifiable information.

Systems in place to review and monitor the quality and safety of care required review to ensure that improvements are brought about in work practices and to achieve optimal outcomes for residents. Recent audits had been completed in relation to care plans, mattress and cushions, infection prevention and control relating to glucometers and nebulizers. Findings were set out but there was no evidence of action plans in place to address areas for improvement. As discussed under Outcome 1: Healthcare, an audit carried out by the HSE chief pharmacist in June 2018 identified areas for improvement in relation to medication management which had still not been addressed. Some nursing staff spoken with were not aware of the audit findings. The annual review on the quality and safety of care in the centre had been completed for 2018; however, no improvements had been identified and no improvement plan put in place. Copies of the Act and regulations were not readily available to all staff.

The statement of purpose (SOP) required review to include all of the requirements of the regulations. The staffing numbers on the roster provided did not align with the staffing numbers in the SOP.

**Judgment:**

Non Compliant - Major

**Closing the Visit**

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

**Acknowledgements**

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

***Report Compiled by:***

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

## Health Information and Quality Authority Regulation Directorate

### Action Plan



### Provider's response to inspection report<sup>1</sup>

<b>Centre name:</b>	Dean Maxwell Community Nursing Unit
<b>Centre ID:</b>	OSV-0000665
<b>Date of inspection:</b>	09/04/2019
<b>Date of response:</b>	14/06/2019

### Requirements

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

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

### Outcome 01: Health and Social Care Needs

#### Theme:

Safe care and support

#### **The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

There were many inconsistencies in the assessments of the health, personal and social care needs of residents.

- There was no risk assessments completed in one resident's file.
- Some risk assessments had not been fully completed.
- Some risk assessments had been inappropriately completed.

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

- Some risk assessments were not up to date.

Care plans were not available to all staff who provided direct care to residents.

**1. Action Required:**

Under Regulation 05(2) you are required to: Arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to the designated centre.

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

- All risk assessments on all residents are currently up to date.
  
- In relation to the one resident's file specified, all risk assessments have been completed.
  
- In relation to the remaining risk assessments that were not fully completed or had been inappropriately completed, all risk assessments have been reviewed and updated and completed.
  
- Pain assessments are recorded.
  
- Care plans correspond to assessed risks.
  
- Care plans provide guidance for staff.
  
- Social care plans are in place for all residents.
  
- Information regarding residents "likes and dislikes" are been completed.
  
- Resuscitation status for all residents is clear.
  
- All care staff who provide direct care to residents as per Regulation 05 (2) have access to the residents care plan.
  
- Pre-admission assessment is undertaken by the Person in Charge, as per the designated centre's Admission Policy, to ensure health, personal and social care needs can be met in the facility for all long term care individuals.
  
- Audit of care plans was carried out by an external auditor during the week of the 27th May. Findings have been analysed by the external auditor and feedback report provided to the Person in Charge/Person Participating in Management. A time-lined Quality Improvement Plan has been developed by the Person in Charge/Person Participating in Management and has being reported to the Registered Provider.
  
- Audit schedule Quality care matrix 'test your care' is completed monthly. Quality improvement plans are populated and actioned accordingly.
  
- Practice Development Co-ordinator has been supporting the Clinical Nurse Manager 11

in relation to care planning.

- A local care plan policy has been developed and has been implemented. This policy is being discussed daily at Safety Pause. It has been issued to all staff nurses at staff nurse meeting. This policy is filed in the Policy Folder for all staff to review and sign. This policy will be included in the Induction process for new clinical staff.

Actions to be completed by 2nd July 2019:

- A training workshop on DML (2010) /care planning which includes the Scope of Practice (2015) will be facilitated by the Centre for Nursing and Midwifery Education (CNME) on 17th June 2019 and 2nd July 2019.

(2015) will be facilitated by the Centre for Nursing and Midwifery Education (CNME).  
Date: 16th June 2019 and 2nd July 2019.

**Proposed Timescale:** 02/07/2019

**Theme:**

Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

There were no care plans in place to correspond with some residents' assessed risks.

- Care plans did not always reflect the current care needs of residents.
- Some care plans were vague and did not provide adequate guidance for staff.
- Social care plans were still not in place for all residents.
- Information regarding residents' likes and dislikes, 'key to me' were not always completed.
- The resuscitation status of some residents was unclear.

**2. 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:**

- Following revision and evaluation, health, personal and social care plans reflect the current care needs of residents. A 'Care Plan Development and Implementation Policy' has been issued to staff nurses at the staff nurse meeting. This has also been discussed daily at safety pause with all clinical staff.
- Audit of care plans have been completed and a QIP is in place which has been actioned by the Clinical Nurse Manager 11 and all staff nurses.
- A unit based quality improvement team has been set up in the centre in relation to

documentation and care planning.

- Resuscitation status of each resident is documented in their medical notes and resuscitation status for all residents is clear.

Actions to be completed by 31st July 2019:

- Care planning tools "A Key to Me", "My day, my way" 'life stories' has been populated. 'Life stories' have commenced with input from the resident, family member, nominated representative, staff and friends.

**Proposed Timescale:** 31/07/2019

**Theme:**

Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Care plans were not always up to date and did not always reflect the current care needs of residents. Recommendations from allied health professionals were not always reflected in care plans.

**3. 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:**

Care plans

- All care plans have been formally reviewed as recommended in consultation with residents, families, their nominated representative and staff.
- Any recommendations from Allied Health Professionals are documented and communicated to staff at handover including staff who have been absent from work due to leave.  
  
- For example, when a resident has been reviewed by Speech and Language Therapist, the recommendations made are documented in their care plans. A copy of these recommendations are also given to the catering department. The catering department ensures that they are also aware of the changes with regards to the swallow assessment. Changes in either the consistency of food or in the grade of fluids will be handed over to all the care staff.
- Audit of care plans is completed and QIP actioned by CNM11 and residents named nurse.

**Proposed Timescale:** 14/06/2019

**Theme:**

Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

There was inadequate access to physiotherapy services. Some residents assessed by nursing staff as requiring a physiotherapy review had not been reviewed while others had not been referred to the service.

**4. Action Required:**

Under Regulation 06(2)(c) you are required to: Provide access to treatment for a resident where the care referred to in Regulation 6(1) or other health care service requires additional professional expertise.

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

Access to physiotherapy is through the primary care physiotherapy service provided by the local primary care team.

Actions taken:

- All residents, who have been assessed and identified that they require physiotherapy, have had their physiotherapy assessments and interventions carried out by a physiotherapist.
- Two residents have been referred for review by physiotherapy.
- One resident attended their appointment, and the guidance received has been documented in their care plan and implemented.
- The resident, who had fallen and was hospitalised, was prevented from attending their physiotherapy appointment due to their acute admission into hospital. A new date for physiotherapy for this resident has being scheduled for Friday 14th June as they have deemed fit to attend. A member of staff will attend with them and once seen, their care plan will be updated to reflect the advice given by the physiotherapist.
- All staff nurses have been issued with the falls policy at the staff nurse meeting on the 11th June 2019 and will be discussed at staff meetings going forward.
- A meeting was convened with the Primary Care Physiotherapy Manager with responsibility for service delivery in the area that the centre is located. The process and follow up for referral of residents in the designated centre to physiotherapy was discussed and agreed.
- The agreed process for referral to primary care physiotherapy to be followed by the Person in Charge was clarified and the Person in Charge must:

- Provide sufficient and appropriate information on referral to primary care physiotherapy to allow screening and prioritisation of referrals
- Receive documentation from the Primary Care Physiotherapy Service in relation to receipt of referral and an indication of the wait time for access to service
- Advocate on behalf of the resident for access to the primary care physiotherapy if required.
- Ensure attendance of a resident at a physiotherapy clinic
- Follow the Falls Policy in relation to referral to physiotherapy service.

Actions to be completed by 31st July 2019:

- A physiotherapy clinic has been scheduled, specific to the centre. This will commence on site on the 21st June 2019, providing physiotherapy assessment to the residents to establish physiotherapy needs and interventions. This will include identifying any risk e.g. risk of developing contractures.
- A review of the in house exercise programme will be carried out in the centre on the 18th June 2019.

**Proposed Timescale:** 31/07/2019

**Theme:**

Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Nursing staff continued to administer medications from pharmacy labels in place of an original signed prescription. This issue had been highlighted in an audit carried out by the HSE chief pharmacist in June 2018 and had still not been addressed.

2 medication errors were identified by inspectors on inspection which required investigation and review.

**5. 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:**

Actions completed:

- The medication errors have been investigated and reported to the Quality, Risk and Safety Department within CHO3. The National Incident Management Policy was adhered to.



- In relation to the National Incident Management System, no learning notice/outcome has been issued.
- Open Disclosure policy was adhered to.
- All nursing staff completed e learning on medication management. Certificates have been filed.
- Training sessions on medication management were provided on site. RGNs have attended the training sessions provided by the Chief Pharmacist.
- Audit findings have been communicated to RGN staff at daily handover and staff nurse meetings
- A unit based quality improvement team has been set up in the centre in relation to medication management.

Actions in progress:

- Medication audits have been scheduled weekly over a six-week period, until 17th June 2019.
- Thereafter, medication audits will be scheduled on a monthly basis.
- Quality care matrix/test your care will be completed on a monthly basis
- Information collated is analysed and reviewed with action plans developed to address any areas identified that require improvement.

Actions to be taken by 31st July 2019:

- Measures to address the use of pharmacy labels in place of an original signed prescription is being explored under the direction of the HSE chief pharmacy.
- Standard Operating Procedure (SOP) on the use of pharmacy computer generated prescription labels in the Medication, Prescription and Administration Records (MPARS) is being reviewed and updated.
- A further medication training session has been planned for the 4th October facilitated by the CNME Limerick

**Proposed Timescale:** 31/07/2019

## Outcome 02: Safeguarding and Safety

### Theme:

Safe care and support

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

Documentation to support the use of restraints still required improvement in order to reflect the national policy and best practice.

Some risk assessments completed for the use of bedrails did not specify what alternatives had been tried or considered and they did not include a clear rationale for the use of the bedrail. Care plans were not always in place to guide staff in care of a residents' using bedrails.

Records were not always maintained to indicate the rationale for administration of 'as required' (PRN) psychotropic medications, what other interventions had been tried to manage the behaviour and the effect and outcome for the resident following the administration of the medicine contrary to the restraint policy guidance.

### **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:**

Actions taken:

- The use of bedrails/ lap belts restraint practice was reviewed and documented. Following this review, a number of changes have taken place such as, a resident who had been using bedrails at her request is now using a low-low bed with a sensory mat.
- Ongoing revision of the use of any form of restraint is according to the HSE National Restraint Policy (2011).
- Care plans have been updated to reflect each resident's individual risk assessment with regards to restrictive practice. Risk assessments completed identify what alternatives have been tried and they include the rationale for the use of restrictive practice.
- In relation to psychotropic medications, mood and behaviour, care plans have been reviewed and updated to demonstrate alternative interventions that have been used before any psychotropic medication is used. All residents with behavioural and psychological symptoms have a specific care plan in place identifying triggers and de-escalation techniques on an individual basis.
- The use of ABC charts has been revised and one to one training sessions with nursing staff has taken place in relation to use of ABC charts prior to PRN psychotropic medication administration. If any resident receives PRN psychotropic medication, this is

updated on the ABC chart and the effect and outcome is recorded.

- Psychotropic medication is reviewed on a regular basis by the residents' GP and/or old age psychiatry if under their care.
- There is access to specialist services i.e Old Age Psychiatry and Advocacy services.
- A bespoke medicine management training session for nursing staff took place on three separate dates: 22nd, 24th April and 2nd May 2019.

Actions to be completed by 4th October 2019:

- Restraint training based on the National restraint policy 2011 is being facilitated by the CNME on the 11th July for all staff.
- A second training day in 'Responding to behaviours that challenge' facilitated by Dementia course Ireland is scheduled to take place on the 5th July for nominated grades of staff
- There is access to specialist services i.e. Old Age Psychiatry and Advocacy services. SAGE information session will be facilitated on site on the 17th June
- A bespoke medicine management training session for nursing staff took place on three separate occasions: 22nd /24th April and 2nd May 2019. Further training is planned by the CNME on the 4th October 2019

**Proposed Timescale:** 31/07/2019

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

**Theme:**

Person-centred care and support

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

Improvements were required to ensure that all residents were offered a choice of appropriate recreational and stimulating activities based on each residents assessed social care needs, preferences, capabilities, interests and past activities.

**7. Action Required:**

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

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

- In collaboration with the resident and their family, activity and social care plans for

each individual resident were reviewed.

- Audit of care plans were carried out by an external auditor. Findings were analysed by the external auditor and a report was provided to the Person in Charge/Person Participating in Management. A time lined Quality Improvement Plan was developed by the Person in Charge/Person Participating in Management and reported to the registered provider.
- An activity programme is in place to incorporate both group and individual activities, based on residents' choice. This is populated on the activity calendar and displayed in a prominent location. A copy of the activity calendar will also be issued with a copy of the minutes of the residents meeting.
- The activity schedule is displayed on the Engagement Boards located in the dining room and in the main hallway.
- Residents preferences in relation to activities will be an agenda item for the residents' committee meetings.
- Activities are now documented in the residents' activity folder.
- As part of admission process, individual activity preferences will be discussed with the resident and / or their family or nominated representatives.
- Activity programmes that are in place focuses on both the residents as groups and also the individual residents care needs. Each resident/family member/nominated representative are asked on admission what activities they like taking part in. At each monthly residents meeting, the residents who are in attendance are asked if there are any particular activities that they wish to take part in over the coming weeks. A number of residents have made particular requests in regards to trips, one being to the local library to access audio books.
- A unit based quality improvement team has been set up in the centre in relation to residents' activities
- Quality care matrix is completed monthly, QIP are populated and actioned accordingly.
- Practice Development Co-ordinator has been supporting the Clinical Nurse Manager 11 in relation to care planning.
- A local care plan policy has been developed and is been implemented. This has been issued to all staff nurses and is discussed daily at safety pause. It has been read and signed by all clinical staff members. This policy is filed in the Policy Folder. This policy will be included in the Induction process for new clinical staff.

Actions to be completed by 2nd July 2019:

- Care planning tools: "A Key to Me", "My day, my way" and "life stories" were

introduced. "Life stories are ongoing and will be completed by the 31st July 2019

- Two training workshops on DML (2010) /care planning which includes the Scope of Practice (2015) will be facilitated by the Centre for Nursing and Midwifery Education (CNME). Date: 17th June 2019 and 2nd July 2019. All staff nurses are scheduled to attend.

**Proposed Timescale:** 02/07/2019

**Theme:**

Person-centred care and support

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

A baby monitoring camera was in use in a bedroom to monitor a resident, in an area where an individual would have a reasonable expectation of privacy. There was no assessment or justification for its use documented in any of the residents care plans.

**8. Action Required:**

Under Regulation 09(3)(b) you are required to: Ensure that each resident may undertake personal activities in private.

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

- The baby monitor has been removed and is no longer in operation. Completion date 9th April 2019.
- Staff have been made aware of CCTV policy and the inappropriate use of baby monitoring equipment in a designated centre for older persons.
- A Standard Operating Procedure: "Allocation of staff according to Occupancy and Dependency levels for Older Persons Residential Services in Area CHO 3" was developed and implemented. This was issued to staff nurses at the staff nurse meeting and discussed at safety pause thereafter.
- A unit based quality improvement team has been set up in the centre in relation to person-centred care.

**Proposed Timescale:** 16/06/2019

**Theme:**

Person-centred care and support

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

Residents' committee meetings were held infrequently. There was signage in the day

room advising that residents' committee meetings were held every second Sunday and the annual review on the quality and safety of care indicated that meetings were held on a quarterly basis but this was not happening in practice

**9. Action Required:**

Under Regulation 09(3)(d) you are required to: Ensure that each resident is consulted about and participates in the organisation of the designated centre concerned.

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

- Residents' committee meeting has been reviewed and formalised and a schedule of meetings have been developed and communicated to staff, residents and families and or their nominated representative.
  
- Two staff facilitators have been identified to conduct the meetings.
  
- Agenda template and a meeting template have been provided. Minutes from the meetings are recorded and distributed to residents and families. A copy is filed in a meeting folder. This is publicly accessible in the lounge area.
  
- Following the residents meeting, the facilitators of the meeting are feeding back any issue that the residents raise to the Person in Charge. The Person in Charge in turn is reviewing each area of concern that the residents are highlighting and rectifying same. For example, with regards to the dining experience, the Person in Charge is discussing particular requests that the residents have made with the Chef.
  
- At the following monthly residents meeting, the facilitators are updating the residents about the issues they had highlighted the month before and what has been done to rectify it. A copy of this is kept in the residents meeting folder in the main sitting room for everyone to have access to.
  
- There is a schedule of meetings in place which has the date of each residents meeting until December 2019.
  
- A residents' satisfaction survey has been carried out by an external auditor. The data generated from this survey was analysed and has informed service improvement activity. For example, lack of knowledge about SAGE advocacy service was highlighted by the survey. Based on this feedback, SAGE advocacy service was invited to visit the unit and to give a talk to the residents about who they are, and how they can help the residents into the future.
  
- Unit based quality improvement teams have been set up in the centre in relation to residents activities, dining experience and person centredness .

**Proposed Timescale:** 14/06/2019

**Theme:**

Person-centred care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

There was no separate private space available if residents wished to meet visitors in private.

**10. Action Required:**

Under Regulation 11(2)(b) you are required to: Make suitable communal facilities available for a resident to receive a visitor and a suitable private area which is not the resident's room, if required.

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

The front foyer has been refurbished and is a comfortable space for residents and families to meet. Positive feedback has been received on the refurbishment of the front foyer from residents.

Other internal private space available:

- Conservatory area of "The Laurals".
- Conservatory area of dining room outside of meal times.
- The Snug.
- The Oratory.

External areas are:

- Two enclosed court yards with access points to each area.
- On pre admission and orientation to the designated centre, information in relation to private space is made available to the resident and their families.
- This information is included in the Statement of Purpose.
- Residents are reminded of these private areas at the residents' committee meeting

Actions to be completed by 31st July 2019:

- The Snug area and the conservatory area of "The Laurals" are planned for upgrade.

**Theme:**

Person-centred care and support

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

Records containing personal identifiable information relating to residents were stored inappropriately in an open bin in an unsecured rear yard area.

Staff files were found to be disorganised and difficult to review

**11. Action Required:**

Under Regulation 21(6) you are required to: Maintain the records specified in paragraph (1) in such manner as to be safe and accessible.

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

- HSE General Data protection (GDPR) Data Breach Incident Report was submitted to Consumer Affairs, HSE. The incident was reported on the National Incident Management System (NIMS).
- Consumer Affairs, HSE advised that a data breach had not occurred. They advised that there should be a waste management policy in the facility which should include the management and timely disposal of records containing personal data.
- An internal investigation was carried out by Quality, Risk and Safety Department following the report of the incident on NIMS. An investigation report has been made available with a learning outcome notice for circulation, to all residential care services in the Midwest Community Healthcare.
- In relation to the National Incident Management System, no learning outcome has been issued.
- Open Disclosure policy was adhered to.
- The investigation report has a number of recommendations that were actioned.
- A Standard Operating Procedure on "Record Retention" for the designated centre was developed.
- The Person in Charge, the Person Participating in Management and the administration officer have undertaken GDPR training.
- All staff files have been reviewed and re organised in a standard format.

Actions to be completed by 31st July 2019:



- GDPR training is available on line. Staff have been directed to complete this training. Certification will be held on file.
- The GDPR presentation will be communicated to all staff by the Person in Charge and the Person Participating in Management.

**Proposed Timescale:** 31/07/2019

#### **Outcome 04: Complaints procedures**

**Theme:**

Person-centred care and support

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

There were two complaints logged, one in 2016 and another in 2018. The details of the investigation by management, or complainants satisfaction or not with the outcomes were not recorded.

**12. Action Required:**

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

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

- A new complaints management template has been secured. This has been implemented in line with HSE complaint management policy.
- Closure of the complaint is only signed off when the resident is satisfied with the outcome. The HSE complaint policy, "Your Service, Your Say", is followed if an unsatisfactory outcome cannot be achieved.
- Compliments and complaints are logged.
- The HSE complaint policy, "Your Service, Your Say", is made available to the resident/families/nominated representative on pre admission and discussed further on admission.
- Residents are reminded at the residents' committee meetings that they can make a complaint to any member of staff at any time. The complaint policy and procedure is followed.
- The Director of nursing and CNM2 are complaint officers in the designated centre.

Actions to be completed by 18th June 2019:

- The Midwest community healthcare complaints officer will undertake complaints management training with staff on 18th June

**Proposed Timescale:** 18/06/2019

### **Outcome 05: Suitable Staffing**

**Theme:**

Workforce

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

Staffing levels and skill- mix required review to ensure that residents' assessed needs could be met, to ensure that the social care needs of residents were met and to ensure adequate resources were provided to cleaning and decontamination of equipment and premises .

A review of staffing provided on night duty required specific review as the findings on this inspection was that a baby monitoring camera device was being used to monitor a resident in lieu of additional staffing.

**13. 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 Standard Operating Procedure on the allocation of staff according to Occupancy and Dependency levels for Older Persons Residential Services in Area CHO3 has been developed to provide clarification on staff allocation in relation to occupancy and dependency levels.

- The baby monitor has been removed and is no longer in operation.

- Staff have been made aware of CCTV policy and the inappropriateness of baby monitoring equipment in a designated centre for older persons.

Actions to be completed by 11th July 2019:

- Training on the national restraint policy will be facilitated by the CNME on the 11th July.

**Proposed Timescale:** 12/07/2019

**Theme:**

Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Nursing staff required further training in relation to care planning and assessment as evidenced by the many inconsistencies noted in the nursing documentation. Medication management training was also required as 2 medication errors were found which had not been recorded. These required investigation, review and any learning shared. Training was also required on infection prevention and control. MTAs required training specific to cleaning and decontamination practices as well as the equipment in use in the centre.

**14. 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:**

Care Plans:

- Audit of care plans was carried out by external auditor. Findings were analysed by the external auditor and feedback provided to the Person in Charge/Person Participating in Management. A time lined Quality Improvement Plan will be developed by the Person in Charge/Person Participating in Management and reported to the registered provider.
- Quality care matrix/test your care is being carried out monthly, QIP will be populated as result of findings from same.
- Practice Development Co-ordinator has been supporting the Clinical Nurse Manager 11 in relation to care planning.
- A local care plan policy has been developed and has being implemented. This policy is being discussed daily at a Safety Pause. It has been issued to all staff nurses. This policy is filed in the Policy Folder. This policy will be included in the Induction process for new clinical staff.

Actions to be completed by 15th July 2019:

- Two training workshops on DML (2010) /care planning which includes the Scope of Practice (2015) will be facilitated by the Centre for Nursing and Midwifery Education (CNME). Date: 17th June 2019 and 2nd July 2019.
- Person centred care workshop will be facilitated on the 15th July 2019
- Responding to 'Behaviours that challenge' training will be held on the 5th July 2019
- Restraint management training will be held on the 11th July 2019

## Medication Management and Administration:

### Actions completed:

- All nursing staff completed e-learning on medication management. Certificates have been presented and filed.
- Training sessions on medication management were provided on site. All RGNs have attended the training sessions provided by the Chief Pharmacist.
- As an interim measure, medication audits have been scheduled weekly over a six week period, until 17th June 2019.

### Actions in progress:

- Medication audits and quality care matrix audits will be scheduled on a monthly basis.
- Information collated will be analysed and reviewed with effective action plans developed to address any areas identified that required improvement.
- Audit findings will be communicated to RGN staff, at safety pause and staff nurse meetings.

### Actions to be completed by 4th October 2019:

- Further training on medication management facilitated by the CNME will take place on the 4th October.

## Infection Prevention and Control

### Actions completed:

- One staff nurse has been trained as a hand hygiene train the trainer. This staff member provides onsite hand hygiene education.
- Two staff members have completed the hand hygiene auditors training. They organise on site hand hygiene education and carry out spot checks. They complete an audit bi annually.
- Information sessions have been facilitated by the auditors during Hand Hygiene Awareness Week.
- IPC Nurse Specialist undertook a review of implementation of Standard Precautions for Infection Prevention and Control at the designated centre. The report and action plan was submitted on the 7th June 2019.

- A new cleaning schedule has been developed and implemented. This provides structure to staff involved in cleaning which includes a record of cleaning. Monitoring is provided by Nurse Management.
- Additional cleaning equipment has been ordered.
- The Environmental, Health and Safety folder has been revised, updated and issued to the designated centre and located in the staff room.
- The Chemical and Dangerous Goods Management folder have been issued to the designated centre and located in the staff room.
- The Health and Safety officer facilitated chemical awareness training with all staff.
- A unit based quality improvement team has been set up in the centre in relation to IPC and cleaning

Actions to be completed by 31st July 2019:

- Specific training on cleaning will be provided by the company on receipt of the equipment. Cleanpass training is scheduled for the 9th July, 16th July and 23rd July, this is a train the trainer program.
- Staff are required to complete the online Chemical Hazard Training. Certification will be held on file. Completion date 31 July 2019.

Proposed Timescale: 31st July 2019

**Proposed Timescale:** 31/07/2019

**Theme:**  
Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Staff were not appropriately supervised as evidenced by the lack of oversight in reviewing care documentation, medication records, cleaning and decontamination practices and in management of risks.

**15. 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:**

Supervision is provided by Director of Nursing and Clinical Nurse Manager 11:

- Shift to shift handover, safety pause conducted in the morning, clinical round by Person in Charge/Person Participating in Management
- Quality care matrix/test your care audit will be completed monthly.
- Medication management and administration, chemical hazard, care planning and IPC audits have taken place. The baseline audits have been carried out by external auditors and QIP plans have being populated and actioned.
- On site spot checks have commenced by Nursing Management in relation to cleaning, medication management and administration.
- Staff meetings have been scheduled for 2019 and are displayed in the staff room.
- Roll over agenda items for staff meetings will include health and safety, IPC, Regulations and legislation, quality and risk and resident feedback and satisfaction and training. Completion date: 10th May 2019.
- Training on risk assessment for staff was scheduled for 20th and 22nd May 2019 by risk advisor and completed.
- Five unit based quality improvement teams have been set up in relation to person centredness/ dining experience/ residents activities / medication management/ care planning and documentation / IPC and cleaning.

**Proposed Timescale:** 31/07/2019

**Theme:**

Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Copies of the Act and regulations were not readily available to staff.

**16. Action Required:**

Under Regulation 16(2)(a) you are required to: Make copies of the Act and any regulations made under it available to staff.

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

- Copies of the legislation, HIQA national standards and HIQA guidance documents have been provided to and are available to staff.

- Information sessions facilitated by Practice Development coordinator will be conducted to all staff and residents on the 11th June and 14th June; this will be also carried out at safety pause.
- Provision of information on the regulations and legislation by Person in Charge / Person Participating in Management has commenced and communicated to staff at safety pauses.
- Regulations and legislation are a standard agenda item at staff meetings.

**Proposed Timescale:** 31/07/2019

**Theme:**

Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Copies of any relevant standards set and published by the Authority under section 8 of the Act were not readily available for staff for example National standards for infection prevention and control in community services published in 2018 .

**17. Action Required:**

Under Regulation 16(2)(b) you are required to: Make copies available to staff of any relevant standards set and published 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:**

- Copies of the legislation, HIQA national standards and HIQA guidance documents are now available to staff.
- Information sessions facilitated by Practice Development coordinator have been delivered to all staff and residents, and is carried out at the safety pause.

Actions in progress:

- Provision of information and discussions on the regulations and legislation by Person in Charge / Person Participating in Management will commence at staff safety pauses; to be completed by 31st July 2019.
- Regulations and legislation will be a standard agenda item at the staff meetings.

**Proposed Timescale:** 31/07/2019

**Theme:**

Workforce

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

There was no actual and planned roster specific to staff in the designated centre. There was an integrated roster which included staff for both designated centre and day care service.

**18. 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:**

- A desk top exercise has been undertaken to review the existing roster. Staff allocated to the designated centre and staff allocated to the day centre have been identified on both rosters.
- Staff allocation is reviewed on a daily basis in line with the Standard Operating Procedure 'Allocation of Staff According to Occupancy and Dependency Levels for Older Persons Residential Services in Midwest Community Healthcare'.

**Proposed Timescale:** 10/05/2019

**Outcome 06: Safe and Suitable Premises**

**Theme:**

Effective care and support

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

There was inadequate space for the storage of equipment.

There was no private visitors space available should residents wish to meet visitors' in private.

Some bedrooms and other areas of the building required maintenance, repainting and redecorating.

The outdoor smoking gazebo was maintained in an unclean, unkept condition and required thorough cleaning.

The pipework to many toilet and bathroom areas were rusted. The wall surfaces particularly at the rear of wash hand basins were worn, defective and not readily cleanable.

Some mechanical extract ventilation fans in bathrooms showed obvious lack of regular cleaning and some were not in working order.

Service records for all equipment was not made available during the inspection.

There were no systems in place to oversee or monitor the temperature of individual rooms to ensure suitable heating for residents.



**19. 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 review of equipment was undertaken and any equipment not required was decommissioned and removed from the site. Only essential equipment is now stored on site.
  
- Internal private space is available:
  - Conservatory area of "The Laurals".
  - Conservatory area of dining room outside of meal times.
  - The Snug.
  - The Oratory
  - The front foyer
  
- External areas are:
  - Two enclosed court yards with access points to each area.
  
- On pre admission and orientation to the designated centre, information in relation to private space is made available to the resident and their families and nominated person.
  
- This information is included in the Statement of Purpose.
  
- Residents are reminded of these private areas at the residents' committee meeting.
  
- The outdoor smoking gazebo cleaning took place on the 9th April 2019 and is maintained as part of the General Operative cleaning schedule.
  
- Pipework in the toilets and bathroom areas has been repaired and repainted.
  
- The flooring in the dining area was replaced.
  
- All the vents have been checked, repaired or replaced as required.
  
- Equipment service records are held by Maintenance and copies are now available at the designated centre.
  
- A Standard Operating Procedure has been developed for the 'Monitoring, Ordering of Oil and Checking Room Temperature', this has been implemented.

**Actions in progress:**

- There is an ongoing schedule of re painting and redecorating in progress

Actions to be completed by 31st July 2019:

- The Snug area and the conservatory area of "The Laurals" are planned for upgrade.
- Painting of communal bathrooms and toilets and additional four bedrooms will be completed.
- An environmental walkabout was carried out by the Maintenance; areas deemed defective are being addressed.

**Proposed Timescale:** 31/07/2019

### **Outcome 07: Health and Safety and Risk Management**

**Theme:**

Safe care and support

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

Risks identified during the inspection in the enclosed garden area included loose and hanging cables and wires, hose pipes on the ground and unsecured garden tools.

**20. Action Required:**

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

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

- All risks identified during the inspection were immediately addressed.
- All staff have been directed to risk assess the external environment on a daily basis, modify where possible and report to the Person in Charge if unable to modify risk.
- External environmental checklist carried out by General Operative.
- Training on risk assessment for staff has been provided by risk advisor

**Proposed Timescale:** 14/06/2019

**Theme:**

Safe care and support

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

Cleaning duties were fragmented and carried out by a multi- task attendant, laundry

personnel and general operative. The multi-task attendant assigned to cleaning duties was also involved in providing care to residents in the mornings. There was a lack of supervised cleaning and decontamination processes taking place. Procedures, consistent with the standards for the prevention and control of healthcare associated infections were not implemented by staff. Details of non compliances are outlined under outcome 7.

**21. 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:**

- IPC Nurse Specialist has undertaken a review of implementation of Standard Precautions for Infection Prevention and Control at the designated centre. The report and action plan has been submitted on the 7th June 2019.
- A new cleaning schedule has been developed and implemented. This provides structure to staff involved in cleaning which includes a record of cleaning. Supervision and monitoring is provided by Nurse Management.
- Additional cleaning equipment has been ordered.
- Hand sanitizers are available throughout the designated centre, ongoing education session on hand hygiene training for residents' families and staff.
- The Multi Task Attendant assigned to cleaning is no longer involved in direct care. Completion date: 13th May 2019

Actions to be completed by 31st July 2019:

- Specific training on cleaning equipment will be provided by the company on receipt of the equipment. Completion date: 30th June 2019.
- Cleanpass training has being scheduled for July 9th, 16th and 23rd. This will be train the trainer training.

**Proposed Timescale:** 31/07/2019

**Theme:**

Safe care and support

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

There was still no fire extinguisher provided in or near the designated smoking area.

**22. Action Required:**

Under Regulation 28(1)(a) you are required to: Take adequate precautions against the risk of fire, and provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.

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

Actions completed:

- The fire extinguisher is now located in the gazebo.
- A fire drill was undertaken on the 11th May and a report issued to the regulatory body on the 12th May 2019.
- The fire drill records now include the number of residents evacuated in a timed simulated evacuation.
- All staff have attended fire training as per the fire safety policy
- There is a check list in place that ensure that all fire extinguishers are in place
- Future fire drills documentation has been revised to ensure that the number of residents to be evacuated is recorded accurately.

**Proposed Timescale:** 14/06/2019

**Theme:**

Safe care and support

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

Fire drill records maintained did not include the number of residents involved in a full compartment evacuation drill and therefore still did not provide assurance that staff could evacuate residents' safely and in a timely manner in the event of fire particularly at night time.

**23. Action Required:**

Under Regulation 28(2)(iv) you are required to: Make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and safe placement of residents.

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

- A fire drill was undertaken on the 11th May and a report issued to the regulatory body on the 12th May 2019.
- The fire drill records now include the number of residents evacuated in a timed simulated evacuation.

- All staff have attended fire training as per the fire safety policy.

**Proposed Timescale:** 14/06/2019

## **Outcome 08: Governance and Management**

### **Theme:**

Governance, Leadership and Management

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

Governance and Leadership arrangements required review to ensure that management systems in place effectively monitored the totality of the service to ensure it was safe, appropriate, consistent and met regulatory requirements.

The statement of purpose (SOP) required review to include all of the requirements of the regulations. The staffing numbers on the roster provided did not align with the staffing numbers in the SOP.

### **24. 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:**

- The governance and management structure of the unit are clearly defined.
- Lines of authority, accountability and reporting relationships are clearly defined, staff are made aware of the management structure and who they should be reporting to on an ongoing basis.
- Staff are aware and have been communicated their roles, responsibilities and reporting relationships, this is done at all staff meetings.
- Supervision of nursing and non-nursing staff is provided by nursing management
- Monthly governance / business meetings are convened by the General Manager and attended by the Person in Charge.
- Monthly quality, risk and safety meetings are convened by the General Manager and attended by the Person in Charge. The minutes indicate that key aspects of the quality and safety of the service including risk management are reviewed by the senior management team at this forum.
- One to one business meetings are held quarterly between the Provider Representative and the Person in Charge.

- An audit schedule has been agreed. An audit schedule has been developed which include monthly quality care matrix/test your care, IPC audits, medication management and care planning. This will be on a rolling basis and in place until December 2019. A schedule of audit will be planned for the following year as part of the QRPS remit.
- This centre has all of the written operational policies required by Schedule 5 of the regulations.
- In addition, this centre has made available to staff, the legislation, HIQA national standards and HIQA guidance documents.
- All staff files have been reviewed and organised according to the staff index.
- The Statement of Purpose (SOP) has been reviewed and updated to include all of the requirements of the regulations. Completion date: 15th May 2019.
- The staffing numbers on the roster are now aligned with the staffing numbers in the Statement of Purpose. Completion date: 15th May 2019
- Practice Development Co-ordinator has been supporting the staff in relation to care planning.
- Quality care matrix/test your care is completed on a monthly basis
- The Person in Charge and the CNM11 will participate in performance appraisal with their respective managers
- The Person in Charge has participated in HR training on people management. Following completion of training, all staff will be offered to participate in performance appraisal.
- The Person in Charge has arrangements in place to ensure effective team communication and feedback with all staff. The frequency is under review.
- The Person in Charge is meeting with staff nurses and non-nursing staff every other week.
- The Person in Charge updates the registered provider on a weekly basis on developments with regards to QIP teams that have been established.
- The annual review on the quality and safety of care has been reviewed and incorporates areas for improvement, inclusive of improvement plans.

Actions to be completed 31st July 2019:

- The audit schedule has been agreed until years' end. Data collected will be analysed and reviewed with action plans developed to address any areas identified as requiring any improvement. Completion date 30th June 2019

<b>Proposed Timescale: 31/07/2019</b>