<table>
<thead>
<tr>
<th><strong>Centre name:</strong></th>
<th>Tralee Community Nursing Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Centre ID:</strong></td>
<td>OSV-0000566</td>
</tr>
<tr>
<td><strong>Centre address:</strong></td>
<td>Teile Carraig, Killerisk Road, Tralee, Kerry.</td>
</tr>
<tr>
<td><strong>Telephone number:</strong></td>
<td>066 719 9250/ 066 719 9251</td>
</tr>
<tr>
<td><strong>Email address:</strong></td>
<td><a href="mailto:jacqueline.brick@hse.ie">jacqueline.brick@hse.ie</a></td>
</tr>
<tr>
<td><strong>Type of centre:</strong></td>
<td>The Health Service Executive</td>
</tr>
<tr>
<td><strong>Registered provider:</strong></td>
<td>Health Service Executive</td>
</tr>
<tr>
<td><strong>Lead inspector:</strong></td>
<td>Mary Costelloe</td>
</tr>
<tr>
<td><strong>Support inspector(s):</strong></td>
<td>None</td>
</tr>
<tr>
<td><strong>Type of inspection:</strong></td>
<td>Announced</td>
</tr>
<tr>
<td><strong>Number of residents on the date of inspection:</strong></td>
<td>41</td>
</tr>
<tr>
<td><strong>Number of vacancies on the date of inspection:</strong></td>
<td>2</td>
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About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

<table>
<thead>
<tr>
<th>From</th>
<th>To</th>
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<tbody>
<tr>
<td>15 January 2018 09:00</td>
<td>15 January 2018 19:00</td>
</tr>
<tr>
<td>16 January 2018 08:30</td>
<td>16 January 2018 15:30</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Our Judgment</th>
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<tbody>
<tr>
<td>Outcome 01: Statement of Purpose</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 02: Governance and Management</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 04: Suitable Person in Charge</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 07: Safeguarding and Safety</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 08: Health and Safety and Risk Management</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 09: Medication Management</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 11: Health and Social Care Needs</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 12: Safe and Suitable Premises</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 13: Complaints procedures</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 15: Food and Nutrition</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 16: Residents' Rights, Dignity and Consultation</td>
<td>Non Compliant - Major</td>
</tr>
<tr>
<td>Outcome 17: Residents' clothing and personal property and possessions</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 18: Suitable Staffing</td>
<td>Non Compliant - Major</td>
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**Summary of findings from this inspection**

This report sets out the findings of an inspection, which took place following an application to the Health Information and Quality Authority, to renew registration and a notification to the Chief inspector of a change to the person in charge. This inspection was announced and took place over two days. As part of the inspection the inspector met with residents, relatives and staff members. The inspector observed practices and reviewed documentation such as care plans, medical records, complaint logs, health and safety records, policies, procedures and staff files.

Overall, the inspector found that the provider and person in charge demonstrated a commitment to meeting the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations and the National Quality Standards for Residential Care Settings for Older People in Ireland. Many
improvements had been completed since the previous inspection.

On the days of inspection, the inspector was satisfied that residents nursing and healthcare needs were being met. Nursing documentation was completed to a high standard.

The centre was well maintained and nicely decorated. It was warm, clean and odour free throughout. All areas were bright and well lit, with lots of natural light in all areas.

There was evidence of good practice in many areas. Staff demonstrated a comprehensive knowledge of residents’ needs, their likes, dislikes and preferences. Staff and residents knew each other well, referring to each other by first names.

However, the inspector found that there was major non-compliance in the centre with the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 in regard to residents' rights, choice and staffing levels. There were five moderate non compliances in relation to health and safety, medication management, premises, food and nutrition and residents' personal property. The action plan at the end of the report specifies the actions to be taken by the provider to bring the centre into compliance with the aforementioned regulations.
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 inspector reviewed the statement of purpose dated November 2017. The statement of purpose was displayed in the centre and clearly described the services provided. However, it required updating to include the Health Service Executive as the registered provider.

Judgment:
Substantially 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):
No actions were required from the previous inspection.

Findings:
The provider had established a clear management structure. The person in charge worked full time in the centre. She had been recently appointed in November 2017. The clinical nurse manager 2 (CNM2) supported the person in charge and deputised in her absence. There was an on call-out-of-hours system in place. The person in charge was
further supported by the administrator and management team including the general manager who was the person nominated to represent the provider, clinical development coordinator, clinical placement coordinator, fire safety officer and human resource department. The management team were in regular contact. Formal management and staff meetings took place on a regular basis. A quality and patient safety team meeting took place on a monthly basis. The person nominated to represent the provider visited the centre and was available for support at all times. There were established regular meetings of persons in charge to discuss issues of concern and share learning.

Systems were in place to review the safety and quality of care. There was an audit schedule in place, recent audits completed included medication management, psychotropic medications, oral hygiene, dining experience, skin integrity and hand hygiene assessments. Recommendations were documented and action plans were in place. The results of audits were discussed with staff and there was evidence of learning and improvement as a result. Nursing staff completed a daily safety report which included information on the number and dependency of residents, falls, incidents, complaints, use of restraint, infection control, wounds and pain. This report was reviewed on a daily basis by the person in charge.

A review of performance against the National Standards for Residential Services for Older People in Ireland was completed for 2016. An improvement plan for 2017 setting out identified areas for improvement was included. Improvements identified such as new person centered nursing documentation and observation charts had been put in place. The person in charge advised that the annual review for 2017 was currently being compiled.

There was evidence of consultation with residents and their representatives. Residents meetings continued to take place regularly and minutes of meetings were recorded. The inspector was informed that issues raised at the residents meetings were acted upon. For example, a resident had recently requested to go on a shopping trip and this had been facilitated with the support of staff. Another resident had requested a table for his bedroom and this had been provided. Following the last inspection, a relatives forum was set up and one meeting had been held to date. Residents were involved in the development of a monthly newsletter which included information on religious ceremonies and upcoming activities and events.

There was evidence that both residents and their relatives continued to be involved and consulted with in the development and review of their care plans.

**Judgment:**

Compliant

**Outcome 04: Suitable Person in Charge**

The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.

**Theme:**
Governance, Leadership and Management

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

Findings:
The person in charge was a registered nurse with the required experience in the area of nursing older people and worked full-time in the centre. She normally worked Monday to Friday and she was on call out-of-hours and at weekends.

The person in charge demonstrated good clinical knowledge and she was knowledgeable regarding the regulations, the Authority's Standards and her statutory responsibilities.

The person in charge had engaged in continuous professional development. Having previously completed a postgraduate diploma in gerontological nursing, she had recently completed training courses in care of the older person, advance care directive, designated officer training in relation to safeguarding and complaints management.

The inspector observed that she was well known to staff, residents and relatives.

Judgment:
Compliant

Outcome 07: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe care and support

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

Findings:
The provider and person in charge had taken measures to safeguard residents from being harmed and from suffering abuse. The person in charge advised that all staff and persons who provided services to residents had Garda vetting in place. A sample of staff files reviewed by the inspector confirmed this to be the case.

There was a comprehensive safeguarding policy in place. Staff spoken with and training records viewed confirmed that staff had received ongoing education on elder abuse. Further safeguarding training was planned. Staff spoken with were knowledgeable regarding their responsibilities.

The inspector reviewed the policies on the support of residents with responsive
behaviour and use of restraint. The policy on responsive behaviour outlined guidance and directions to staff as to how they should respond and strategies for dealing with behaviours. The policy on restraint was based on the national policy and included clear directions on the use of restrictive procedures including risk assessment and ensuring that the least restrictive intervention was used for the shortest period possible. There were 31 residents using bed rails at the time of inspection some at the residents own request. A review of a sample of residents' files indicated that consent, risk assessments, care plans and regular checks were documented in line with national policy.

A number of residents were prescribed psychotropic medicines on a 'PRN' as required basis and these were administered occasionally. Staff spoken with informed the inspector that these were always administered as a last resort only when other strategies had been trialled and possible underlying causes had been eliminated. While improvements were noted to the records maintained to indicate the rationale for administration of these medications or what other interventions had been tried to manage the behaviour, there were still some inconsistencies in the recording of this information. Some nursing staff spoken with were not aware of the protocols as outlined in the medication management policy.

Many staff spoken with and training records reviewed indicated that staff had attended training on restraint management and many had attended training on dementia awareness and person centred care.

The inspector reviewed a sample of files of residents presenting with responsive behaviour and noted that comprehensive care plans were in place to guide staff including summary of behaviour, known triggers and effective interventions. There was evidence of regular multidisciplinary review as well as regular reviews of medications.

The inspector was satisfied that systems in place to manage residents finances were clear and transparent. There were regular reviews of individual accounts which were overseen by administrative officers.

The inspector observed staff interacting with residents in a respectful and friendly manner. Residents were observed to be relaxed and happy in the company of staff. Questionnaires completed by residents in advance of the inspection by way of feedback to the authority indicated that residents felt safe in the centre and all residents spoke highly of staff.

Judgment:
Non Compliant - Moderate

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

Theme:
Safe care and support
Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
The inspector was satisfied that risk was generally well managed however, improvements were required to ensure that regular fire drills were carried out, all risks were identified and assessed and infection control training was provided to staff.

There was a recently updated health and safety statement available. The risk management and incident policy set out the measures and actions in place to control the risks specifically mentioned in the regulations.

The inspector reviewed the risk register and noted 16 open risks. The register had last been updated in September 2017. The inspector noted that all risks throughout the centre had not been identified and assessed such as those associated with needle stick injury, clinical waste, chemicals, laundry, kitchen, medication and smoking. The person in charge told the inspector that she was currently in the process of reviewing and updating the register. She advised that two members of staff were attending safety representative training on the day of inspection and it was planned to establish a local quality, patient safety committee. The person in charge stated that risks were discussed at the monthly management meetings.

The inspector reviewed the emergency plan which included clear guidance for staff in the event of a wide range of emergencies including the arrangements for alternative accommodation should it be necessary to evacuate the building.

Training records reviewed indicated that all staff members had received up-to-date training in moving and handling. Staff spoken with confirmed that they had received training. The inspector observed good practice in relation to moving and handling of residents during the inspection. The service records of manual handling equipment such as hoists were up-to-date.

The inspector reviewed the fire policies and procedures. Records indicated that all fire fighting equipment had been serviced in September 2017 and the fire alarm was serviced on a quarterly basis. The fire alarm was last serviced in November 2017. Daily and weekly fire safety checks were carried out and these checks were recorded.

Fire safety training took place regularly and included evacuation procedures and use of fire equipment. All staff spoken with told the inspector that they had received recent fire safety training. Training records reviewed indicated that all staff had received up-to-date formal fire safety training. However, there had been no recent fire drills at regular intervals to ensure that staff were knowledgeable, competent and aware of the procedures to be followed in the event of fire.

Handrails were provided to all circulation areas and grab rails were provided in all toilets and bathrooms. Call-bell facilities were provided in all rooms. Safe floor covering was provided throughout the building.
The inspector noted that infection control practices in relation to hand hygiene were robust. There were policies in place which guided practice. Hand sanitizer dispensing units were located at the front entrance and throughout the building. Staff were observed to be vigilant in their use. Two staff members had recently trained as hand hygiene assessors and had completed hand hygiene knowledge and technique assessments with all staff.

The building was found to be clean and odour free. The inspector spoke with housekeeping staff regarding cleaning procedures. Staff were knowledgeable regarding colour coding and use of appropriate chemicals. However, staff had not received infection control training and there was no infection control audit schedule in place to ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the authority were implemented by staff.

**Judgment:**
Non Compliant - Moderate

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**Outcome 09: Medication Management**

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

**Theme:**
Safe care and support

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

**Findings:**
The inspector noted sufficient policies and procedures to support and guide practice. However, improvements were required to some aspects of medicines management.

The pharmacy service was provided by the pharmacist in the local hospital. Prescribed medicines were ordered as required and medicines were administered from a general stock. Medicines were not individually labelled with residents details. This posed an increased risk of medicine error during the medicines administration round and also posed difficulties with regard to accountability as there was no comprehensive accurate medicines stock list. These issues had been identified by staff and included in the risk register. The person in charge told the inspector that they were currently in the process of reviewing the existing pharmacy arrangements.

Medicines requiring strict controls were appropriately stored and managed. Secure refrigerated storage was provided for medicines that required specific temperature control. The temperature of the refrigerator was monitored and recorded on a daily basis.

The inspector reviewed a sample of medicines prescribing and administration sheets. All
medicines were prescribed by the general practitioners (GP) including those that were required to be crushed.

There was evidence of regular reviews of residents’ medicines by the General Practitioner (GP).

The inspector reviewed a sample of medicine prescription records in both wards, the records were found to be current and clearly legible. The inspector noted that there were no omissions and administration recording practice was the subject of regular internal audit.

Systems were in place to record medicine errors which included the details, outcome and follow-up action taken. Staff were familiar with these systems.

Systems were in place for the return of unused and out-of-date medicines to the pharmacy.

Regular medicine management audits were carried out by nursing management. There were no issues of concern noted during recent audits.

Some nursing staff had not completed recent medicines management training. Training records indicated that most nursing staff had completed training during 2015. The person in charge confirmed that medicines management training was planned for 2018.

**Judgment:**
Non Compliant - Moderate

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**Outcome 11: Health and Social Care Needs**

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

**Theme:**
Effective care and support

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

**Findings:**
The inspector found that residents’ healthcare needs were met and they had access to appropriate medical and allied healthcare services. Residents had some opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. Issues identified at the previous inspection in relation to nursing documentation had been addressed.
All residents had access to general practitioner (GP) services. 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.

A range of other services was available including speech and language therapy (SALT), physiotherapy, occupational therapy (OT), dietetic services, tissue viability, palliative care and psychiatry of later life. Chiropody and optical services were also provided. The inspector reviewed residents’ records and found that residents had been referred to these services and results of appointments and recommendations were written up in the residents’ notes. Nursing staff advised that access to physiotherapy was limited and currently only available to residents for half a day every two weeks.

The inspector reviewed a number of residents’ files including the files of residents with restraint measures in place, presenting with responsive behaviour, with wounds, at high risk of falls, at risk of absconson with communication difficulties and with specific healthcare needs. See Outcome: 7 Safeguarding and Safety regarding restraint and responsive behaviour.

The inspector found that nursing documentation had greatly improved following the last inspection. Comprehensive up-to-date nursing assessments were completed. A range of up-to-date risk assessments and care plans had been completed including mood and behaviour, communication and cognition, breathing and circulation, personal hygiene, oral health, skin integrity, risk of developing pressure ulcers, nutrition, elimination, mobility, sleep and rest, pain, use of restraint measures including bed rails and recreation and social interaction. Care plans were in place for all identified issues. Care plans were found to be person-centred, individualised and clearly described the care to be delivered. Care plans had been reviewed and updated on a regular basis. Systems were in place to record evidence of residents’ and relatives’ involvement in the development and review of their care plans. Nursing staff stated that they received on going support from the clinical development coordinator in regard to the development and implementation of the new nursing documentation and that there were on going study days in relation to its implementation.

Judgment:
Compliant

**Outcome 12: Safe and Suitable Premises**
The location, design and layout of the centre is suitable for its stated purpose and meets residents’ individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

**Theme:**
Effective care and support

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

Findings:
Tralee Community Nursing Unit consisted of a single storey, purpose built building and its total capacity was 43 residents. There was ample parking for staff and visitors. The centre was clean and well decorated throughout in a homely manner. All areas were bright and well lit, with lots of natural light in the all areas. Recent improvements including the refurbishment of the front entrance and reception area, visitors’ room, dining rooms and communal library area to provide a more homely, cosy environment.

Residents accommodation was provided in two wards, Lohar and Dinish. Bedroom accommodation was provided in 19 single bedrooms, two twin bedrooms and five four-bedded rooms. There was a spacious and bright dining room and communal day room provided in both wards.

The multi occupancy rooms presented challenges to the provision of adequate space, privacy and dignity for each resident. The physical environment posed challenges when delivering personal care; attending to residents’ care needs, infection control and communicating in privacy. Residents had limited space for the storage of personal belongings.

There were ample numbers of toilets and showers in the centre and three single bedrooms had an ensuite shower room and toilet. The toilets and showers had grab rails for safety. There was two assisted specialised baths available in the centre.

Screening curtains were in place to protect residents' dignity when care was being given. There were wash-hand basins and call bells in all rooms.

There was a variety of communal day space available to residents and their families. There was a large communal area located between both wards and this space was used frequently for group activities or for visitors to spend time with residents. There was separate visitors room.

Residents had access to two, secure, enclosed garden areas which were paved and landscaped, they provided a safe space for residents to walk or sit out in the fresh air. The gardens were easily accessible and could be viewed from many areas in the centre.

The corridors were wide and bright and allowed for freedom of movement. Corridors had grab rails, and were seen to be clear of any obstructions. Residents were seen to be moving as they chose within the centre. The floor covering was consistent in colour and non slip.

The inspector noted good signage and sign posting throughout the centre. Appropriate signage was provided on doors, there was a sign with a word and a picture for bathrooms and other rooms residents would use. However, the inspector noted that bedroom doors were not provided with visual cues to assist residents recognise their own bedroom.
There was a range of equipment in the centre to aid mobility. Overhead ceiling hoists were provided in all bedrooms. Hoists and other equipment seen in the centre were in working order, and records showed they had been regularly serviced. Staff records showed that staff had completed manual handling training in relation to the equipment available in the centre.

**Judgment:**
Non Compliant - Moderate

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**Outcome 13: Complaints procedures**

The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

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

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

**Findings:**
The management team had a positive attitude to receiving complaints and considered them a means of learning and improving the service. Relatives spoken with told the inspector that they could raise concerns or issues with the nursing management and felt they would be listened to and issues raised would be addressed.

The complaints policy ‘Your service, Your say’ as well as the local complaints procedure were displayed prominently in the centre. A summary of the complaints procedure was included in the residents guide and statement of purpose.

Complaints were logged on both wards. Nursing management advised that all formal complaints were recorded however, some verbal complaints were not documented. The person in charge advised that some verbal complaints had not been logged due to confidentiality. The person in charge advised that they would consider reviewing how complaints were logged to ensure that all complaints including verbal complaints were logged.

**Judgment:**
Substantially Compliant

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**Outcome 15: Food and Nutrition**

Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.
<table>
<thead>
<tr>
<th>Theme:</th>
<th>Person-centred care and support</th>
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<tbody>
<tr>
<td>Outstanding requirement(s) from previous inspection(s):</td>
<td>The action(s) required from the previous inspection were satisfactorily implemented.</td>
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<tr>
<td>Findings:</td>
<td>There were polices in place for the monitoring and recording of nutritional intake which were reflected in practice. Some of the issues identified at the previous inspection had been addressed. Improvements were still required with regard to ensuring choice of modified meals. The inspector was 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). Files reviewed by the inspector confirmed this to be the case. Nutrition and hydration care plans in place were found to be person centered and comprehensive. Nutritional supplements were administered as prescribed. Staff were aware of residents who required specialised diets or modified diets and were knowledgeable regarding the recommendations of the dietician and SALT. Meals were prepared and cooked in the local Kerry General Hospital. Following the last inspection menus had been reviewed in consultation with the dietician to ensure that food was nutritious, varied and choice was provided for all residents. There was now a three rolling menu in place. The daily and weekly menus were displayed. Residents spoken with told that the inspector that the food was usually very nice. The inspector noted that residents were now offered a choice of drinks at mealtimes and gravy and sauces were offered separately. Additional choices were now provided for the evening meal. Some residents required special diets or modified consistency diets however, these residents still did not have the same choices as residents with regular diets. Staff told the inspector that the hospital catering department were unable to provide a choice of modified meal options but that an alternate option was now provided by a frozen food company. Catering staff confirmed that residents who required texture A modified diets were still not offered choice at mealtimes. Catering staff also advised that it was difficult to facilitate residents who had specific requests for a particular food in that it had to be ordered from the hospital catering department and may take up to two days to be delivered. Some relatives spoken with said that they were unsatisfied with the modified meals provided, stating that they were often unappetising in appearance, lacked colour and offered little variety. Catering staff and the person in charge told the inspector that the current catering arrangements were unsatisfactory and under review. The person in charge outlined how she had consulted with the local environmental health department in relation to upgrading the existing kitchen to facilitate the provision of full on site catering.</td>
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Meals were provided to residents in two dining rooms located in each ward area. The dining rooms were bright, comfortable and furnished in a homely manner. The table settings were attractive. Staff were observed to engage positively with residents during meal times, offering choice and appropriate encouragement while other staff sat with residents who required assistance with their meal. The inspector noted that nine residents used each dining room at lunch time while four residents used each dining room at the evening mealtime.

**Judgment:**
Non Compliant - Moderate

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**Outcome 16: Residents' Rights, Dignity and Consultation**

Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

**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 inspector noted that staff were sensitive to residents’ rights for privacy and dignity, however some practices did not enhance or promote person-centred care nor did they promote the privacy and dignity of the residents. The physical environment still posed significant challenges when delivering personal care and attending to residents’ end of life care needs. Other improvements were still required to ensuring that all residents had choice at meal times and were provided with adequate personal storage space. Further improvements were required to providing meaningful and purposeful activities for residents, improved access to information, television, newspapers and the internet.

Staff were observed to treat residents in a dignified manner. The inspector observed that residents were always referred to by their first name and politely asked if they needed anything. The inspector noted that staff tried to promote the privacy and dignity of residents. Bedroom and bathroom doors were closed, screening curtains were in place in shared bedrooms when personal care was being delivered. Staff were observed to knock and wait before entering bedrooms. Many residents spoken with praised the staff stating that they were kind, caring and treated them with respect.

Residents’ religious rights were facilitated. Mass was celebrated monthly in the centre. Eucharistic ministers visited monthly and offered Holy Communion to residents. The
activities coordinator facilitated the saying of the rosary with some residents. Arrangements were in place for residents of different religious beliefs. A prayer room was provided for residents of varying beliefs. Residents were facilitated to vote and residents had been facilitated to vote in-house during past elections.

There was an open visiting policy in place. Residents could meet with family and friends in private if they wished. The inspector observed many visitors coming and going throughout the inspection. Tea and coffee making facilities were available to visitors if they wished.

Residents had access to the centre's cordless phones and some residents had their own mobile handset device. Staff were aware of the different communication needs of residents and care plans set out the ways in which those who had a communication impairment required intervention.

The inspector noted that improvements were required to ensuring that residents had access to information. Televisions were provided in the communal areas and in bedrooms. Some residents in the four bedded rooms complained that it was difficult to view the televisions because of their placement. The weekly regional newspapers were provided, however, daily newspapers were not. One resident had access to the internet however, access to the internet was generally not available to residents.

Storage space for personal possessions continued to pose to a challenge in shared bedrooms due to the small size of individual wardrobes. This impacted on residents choice and dignity. The person in charge advised that additional storage facilities had been provided to some bedrooms and that additional storage space for shared bedrooms was being considered. This is discussed further and under Outcome 17: Residents clothing, and personal property and possessions.

Residents were accommodated in 19 single, two twin and five four-bedded rooms. Nursing staff told the inspector that residents in shared bedrooms were offered a single bedroom in order to provide end of life care in a respectful, dignified and calm environment. However, as there was no dedicated single room for end of life care, residents who occupied single bedrooms would have to vacate their bedrooms to facilitate this practice. This had the potential to impact negatively on the privacy and dignity of residents who occupied single bedrooms.

A recreation and social interaction assessment had been completed for each resident and the person in charge advised that life story books were in the process of being compiled. There was a rehabilitation assistant employed 5 days a week who coordinated activities in the centre. She worked under the auspices of Kerry General Hospital Occupational Therapy department.

The daily and weekly activity schedule was displayed. She carried out both group and individual activities with residents. Most group activities took place in the activities room located centrally between the two wards. On day one of the inspection, the inspector observed a group of approximately 8-10 residents enjoying a light exercise session. Other activities that took place included Sonas (therapeutic programme specifically for people with Alzheimer's disease), the rosary, social chats and sensory time.
However, the inspector noted that further improvements were required to ensure that a choice of meaningful, appropriate recreational and stimulating activities were provided to meet all residents individual needs and preferences. There were no activities scheduled at the weekends or evenings. The activities room was small and could only accommodate approximately 8-10 residents. The inspector noted that on both days of inspection, activities were available to a limited number of residents. There were no activities taking place in the communal day rooms in both wards. Residents and relatives spoken with told the inspector that activities did not take place in these rooms. The inspector observed that both day rooms were occupied by few residents and then only for short periods of the day. Many residents were seen to spend long periods of the day sitting in their bedrooms. Many staff spoken with told the inspector that due to the current high dependency of many residents and resultant workload, they were unable to spent social time with residents.

The impact of residents spending long periods of time in their bedroom accommodation meant that residents had limited opportunities to meet, interact and engage with one another on a social basis. The inspector noted that at 16.30 hours, 23 residents were in bed and a further eight residents sat beside their beds having their evening meal. Four residents were having their evening meals in each of the two dining rooms. Following the evening meals there were no residents in either day rooms. Reduced staffing levels in the evening were also seen to contribute to the number of residents going back to bed in the late afternoon prior to a number of staff going on their break or finishing duty at 17.00 hours. Some relatives spoken with confirmed that residents were assisted to bed early in the evening and it was their opinion that this was to facilitate staff going off duty. Some staff spoken with told the inspector that because of the reduced staffing levels in the evening time that residents who were not assisted to bed before the night staff came on duty would have to wait until after 22.00 hours to be assisted to bed. The inspector felt this did not offer a real choice of bedtimes to residents. These practices did not enhance or promote person-centred care nor did they promote the privacy and dignity of the residents.

Judgment:
Non Compliant - Major

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

Theme:
Person-centred care and support

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

Findings:
Storage space for personal possessions continued to pose to a challenge in shared
bedrooms due to the small size of individual wardrobes. Some residents had personal possessions stored in bags which were stored on the floor or on top of wardrobes. Residents spoken with stated that wardrobe space was small and they were limited in the amount and variety of clothing they could retain. This impacted on residents choice and dignity.

**Judgment:**
Non Compliant - Moderate

<table>
<thead>
<tr>
<th><strong>Outcome 18: Suitable Staffing</strong></th>
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<tbody>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>

**Theme:**
Workforce

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

**Findings:**
The inspector had concerns that there were inadequate staff on duty taking into account the dependency and individual needs of residents. The inspector spoke with residents, relatives and staff and also reviewed residents dependency levels, staffing rosters, the layout of the centre, complaint logs in regard to staffing levels.

At the time of inspection there were 41 residents living in the centre. Twenty one residents had been assessed as maximum dependency, eight as high, nine as medium and three as low dependency. There were many residents with complex care needs, some presenting with responsive behaviours and some who required three staff to assist with aspects of their care needs. The centre was single storey building however, the two wards were located at opposite ends and had separate staff rosters. The Loher ward had 21 beds and the Denish ward had 22 beds.

There were normally two nurses and three care assistants on duty on each ward in the morning time and afternoon, two nurses and one care assistant on duty on each ward in the evening time and one nurse and one care assistant on duty on each ward at night time. An additional carer was provided on a one to one basis for one resident from 17.00 to 23.00 hours daily. The person in charge and clinical nurse manager 2 were normally on duty during the day time Monday to Friday. The staffing complement included a rehabilitation assistant for activities, catering and housekeeping staff.

Nursing staff told the inspector that the nurse on night duty was involved in attending handover, checking of MDA medicines and administering medications until
approximately 22.00 hours. At this time, there was only one care assistant on duty in
each ward so staff were not available to assist residents who may wish to go to bed
until after 22.00. As a result, the inspector was concerned that some residents may not
be afforded choice around going to bed times.

Some relatives spoken with told inspectors that they were not satisfied with staffing
levels, commenting that staff were wonderful but always busy, relatives commented that
there were no meaningful activities taking place in the communal day areas and very
little stimulation for many residents during the day and evening times. One relative had
complained that a resident had been left in bed on a number of occasions due to
staffing shortages and had been advised by staff that it was safer to leave the resident
in bed as they would be of risk of falling and injuring themselves.

Many staff spoken with told the inspector that due to the current high dependency of
many residents and resultant workload, they were unable to spent social time with
residents. Some staff commented that they were worried about the staffing levels.

There was a varied programme of training for staff. Staff spoken with and records
reviewed indicated that staff had completed mandatory training in areas such as
safeguarding and prevention of abuse, manual handling and fire safety.

The staff also had access to a range of education, including training in specific dementia
care training courses, nursing documentation and care planning, person centred care
education, hand hygiene. There was a training plan in place for 2018 which included
basic life support, cardiac pulmonary resuscitation, vena puncture and cannulation, male
catherisation, complaints management, medicines management, safety representative
and further dementia training courses.

There were robust recruitment procedures in place. Staff files reviewed were found to
contain all the required documentation as required by the Regulations including Garda
vetting. The person in charge confirmed that Garda Síochána vetting was in place for all
staff. Nursing registration numbers were available for all staff nurses. Details of
induction and orientation received, training certificates and appraisals were noted on
staff files.

There were no volunteers attending the centre and the person in charge confirmed that
Garda Síochána vetting was in place for all persons who provided services to residents
on a regular basis including the chiropodist and hair dresser.

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
Provider’s response to inspection report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Tralee Community Nursing Unit</th>
</tr>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000566</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>15/01/2018</td>
</tr>
<tr>
<td>Date of response:</td>
<td>15/03/2018</td>
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</tbody>
</table>

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: Statement of Purpose

Theme:
Governance, Leadership and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The statement of purpose required updating to include the Health Service Executive as the registered provider.

1. Action Required:
Under Regulation 03(1) you are required to: Prepare a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Welfare of

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Residents in Designated Centres for Older People) Regulations 2013.

Please state the actions you have taken or are planning to take:
• The Statement of Purpose will be amended to state the Health Service Executive is the Registered Provider.

Proposed Timescale: 06/02/2018

Outcome 07: Safeguarding and Safety

Theme:
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
While improvements were noted to the records maintained to indicate the rationale for administration of PRN prescribed psychotropic medicines, there were still some inconsistencies in the recording of this information. Some nursing staff spoken with were not aware of the protocols as outlined in the medication management policy.

2. 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:
• Nurses have been informed of their responsibility to read and sign the declaration of understanding – Medication Management Policy, 2018 and also to read and sign the declaration of understanding specific policies interlinked to the Medication management Policy, 2018 such as Psychotropic Drugs Policy.
• A notice has been placed on each Unit stating what the related policies are and nurses have been asked to read and sign this notice.
• Nurses have been asked to complete the Medication management e-learning programme – and submit a certificate to the A/DON Office which will be retained in their personnel file.
• Resident specific caseload presentation for all staff – The CNM2 / A/DON to review and present specific residents requiring PRN use of psychotropic medication; the triggers; actions carried out; the outcome and recording of same. To identify any trends and ensure that all staff contribute to the residents experience and learn from episodes.

Proposed Timescale: 06/04/2018

Outcome 08: 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:
Fire drills were not carried out at regular intervals to ensure that staff were knowledgeable, competent and aware of the procedures to be followed in the event of fire.

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

Please state the actions you have taken or are planning to take:
- The A/DON has scheduled Fire Drills (Evacuation procedures) at regular intervals; February, April, June, September, October and November 2018. All staff will attend Fire Drill Training every 6 months (minimum) – completed February 2018.
- A record of attendance will be kept in the Training File – February 2018 and after each training session thereafter.
- All staff will attend Fire Safety Training – Annually and a record of this will be maintained in the Training File. Completed 12th February 2018.
- The CNM2 / A/DON will hold spot checks / drills on the ward Bi-monthly, involving staff and residents. The details of these spot checks will be recorded in the Training File. Commenced March 2018.
- An updated Training Database will be put in place to incorporate all of the above named Fire Training Sessions and record attendance of each individual member of staff.
- All Fire Safety Records will be stored in the DONs Office; associated documents (Certificates of Compliance) will be stored in their designated place and a copy of same will be stored in the Fire Safety File located in the DON Office. Action completed 12th February 2018.

Proposed Timescale: 12/02/2018

Outcome 09: Medication Management

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Prescribed medicines were administered from a general stock of medicines which were not labelled per resident. This posed an increased risk of medication error during the medicines administration round and posed difficulties with regard to accountability as there was no comprehensive and accurate medicines stock list.

4. 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:
• Medication Stock List will be placed in a Folder on each Unit – 22nd March 2018
• A laminated list will be placed on the inside of each stock cupboard – 22nd March 2018
• A Procurement Support Request to outsource Pharmacy Services has been submitted – January 2018.
• Resident specific (named) medications will be supplied as per individual prescription – As part of the above action.
• Pharmacist review of medication charts, audit, information resource and training support – as part of above action.
• Purpose built - Medication Trolleys (2 for each Unit) have been sourced to meet the required specification; for named resident medication management administration.
• Medication Trolley’s estimated delivery time is an estimated 6 weeks.
• Designated medication store room will be set up and operational.

Proposed Timescale: 30/06/2018

Outcome 12: 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:
The multi occupancy rooms presented challenges to the provision of adequate space, privacy and dignity for each resident. The physical environment posed challenges when delivering personal care; attending to residents’ care needs, infection control and communicating in privacy. Residents had limited space for the storage of personal belongings.

5. 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:
• The multi- occupancy rooms measure at 40m2 which allows 10m2 per resident. This exceeds the required 7.4m2.
• New purpose built wardrobes will be ordered by (22nd March 2018) to replace the existing wardrobes the specification of the new wardrobes is: 800 (W) x 565 (D) x 172 (H); to incorporate hanging space and shelving.
• A number of infection prevention and control audits have been scheduled to commence on the 26th March 2018. The Audits scheduled include Hand Hygiene, Glucometer, Sharps and the environment.
• The Infection Control Nurse Specialist will provide audit feedback and results; outcomes and an action plan in conjunction with Infection Prevention and Control Training for staff.
• The A/DON / CNM2 will continue to monitor the environment for cleanliness and hygiene feedback will be given to domestic staff on the day and to Unit staff at the end of handover.
• Screens are in place and used during personal care to ensure privacy and dignity is maintained; the double doors are closed when delivering personal care.
• Residents will be encouraged and facilitated to utilise other private areas of the Unit
• Consideration will be given to each resident to ensure communication in privacy. Staff will be asked to monitor and record any issues or concerns raised by each resident / relative in relation to same.

Proposed Timescale: 30/03/2018

Outcome 13: Complaints procedures

Theme:
Person-centred care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Verbal complaints were not always documented.

6. 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:
• All staff will be asked to read the Complaints Policy ‘Your Service Your Say, 2018 and sign the declaration of understanding.
• The A/DON will ensure that all staff are aware that all verbal complaints are recorded in the complaints log.
• On occasions when residents, relatives or visitors request that their complaint is ‘anonymous’ or ‘confidential’ the A/DON will record private and confidential in the complaints log. This request will continue to be upheld and a note will be made in the resident’s confidential file which can only be accessed by management.
• The A/DON will continue to ensure that anonymous or confidential complaints are monitored and managed in the same way as all other complaints.
• The A/DON will always revert with the complainant to ensure the complaint is resolved to their satisfaction.
• The complaint will continue to be recorded and reported to the senior management team and incorporated into monthly, quarterly and end of year statistics in line with HSE Policy.

Proposed Timescale: 26/01/2018

Outcome 15: Food and Nutrition
Theme:
Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some residents required special diets or modified consistency diets however, these residents still did not have the same choices as residents with regular diets. Staff told the inspector that the hospital catering department were unable to provide a choice of modified meal options but that an alternate option was now provided by a frozen food company. Catering staff confirmed that residents who required texture A modified diets were still not offered choice at mealtimes. Catering staff also advised that it was difficult to facilitate residents who had a specific request for a particular food in that it had to be ordered from the hospital catering department and may take up to two days to be delivered. Some relatives spoken with said that they were unsatisfied with the modified meals provided, stating that they were often unappetising in appearance, lacked colour and offered little variety.

7. Action Required:
Under Regulation 18(1)(b) you are required to: Offer choice to each resident at mealtimes.

Please state the actions you have taken or are planning to take:
• A Plan is in place to utilise the onsite main Kitchen to prepare, cook and serve fresh main meals (dinner) to residents. This will ensure that meals onsite are prepared to each resident’s individual requirements; modified consistency and choice for all residents is paramount to relocating the service.
• The Catering Manager from Killarney Community Hospital has visited and made recommendations in December 2017.
• The Environmental Health Officer inspected the main kitchen for approval and recommendations in January 2018.
• A proposal was submitted to procurement for outstanding equipment.
• A review of the systems of work and work practices was undertaken and a business case was submitted in February 2018 to request additional, suitably qualified staff.
• UHK was contacted and informed that residents requiring a modified consistency texture A diet must be given a choice at mealtimes.
• A food processor has been purchased for staff to modify the consistency of meals (as per resident choice) to a Texture A modified consistency standard once training has been provided.
• Staff will be given training on the consistency of Texture A modified consistency standard by the Dietician (April 2018).

Proposed Timescale: 30/06/2018

Outcome 16: 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:
There were no activities scheduled at the weekends or evenings. The activities room was small and could only accommodate approximately 8-10 residents. The inspector noted that on both days of inspection, activities were available to a limited number of residents. There were no activities taking place in the communal day rooms in either ward. The inspector observed that both day rooms were occupied by few residents and then only for short periods of the day. Many residents were seen to spend long periods of the day sitting in their bedrooms. Many staff spoken with told the inspector that due to the current high dependency of many residents and resultant workload, they were unable to spent social time with residents.

8. 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:
• Nurse Management & Team Members have set up a Cultural Transformation group with the support of the assigned Projects Officer (commenced March 14th)
• The Cultural Transformation group is comprised of Nurse management and nominees from both units, who are meeting weekly and will continue to meet for 12 weeks (minimum); supported by the assigned Projects Officer.
• This group have committed to drive an action learning initiative based on the framework and methodology of the ‘Developing a Culture of Person Centredness Programme within the HSE.’: Where the team within Tralee CNU will coordinate development activities arising from the programme work and work-observations of this local group, which will look at their own individual values, the values of their unit, Ways of Working, the use of Person Centred language, team building and developing a culture of Person centredness.
• The Projects officer in collaboration with the ADON & CNM2 is holding an ‘Enabling Workshop’ with all team members: Where affirmation of Roles and Responsibilities are highlighted, Team Building Exercises undertaken, Best Practice Scenario’s discussed and a Culture of Person Centredness is endorsed.
• The Projects officer in collaboration with the ADON & CNM2 is endorsing the ‘What Matters to You’ programme with all team members.
• The A/DON has devised a roster with team members to engage in a choice of activities with resident’s and their families in various areas of the unit, the day rooms, The Rose Café and our beautiful outside spaces at various intervals of the day. (Morning, Afternoon & Evening)
• The A/DON is devising a template for staff to provide Activities feedback (evenings and Weekends) to Management.
• The Activities Therapist is providing assistance and support in establishing an evening and weekend activities programme.

• The Activities Rehabilitation Therapist has adapted her schedule, to work evenings 2 days per week, this is to further embrace and facilitate the change culture to assist, advise and guide staff through the transition.

• As part of this programme staff are devising a resident’s activities schedule in
conjunction with the resident’s wishes and the wishes of their families.

• The A/DON will discuss and give guidance and support and feedback progress on all of the above with team members at a general staff meeting (27th March 2018)

Proposed Timescale: in progress 4th June, 2018 (initial 12 weeks & ongoing)

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Proposed Timescale: 04/06/2018

Theme: Person-centred care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Some residents were limited in their choice of TV programme as TVs were difficult to view due to their placement.
Some residents did not have a choice of bedtimes due to the fact that staffing was reduced during the evening time.
Some residents were limited in their choice of appropriate and meaningful activities.

9. Action Required:
Under Regulation 09(3)(a) you are required to: Ensure that each resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.

Please state the actions you have taken or are planning to take:
• The televisions will be removed from above the door and placed on a portable stand for use at the resident’s request.
• Access to a television will also continue to be provided via the Dayroom and a television will be placed in the Rose Cafe, March 2018.
• A comprehensive activities programme is in place however a review of each resident’s choice will be undertaken to establish if they are satisfied with their participation in activities and to ensure activities are undertaken in an appropriate area of the Unit (not interfering with other residents).
• The Cultural Transformation Programme along with The Enabling Workshops and the engagement of the ‘What Matters to you’ guidelines will implement and enable team members (as stated in Outcome 16, Action 10) to facilitate resident’s choice in respect of their bedtime and enhancing meaningful activities as a role for all team members.
• The staffing levels in the evening will increase to meet the healthcare needs of residents.

Proposed Timescale: 30/03/2018

Theme: Person-centred care and support
The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
There was no dedicated single room for end of life care, residents who occupied single bedrooms would have to vacate their bedrooms to facilitate this practice. This had the potential to impact negatively on the privacy and dignity of residents who occupied single bedrooms.

10. **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:**
- Residents will not be asked to vacate their bedroom for the purpose of providing end of life care to another resident.

**Proposed Timescale:** 31/01/2018

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

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Some residents in the four bedded rooms complained that they were unable to view the televisions because of their positioning. The weekly regional newspapers were provided, however, daily newspapers were not. One resident had obtained his own internet access however, access to the internet was generally not available to residents.

11. **Action Required:**
Under Regulation 09(3)(c)(ii) you are required to: Ensure that each resident has access to radio, television, newspapers and other media.

**Please state the actions you have taken or are planning to take:**
- A review of the location of the television was undertaken in February 2018; the Electrician was asked for a suitable alternative place to put the television.
- The television will be removed from above the door and placed on a portable stand for use at each resident’s request.
- Access to a television will also continue to be provided via the Dayroom and a television will be placed in the Rose Cafe, March 2018.
- The Newsletter will continue to be published monthly
- The A/DON will purchase and supply laptops / tablets and IPOD’s for each Unit to facilitate access to the internet, April 2018.
- A survey of resident’s wishes, preferences and choice will be conducted to ascertain each resident’s specific needs and requirements in regard of access to newspapers, radio, television and access to media.
- Daily Newspapers will be delivered to the Unit for residents (March 2018), in the interim period they will be collected by a member of staff (February 2018) for residents.
- Residents have been provided with access to radio. The A/DON / CNM2 will continue to ensure adequate numbers of radios are provided and purchase same as required.
• A compilation of daily Sitcoms; Programmes and Movies will be in place in each dayroom.
• A Journal / Reading Club is being compiled to initially include Old Almac Magazine; The Farmer’s Journal, National Geographic; Woman’s Own; Ireland’s Own – relatives and staff to be included in supply of journals and books. This is not an exhaustive list.
• A Weekly Programme / Schedule will be displayed for residents in each Unit.
• An Active Retirement Group visited TCNU on 5th March 2018 and are encouraged by team members & resident’s to visit regularly and a designated area will be provided to facilitate the storage of Traditional and Cultural Ireland Books and Reading Groups.

Proposed Timescale: 30/04/2018

Outcome 17: Residents' clothing and personal property and possessions

Theme:
Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Storage space for personal possessions continued to pose a challenge in shared bedrooms due to the small size of individual wardrobes. Some residents had personal possessions stored in bags which were stored on the floor or on top of wardrobes. Residents spoken with stated that wardrobe space was small and they were limited in the amount and variety of clothing they could retain. This impacted on residents choice and dignity.

12. Action Required:
Under Regulation 12(c) you are required to: Provide adequate space for each resident to store and maintain his or her clothes and other personal possessions.

Please state the actions you have taken or are planning to take:
• In addition to the Wardrobes a designated storage room will be provided with hanging space for overcoats; footwear etc and seasonal change.

Proposed Timescale: 30/04/2018

Outcome 18: Suitable Staffing

Theme:
Workforce

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The inspector had concerns that there were inadequate staff on duty taking into account the dependency and individual needs of residents.

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 review of evening staffing levels, complement of staff and skill mix was undertaken in February, 2018 taking into consideration dependency of residents.
- A business case was submitted to the Residential Service Manager to increase staff.
- The A/DON will facilitate the change of Wards to be named as Units.
- The overall structures in place will be changed to unify staff and dissolve segregation. The Nurses and Healthcare Assistants will have one duty roster
- The segregation of staff will be eliminated to put in place a system whereby staff rotate between Units.
- The evening staffing levels will increase to ensure that staffing is adequate in the evening to provide choice at bedtime – this will be completed as part of outcome 18 action plan.
- There will be (daily) regular and ongoing communication with staff in respect of this action plan.

Proposed Timescale: 30/04/2018