<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Maynooth Lodge Nursing Home</th>
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<tbody>
<tr>
<td>Centre I D:</td>
<td>OSV-0004593</td>
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<tr>
<td>Centre address:</td>
<td>Rathcoffey Road, Crinstown, Maynooth, Kildare.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>01 629 2433</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:info@maynoothlodge.ie">info@maynoothlodge.ie</a></td>
</tr>
<tr>
<td>Type of centre:</td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
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<tr>
<td>Registered provider:</td>
<td>Maynooth Lodge Nursing Home Partnership</td>
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<tr>
<td>Lead inspector:</td>
<td>Sonia McCague</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td></td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Announced</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>37</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>42</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).
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: 09 November 2017 10:10
To: 09 November 2017 17:30
10 November 2017 07:20 10 November 2017 14:45

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 02: Governance and Management</td>
<td>Non Compliant - Major</td>
</tr>
<tr>
<td>Outcome 07: Safeguarding and Safety</td>
<td>Non Compliant - Major</td>
</tr>
<tr>
<td>Outcome 08: Health and Safety and Risk</td>
<td>Non Compliant - Major</td>
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<tr>
<td>Management</td>
<td></td>
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<tr>
<td>Outcome 09: Medication Management</td>
<td>Non Compliant - Moderate</td>
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<tr>
<td>Outcome 11: Health and Social Care Needs</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 12: Safe and Suitable Premises</td>
<td>Non Compliant - Moderate</td>
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<tr>
<td>Outcome 13: Complaints procedures</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 18: Suitable Staffing</td>
<td>Non Compliant - Moderate</td>
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Summary of findings from this inspection

This report sets out the findings of an announced inspection carried out over two days. The purpose of which was to inform a decision of the renewal of the centre's registration following an application by the provider to accommodate up to 79 residents.

There were 37 residents admitted and 34 being accommodated on the days of inspection. Two residents were in hospital and one was on leave with family.

The centre is registered for a maximum of 79 residents. During the course of the inspection, the inspectors met with residents, relatives and staff, the person in charge and the provider representative. Changes had occurred to the entire management structure since the previous inspection in March 2017. However, the registered provider (entity) remained the same. The provider representative was a group manager who had responsibilities for two other centres.

Solicited and unsolicited information received by the Health Information and Quality Authority (HIQA) since the previous inspection was followed up. The views of residents, relatives and staff were listened to, practices were observed and documentation was reviewed.
The intention was to assess 10 outcomes; however the inspection was focused on eight due to the level of non-compliance found. There were three major non-compliances identified in governance and management, safeguarding and risk management, and four moderate non-compliances in medicine management, health and social care, premises and staffing. One of the eight outcomes inspected was substantially compliant. Actions required from the previous inspection had not been fully addressed in accordance with the action plan response.

The cumulative findings across all outcomes resulted in an immediate action plan requirement being issued to the group manager (provider representative) and person in charge to address the lack of resources and deficiencies within the governance and management arrangements found. The group manager and person in charge agreed to cease resident admissions until the centre’s compliance level had improved and were to provide an update on immediate actions taken by 15 November 2017. The provision of consistent care by a skilled team who were resourced and effectively monitored was a main failing within outcomes inspected.

The application submitted October 2017 to renew the registration of the centre, which expires March 2018, was dated July 2017 and was incomplete and did not reflect the current management arrangements in place or found.

The inspection findings are discussed within the body of the report, and the areas for improvement are outlined in the Action Plan at the end of the report for response. The registered provider has 19 actions to address and the person in charge has seven.
Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

Outcome 02: Governance and Management
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.

Theme:
Governance, Leadership and Management

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

Findings:
There was evidence that the provider, person in charge and persons participating in the management of the centre were not fully engaged in the governance, operational management and administration of the centre to ensure effective management systems and sufficient resources were in place to ensure the delivery of safe quality care services and practices.

A lack of oversight, controls and directives, risk management and strategic vision was found. Reporting structures, communication and accountability arrangements within the organisational structure required improvement. Poor governance and management of the centre had led to poor standards of care and practice, and had resulted in a number of major failings and non-compliances.

As a result, an immediate action plan requirement was issued to the group manager (provider representative) and person in charge to address the lack of resources and deficiencies within the governance and management arrangements found. The group manager and person in charge agreed to cease resident admissions until the centre’s compliance level had improved and provide an update on actions taken by 15 November 2017.

Changes had occurred to the organisational and management structure during 2017. However, the registered provider (entity) remained the same. A new person in charge (April 2017), clinical nurse manager (CNM) and a group manager (September 2017) were in post since the previous inspection in March 2017. The group manager also had responsibilities for two other centres.

The management structure was defined within the statement of purpose and both the person in charge and group manager were onsite during this announced inspection. The
CNM and administrator were on leave. While there was a clearly defined management structure in place that identified the lines of authority and accountability, the oversight and supervision arrangements were not sufficiently robust to ensure effective and efficient services or to monitor staff performance in their roles and responsibilities.

Based on the cumulative finding on this inspection inspectors were not assured that the registered provider had ensured that the designated centre had sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose. Insufficient recruitment and appraisal procedures were found that compromised residents’ safety and their quality of life. For example staff had worked in the delivery of direct care to residents prior to the completion of Garda vetting and without formal induction and appraisal. The admission of residents continued during periods of high staff absenteeism and staff turnover. Deficiencies were found in relation to staffing levels, skill mix, recruitment procedures, and the assessment of staff competency for delegated responsibilities. Some staff worked full-time on night duty without oversight or supervision. The turnover of staff was high and the current whole time staff numbers rostered did not facilitate reasonable staff ratios to existing resident dependency or allow for planned or unplanned leave. Contingency measures were not in place to support staff when activity levels increased to ensure suitable and sufficient health and social care services was consistently provided. Staffing levels and skill mix were depleted at weekends and minimum staff levels at night included three staff (one nurse and two care attendants and two of the three were often male staff). One nurse was on duty 66% of the time Monday to Friday and 100% at weekends.

Care provision lacked strategic vision and probability assessment. From a review of notifications and roster records, inspectors found that the death of two residents had occurred on the same night and was managed by the three rostered staff. On enquiry, inspectors were informed that staff did the best they could and were not aware of a contingency plan or measures to be taken for periods of heightened activities, or when medical and family engagement was necessary. This demonstrated insufficient consideration, arrangements and responses to likely operational matters.

Relatives, residents and staff informed inspectors they had to prompt professional staff to take action or make decisions at times and following incidents. Records reviewed and observations made by inspectors reflected this. The lack of adequate and appropriate professional responses and clinical judgements required by responsible staff required improvement. Examples of this were reported to the person in charge and group manager who acknowledged same. Management told inspectors that they were in the process of recruiting staff. However, they had not ceased the admission of residents in times of staffing difficulties and high turnover of both staff and residents. From discussions with staff and a review of the previous rosters and resident admissions dates, inspectors found that the with the exception of one nurse, all other nursing staff had completely changed July 2017.

Resident admission activity had continued through staff turnover, absenteeism and recruitment periods. Records reviewed showed 37 resident admissions from May to October 2017, four admissions in May, six in June, two in July, nine in August, seven in September and nine in October 2017. Twenty discharges were also processed within this timeframe. Inspectors were also told by staff, residents and relatives that management’s
response to concerns raised by them in relation to inadequate staffing and supervision was that they were recruiting more staff. The rosters reviewed showed that the whole time equivalent staff available was still not sufficient to meet existing residents numbers and needs in a safe and appropriate manner or to maintain this large building layout that included 79 en-suite bedrooms (42 vacant). Two new admissions were planned next week.

The use of resources was not sufficiently planned and managed to provide person-centred, effective and safe services and supports to residents. Staff were well intended but not sufficiently informed, supported or appraised, based on the collective findings in the outcomes that follow. Communication arrangements were inadequate. The handover arrangements between staff and communication during and between shifts were insufficient and unsafe. Staff working on the same shift did not know the whereabouts of other staff on duty to support them and all staff did not get a verbal or detailed handover of residents between shifts or prior to their interaction with residents. The provision of three staff to dependent residents accommodated within this large building operating with three separate wings was inadequate, not sufficiently risk assessed and was unsafe.

Due to the limited availability of staffing levels and skill mix, care provided was task orientated and not person centred, and the resources (staff numbers, skill mix and training) were insufficient to meets all residents needs in a safe and suitable manner. Three wings were occupied by residents with a range of varying conditions, dependency levels, activity levels, abilities and needs. Twenty two (65%) of the 34 residents were assessed as being maximum or high dependency. Many residents required the assistance of two staff for repositioning, mobility and continence management. One nurse was responsible for medicine administration, clinical observations, monitoring and recording across all wings and many of the residents were on hourly or frequent checks. The inspectors were informed that three residents had pressure ulcers and seven had wounds, 19 residents had dementia, four had responsive behaviours, and eleven residents were bedbound, immobile or wheelchair dependent. Staff told inspectors that six residents were diagnosed diabetics, two had percutaneous endoscopic gastrostomy (PEG) feeding regimes and at least eight had modified diet requirements, seven had indwelling catheters and one had a colostomy, and nine residents had restraint measures. During the inspection inspectors observed two residents smoking in a designated smoke room within the centre without supervision.

The quality of care and experience of residents was not sufficiently monitored, reviewed and improved on an ongoing and consistent basis. The allocation of staff for the areas of care provision within each of the three wings was inadequate to ensure effective leadership, governance and management arrangements in place with clear lines of accountability. Care was being delivered and recorded without adequate professional oversight or supervision. This arrangement compromised residents' well-being. Inspectors found that the training matrix maintained did not match the training attendance records. Staff had signed for completing medicine checks when not on duty and had signed repositioning records in advance of the act. Staff contracted to work as a care attendant was rostered along with nurses. All staff rostered were not included in the training record matrix. Records were unreliable, incomplete in parts, and not completed in accordance with professional standards and guidance documents.
Operational policies were under review, and some were incomplete or not implemented in practice to ensure the health and safety of residents, evaluate practice and to identify and manage risks appropriately.

A range of audits and registers were completed and valuable information was gathered. However, information gathered was not used to plan and deliver person-centred, safe and effective residential services and supports. The learning outcomes and measures put in place following incidents and findings as a result of audits were unclear. From a review of incident and accident records it was noted that 60% of falls occurred at night and many incidents were un-witnessed. There was a lack of action found to mitigate identified risks and the rate of falls was very high in recent months with 53 reported falls within a three month period for fewer than 35 residents. From a review of a sample of residents’ records inspectors found that an incident relating to a physical assault between two residents had not been identified, recorded or reported as an incident to ensure an investigation was carried out to identify the attributes, conditions and consequences for residents or inform learning to bring about improvements.

Unsolicited information received by HIQA and records reviewed by inspectors showed that a resident discharged from the centre three months previous was invoiced for services they did not receive. The person responsible for invoicing and issuing bills was on leave during this inspection so the group manager agreed to follow-up on this matter also. An audit of residents’ accounts and transactions was required.

An annual review of the quality and safety of care delivered to residents in the designated centre for 2016 was completed and submitted to HIQA in May 2017 with 15 quality improvement goals. It included information regarding admissions, discharges, deaths, falls and the results of a resident (14) satisfaction survey at year end (2016). The review stated that a total of 39 falls had occurred within the 12 month period, and a plan to reduce the incidence of falls and identify learning for 2017. However, as indicated above the number of falls has increased dramatically and there was little evidence of learning or appropriate measures being put in place to achieve the goals.

The collective findings support the judgment that the governance and management systems in place did not ensure that the service had sufficient resources or that care provided was safe, appropriate, consistent and effectively monitored. In addition, the application submitted October 2017 to renew the registration of the centre, which expires February 2018, was dated July 2017 and was incomplete and did not reflect the current management arrangements in place.

There was evidence of a lack of leadership and understanding of the regulatory requirements in relation to many aspects of the running of the centre which included risk management, management of the premises, supervision of residents and staff, assessment and care planning, medicine management practices, the implementation of a quality management system and on-going monitoring of the quality and safety of care for residents.

There were three major non-compliances identified and four moderate non-compliances out of eight outcomes inspected. All actions required from the previous inspection had not been fully addressed in accordance with the action plan response.
The current management group acknowledged the deficits and limitations found within the service to date. Management and staff were keen to meet the requirements of the regulations and gave assurances that they would take appropriate action to address the findings conveyed to them throughout the inspection and summarised during the feedback meeting.

**Judgment:**
Non Compliant - Major

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

**Theme:**
Safe care and support

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

**Findings:**
The HSE safeguarding policy was available and adopted to guide staff in relation to the prevention, detection and reporting of abuse or neglect. A policy specific to the centre was to be developed by the current management group. As referenced in Outcome 2, staff had worked in the delivery of direct care to residents prior to the completion of Garda vetting and without formal induction and appraisal. An audit of residents’ accounts and transactions was also required.

Training records identified that staff had participated in training in the protection of residents from abuse and those spoken with were reasonably knowledgeable regarding identifying the signs of abuse and reporting concerns to their line manager.

The ‘challenging behaviours’ policy was described as under review as the protocols and assessment procedures identified within it were not implemented in practice. A draft policy was also on file. Training and knowledge gaps were identified for staff working with residents with responsive behaviours. Inspectors found staff did not have sufficient knowledge and skills, appropriate to their roles, to manage behaviour that is challenging. A lack of a proactive planning and developed strategies for residents with responsive behaviours was evident which negatively impacted on other residents.

One area was identified as a ‘specialised unit for wanderers’ however, it appeared to be an area that contained residents with little meaningful engagement, occupation or activity. The demands and focus on one resident took up most of the staff member’s time and the three other residents had no meaningful stimuli or planned programmes implemented. The lack of suitable staffing and resident supervision and support in the
centre required immediate attention during this inspection. A review of staff response to a resident attempting to exit the 'specialised unit for wanderers' was to be undertaken by management to ensure safeguarding procedures were appropriately implemented to protect residents from harm, abuse or neglect. The management of care for a resident of maximum dependency who was immobile within this secure unit/wing staffed by one care attendant or a social care worker also required immediate review.

An incident where a resident behaved in a manner that was challenging which resulted in a physical assault on another resident had not been documented as an incident for investigation, learning and improvement. It was also unclear if the family or residents’ representatives had been informed of the incident. Residents with responsive behaviour did not have a comprehensive assessment completed to identify antecedents, behaviours and consequences to identify triggers and trends, inform evaluations or provide rationales for PRN (a medicine only taken as the need arises) medicines administered regularly.

A low level of bedrail use was reported. Records of decisions regarding the use of bedrails were available to show the decision was made in consultation with the resident or representative and a staff nurse. From discussions with staff, observations, information from relatives and records reviewed alternative equipment available to some included low low beds, sensory alarms and floor mats. However, these or other alternatives to bedrails and protective measures had not been consistently available to residents and were not detailed as measures considered or available to residents following falls in the incident records reviewed.

Oversight of residents with responsive behaviours was not sufficient.

Care plan reviews had not been undertaken or managed at suitable intervals to ensure appropriate health and social care provision. Boredom and a lack of meaningful activity and availability of skilled staff to support residents with responsive behaviours was a likely trigger for behaviours observed during this inspection. Staff were reactive rather than proactive to residents with responsive behaviours, and it was unclear why all four residents were contained within the secure key coded wing.

**Judgment:**
Non Compliant - Major

<table>
<thead>
<tr>
<th><strong>Outcome 08: Health and Safety and Risk Management</strong></th>
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<tr>
<td><em>The health and safety of residents, visitors and staff is promoted and protected.</em></td>
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</tbody>
</table>

**Theme:**
Safe care and support

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

**Findings:**
The centre had policies and procedures relating to health and safety that included
emergency procedures. However, a health and safety statement was absent from the file provided and the risk management policy did not include some items set out in Regulation 26(1) such as the unexplained absence of any resident, accidental injury to residents, visitors or staff, and aggression and violence.

A risk register was available that include clinical, hospitality and catering risks. The register included residual ratings for the risks identified and assessed, with associated control measures. All clinical risks identified were all shaded red and likelihood/impact rates of 12 were recorded against falls and smoking risks. However, hazard identification and assessment of risks throughout the designated had not been identified for assessment and control to ensure resident, visitor and staff safety. For example, maintenance requirements and operational risks associated with the high staff turnover, gaps in training, numbers and skill mix was not recorded in the risk register.

Training deficits in first aid, cardio pulmonary resuscitation (CPR), manual handling and fire drills were found which may compromise residents’ health and safety. Some manual handling practices by trained staff and arrangements observed were not in accordance with best practice guidance and this was pointed out to the person in charge and group manager at the time. Key staff recorded as having attended fire safety training were vague regarding the appropriate evacuation procedures to be implemented.

As referenced in outcome 2 and 7, incident reporting, management and recording practices required improvement to ensure adequate arrangements were in place for the identification, recording, investigation and learning from serious incidents such as falls, head injuries and peer to peer assaults or adverse events involving residents.

The incidence of 53 falls during a three month period from July to September 2017 was significantly higher than the annual total of 19 for 2016. The frequency and recurrence of falls was higher than national averages. Clinical observations and incident recording deficits found did not demonstrate appropriate clinical supervision, monitoring and referral to ensure timely action was taken. A lack of neurological observations following un-witnessed falls and head injuries was found and further monitoring and observations following an irregular clinical recording (blood pressure) demonstrated a lack of appropriate clinical knowledge by those involved which could compromise residents’ well-being and timely treatment.

Reviews of incidents were not sufficiently detailed to ensure adequate preventative measures were considered, working as required or put in place to mitigate risks. Most learning outcomes following incidents and falls stated ‘needs closer observation’. This statement was vague and immeasurable resulting in repeated falls and recurrent incidents occurring. One resident had a recent choking incident during a recent lunchtime. The resident was responded to by a nurse on duty and had recovered. However, risk associated had not been assessed in relation to the expansive layout of the centre, limited availability of one nurse between 4pm and 8am daily, and dining taking place in more than one area. The risk to residents assessed as requiring assistance and modified diets and fluids following this incident should similar one occur at a weekend, tea or night time when one nurse was available for the entire centre had not been assessed.
The registered provider had not ensured that procedures, consistent with the standards for the prevention and control of healthcare-associated infections published by the Authority are available and implemented by staff. While the centre was clean in the majority of areas inspected, cleaning arrangements, staffing and operational protocols to prevent infections required improvement. One cleaner responsible for the entire centre that includes 79 en-suite bedrooms and auxiliary rooms was not enough. On inspection of a sample of unoccupied rooms, inspectors noted a malodour of stagnant water. It was subsequently confirmed with staff that an audit, check, and run of water in the wash hand basins and showers and flush of toilets had not been maintained as previously set up due to a lack of staff available. Records seen in the cleaning room showed that this protocol has ceased from July 2017. This risk was not identified or recorded for assessment with appropriate controls measures identified. The cleaner’s room did not have a wash hand basin or sluice sink for mops. This was previously reported and had not been addressed. The ventilation in a cleaners store room required review as a strong chemical smell was detected on opening the door. Cigarette smoke migrated from the smoking room onto corridors when the door was opened and the unsupervised arrangements found posed a risk to all.

A maintenance schedule of works on an on-going basis to monitor outstanding work was unknown to management. Some rooms examined had been left in an unsatisfactory state of repair and the rationale for this was unknown. An audit of all rooms was requested to be completed by the person in charge or persons participating in management along with an equipment inventory to confirm which rooms and bedrooms were totally and suitably equipped and to identify those in need of equipment or repair. This requirement is reported in the action plan of Outcome 12.

Hand rails on corridors, grab-rails in bathrooms and call-bell facilities were in place in rooms seen occupied by residents. Staff had three pagers that were linked to the call bell system. These facilities supported residents; however, the timeliness of responses was to be evaluated by management. Staff working remotely in wings relied on the telephone or call-bell system to contact other staff and they did not have remote alarms or mobile communication devices. As referenced in Outcome 2 and 18, staff were unsure of the whereabouts of other staff on duty posing a risk to residents' safety.

Records were available for the servicing of the fire alarm, fire extinguishers and emergency lighting, and routine safety checks had been recorded as having been completed weekly. Training in fire safety had been provided in January and September this year. However, due to the high and frequent turnover of staff, some had not attended or completed fire safety training and those that had attended were not confident or consistent in their responses. The staff training matrix record stated that all staff had attended fire safety training. However, when it was compared against the attendance sheet signed at fire safety training and discussed with staff on duty, inspectors found that all staff had not attended fire safety training or participated in a simulated fire evacuation drill. Fire drills had not been maintained at suitable intervals.

New staff had not received fire safety induction. Core and new staff were not familiar with emergency procedures, equipment or the means of escape from all parts of the centre. A consistent emergency response was lacking among staff spoken with. Staff spoken with told the inspectors they would respond in different ways if the fire alarm
sounded. Some would evacuate dependent persons before mobile residents, some would evacuate residents in beds to an assembly point outside rather than to the next internal compartment, while others said they would evacuate using ski sheets that were not available in this centre. The whereabouts or availability of fire safety and response equipment was unknown to some staff, and an up-to-date personal emergency evacuation plan for all residents had not been completed.

The risk of an evacuation at night with three staff had not been assessed for suitable control measures. The overall fire evacuation plan/policy and procedures required immediate review and communication to all relevant staff for the event of an emergency or fire. The management team were made aware of these findings on inspection.

**Judgment:**
Non Compliant - Major

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

**Findings:**
Policies and procedures were available in relation to the use of restraint; however, improvements were required and a review of policy, procedures and staff practices was required.

Inspectors found that the arrangements and practices recorded had not ensured that, where chemical restraint was used, it was done in accordance with national policy as published on the website of the Department of Health. There was no evidence that alternative least restrictive measures or interventions were trialled in advance of PRN (a medicine only taken as the need arises) psychotropic medicines administered to demonstrate that this restraint measure was used as a last resort. This matter is included in the action plan of Outcome 7. Practice for administration and checking of medicines was not in accordance with professional standards. Reconciliation of medicines were not carried out and recorded appropriately. Medicines had been signed as witnessed at an administration time of 22:00 and 23:30 by a signatory that was not on duty at this time. Medicine prescription sheets had not been updated to reflect decisions regarding the discontinuation of PRN medicines confirmed by staff.

A recent medicine audit carried out by the pharmacist 22 September 2017 identified a number of improvements to be implemented that included the checking of controlled medicines by two nurses at the beginning and end of each shift, administration errors, labelling, reconciling and storage deficiencies related to psychotropic medicines. Some improvements were implemented but further improvement was required overall in the...
Judgment:
Non Compliant - Moderate

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

Theme:
Effective care and support

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

Findings:
Arrangements in place did not ensure each resident’s wellbeing and welfare was maintained by a high standard of nursing care and appropriate medical care and allied healthcare. Improvements required within this outcome are interlinked with those outlined in previous Outcomes 2, 7, 8 and 9.

Residents’ health and social care needs were not sufficiently met through timely access to appropriate professionals and treatment plans. From an examination of a sample of residents’ recorded assessments and care plans and discussions with residents and staff, the inspectors found that the health and social care needs of residents were not suitably assessed with appropriate interventions and or treatment plans implemented accordingly. For example, the assessment of residents with wounds and grade 3 to 4 pressure ulcers were incomplete, not treated as recommended by a specialist allied health care advisor and had not been evaluated by nursing staff on a daily basis or as changes occurred. The grading and measurement of pressure ulcers or wounds had not been completed to aid review and evaluation.

A comprehensive assessment of residents and review of resident was lacking. Prior to this inspection HIQA were notified in September 2017 that 32 of the 35 residents being accommodated were using psychotropic medicines. Following a review of a sample of residents prescription records it was evident that some residents had been administered regular PRN psychotropic medicines in the absence of a behavioral log or indication provided for the rationale. Care plans and reviews carried out were not sufficient in this regard or to inform improvements.

Care delivered did not consistently encourage the prevention and early detection of ill health. Access to allied health care providers were generally prompted or organised privately by relatives. Delays in the referral of residents for specific allied services such
as physiotherapy or occupational therapists following falls and for chiropody services was observed.

Arrangements to involve residents and relatives in the care planning and review process were described and seen in some of the records reviewed. However, as stated in Outcome 2, it was unclear if residents' relatives were informed of all incidents and of the actual treatment plan being implemented.

Care plans did not sufficiently guide practice and the evaluation of care was not completed at suitable intervals.

Poor standards of nursing and care practices were found. 22 of the 34 residents (65%) were assessed as being maximum or high dependency. Many residents required the assistance of two staff for repositioning, mobility and continence management. One nurse and two carers were responsible for the care and services provide to residents 10/11pm to 8am nightly. In addition, to the conditions outlined in Outcome 2, some residents had a history of seizure activity and psychotic episodes. On arrival to the centre at 07:20hrs on day 2, inspectors observed two of the four residents in one wing to be fully dressed and asleep in chairs within the day/communal room. Inspectors were informed that one resident had been 'up all night' and another had been agitated for the most part of the night. Inspectors reviewed records within the handover communication book completed between shifts and noted that activity levels at night were high. All resident needs and the checking on an hourly basis or more frequently was not sufficiently assessed to ensure appropriate resources were available to provide safe, appropriate and evidence based care.

Cumulative findings and observations demonstrated that the registered provider had not ensured a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time. Guidance and principles in relation to the quality of recording clinical practice, medicine management, professional ethical conduct (code) and care of older people standards were not consistently reflected in practices and records inspected.

**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):**
No actions were required from the previous inspection.
Findings:
This outcome and the premises was not inspected in full due to the need to focus our attention in other outcomes.

The premises were visibly clean in parts occupied by residents (other parts were locked) and suitably decorated and benefited from good natural and artificial lighting. The view outdoors from rooms occupied by residents was pleasant, and decor was of a high standard. Some residents along with relatives and staff had personalised their bedrooms with mementoes, photographs and pictures.

The main entrance and foyer, main dining, day and oratory room were completed to a high standard. The management office and nurses' station was located at reception. Resident care and progress records for all residents were located centrally and not within the wings. Some were kept in their bedrooms such as manual handling assessments and repositioning records.

The centre was tastefully decorated with further improvements to be made to add colour and directional signage identified. Rooms were spacious and decorated to a high standard with colourfully co-ordinated furnishings and fittings. The centre was laid in wings named after local stud farms and residents were being accommodated in three wings. Features and signposting painted on walls within one units communal area had been completed recently to add to the décor and attract attention. This wing was a secure key coded area where meals were provided to four residents and transported from the main kitchen by care staff. Meals were pre-plated and arrived on trays. There was no facility to reheat food, or store refrigerated snacks or to make hot drinks in this area where residents came and went from the dining table frequently. These deficits were highlighted to management given the limited staffing provision and ability of staff to leave the area unsupervised. Other observations for consideration included stains on the ceiling of the main sitting room and covers removed from the heating system that had caused leaks in July 2017.

A review of the privacy arrangement was required. A view of inside some residents' bedrooms was available for internal courtyards and areas. Corridors, entry and exit locations including the communal sitting/dining area of the 'specialised unit for wanderers' were monitored by CCTV. However, a notice to inform residents and visitors of this was not displayed throughout the centre.

As referenced previously in Outcome 2, an audit of the premises was required to ensure it was maintained in a safe and suitable manner, appropriate to its intended purpose and function. A room identified and listed as toilet (WC) was used for storage of wheelchairs, mops and buckets in one unit. The floor plans received and management told inspectors that all bedrooms were for single occupancy and fitted with a full en-suite. All vacant bedrooms were locked and from a sample inspected some improvements were required. A maintenance schedule of works on an on-going basis to monitor outstanding work was unknown to management. Some rooms examined had been left in an unsatisfactory state of repair and the rationale for this was unknown.

An audit of all rooms was requested to be completed by the person in charge or persons...
participating in management along with an equipment inventory to confirm which rooms and bedrooms were totally and suitably equipped and to identify those in need of equipment or repair.

**Judgment:**
Non Compliant - Moderate

**Outcome 13: Complaints procedures**
The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

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

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

**Findings:**
Inspectors assessed the procedures in place in the Designated Centre to manage complaints.

To assess the compliance of this outcome; Inspectors reviewed documentation; policies and complaints investigations, observed the environment for advertisements regarding complaints procedures, interviewed family members and residents, reviewed the returned HIQA questionnaires.

Feedback on this outcome was given to the person in charge and the person participating in management throughout the inspection, and detailed in the Feedback meeting.

The person in charge had responsibility to investigate all complaints. No appeals had been sought in 2017. Recent complaints were promptly investigated.

Inspectors observed an A4 poster detailing the process involved in making a complaint on display in the reception area. This did not clearly state the names of the staff involved in complaints management, but did list the different phases of complaints investigations and the roles each played.

The complaints policy of the Designated Centre was reviewed. Inconsistencies were noted regarding the named individuals and the roles they played in the complaints process, different names were included in the policy in comparison with other documentation on complaints located in the complaints documentation. The independent appeals person is now listed as one of the persons participating in management, therefore, objectivity and independence may be lacking with this arrangement. Inspectors acknowledged the person in charge had recently implemented a “comments card” initiative, and saw these cards left at the sign in / out book at the entrance.
The complaints folder was reviewed, to assess the investigation processes used and the responses to complaints. There was no documentation located to suggest the centre received or processed complaints from January to April, or June to August. There were complaints documented in May and again in September and October. However, this was not reflected in the monthly quality audit records.

The investigations into these complaints took place promptly, and were thoroughly investigated. Documented evidence was reviewed that showed the action plan deployed following the investigation. Gaps were identified in staff meeting records regarding learning outcomes from complaints. Following the investigations complainants were reported as satisfied through the use of email.

Families who had responded to HIQA and feedback in questionnaires indicated they would speak with the person in charge or administrator or discuss with a nurse if they wished to raise a complaint. The residents spoken with suggested they would speak with their nurse if they had any complaints.

**Judgment:**
Substantially Compliant

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**Outcome 18: Suitable Staffing**

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

**Theme:**
Workforce

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

**Findings:**
Inspectors assessed the appropriateness and skill mix of staff, with reference to the size and layout of the centre and the needs of the residents that is discussed in the previous outcomes (2, 7, 8, 9 and 11).

Inspectors reviewed documentation, observed staff working in the centre, and spoke with staff, family members and residents. Feedback on this outcome was given to the person in charge and the person participating in the management (group manager) throughout the inspection, and detailed in the feedback meeting.

This centre is modern and large, and is registered to accommodate 79 residents.
Management told inspectors occupancy had not exceeded 40. On the day of inspection there were 37 residents admitted. This number included two in hospital, and one resident who was on temporary leave at home. Four residents were accommodated in one unit referred to as the ‘secure specialised unit for wandering’, which is part of the building but separated from the other wings by a key coded entry and exit. At night there is one nurse and two health care assistants rostered, between 10/11pm and 8am. Staff did not carry communication devices or personal alarms. The Nurses’ Station was located in the main reception area. There were telephones on each unit and a call bell system in place for residents and on the wall of the communal area in the secure unit.

During the inspection, inspectors observed a resident experiencing high levels of responsive behaviours. Staff were fully engaged with this resident. This resulted in limitations to their availability to engage the remaining residents in meaningful communications or activity.

As discussed in previous outcomes, staffing levels and skill mix were not sufficient to meet the needs of residents or layout of the centre. The standard of care, practices and services observed demonstrated this. Staff were at risk of being unable to respond to call bells, or alert fellow colleagues to emergencies due to the size and layout of the centre. On weekday nights there were two additional HCAs rostered to attend to the needs of Residents between 5 and 11pm. On weekend nights this decreased to one care attendant. Staffing levels were depleted to three staff after 11pm and the dependency and activity levels of residents were high.

During the weekdays, the skill mix and numbers of staff were better, but not sufficient. There were no capacity or contingency plans in place to manage staff absences or an amount of annual leave occurring simultaneously. In August this year several staff were on approved leave, and this created a staffing shortage. The person in charge acknowledged this as a causative factor in a complaint investigation arising in the same month in relation to lack of staff.

On interview, several staff members reported inconsistent information about fire and emergency procedures. On interview, staff reported that if they became aware of an incident of abuse they would report to the nurse in charge. Staff reported that at times answering call bells may be delayed if staff were busy attending to an incident or working together with a resident who requires the assistance of more than one staff member. An inspector observed a call bell for a specific room, ringing for 10 minutes during the day shift.

Inspectors reviewed a selection of rosters, however some inaccuracies in these were noted, shift changes were not consistently recorded, and some staff were listed as fulfilling different roles to the ones for which they were in position.

Inspectors acknowledged that there was a procedure in place to replace the person in charge when she is on leave. However, they did not meet this person as she was on leave during this announced inspection.

The person in charge also reported that there are no volunteers on site / recruited by the centre.
The centre has a falls rate higher than the national average, and incidents were reviewed for a recent calendar month indicated more than 60% of these falls occur at night.

HIQA was also in receipt of unsolicited information that highlights concerns regarding the lack of staff numbers especially at weekends and at night. Family members interviewed by inspectors shared credible examples which were in keeping with the rosters reviewed. Families also shared examples of well-meaning staff, but concerned they were too busy to respond to their needs quickly.

The inspectors observed mealtimes in the main units and in the secure unit. The inspectors acknowledge that the person in charge and the person participating in the management have recently implemented a “two sittings” format for meal times to allow staff and residents to have safe and high quality mealtime experiences. The inspector observed good supervision levels during mealtimes in the main units shared dining room but interrupted and disruptive behaviour during the mealtime experience in one unit.

As previously discussed, gaps were identified in the staff training matrix, induction records and Garda vetting. There was no recent evidence of staff appraisal or supervision, for staff that have been in place over one year. Inspectors acknowledged that the person in charge was planning some appraisals before year end. Staff working nights were not rotated to day shift since March 2017 for supervision or appraisal.

Fire training was detailed on the training matrix as an obligation every 2 years. On interview, staff were inconsistent in their information regarding fire and emergency evacuation procedures. Staff personnel files had copies of courses recently completed, and a selection of files reviewed detailed that some staff had attended additional dementia training. However, based on the findings and gaps in induction, training and knowledge, improvements were required in the supervision and development arrangements of staff.

There was an absence of appraisal and supervision records in the personnel files reviewed. Staff and the person in charge reported there was an induction process however in recently recruited staff files, this was not documented. In a sample of personnel files examined, inspectors found staff had commenced employment before receiving Garda vetting in 2016. This was not the case in the sample of personnel files reviewed for 2017.

Evidence was also gathered that a staff member was practicing and signing medication documentation by a name different to the one they are registered with their professional regulator. The person in charge should ensure that all staff have access to relevant guidance published by Government and statutory agencies in relation to designated centres for older people.

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:

Sonia McCague
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider’s response to inspection report

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<tr>
<th>Centre name:</th>
<th>Maynooth Lodge Nursing Home</th>
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<tr>
<td>Centre ID:</td>
<td>OSV-0004593</td>
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<td>Date of inspection:</td>
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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 (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The application submitted in October 2017 to renew the registration of the centre, which expires February 2018, was dated July 2017 and was incomplete.

The application submitted in October 2017 did not reflect the management arrangements in place.

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
1. **Action Required:**
Under Regulation 4 of the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 you are required to: Provide all documentation prescribed under Regulation 4 of the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015.

**Please state the actions you have taken or are planning to take:**
This documentation has been re-submitted to reflect the recent changes.

**Proposed Timescale:** 07/12/2017

**Theme:**
Governance, Leadership and Management

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
Based on the collective finding on this inspection inspectors were not assured that the registered provider had ensured that the designated centre had sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.

Insufficient recruitment and appraisal procedures were found that compromised residents’ safety and their quality of life. Staff had worked in the delivery of direct care to residents in 2016 prior to the completion of Garda vetting and without formal induction and appraisal.

The admission of residents continued during periods of high staff absenteeism and turnover.

Deficiencies were found in relation to staffing levels, skill mix, recruitments procedures, and assessment of staff competency for delegated responsibilities.

Staff worked full-time on night duty and without oversight.

The turnover of staff was high and the current whole time staff numbers rostered did not facilitate reasonable staff ratios to resident dependency or allow for planned or unplanned leave.

Contingency measures were not in place to support staff when activity levels increased to ensure suitable and sufficient health and social care services was consistently provided.

Staffing levels and skill mix were depleted at weekends and minimum staff levels included three night staff (one nurse and two care attendants and two of the three were often male staff).

2. **Action Required:**
Under Regulation 23(a) you are required to: Ensure the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of
Please state the actions you have taken or are planning to take:

This is a relatively new centre which had 37 residents during the inspection. Recruitment is ongoing and very active. Under the new management, a social care practitioner with a Level 8 degree and experience in working with older people in residential care was appointed in September 2017, 10 health care assistants were appointed and 2 new part time staff were recruited for the hospitality department. A senior staff nurse had recently been employed (09/11/2017) to provide team leadership and supervision to the care team. An additional 3 new care staff had been appointed at the time of the inspection and were awaiting Garda Vetting and Induction. All appointments since September 2017 have been Garda Vetted prior to commencing induction.

One new nurse was inducting at the time of the inspection. All staff are inducted and all induction records are now complete in their files.

A full review of the resources has taken place and new shift patterns have been introduced in order to ensure clinical supervision on all shifts and equal staffing for weekdays and weekends. For example a twilight nursing shift has been introduced (4pm-10pm or 5pm-11pm). The activities co-ordinator now currently works 10am-6pm and the Social Care Practitioner works 8am-4pm. All shift patterns and rosters will remain under review and will be planned according to resident need. In addition to this night staff are rotating onto day shifts. Allocation of staffing is determined by resident dependency and Barthel scores. There are currently 12 residents who are maximum dependent on their Barthel score, 11 who are high dependency, 9 who are medium dependency and 4 who are low dependency. There are currently 20 male residents and 17 female residents and the gender balance of the staffing is appropriate to meet both needs.

All staff have had appraisals completed and these were not viewed by the inspectors as they were filed separate to the staff files – this has now been addressed. As per home policy all staff have had an appraisal every 6 months.

The Person in Charge and the Clinical Nurse Manager both live close by and they are as they have always been available to be contacted in the event that staff need their support during shifts of high levels of activity. The Clinical Nurse Manager is rostered every second weekend.

There is an operational plan, an audit schedule, a weekly person in charge report and a weekly operational meeting schedule in place and this will be embedded now into the new management team.

All staff now attend a morning handover. Team allocations continue and are reviewed daily.

A new repositioning chart and air mattress check is now in place.

All of the HR policies had been reviewed and updated in September 2017 and the remaining policies are undergoing reviews and updates by the new management team. The policies are being streamlined and made more user friendly. All Schedule 5 policies
have now been reviewed. The Director of Nursing discusses these new policies with staff at morning handover and supervises their implementation in practice. A falls awareness month is taking place this month with the aim of reducing the significant number of falls. Of the 53 falls recorded for July, August and September there were multiple falls by 6 residents. Care plans were reviewed at the time and these residents are no longer falling.

An issue concerning pharmacy invoices has been resolved. This issue did not originate in the Nursing Home.

**Proposed Timescale: 21/12/2017**

**Theme:**
Governance, Leadership and Management

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
Care provision lacked strategic vision and possibility measures.

The collective findings reported throughout the outcomes demonstrated that the governance and management systems in place did not ensure that the service provided was safe, appropriate, consistent and effectively monitored.

A lack of leadership and understanding of the regulatory requirements in relation to many aspects of the running of the centre which included risk management, management of the premises, supervision of residents and staff, vetting of staff prior to working, assessment and care planning, medicine management practices, quality management systems and on-going monitoring of the safety of care for residents was evident.

There were three major non-compliances identified and four moderate non-compliances out of eight outcomes inspected. Actions required from the previous inspection had not been fully addressed in accordance with the action plan response.

A contingency plan was not in place for periods of heightened activities, resident deaths or when medical and family engagement.

A lack of adequate and appropriate evidence based professional standards, responses and judgements were found.

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

**Please state the actions you have taken or are planning to take:**
This is a new team and the structure which has been put in place is as follows: The Director of Nursing (Person in Charge) reports to the Group Manager (Provider
Representative). There are individual home weekly reports and meetings and group operational meetings between the Director of Nursing and the Group Manager. The Director of Nursing is supported by a Clinical Nurse Manager, a Senior Staff Nurse and a Social Care Practitioner, Senior Health Care Assistants, a Catering Manager and an Administrator. Communication and reporting relationships are being embedded.

All health and safety risks have been reviewed and the risk register has been updated. Appraisals are up-to-date.

Re-induction education has now taken place with all staff. This included fire safety, safeguarding, falls management, pressure ulcer and wound care, how to respond to complaints.

As part of the operational plan the new management team will be addressing the issues identified. This plan has been progressed in order to meet the immediate needs.

The Person in Charge and the Clinical Nurse Manager are available as they have always been available during heightened activity levels. Staff have been re-alerted to this.

A new monthly Continuing Professional Development programme was introduced in September – the aim of this is to enhance knowledge, education and ensure evidence based care.

Members of the multi-disciplinary team are available if required – for example psychiatry of later life, tissue viability, physiotherapy, SALT, dietician, pharmacist. All referrals have been made and actions taken. This is now closely monitored by the Director of Nursing.

**Proposed Timescale:** 21/12/2017

**Theme:**
Governance, Leadership and Management

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
The use of resources was not sufficiently planned and managed to provide person-centred, effective and safe services and supports to residents.

Staff were well intended but not sufficiently informed, supported or appraised based on the collective findings in the outcomes that follow.

The handover arrangements between staff and communication were insufficient and unsafe.

Staff working on the same shift did not know the whereabouts of other staff on duty to support them and all staff did not get a verbal or detailed handover of residents between shifts or prior to their interaction with residents.
The provision of three staff to dependent residents accommodated within this large building with three separate wings operating was inadequate, not sufficiently risk assessed and was unsafe.

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

**Please state the actions you have taken or are planning to take:**
The nurse call system in place in the home is very adaptable. There are in excess of 120 call points installed throughout the home thus ensuring immediate access of the system. The function of the nurse call system is two-fold. Firstly, the resident can use it to request help and secondly, staff can seek assistance from another staff member. The call points are linked to pagers which staff carry. The display unit at reception shows where the call has originated. All staff have had re-education of how to use this system effectively.
Morning handover now takes place for all staff.
Team allocations continue to be reviewed daily.
Staff work in designated areas as per the daily allocations.
One block of the home (the home is one level only) is currently occupied – this is a square block which can be navigated clockwise or anti-clockwise. 12 vacant bedrooms remain in this block.

The remaining building has been blocked off and sectioned as a “restricted area”. It is not for daily use and is managed by maintenance.

Signage has been enhanced. A new resident and staff location monitoring system which was ordered in July is currently being fitted – this is will assist further with resident and staff location and safety. Walkie talkies have also been purchased as a back up.
All staff have undergone a “re-induction” programme so that they are sufficiently informed.

**Proposed Timescale:** 21/12/2017

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**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:**
The ‘challenging behaviours’ policy was described as under review as the protocols and assessment procedures identified within it were not implemented in practice.

Training and knowledge gaps were identified for staff working with residents with responsive behaviours. Staff did not have sufficient knowledge and skills, appropriate to their roles, to manage behaviour that is challenging.
A lack of a proactive planning and a developed strategies for residents with responsive behaviours was evident which negatively impacted on other residents.

The 'specialised unit for wanderers’ contained residents with little meaningful engagement, occupation or activity. The demands and focus on one resident took up most of the staff member's time and the three other residents had no meaningful stimuli or planned programmes implemented. The lack of suitable staffing and resident supervision and support in this area required immediate attention during this inspection.

5. 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:
The responsive behaviour policy had been recently revised (Nov. 2017) in order to enhance practices. This has now been changed from “draft” to “final” policy. This was a piece of work in progress during the inspection. 33 staff had recently attended (18/11/17) responsive behaviour education and work is ongoing in order to enhance all practices.

The entire activities programme for all residents in the home is now currently under review. The activity co-ordinator has a changed shift pattern 10am-6pm and this will remain under review as per resident need. The activities co-ordinator is providing a range of both group and one-to-one activities. The activities co-ordinator is now supported by the care team who also assist by supervising in the main sitting room so that activities can take place as planned. ABC charts are informing therapies required. The three residents observed have sensory cushions and rummage boxes and we are working on developing more activities that they may like to engage in. They also have the option to go to the activities in the main sitting room and do so most days at present.

Proposed Timescale: 21/12/2017

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Care plan reviews had not been undertaken or managed at suitable intervals to ensure appropriate health and social care provision.

Staff were reactive rather than proactive to residents with responsive behaviours, and it was unclear why the four residents were contained within the secure key coded wing.

6. Action Required:
Under Regulation 07(2) you are required to: Manage and respond to behaviour that is
challenging or poses a risk to the resident concerned or to other persons, in so far as possible, in a manner that is not restrictive.

Please state the actions you have taken or are planning to take:
All care plans are reviewed at no more than 4 monthly intervals and families and residents are involved in same. The Director of Nursing now ensures that all acute care needs are acted upon in timely manner and that care plans and interventions are responsive to immediate needs.

Families were offered this wing for their relatives as a safe wing to wander as all residents who reside in this wing like to wander. However, the residents in this wing can go to the main sitting room or dining room if they choose or they can have quiet time in their own wing. The new allocation of staffing and the full review of resources is aimed at ensuring a good quality of life for all residents. Currently these residents spend the majority of their time in the main communal areas.

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<td>Safe care and support</td>
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The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Inspectors found that the arrangements and practices recorded had not ensured that, where chemical restraint was used, it was done in accordance with national policy as published on the website of the Department of Health.

There was no evidence that alternative least restrictive measures or interventions were trialled in advance of p.r.n. (a medicine only taken as the need arises) psychotropic medicines administered to demonstrate that this restraint measure was used as a last resort.

7. 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:
All residents requiring PRN chemical restraint are reviewed regularly. ABC charts are used to determine triggers for behaviour and develop plans for managing same. All drug Kardex’s specify the clinical indication for the administration of PRN chemical restraint. Over the last number of months and under the new management, psychotropic medications were reduced from 32 to 8 and this is an ongoing piece of work. All nurses have been spoken to regarding the use of chemical restraint and the team are committed to trying alternatives and only using chemical restraint as a last resort. The Person in Charge monitors this weekly on the Care Indicators analysis. The pharmacist delivered a psychotropic medication education session to the nurses in October 2017.
The psychotropic stock record book had two signature columns “witness and administration” these have now been amended to “stock check signatures” to record the practice of stock checking the psychotropics. The issue with the controlled drug signatures has now been resolved by the presence of the twilight nurse.

**Proposed Timescale:** 21/12/2017

**Theme:**
Safe care and support

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
Staff had worked in the delivery of direct care to residents prior to the completion of Garda vetting and without formal induction and appraisal.

An audit of residents’ accounts and transactions was also required.

A review of staff response to a resident attempting to exit one unit was to be undertaken by management to ensure safeguarding procedures were appropriately implemented to protect residents from harm, abuse or neglect.

The management of care for a maximum dependent who was immobile within this secure unit/wing staffed by one care attendant or a social care worker also required immediate review.

A policy specific to the centre was to be developed by the current management group.

**8. Action Required:**
Under Regulation 08(1) you are required to: Take all reasonable measures to protect residents from abuse.

**Please state the actions you have taken or are planning to take:**
Staff will not commence induction until Garda vetting is in place.

The responsive behaviour policy which was in draft form during the inspection and is now home policy and is being rolled out in practice. The Dementia care policy (Oct.2017) contains guidelines for admissions to the secure wing.

Staff are aware and have been reminded not to restrict residents movements.

A matter relating to a residents account has been resolved.

**Proposed Timescale:** 21/12/2017

**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:

Hazard identification and assessment of risks throughout the designated had not been identified for assessment and control to ensure resident, visitor and staff safety.

Staff were unsure of the whereabouts of other staff on duty posing a risk to residents safety.

Cigarette smoke migrated from the smoking room onto corridors when the door was opened and the unsupervised arrangements found posed a risk to all.

Maintenance requirements and operational risks associated with the high staff turnover, gaps in training, numbers and skill mix was not recorded in the risk register.

Training deficits in first aid, cardio pulmonary resuscitation (CPR), manual handling and fire drills were found which may compromise residents' health and safety.

Some manual handling practices by trained staff and arrangements observed were not in accordance with best practice guidance and this was pointed out to the person in charge and group manager at the time.

Key staff recorded as having attended fire safety training were vague regarding the appropriate evacuation procedures to be implemented.

The risk of an evacuation at night with three staff had not been assessed for suitable control measures.

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

Please state the actions you have taken or are planning to take:
The risk register was updated during the inspection and this is ongoing as risks are identified.

In addition to the two windows, the smoking room extraction fan has now had a motion sensor installed and this has a time delay installed so that the fan remains operational after the room has been vacated. A smoking room checklist has also been introduced.

All staff have had fire warden induction training. All staff except two newly appointed staff had attended fire extinguisher and safety training. The two newly appointed staff had received fire warden training as per induction. We have now re-educated all staff. There was one staff member who had attended in Oct.2017 but who had been recorded on the matrix as Jan.2017 hence the discrepancy between the attendance record and the matrix.

Fire training had taken place annually and it was an administrator error that the matrix
said 2 years.

Further fire training was scheduled for 06/12/17. This was provided by a different educator with very positive results. Staff are confident in their responses to fire safety. They have undertaken an evacuation, they participate in weekly fire alarm tests and they are able to speak more confidently about what to do in the event of a fire.

Evacuation drills take place six monthly and the second one for 2017 was scheduled for December. This took place on 06/12/17.

All staff have been reminded to use the manual handling aids supplied such as manual handling belts.

**Proposed Timescale:** 21/12/2017

**Theme:**
Safe care and support

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
Incident reporting, management and recording practices required improvement to ensure adequate arrangements were in place for the identification, recording, investigation and learning from serious incidents such as falls, head injuries and peer to peer assaults or adverse events involving residents.

The incidence of 53 falls during a recent three month period in 2017 was significantly higher than the annual total of 19 for 2016.

The frequency and recurrence of falls was higher than national averages.

Clinical observations and incident recording deficits found did not demonstrate appropriate clinical supervision, monitoring and referral to ensure timely action was taken.

A lack of neurological observations following un-witnessed falls and head injuries was found and further monitoring and observations following an irregular clinical recording (blood pressure) demonstrated a lack of appropriate clinical knowledge by those involved which could compromise residents’ well-being and timely treatment.

Reviews of incidents were not sufficiently detailed to ensure adequate preventative measures were considered, working as required or put in place to mitigate risks. Most learning outcomes following incidents and falls stated ‘needs closer observation’. This statement was vague and immeasurable resulting in repeated falls and recurrent incidents occurring.

A recent choking incident involving a resident during lunchtime (Friday) was responded to by a nurse on duty. However, the risk associated with the expansive layout of the centre, limited availability of one nurse between 4pm and 8am daily, and dining taking place in more than one area had not been assessed.
The risk to residents assessed as requiring assistance and modified diets and fluids following this incident should a similar incident occur at a weekend, tea or night time (when one nurse was available for the entire centre) had not been assessed.

During the inspection inspectors observed two residents smoking in a designated smoke room within the centre without supervision. This was rated as a high risk in the risk register.

From a review of a sample of residents’ records inspectors found that an incident record relating to a physical assault between two residents had not been completed to identify the attributes, conditions and consequences for residents or inform learning to bring about improvements.

10. **Action Required:**
Under Regulation 26(1)(d) you are required to: Ensure that the risk management policy set out in Schedule 5 includes arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents.

Please state the actions you have taken or are planning to take:
The home commenced an immediate “Falls Awareness Month”. A new Falls Protocol (which includes guidelines on neuro-obs) and a revised policy have now been issued. A new multifactorial risk assessment has now been introduced for post fall analysis of each fall. The team are focused on reducing the number of falls.

Two sittings had recently, been introduced for meal times and this was also subsequent to the choking incident. This enables good supervision. Residents who need assistance dine first and residents who need supervision dine second but some independent residents also choose the early sitting. Staff are present at all times. The Director of Nursing has observed all mealtimes in order to assess this new change and same is working well. Nurses are always present at meal times. The nurse roster has been changed so that there is sufficient nursing hours throughout the day and night.

All residents who wish to smoke have a smoking risk assessment. The smoking room is beside the sitting room and can be closely monitored. A new smoking checklist has been introduced to maximise safety.

All required notifications have been submitted and incidents are discussed at morning handover in order to reduce and learn from same.

The risk register has been updated.

**Proposed Timescale:** 21/12/2017

**Theme:**
Safe care and support

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
The risk management policy did not include some items set out in Regulation 26(1)
such as the unexplained absence of any resident, accidental injury to residents, visitors or staff, and aggression and violence.

A health and safety statement was absent from the file.

11. **Action Required:**
Under Regulation 26(1) you are required to: Ensure that the risk management policy set out in Schedule 5 includes all requirements of Regulation 26(1)

**Please state the actions you have taken or are planning to take:**
A “Resident Elopement” policy and an “Emergency/Incident” policy have now been reviewed and updated to ensure that they include all requirements of Regulation 26(1).

The Health & Safety statement has been reviewed and updated.

**Proposed Timescale:** 21/12/2017

**Theme:**
Safe care and support

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
The registered provider had not ensured that procedures, consistent with the standards for the prevention and control of healthcare-associated infections published by the Authority are available and implemented by staff.

Cleaning arrangements, staffing and operational protocols to prevent infections required improvement.

One cleaner responsible for the entire centre that includes 79 en-suite bedrooms and auxiliary rooms was not enough.

On inspection of a sample of unoccupied rooms, inspectors noted a malodour of stagnant water. It was subsequently confirmed with staff that an audit, check, and run of water in the wash hand basins and showers and flush of toilets had not been maintained as previously set up due to a lack of staff available. Records seen in the cleaning room showed that this protocol has ceased from July 2017.

This risk was not identified or recorded for assessment with appropriate controls measures identified.

The cleaner’s room did not have a wash hand basin or sluice sink for mops. This was previously reported and had not been addressed.

The ventilation in a cleaners store room required review as a strong chemical smell was detected on opening the door.

12. **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:**
The home has now been divided between the occupied wings and the unoccupied wings (24 bedrooms). The unoccupied wings will be managed by maintenance and records will be maintained and monitored by the Director of Nursing and the provider. A new daily checklist has been introduced for the hospitality team for the occupied wings. This will also be monitored by the Director of Nursing and the provider. Two part-time staff had recently been added to the hospitality team which also has one full time staff member.

Hospitality and Infection Control audits take place quarterly. As a result of these audits (May & October 2017) staff have had handwashing competencies completed and a risk assessment for hand gel was added to the risk register.

A cleaning product had been spilled on the morning of the inspection hence the strong odour. There is a window in this room for ventilation.

A wash hand basin and sluice sink for mops for the hospitality team have been installed.

**Proposed Timescale:** 21/12/2017

**Theme:**
Safe care and support

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
Some staff had not attended or completed fire safety training and those that had attended were not confident or consistent in their responses.

The staff training matrix record stated that all staff had attended fire safety training. However, when it was compared against the attendance sheet signed at fire safety training and discussed with staff on duty, inspectors found that all staff had not attended fire safety training or participated in a simulated fire evacuation drill.

New staff had not received fire safety induction. Core and new staff were not familiar with emergency response procedures, equipment or the means of escape from all parts of the centre. A consistent emergency response was lacking among staff spoken with.

Staff responded in different ways if the fire alarm sounded. Some would evacuate dependent persons before mobile residents, some would evacuate residents in beds to an assembly point outside rather than to the next internal compartment, while others said they would evacuate using ski sheets that were not available in this centre. The whereabouts or availability of staff and fire safety and response equipment was unknown to some staff.

An up-to-date personal emergency evacuation plan for all residents had not been
The overall fire evacuation plan/policy and procedures required immediate review and communication to all relevant staff for the event of an emergency or fire. The management team were made aware of these findings on inspection.

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

**Please state the actions you have taken or are planning to take:**
All staff have had fire warden induction training. All staff except two newly appointed staff had attended fire extinguisher and safety training. Additional fire training was provided on 06/12/17. This was provided by a different educator with very positive results. Staff are confident in their responses to fire safety. They have undertaken an evacuation, they participate in weekly fire alarm tests and they are able to speak more confidently about what to do in the event of a fire.

Evacuation drills take place six monthly and the second one for 2017 was scheduled for December. This took place on 21/12/17.

Fire training has taken place annually and it was an administrator error that the matrix said 2 years.

The home is purpose built with large corridors and extra wide bedroom doors. In the event of a fire the residents are moved from one wing (compartment) to another. All staff have been re-educated about this. Staff are now being asked on a regular basis about emergency procedures and all staff are able to consistently answer this question.

The remainder of this action plan submitted by the provider does not satisfactorily address the failings identified in this report.

**Proposed Timescale:** 21/12/2017

**Theme:**
Safe care and support

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
Staff had not attended fire safety training or participated in a simulated fire evacuation drill.

Fire drills had not been maintained at suitable intervals.

14. **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:
Additional fire training was provided on 06/12/17. This was provided by a different educator with very positive results. Staff are confident in their responses to fire safety. They have undertaken an evacuation, they participate in weekly fire alarm tests and they are able to speak more confidently about what to do in the event of a fire.

Evacuation drills take place six monthly and the second one for 2017 was scheduled for December. This took place on 06/12/17.

Fire drills now take place every Wednesday at 2pm.

Proposed Timescale: 21/12/2017

Outcome 09: Medication Management

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Improvements were required in relation to medicine management procedures and staff practices.

A review of medicine management policies was required to protect residents.

Practice for administration and checking of medicines was not in accordance with professional standards.

Reconciliation of medicines were not carried out and recorded appropriately. Medicines had been signed as witnessed at an administration time of 22:00 and 23:30 by a signatory that was not on duty at this time.

Medicine prescription sheets had not been updated to reflect decisions regarding the discontinuation of prn medicines confirmed by staff.

A recent medicine audit carried out by the pharmacist 22 September 2017 identified a number of improvements to be implemented that included the checking of controlled medicines by two nurses at the beginning and end of each shift, administration errors, labelling, reconciling and storage deficiencies related to psychotropic medicines. Some improvements were implemented but further improvement was required overall in the interest of resident safety.

15. 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:
Under the new management a full review of the Pharmacy service and medication management practices had taken place in September 2017. The action plan relating to this was underway during the inspection. All actions are now complete. This has included a weekly onsite visit from the pharmacist to complete audits, check residents files and monitor for any errors. As part of these visits the pharmacist also provides education on various topics relevant to the resident’s diagnosis.
A stop and start form for medications has been introduced.
A psychotropic medication register has been introduced and this is used to monitor frequency and dosage, specifically of psychotropic medication.

Proposed Timescale: 21/12/2017

Outcome 11: Health and Social Care Needs

Theme:
Effective care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Arrangements in place did not ensure each resident’s wellbeing and welfare was maintained by a high standard of nursing care and appropriate medical care and allied healthcare.

Residents’ health and social care needs were not sufficiently met through timely access to appropriate professionals and treatment plans.

The health and social care needs of residents were not suitably assessed with appropriate interventions and or treatment plans implemented accordingly. For example, the assessment of residents with wounds and grade 3 to 4 pressure ulcers were incomplete, not treated as recommended by a specialist allied health care advisor and had not been evaluated by nursing staff on a daily basis or as changes occurred.
The grading and measurement of pressure ulcers or wounds had not completed to aid review and evaluation. a review of intervention and measures following incidents.

Residents said they were bored and reported a lack of stimulating activity.

16. Action Required:
Under Regulation 05(1) you are required to: Arrange to meet the needs of each resident when these have been assessed in accordance with Regulation 5(2).

Please state the actions you have taken or are planning to take:
Members of the multi-disciplinary team are available if required – for example
psychiatry of later life, tissue viability, physiotherapy, SALT, dietician, pharmacist. All referrals have now been made and action taken. This is monitored by the Director of Nursing.

All nurses have received updated education on wound and pressure ulcer care as per EUPAP guidelines. The Director of Nursing now oversees the management of all wounds.

A new repositioning chart also now contains a mattress check.

A full review of the activities programme has taken place and a new roster has been implemented.

**Proposed Timescale:** 21/12/2017

**Theme:** Effective care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
A comprehensive assessment and review of residents was lacking.

It was unclear why four residents were being contained within the secure key coded wing referred to a 'specialised unit for wandering'. One of the four resident was immobile and remained in bed on both days of inspection.

In September 2017 that 32 of the 35 residents being accommodated were using psychotropic medicines. Following a review of a sample of residents prescription records it was evident that some residents had been administered regular PRN psychotropic medicines in the absence of a behavioural log or indication provided for the rationale.

Care plans and reviews carried out were not sufficient in this regard or to inform improvements.

Care delivered did not consistently encourage the prevention and early detection of ill health.

Access to allied health care providers were generally prompted or organised privately by relatives. Delays in the referral of residents for specific allied services such as physiotherapy or occupational therapists following falls and for chiropody services was observed.

**17. 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:**
Residents who live in the secure unit can now access the communal area for activities
or to wander. When they get restless or anxious they are offered quiet time. Comprehensive care plans are now in place.

All residents requiring PRN chemical restraint are reviewed regularly and an ABC chart is commenced if behaviours change. Currently, their drug Kardex specifies the clinical indication for the administration of PRN chemical restraint. Over the last number of months and under the new management, psychotropic medications were reduced from 32 to 8 and this is an ongoing piece of work. All nurses have been spoken to regarding the use of chemical restraint and the team are committed to trying alternatives and only using chemical restraint as a last resort. The Person in Charge monitors this weekly on the Care Indicators analysis. The pharmacist delivered a psychotropic medication education session to the nurses in October 2017.

Members of the multi-disciplinary team are available if required – for example psychiatry of later life, tissue viability, physiotherapy, SALT, dietician, pharmacist. All referrals have been made and action taken.

The Director of Nursing has undertaken a full case study review of each resident to ensure that all care interventions are in place. For example, enhancements made by the Director of Nursing include crash mats being in place either side of some residents beds, staff reminded to maintain beds at lowest position, bed rails were removed for the enhanced safety of some residents. Additional rummage boxes and individual therapeutic activities have been introduced. Medications have been further reviewed by the GP. 15 minute observation charts are now commenced if behaviours escalate or if falls risk increases.

Additional behavioural support plans have also been introduced for residents with responsive behaviour. All residents are up-to-date with their dietician reviews.

Proposed Timescale: 21/12/2017

Theme: Effective care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Cumulative findings and observations demonstrated that the registered provider had not ensured a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time.

Guidance and principles in relation to the quality of recording clinical practice, medicine management, professional ethical conduct (code) and care of older people standards were not consistently reflected in practices and records inspected.

18. 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:**
New management had commenced in the centre and new management systems were being introduced at the time of the inspection.

All quality indicators have now been assessed and actions implemented. Nursing staff have undergone supervision and continue to do so. Action plans are in place as per previous outcomes. Nursing staff have been alerted to their NMBI requirements and copies of same have been made available for reading.

**Proposed Timescale:** 21/12/2017

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**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:**
One wing (a secure key coded area) where residents remained all day and had their meals did not have a facility to reheat food, or store refrigerated snacks or to make hot drinks and staff were unable to leave the area unsupervised.

A review of the privacy arrangement was required:
- A view of into some resident’s bedrooms from internal courtyards and areas was seen.
- Corridors, entry and exit locations including the communal sitting/dining area in one unit were monitored by CCTV and notices to inform residents and visitors of this was not displayed throughout the centre.

An audit of the premises was required to ensure it was maintained in a safe and suitable manner, appropriate to it’s intended purpose and function.

An audit of all rooms was requested to be completed by the person in charge or persons participating in management along with an equipment inventory to confirm which rooms and bedrooms were totally and suitably equipped and to identify those in need of equipment or repair to include the ceiling of the main sitting room and covers removed from the heating system that had caused leaks in July 2017.

The floor plans received and management told inspectors that all bedrooms were for single occupancy and fitted with a full en-suite. All vacant bedrooms were locked and from a sample inspected some improvements were required. A maintenance schedule of works on an on-going basis to monitor outstanding work was unknown to management. Some rooms examined had been left in an unsatisfactory state of repair and the rationale for this was unknown.

**19. Action Required:**
Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.
Please state the actions you have taken or are planning to take:
The home is currently asking residents who occupy bedrooms which are overlooked by courtyards or the oratory what their preferences’ are for putting screening or blinds or nets on their windows. Currently no resident has consented to changing this as they like looking out. Partial screening has been applied to the glass corridors as full screening would reduce supervision. CCTV has been turned off in the communal area in the secure wing. CCTV notices have been placed around the centre and a policy is in place.

A full audit of the premises has been completed. The unoccupied wing (24 bedrooms) is zoned off and is now being managed by maintenance and overseen by the Director of Nursing and the Provider. The room where the leak occurred has been cleaned. The ceiling in the sitting room will be painted on 05/12/17.

10 vacant bedrooms are fully kitted out and ready for admissions. Their inventories are complete.

There is a room in the secure unit which has tea and coffee making facilities and snacks. Fresh drinks are supplied daily. If food needs to be delivered here it is now done by the catering staff.

Proposed Timescale: 21/12/2017

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:
The complaint’s procedure on display in the reception area did not clearly state the names of the staff involved in complaints management.

20. Action Required:
Under Regulation 34(1)(e) you are required to: Assist a complainant to understand the complaints procedure.

Please state the actions you have taken or are planning to take:
The complaint procedure has been updated.

Proposed Timescale: 21/12/2017

Theme:
Person-centred care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Complaints documented in May and again in September and October were not reflected in the monthly quality audit records.
### 21. **Action Required:**
Under Regulation 34(2) you are required to: Fully and properly record all complaints and the results of any investigations into the matters complained of and any actions taken on foot of a complaint are and ensure such records are in addition to and distinct from a resident’s individual care plan.

Please state the actions you have taken or are planning to take:
There were no complaints in June, July & August. The first quarterly review took place for July, August & September. Complaints for October will be analysed in the next quarterly review.

Quarterly reviews had just commenced in the third quarter therefore May was not part of this review.

**Proposed Timescale:** 21/12/2017

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

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Inconsistencies were noted regarding the named individuals and the roles they played in the complaints policy and in the complaints process. Different names were included in the policy in comparison with other documentation on complaints located in the complaints documentation.

The independent appeals person is now listed as one of the PPIM.

### 22. **Action Required:**
Under Regulation 34(3) you are required to: Nominate a person, other than the person nominated in Regulation 34 (1)(c), to be available in a designated centre to ensure that all complaints are appropriately responded to and that the person nominated under Regulation 34 (1)(c) maintains the records specified under in Regulation 34 (1)(f).

Please state the actions you have taken or are planning to take:
The complaint procedure and policy has been updated to reflect the new management.

The independent appeals person is no longer one of the PPIMs and is a Director of nursing in another home.

**Proposed Timescale:** 21/12/2017

### Outcome 18: Suitable Staffing

**Theme:**
Workforce

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Inconsistencies were noted regarding the named individuals and the roles they played in the complaints policy and in the complaints process. Different names were included in the policy in comparison with other documentation on complaints located in the complaints documentation.

The independent appeals person is now listed as one of the PPIM.
**Requirement in the following respect:**
During the inspection, inspectors observed a resident experiencing high levels of responsive behaviours. Staff were fully engaged with this resident. This limited their availability to engage the remaining residents in meaningful communications or activity.

Staffing levels and skill mix were not sufficient to meet the needs or layout of the centre.

The standard of care, practices and services observed demonstrated this.

Staff were at risk of being unable to respond to call bells, or alert fellow colleagues to emergencies due to the size and layout of the centre.

At night and at weekends nights staffing levels were depleted and the dependency and resident dependency remained the same, as outlined in outcome 2.

23. **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:**
Recruitment is ongoing and very active. Under the new management, a social care practitioner with experience in working with older people in residential care was appointed in September 2017, 10 health care assistants were appointed and 2 new part time staff were recruited for the hospitality department. A senior staff nurse had recently been employed to provide team leadership and supervision to the care team. An additional 3 new care staff had been appointed at the time of the inspection and were awaiting Garda Vetting and Induction. One new nurse was inducting at the time of the inspection.

All staff are inducted and all induction records are now complete in their files.

A full review of the resources has taken place and new shift patterns have been introduced in order to ensure clinical supervision on all shifts and equal staffing for weekdays and weekends. In addition to this night staff are rotating onto day shifts.

A full review of activities and resident engagement has taken place.

**Proposed Timescale:** 21/12/2017

**Theme:**
Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Significant gaps in training such as fire safety, manual handling, CPR, medicine management and safeguarding practices were identified.
### 24. Action Required:
Under Regulation 16(1)(a) you are required to: Ensure that staff have access to appropriate training.

**Please state the actions you have taken or are planning to take:**
All staff had undertaken mandatory education except two new staff who needed fire extinguisher education. Further fire training took place on the 06/12/17.

All staff have now undergone re-education of all mandatory education requirements.

The administrator has updated the training matrix.

**Proposed Timescale:** 21/12/2017

**Theme:** Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Staff had been working in the centre without formal induction records and completion of Garda vetting

There was no recent evidence of staff appraisal or supervision, for staff that have been in place over one year. Fire training was detailed on the training matrix as an obligation every 2 years. It is an annual requirement. On interview, staff were inconsistent in their information regarding fire and emergency evacuation procedures.

Staff working on nights full-time were not rotated to day shift since March 2017 for supervision or appraisal.

Reporting structures, communication and accountability arrangements required improvement to safeguard residents.

### 25. Action Required:
Under Regulation 16(1)(b) you are required to: Ensure that staff are appropriately supervised.

**Please state the actions you have taken or are planning to take:**
All staff are inducted and all induction records are now complete in their files. A full review of the resources has taken place and new shift patterns have been introduced in order to ensure clinical supervision on all shifts and equal staffing for weekdays and weekends. In addition to this night staff are rotating onto day shifts.

All staff have had appraisals completed and these were not viewed by the inspectors.

As per home policy all staff have an appraisal every 6 months. These are now added to the staff files.

The new management system of weekly reporting, meetings and clinical supervision was being implemented at the time of inspection. This will continue.
**Proposed Timescale:** 21/12/2017

**Theme:**
Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The person in charge should ensure that all staff have access to relevant guidance published by Government and statutory agencies in relation to designated centres for older people.

**26. Action Required:**
Under Regulation 16(2)(c) you are required to: Make copies available to staff of relevant guidance published from time to time by Government or statutory agencies in relation to designated centres for older people.

**Please state the actions you have taken or are planning to take:**
All guidelines are now available in reception and staff have been alerted to same.

**Proposed Timescale:** 21/12/2017