

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Maypark House Nursing Home
Centre ID:	OSV-0000249
Centre address:	Maypark Lane, Waterford.
Telephone number:	051 301 848
Email address:	info@mayparkhouse.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Maypark Lane Limited
Provider Nominee:	Michael Dwyer Snr.
Lead inspector:	Vincent Kearns
Support inspector(s):	Una Fitzgerald
Type of inspection	Announced
Number of residents on the date of inspection:	27
Number of vacancies on the date of inspection:	15

About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

- **Registration:** under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- **Monitoring of compliance:** the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- to carry out thematic inspections in respect of specific outcomes
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or wellbeing of residents.

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.

Please note the definition of the following term used in reports: responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration renewal decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
16 May 2017 08:30	16 May 2017 18:00
17 May 2017 07:00	17 May 2017 15:00

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

Outcome	Our Judgment
Outcome 01: Statement of Purpose	Compliant
Outcome 02: Governance and Management	Substantially Compliant
Outcome 03: Information for residents	Compliant
Outcome 05: Documentation to be kept at a designated centre	Substantially Compliant
Outcome 07: Safeguarding and Safety	Substantially Compliant
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 09: Medication Management	Compliant
Outcome 11: Health and Social Care Needs	Non Compliant - Moderate
Outcome 12: Safe and Suitable Premises	Non Compliant - Major
Outcome 14: End of Life Care	Compliant
Outcome 18: Suitable Staffing	Non Compliant - Moderate

Summary of findings from this inspection

This report sets out the findings of a two day announced inspection to inform a decision for the renewal of registration. Maypark Nursing Home is divided into two floors and is registered to accommodate 42 residents. On the days of inspection there were 27 residents living in the centre. The centre is located in the south east side of Waterford city. The premise was originally opened as Maypark House in the 1780's. The house was converted to a private hospital in the early 19th century. There has been significant extensions and renovations since then including the recent completion of suitable access to garden space to the rear of the centre. However, the overall the design and layout of the premises was largely reflective of a large house from this period.

As part of the inspection process, the inspectors met with residents, staff members, the senior nurse manager, the operations manager and the provider representative. Inspectors observed practices and reviewed documentation such as policies and

procedures, care plans, medication management, staff records and accident/incident logs. Residents told inspectors that they were happy living in the centre and that they felt safe there. Overall staff were able to demonstrate good knowledge of the residents' care needs when speaking with inspectors.

There were 11 outcomes reviewed as part of this inspection, four of the 11 outcomes were compliant and three outcomes substantially compliant with the regulations. However, the following three outcomes were deemed to be moderately non-compliant; health and safety and risk management, health and social care needs and suitable staffing. In addition, there was one outcome found to be at major non-compliance; suitable premises. These non-compliances are discussed throughout the report and the action plan at the end of the report identifies where improvements are needed to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Standards for Residential Care Settings for Older People in Ireland.

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: Statement of Purpose

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The statement of purpose and function was viewed by inspectors and was found to be adequate. For example it clearly described the service and facilities provided in the centre and identified the staffing structures and numbers of staff in whole time equivalents. It also described the aims, objectives and ethos of the centre. This ethos was reflected in day-to-day life, through the manner in which staff interacted, communicated and provided care. The statement of purpose included the registration date, expiry date and the conditions attached by the Chief Inspector to the designated centre's registration under Section 50 of the Health Act 2007. There was evidence that the statement of purpose was kept under review and readily available for residents and staff to read.

Judgment:

Compliant

Outcome 02: Governance and Management

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

Theme:

Governance, Leadership and Management

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

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

Findings:

The operations manager was replacing the person in charge who was not available on the days of inspection. The operations manager was a person participating in management (PPIM), had previously worked as a person in charge and was a suitably qualified nurse with the required experience and qualifications. There was a senior nurse manager available to provide managerial support to the operations manager. The operations manager confirmed that there was sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.

Since the last inspection which was a triggered inspection following receipt of unsolicited information, inspectors were informed that further action had been taken in order to ensuring that care provided was safe, high quality and met the needs of residents. Inspectors noted that overall improvements had been made in the governance of the centre. For example there had been improved staff supervision, staff training, enhanced communication/reporting and monitoring of residents. The person in charge and senior nurse manager had worked a number of shifts including night duty to enhance and improve the supervision of all staff. Improvements had occurred in the staffing with an increase in the number of staff nurses and health care staff available and the rotation of all staff onto day and night duty. The centre was registered for 42 beds however, in the context of the current design, layout and allocated staffing resources; the provider representative confirmed that he had agreed to continue operating to a maximum of 30 bed occupancy level.

The provider representative was based on site as well as the general manager and the human resource manager. There was a clearly defined management structure that identified who was in charge and the lines of accountability were clearly defined. There was an annual review of the quality and safety of care delivered to residents. Improvements were brought about as a result of the learning from this monitoring review. For example: the centre has implemented a policy on clinical incident debriefing that was aimed at informing future care practices.

Areas of concern identified in the last inspection had been addressed or were in the process of being addressed. There was now a system in place to monitor staff practice, acts or omissions and procedures carried out to identify areas for improvement. The arrangements for the review of incidents within the centre had been revised. Inspectors noted that changes had been made to ensure robust arrangements were available for the identification, recording, investigation and learning from serious incidents or adverse events involving residents. For example, the centre has commenced staff appraisals since 24 April 2017. All staff spoken to, including staff working night duty confirmed enhanced supervision arrangements were in place in the centre.

While overall improvements had been made since the last inspection however, concerns did arise in relation to the management systems in place to ensure that the service provided was safe and effectively monitored at all times. There was a call bell facility provided in the centre however, inspectors were concerned regarding the monitoring of two residents that could not use the nurse call bell system. This issue was further discussed under outcome 11 of this inspection report.

Judgment:

Substantially Compliant

Outcome 03: Information for residents

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

Copies of both the standards and regulations were maintained on site. A sample of residents' contracts of care were viewed by inspectors who noted that contracts had been signed by residents/relatives. Generally the contract was clear and outlined the services and responsibilities of the provider to the resident and the fees to be paid. The contracts viewed contained details of the terms relating to the bedroom to be provided to the resident and the number of other occupants (if any) of that bedroom, "after" the terms, as required by regulation.

A Residents' Guide was also available which included a summary of the services and facilities provided, terms and conditions relating to residence, procedure respecting complaints and the arrangements for visits. This guide was found to meet the requirements of legislation.

Judgment:

Compliant

Outcome 05: Documentation to be kept at a designated centre

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

Theme:

Governance, Leadership and Management

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

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

Findings:

A sample of records was reviewed by inspectors. These included records relating to fire safety, staff rosters, training records and recruitment files, residents' medication and clinical records, as well as the centre's directory of residents.

Inspectors reviewed the centre's operating policies and procedures and noted that the centre had policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and these were reviewed and updated at intervals not exceeding three years as required by Regulation 4. The centre-specific policies reflected the care given in the centre and informed staff with regard to up-to-date evidenced best practice or guidelines. There was evidence that there was on-going training to staff on policies and procedures and staff had signed off on these once they had received the training. As per the action plan arising out of the last inspection the centre had carried out a review of the admissions policy.

Inspectors reviewed the directory of residents. While the directory held most of the information required under regulation however, inspectors noted that there were 19 gaps seen directory in relation to the date, time and cause of death.

Inspectors reviewed the documents to be held in respect for each member of staff and from a sample of staff files found that they contained all of the information required under Schedule 2 of the Regulations.

While some improvements were required in relation to care planning documentation which was discussed and actioned under outcome 11 of this report. However, there were suitable resident records in place and these included care plans, care assessments, medical notes, nursing records.

The inspector viewed the insurance policy and saw that the centre was adequately insured against accidents or injury to residents, staff and visitors.

The inspector was satisfied that the records listed in Part 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 were maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. Overall records were seen to be maintained and stored in line with best practice and legislative requirements.

Judgment:

Substantially Compliant

Outcome 07: Safeguarding and Safety

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

Theme:

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

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

Findings:

Inspectors noted that there was a culture of promoting a restraint free environment which was evidenced by a reduction in the use of restraints. For example the use of bedrails had reduced since the last inspection and the use of alternative measures such as low-low beds, mat and bed alarms had increased. There were clear rationale in residents care plans in relation to the use of bed rails. Inspectors looked at a sample of the decision making tools used when considering the use of restraints. The documentation of alternatives considered or trialled in some risk assessments was clear. Balancing risk with residents choice was evidenced for example following suitable risk assessments; residents and when appropriate their representatives were consulted/involved in relation to such residents continuing to mobilise with the least restrictive supports possible. In conversations with residents, inspectors were told by a number of residents that they felt safe and secure in the centre.

Inspectors saw positive and respectful interactions between staff and residents and that residents were comfortable in asserting themselves and bringing any issues of concern to staff. Residents and relatives spoken to articulated clearly that they had confidence in the staff and expressed their satisfaction in the care being provided. Inspectors reviewed the system in place to manage residents' money and found that overall reasonable measures were in place and implemented to ensure the management of resident's finances were fully safeguarded. Each resident had a lockable cupboard in their bedroom to store if they wished, small amounts of money and valuables.

Inspectors were satisfied that there were policies and procedures in place for the protection of residents. The person in charge and the operations manager were actively engaged in the operation of the centre on a daily basis. There was evidence of adequate recruitment practices including verification of references and a good level of visitor activity. All staff had received training on the prevention of elder abuse and staff spoken to were clear on their role and responsibilities in relation to reporting abuse. Staff were also knowledgeable in recognising the possible signs and symptoms, responding to and managing abuse. Procedures to protect residents, such as a structured staff induction process and a continuous staff appraisal, development and training were also in place. Training in the prevention of elder abuse was provided for all staff however, from records reviewed inspectors noted some staff had yet to receive refresher training.

Since the last inspection, there were improvements in the arrangements for the review of accidents and incidents within the centre and all residents had received a falls risk assessment completed as part of their care planning process.

The management of behaviours that challenge policy was adequate. There was evidence that residents who presented with behaviours that challenge were reviewed by their General Practitioner (GP) and referred to other professionals. For example referrals to psychiatry of old age and community psychiatric nurse for review and follow up as

required. Inspectors saw evidence of positive behavioural strategies and staff spoken to outlined suitable practices to prevent behaviours that challenge. Care plans reviewed by inspectors for residents exhibiting behaviours that challenge were seen to reflect the positive behavioural strategies proposed including staff using person-centred de-escalation methods. The training records of responding to behaviours that challenge training indicated that staff had received training in 2016/2017. Inspectors noted that all staff had attended training in responding to behaviours that challenge however, from records reviewed inspectors noted some staff had yet to receive refresher training.

Staff training in relation to dementia care had commenced however, a number of staff had yet to receive this training. The operations manager outlined plans for further training in relation to the management of residents with dementia to be provided to all staff by end of this year.

Judgment:

Substantially Compliant

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

Theme:

Safe care and support

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

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

Findings:

There were adequate policies and procedures relating to health and safety. There was an up-to-date health and safety statement. The centre had a risk management policy and a risk register that included items set out in regulation 26(1). An inspector reviewed the risk register. Actions that were identified on the last inspection had been addressed. For example the register addressed the risk of the fire exit from within a residents' bedroom. Extra control measures were also identified.

Arrangements were in place for the investigating and learning from incidents and accidents. The inspectors reviewed the incidents and accidents log. The log captured the detail of all events and follow up action required. The person in charge had reviewed all incidents prior to close out of each recorded incident. Any learning was identified and communicated to staff.

However, satisfactory procedures, consistent with the Authority's standards were not in place for the prevention and control of healthcare associated infections. While processes were in place they are not always followed by staff. Cleaning schedules required review and areas of improvement in practice was required. On review of the sign off sheets on cleaning schedules; inspectors noted a number of recording gaps existed. For example, the weekly cleaning of shower heads and trays had not been filled in for 2017.

Inspectors brought the following areas of concern to the attention of the provider representative:

- layers of dust on the stair rails
- encrusted dust on extraction fan in wing C sluice room
- main bathroom – bath surface was worn and so cleaning ability was compromised
- sluice room in B wing was visibly unclean.
- toilet seat in downstairs assisted bathroom stained
- cobwebs in dining room ceiling
- storage racks in sluice rooms in poor state of repair
- one resident with a known infection had an inadequate waste bin in their bedroom for the disposal of clinical waste
- paintwork on the wall of the sluice room on B wing was damaged compromising cleaning ability.

There was suitable fire equipment provided within the centre. All fire equipment had the required service history. Fire exits were unobstructed and there were means of escape identified. From the last inspection the safety exit for ease of evacuation for residents in the dining room who required wheelchair access was addressed. Fire evacuation procedures were prominently displayed throughout the building. The fire alarm was serviced on a quarterly basis. Weekly bell tests were carried out and documented. Staff were trained in what to do in the event of a fire. As per the action plan from the last inspection simulated fire drills had been carried out, including one night time drill.

Judgment:

Non Compliant - Moderate

Outcome 09: Medication Management

Each resident is protected by the designated centre's policies and procedures for medication management.

Theme:

Safe care and support

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

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

Findings:

There are written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents. Staff were observed to adhere to appropriate medication management practices. A system was in place for reviewing and monitoring safe medication management practices. The person in charge had carried out a medication management audit on the 30 March 2017. All medication related incidents were recorded and appropriate steps taken by management. Actions from the last inspection had been addressed.

Inspectors reviewed a number of medication administration records. All residents that required their medications to be crushed had the order signed by a medical doctor. Of

the files reviewed medications had the maximum dose to be administered within a 24 hour period clearly prescribed. Residents had a choice of pharmacist. Residents had the choice to self administer. From a review of residents records there was an appropriate assessment available and any risks had been identified in relation to self administration of medication. Both the resident and staff were clear on how any medication administered by the resident was to be recorded.

As per the last inspection action plan response the centre was currently reviewing the current medication administration system. Inspectors were shown a sample of the proposed new medication kardex.

Judgment:

Compliant

Outcome 11: Health and Social Care Needs

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

Theme:

Effective care and support

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

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

Findings:

Residents' health care needs were met through timely access to medical and allied healthcare treatment. Residents had access to allied health care services which reflected their different care needs. Residents had access to GP services and out-of-hours medical cover was provided. A full range of other services was available if required including speech and language therapy (SALT), occupational therapy and dietetic services. The centre has a physiotherapist who worked full time between this and another centre. The clinical nurse specialist for palliative care and old age psychiatry had been in the centre in recent weeks to provide specialist advice where needed and recommendations were reflected in residents care plans.

The person in charge had conducted pre assessments on all prospective residents to identify if the centre could adequately meet their individual care needs. Care plans were prepared within 48 hours of admission into the centre as required by regulation. Staff to whom inspectors spoke with were knowledgeable of residents' health and social care needs. However the care plans reviewed were not personalised or adequately resident focused to guide practice. For example, one resident with known behaviours that challenge prior to admission did not have a care plan specific to their care needs developed for two calendar months after the date of admission.

The last inspection action plan had identified gaps in documentation on resident involvement in the development and ongoing review of their care plan. While some progress had been made there continued to be some gaps. A care plan audit was carried out on the 03 April 2017 which also identified a number of improvements. On the second day of inspection the inspectors identified two residents who had communication difficulties and who could not use the centres' nurse call bell system. Inspectors spoke with nursing and care staff who were knowledgeable on these residents' care needs and confirmed that they had been suitably monitoring these residents. However, the care plans did not guide practice. Inspectors spoke with the management team and immediate assurances from the nurse management team was provided to ensure that all residents were appropriately safeguarded and their health and social care needs met. The senior nurse manager actioned recorded increased monitoring with immediate effect and the template for these document checks to ensure compliancy was shown to the inspectors. Management also reassured inspectors that this change in practice will be communicated to all members of the care team. The senior nurse manager also gave an undertaking to keep this practice under regular review to ensure its effectiveness and make any further changes that may be required.

Judgment:

Non Compliant - Moderate

Outcome 12: Safe and Suitable Premises

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

Theme:

Effective care and support

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

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

Findings:

Maypark Nursing Home was divided into two floors and the centre was registered to accommodate 42 residents. On the days of inspection there were 27 residents living in the centre. The premises was originally opened as Maypark House and was built in 1780's. The house was converted to a private hospital in the early 19th century and was located in the south east side of Waterford city. While there had been significant extensions and renovations since then however, the overall the design and layout of the premises was largely reflective of a large house from this period.

Residents' accommodation was laid out over two floors and was observed to be homely,

bright and spacious. Entry to and exit from the building was restricted and access was via a coded key pad. There was a lift provided between floors and there were regular service records viewed in relation to this lift.

Since the last inspection significant works had been completed in relation to providing suitable access to appropriate garden space at the rear of the centre. There was adequate private and communal accommodation for residents, including space for residents to receive visitors in private. There was a large welcoming reception area with fine examples of local art work including a hand crafted patchwork quilt hung on the entrance stairwell wall. The centre had a separate sitting room and dining space that met the needs of the residents. There were handrails on both sides of the corridors and an operating lift between floors that could accommodate a stretcher. There was a magnetic rail across the bottom of the stairs which restricted residents from using the stairs and a wooden gate at the top of both stairs. During the last inspection inspectors had requested that management complete a comprehensive risk assessment in relation to this arrangement and inspectors noted that a suitable risk assessment had been completed in relation to this arrangement.

The ground floor also contained a chapel, a lounge/day area, kitchen, administrative offices and a staff changing area.

The centre comprised of 25 single bedrooms, five with full en-suite facilities, seven twin bedrooms, two with en-suite facilities and a three bedded room that was vacant at this time. All occupied bedrooms viewed were individualised with residents' personal belongings, photographs and personal memorabilia.

Bedroom accommodation on the ground floor comprised of two wings. "A" wing had nine single bedrooms, each with a wash-hand basin. This wing had one shower and two toilets located at the end of the bedroom corridor. There was a small sluice room also located adjacent to the shower room.

"B" wing had three twin rooms and one single room with adequate toilet and shower facilities. This wing contained a sluice room with a bed pan washer.

Bedroom accommodation on the first floor also comprised of two wings; "C" wing had nine single bedrooms, each with a wash-hand basin. This wing had one shower, three toilets located at the end of the bedroom corridor. There was a small sluice room also located adjacent to the shower room.

"D" wing had one twin bedroom with a wash-hand basin, four single rooms with wash-hand basin and six single rooms which were en-suite. This wing also had two bathrooms both with toilet and shower facilities, a sluice room, a room reserved for hairdressing and a parlour room for visitors. All windows on the first floor were suitably restricted to prevent full opening.

However, not all resident's bedrooms were adequate in size to meet all residents' needs. In particular in "A" and "C" wings the bedrooms were inadequate to allow for enough space for manoeuvring of assistive equipment such as hoists. Due to the size and layout of these bedrooms, all beds were located against the bedroom wall making it difficult for staff to provide assistance to residents in these bedrooms. For example, in one residents' bedroom in "A" wing staff reported that they removed the bedside locker and bed table each time the resident required the use of a hoist. This resident had been

offered an alternative bedroom but had chosen to stay in this particular bedroom. The operations manager stated that only residents' with lower dependency needs and who did not require assistance or the use of adaptive equipment were admitted into these bedrooms. She informed inspectors that there were a number of people waiting for admission into the centre. However, due to the the design and layout of bedrooms in "A" and "C" wings; they were not suitable to meet their needs. Inspectors noted that three bedrooms of the nine bedrooms in "A" wing and five of the nine bedrooms in "C" wing were unoccupied on the days of inspection.

The size, location and design of the shower facilities and toilets in both "A" and "C" bedroom wings were inadequate to meet all residents needs; particularly residents with mobility issues. The two shower facilities in "A" and "C" wings were not assisted showers. For example the door opening into the shower rooms in "A" and "C" wings measured 686mms and was not accessible for example for residents using wheelchairs or with mobility issues.

In addition, the toilet door opening into the toilets in "A" and "C" wings measured 737mms which was inadequate to meet all residents needs and particularly residents requiring assistance with mobility. There were two small handles on the walls of each toilet cubicles however, there were inadequate grab rails available and the space within the cubicles was inadequate/too narrow for use by residents' with reduced mobility. For example, the space between the partition wall and wall of the toilet in "A" and "C" wings measured 686mms and was inadequate physical space to accommodate residents require assistance, using wheelchairs or other aids.

There were a number of issues in relation to the sluice rooms that required improvements including:

- the wash hand basin in the sluice room in "C" wing contained domestic style taps which did not facilitate the prevention of cross contamination
- the storage of a large waste bin in in the sluice room in "C" wing prevented suitable access to the sluice sink
- the provision of storage including racking for urinals or bedpans was inadequate in the sluice room in "C" wing
- there was no wash hand basin in the sluice room in "D" wing
- the provision of storage including racking for urinals or bedpans was inadequate in the sluice room in "D" wing
- the provision of storage including racking for urinals or bedpans was inadequate in the sluice room in "B" wing
- the storage of a large waste bin in in the sluice room in "A" wing prevented suitable access to the sluice sink
- the wash hand basin in the sluice room in "A" wing contained domestic style taps which did not facilitate the prevention of cross contamination

In addition, the design and layout of the cleaners room required review as it was not ventilated to external air, did not contain a sluice sink or a wash hand sink.

There was a full time maintenance officer on site and the maintenance log showed regular maintenance conducted and suitable repairs recorded. Inspectors reviewed up to date service records for equipment including hoists, wheelchairs, beds and weighing scales.

Judgment:

Non Compliant - Major

Outcome 14: End of Life Care

Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.

Theme:

Person-centred care and support

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

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

Findings:

The centre had a policy in place for end-of-life care which staff were familiar with. The policy had last been updated on the 11 April 2017. On the days of inspection there was no resident receiving end-of -life care. Care plans on end-of-life care were reviewed. Choice on religious and cultural preferences were identified. Overall the care plans guided practice. Some improvement was required to ensure that the care plans were individualized and person centered. This was addressed further under outcome 11 of this report.

As per the last inspection action plan the centre now had in place a process that all new residents have an end-of-life care discussion on what their wishes are within two weeks of admission. This was evidenced in care plans reviewed. An end-of-life care audit had been carried out on the 28 April 2017. Areas for improvement were identified and findings had been communicated to staff at a staff meeting. For example: the audit identified that 56% of families were involved in the end of life discussion that was evidenced in the progress notes but not identified in the care plans.

The centre had access to specialist palliative care services, when appropriate.

Judgment:

Compliant

Outcome 18: Suitable Staffing

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

Theme:
Workforce

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

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

Findings:

On the last inspection, Inspectors found that the levels and skill mix of staff at the time of inspection were sufficient to meet the needs of the 26 residents. However, inspectors were not assured that current staffing levels would be suitable and sufficient to meet the needs of residents if the occupancy levels were above 30.

On this inspection, there were 27 residents living in the centre. The operations manager stated that given the current staffing arrangement; the centre would continue to only admit a maximum of 30 residents. This arrangement was also confirmed to inspectors by the provider representative. In addition, inspectors noted that there had been a recent increase in the availability of nurses to work in the centre with the recruitment of additional nurses bring the nurse complement up from eight to 11 nurses. From a review of the staff roster, from speaking to residents and staff; inspectors found that the levels and skill mix of staff at the time of inspection were sufficient to meet the needs of the 27 residents.

Inspectors were informed that the person in charge, the operations manager and the senior nurse manager were available to support staff each evening to provide assistance. The operations manager gave a number of examples of when she had provided such out of hours managerial assistance. The staffing rota confirmed that there was a nurse on duty at all times. Whilst on the days of inspection, there was an adequate complement of staff according to the staff duty roster.

There was an education and training programme available to staff and the training matrix indicated that most staff were up-to-date with mandatory training. However, as already described in outcome eight of this report there was inadequate training of staff as required by regulation. In addition, most but not all staff had up to date training in relation to fire safety and manual handling training.

There was evidence from staff files, from speaking to staff and the provider representative that staff were suitably recruited, inducted and supervised appropriate to their role and responsibilities. There was suitable recruitment practices including the verification of written references and the on-going staff appraisal and supervision to ensure good quality care provision and improve practice and accountability. The provider confirmed that all staff working in the centre had been Garda vetted.

Staff spoken with were aware of the regulations and the HIQA standards and where to access them in the centre. Up to date registration was seen for nursing staff. A sample of staff files were reviewed and the requirements of schedule 2 of the regulations were met.

A recent notification to HIQA in relation to a member of staff was discussed with the operations manager who outlined suitable actions that had been taken by management in relation to this matter.

There had been a number of improvements since the last inspection including an improved supervision and oversight of all staff including those on night duty to ensure the delivery of care was safe, appropriate and monitored on a consistent basis.

Judgment:

Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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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 report¹

Centre name:	Maypark House Nursing Home
Centre ID:	OSV-0000249
Date of inspection:	16/05/2017 and 17/05/2017
Date of response:	16/06/2017

Requirements

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

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

Outcome 02: Governance and Management

Theme:

Governance, Leadership and Management

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

Management systems in place to ensure that the service provided is safe and effectively monitored at all times required review. Inspectors were concerned about the monitoring of two residents that could not use the nurse call bell system.

1. Action Required:

Under Regulation 23(c) you are required to: Put in place management systems to

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

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 admission checklist has been amended to include a communication section this will identify residents with communication difficulties and the necessary actions required. A personalised care plan will then be completed outlining the measures to be put in place to ensure that the residents individualised needs are met. One of these measures includes an hourly checking form in their room. Residents who require an hourly checking form will have a blue identification sticker on their door and on the resident board in the nurses office to make all staff aware that the resident has difficulties with communication. A pain chart will be put in place if required and a referral sent to the speech and language therapist where necessary.

An SOP is now in place with regard to care of residents who are unable to communicate which includes these measures.

Proposed Timescale: 13/06/2017

Outcome 05: Documentation to be kept at a designated centre

Theme:

Governance, Leadership and Management

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

Inspectors reviewed the Directory of residents. While the directory held most of the information required under regulation 19 gaps were seen with the detail of the date, time and cause of death.

2. Action Required:

Under Regulation 19(3) you are required to: Ensure the directory includes the information specified in paragraph (3) of Schedule 3.

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

The directory has been updated and staff informed that this needs to be done on each occasion, it has also been communicated via Epic. Going forward this area will be included in the next End of Life Care audit.

Proposed Timescale: 22/05/2017

Outcome 07: Safeguarding and Safety

Theme:

Safe care and support

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

To provide suitable training to ensure that all staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging and dementia care.

3. Action Required:

Under Regulation 07(1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.

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

A training programme will be introduced over an 8-week period which will include:

- An introduction to dementia
- Communication and dementia
- Challenging Behaviour
- Medication- dementia care

Health and safety training is ongoing.

Proposed Timescale: 01/09/2017

Theme:

Safe care and support

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

To ensure staff are trained (including updated training) in the detection and prevention of and responses to abuse.

4. Action Required:

Under Regulation 08(2) you are required to: Ensure staff are trained in the detection and prevention of and responses to abuse.

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

Staff will all be trained in prevention and response to abuse, either internally or with an external provider.

Proposed Timescale: 01/09/2017

Outcome 08: Health and Safety and Risk Management

Theme:

Safe care and support

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

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.

Including the following:

- inadequate documentation regarding cleaning schedules
- layers of dust on the stair rails
- encrusted dust on extraction fan in wing C sluice room
- main bathroom – bath surface was worn and so cleaning ability was compromised
- sluice room in B wing was visibly unclean.
- toilet seat in downstairs assisted bathroom stained
- cobwebs in dining room ceiling
- storage racks in sluice rooms in poor state of repair
- one resident with a known infection had an inadequate waste bin in their bedroom for the disposal of clinical waste
- paintwork on the wall of the sluice room on B wing was damaged comprising cleaning ability.

5. 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:

Cleaning regimes have been reviewed. A deep cleaning rota is now in place for all areas. A meeting was held with all housekeepers on 02/06/2017, the areas of improvement were highlighted and the deep cleaning schedule has been explained and put in place. There will be a further housekeeping meeting in 1/12 and a repeat housekeeping audit will be completed prior to this by the SNM.

Infection control procedures have now been reviewed and a closed bin is now in place.

All maintenance issues will be repaired.

Proposed Timescale: 30/08/2017

Outcome 11: Health and Social Care Needs

Theme:

Effective care and support

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

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.

6. 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:

- All family/resident meetings to discuss care plans are ongoing and will be completed by 7/7/2017. Residents who can be involved in their care planning will now be involved from admission.

Proposed Timescale: 07/07/2017

Theme:

Effective care and support

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

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.

7. 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:

- The DON and SNM will meet with each nurse and go through care planning and offer assistance if needed to identify why care plans are not at the required standard and if further training is required.
- Care plans will continue to be audited by the SNM and DON on a fortnightly basis until the care plans are at the required standard.
- The results of these audits will be communicated to staff nurses via epic and named nurses will be responsible for improvements in their resident's care plans. Appraisals are ongoing this will be an area of focus and a timeframe for improvement will be given.
- A staff nurse meeting will be held on 6/7/2017 to discuss any further issues.
- Protected time will be provided for staff nurses for care planning.

Proposed Timescale: 07/07/2017

Theme:

Effective care and support

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

To having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care for a resident, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais including any monitoring checks of any resident with communication needs.

8. Action Required:

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

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

All residents who are unable to communicate or use a call bell have the hourly resident check form in place, all care staff and staff nurses have been informed of this. Four residents who currently require this form also have updated communication care plans to reflect this change in care. An SOP is now in place to advise staff of this change in practice. This will also be communicated via Epic and in the next care staff and staff nurse meeting.

Proposed Timescale: 13/07/2017

Outcome 12: Safe and Suitable Premises

Theme:

Effective care and support

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

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 including the following:

- that all resident's bedrooms are adequate in size, design and layout to meet all residents' needs
- that the size, location and design of showers and toilets are adequate to meet all residents needs
- that all sluice rooms are suitable in design and layout
- that the design and layout of the cleaner's room is suitable
- that the cleaner's room is suitable design and layout

9. 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:

In relation to the size, design and layout of resident's rooms, the showers, toilets and sluice rooms all these areas will be addressed with the refurbishment of C wing which will commence on 30/06/2017. The refurbishment of A wing will commence in nine months time.

The design and layout of the cleaners room will be addressed with the refurbishment of A wing.

Proposed Timescale: 31/03/2018

Outcome 18: Suitable Staffing

Theme:

Workforce

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

To ensure that staff have access to appropriate training including: fire safety and manual handling training .

10. 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:

Manual handling training has been organised and all relevant staff have been scheduled to attend.

Fire safety training has been organised and staff will be scheduled to attend.

Proposed Timescale: 30/09/2017