<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Maynooth Lodge Nursing Home</th>
</tr>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0004593</td>
</tr>
<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>
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<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>
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<td>Support inspector(s):</td>
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<td>Type of inspection</td>
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<td>Number of vacancies on the date of inspection:</td>
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About Dementia Care Thematic Inspections

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

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

Please note the definition of the following term used in reports: responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).
Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor compliance with specific outcomes as part of a thematic inspection. This monitoring inspection was unannounced and took place over 2 day(s).

The inspection took place over the following dates and times

From: 18 September 2018 10:00
To: 18 September 2018 19:30
19 September 2018 10:00
19 September 2018 17:30

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

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Provider’s self assessment</th>
<th>Our Judgment</th>
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<tr>
<td>Outcome 01: Health and Social Care Needs</td>
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<td>Non Compliant - Moderate</td>
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<td>Outcome 02: Safeguarding and Safety</td>
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<td>Outcome 08: Governance and Management</td>
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Summary of findings from this inspection

This inspection report sets out the findings of an unannounced thematic inspection which focused on six specific outcomes relevant to dementia care. An additional outcome was partially inspected in relation to governance and management following changes in the person in charge and other members of the management team since the previous inspection 14 February 2018.

The purpose of this inspection was to determine what life was like for residents with dementia living in the centre. The inspection also considered findings from the last inspection, and notifications, unsolicited and solicited information received by the Health Information and Quality Authority (HIQA) since the last inspection.
The provider had recently completed a self-assessment questionnaire on dementia care at the request of HIQA. This assessment was received during this inspection. The provider had assessed the compliance level in the centre through the self-assessment tool which was comparable to the inspector’s judgments. The table above demonstrates a summary of all judgments made. The provider and person in charge had developed an action plan to address their identified deficiencies and non-compliances by December 2018.

On the days of inspection, the person in charge was working in the centre. The registered provider representative arrived to the centre soon after the commencement of the inspection. Both were informed of the purpose of the inspection and of unsolicited information received by HIQA in relation to the centre. Both were present during the inspection and were provided with feedback throughout and a summary of the findings at the end.

The provider representative and person in charge reported that the centre does not have a dementia specific unit, but one of the three units within the centre is secure and primarily occupied by residents with dementia. It was accessible by a key code.

At the time of inspection 24 residents of the 46 (52%) had a formal diagnosis of dementia and a further eight residents were suspected of having dementia by nursing staff.

The inspector observed that residents living with dementia within the secure unit required a high level of support and monitoring due to their individual needs and dependencies. Some displayed behavioural and psychological signs of dementia (BPSD). Although some progress was made by the provider in implementing some of the previous action plans, recurrent non-compliances were found. Recurrent findings in relation to the lack of person-centred care with individualized meaningful activities and occupation was again evident on this inspection.

In addition to a lack of meaningful activity and occupation available for residents, improvements were required in relation to residents’ assessments and care plans, the management of responsive behaviours, staffing levels, staff competency and training and in medication management practices. Aspects of the physical environment to promote way finding, independence, access and orientation also required improvement to support people living with dementia.

Overall, the inspector found that improvement was required in all outcomes specific to the dementia thematic inspection with moderate non-compliances found under Outcomes 1 (Health and Social Care Needs), 2 (Safeguarding and Safety), 3 (Residents Rights, Communication and Consultation) and 5 (Suitable Staffing). Outcome 6 (Premises), and Outcomes 4 (Complaints Management) and 7 (Governance and Management) were substantially compliant.

The findings are discussed throughout the report and set out in seventeen action plans (seven associated directly to the provider and 10 to the person in charge) at the end of the report for response.
Outcome 01: Health and Social Care Needs

Theme: Safe care and support

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

Findings:
This outcome sets out the inspection findings relating to individual assessments and care planning, access to healthcare, maintenance of records and policies available governing practice. The social care of residents with dementia is reported in Outcome 3.

The self-assessment tool (SAT) completed by the provider and person in charge was rated moderately non-compliant in this outcome with some areas for improvement highlighted.

Areas of improvement identified and outlined in the SAT was to progress a dementia care plan guide, completing and having residents care plans person-centred by 31 October 2018, completing a food plan template for all residents by 30 November 2018, provide staff with training in palliative care, dementia and behavioural and psychological signs of dementia (BPSD) by the end of November 2018.

The inspector focused on the experience of residents with dementia and tracked the journey prior to and from the admission of residents. Specific aspects of care such as nutrition, wound care, mobility, access to healthcare and supports, medication management, end of life care and maintenance of records was also reviewed.

Arrangements were in place to support communications between the resident and family, and or the acute hospital and the centre. The person in charge visited prospective residents in hospital or at home prior to their admission. This arrangement gave the resident and or their family an opportunity to meet in person, provide relevant information and assess or determine if the service could adequately meet the needs of the resident.

An admission policy was in place. Residents’ files held a copy of their hospital discharge and/or transfer letters (medical and nursing). However, some residents files examined did not include the copy of the Common Summary Assessments (CSARS) which details assessments undertaken by professionals such as a doctor, social worker and nurse previously involved in their care. In addition, details such as establishing each resident’s
mental health and legal status such as ward of court or enduring power of attorney at the pre-admission stage was not established. At the time of inspection, the inspector was told that none of the residents in the centre were represented by a ward of court order.

Residents had a nursing and General Practitioner (GP) assessment following admission. Clinical observations such as blood pressure, pulse and weight were assessed on admission and monthly or as required thereafter. A range of validated assessment tools were available to assess each resident's dependency level, risk of pressure ulcers/skin integrity, malnutrition, falls, cognitive function, mood and behaviour. However, some of these assessments were not consistently completed as required for residents with a diagnosis of dementia or linked to the care plan and interventions thereafter. Gaps in the assessment and care planning process and in the implementation of required interventions was found. Some care plans did not contain sufficient information to specify the actual needs of residents and guide the necessary care interventions to be evaluated.

Arrangements were in place to meet the health and nursing needs of residents with dementia. Access to the General Practitioner (GP) and to allied healthcare professionals (AHP) including physiotherapy, dietetic, speech and language, tissue viability, dental, ophthalmology and chiropody services were available and facilitated on a referral basis. Residents also had access to psychiatry of later life services. From the cases tracked it was evident that this service had been available to some residents prior to and since their admission on a referral basis. Records of referrals to AHP were seen in files examined.

Access to occupational therapy (OT) was reported to be limited unless privately sourced. Some resident's seating arrangements had been assessed and reviewed by an OT to ensure the suitability of the equipment in use.

Arrangements were described to evaluate existing care plans routinely on a four monthly basis. However, the evaluation did not ensure the care plan was updated or revised to reflect the residents' changing care needs. Evidence that residents and or family, where appropriate, participated in care plan review meetings at intervals not exceeding four months was reported.

Staff provided end of life care to residents with the support of their GP and community palliative care services. Advanced care directives formed part of the assessment and planning process for planning each resident's end of life care. Gaps in the documentation of those involved in decisions and a lack detail of the resident's end of life preferences or wishes was found in some records examined.

Good facilities were available for relatives or friends to be accommodated. A visitor's room and toilet, a stocked kitchenette and a spacious oratory for prayer and reflection were among the facilities available. Residents and staff outlined how religious and cultural practices were facilitated within the centre. Religious services and prayers were held regularly in the Oratory.

There was good management of pressure ulcers. One resident had a pressure ulcer that
was healing. This resident’s other pressure ulcer had healed since the previous inspection. The management of care had been regularly review by the nurses, GP and tissue viability specialist to promote the healing evidenced. Pressure relieving mattresses and cushions were seen in use by some residents but for other residents deemed at risk of developing pressure ulcers, an assessment of the risk or a care plan to mitigate the risk was not seen in place. On the first day of the inspection many residents had little or no pressure relief from the seated position or chair they were in for lengthy periods. Repositioning regimes or pressure relieving cushions were not observed in practice to maintain mobility and skin integrity.

Arrangements were in place to meet the nutritional and hydration needs of residents with dementia. There were systems in place to ensure residents' nutritional needs were assessed, facilitated and monitored. Residents were screened for nutritional risk following admission and reviewed regularly thereafter. Residents' weights were checked on a monthly basis, and more frequently when indicated. Referrals for review by a dietician and or speech and language therapist were prompted following assessment and reviews and a record to demonstrate the referral were maintained in the centre.

Residents and relatives were complimentary of the meals and food provided. The Inspector saw that a choice of hot meals was offered and available to residents, snacks were also available. There was a system of communication between nursing and catering staff to support residents with special dietary requirements. A menu and attractive table settings were provided and staff sat with residents while providing encouragement or assistance with a meal. Some residents choose to dine in their own bedrooms, and this was facilitated. However, the meal time experience in both dining areas needed improvement to ensure an organised approach was adopted where all residents were served and supported in a timely manner, and monitored and assisted appropriately by all staff. The Inspector observed that the feedback provided to staff on day one of the inspection had brought about a welcomed improvement by residents in one dining area on day two, but further improvement was required in all parts to create dining as social occasions. Residents had highlighted the need to improve the mealtime experience in their recent meeting held 6 September 2018. But this had not been actioned and an adequate number of staff was not available to assist residents at mealtimes observed.

There were arrangements in place to review accidents and incidents within the centre, and residents were assessed for risk of falls. A communication system and handover was in place to highlight the risk rate to all staff.

Residents had access to a pharmacist and general practitioner (GP) of their choice and the majority opted for the services of the GP serving the centre that visited weekly. Arrangements were being explored to improve the involvement of the pharmacist, GP and nursing staff in electronically managing medicine arrangements but this was at an early stage.

The person in charge, deputy or nurse manager’s participated in four monthly medicine reviews or as required with the GP and there were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents. However, the inspector found practices in relation to administration and recording of medicine in
need of improvement. Medicines reportedly given earlier in the day were not recorded as administered until a view of the kardex was sought by the inspector. This was over four hours after the prescribed time. In addition when medicines were accepted by residents at a later time than prescribed, the time medicines were actually given or administered at was not consistently recorded by staff. These practices observed did not meet with professional requirements or sufficiently protect residents.

An audit of psychotropic medication prescribed and administered was maintained reporting a low usage of these medicines.

**Judgment:**
Non Compliant - Moderate

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**Outcome 02: Safeguarding and Safety**

**Theme:**
Safe care and support

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

**Findings:**
The self-assessment tool (SAT) completed by the provider and person in charge for this outcome was rated substantially compliant and the action plan response included continuing to educate staff on dementia and behavioural and psychological signs of dementia (BPSD) to continue in October 2018 having had a training session completed by some staff on 11 September 2018.

Measures were in place to protect residents from harm or suffering abuse and to respond to allegations, disclosures and suspicions of abuse.

Staff and records confirmed they had received safeguarding training to enable them to identify and respond to elder abuse. The person in charge and staff who spoke with the inspector displayed sufficient knowledge of the different forms of elder abuse and were clear on reporting procedures. A recent allegation of abuse was under investigation and subsequently reported as not substantiated.

There were systems in place to safeguard residents’ money and property. The centre’s administrator was the pension agent for two residents and a separate client account was set up to protect their finances. A record of property or monetary transactions to and from the centre was maintained and available to residents or representatives.

A policy was available in relation the management of behaviours that challenge and a focus on training staff in relation to dementia and behavioural and psychological signs of dementia (BPSD) was evident. However, the inspector saw that some staff allocated to care and support residents with dementia, responsive behaviours or BPSD were not
sufficiently equipped, skilled or trained appropriately. The limitations in staff numbers available to residents also impacted negatively on the care and support seen provided to residents. The delivery of care was mainly reactive care rather than pro-active. This is also discussed further in other outcomes related to residents’ rights and staffing.

The allocation and supervision of staff in their delivery of direct care to residents with dementia required improvement to ensure positive behavioural support techniques were adopted for residents’ with dementia and those with behaviours that negatively impacted on others.

A structured activity programme was not evident and interventions to be used to de-escalate behaviour such as effective individualised social activities or divisional therapies were not reflected in an appropriate care plan for residents with dementia to direct staff or guide care.

The use of physical restraint was low and aimed at promoting a restraint free environment in line with the National Policy. A medicine only taken as the need arises (PRN) such as psychotropic medicines as a form of restraint was reportedly low which was confirmed by the Inspector in a review of the nursing and medicine records available and from discussions with nursing staff. Audits of restraints usage were to continue to promote a restraint free environment and the provision of alternatives to be trialled by 20 November 2018.

**Judgment:**
Non Compliant - Moderate

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

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

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

**Findings:**
The self-assessment tool (SAT) completed by the provider and person in charge was rated moderately non-compliant in this outcome. The action plan response stated that an action plan was put in place to address preferences and wishes of expressed choices following a residents' forum held 6 September 2018. The inspector spoke to residents, staff and a relative that attended this meeting and read the minutes recorded.

While the resident forum was a good means of consulting residents for opportunities to communicate their views on the organisation of the centre, actions required or planned following the resident and relative feedback was not yet implemented. For example, the preference expressed to serve each table at mealtimes and lack of activities had not been addressed.
For residents that could communicate their wishes to staff, their choices and preferences in relation to how they spent their day was respected. However, there was limited choice and opportunity for occupation and social engagement within their day. The inspector was informed by staff, residents and relatives that the activity programme seen advertised was not implemented in practice.

Overall, there was much room for improvement in how all residents and those with dementia occupied their day and in relation to the provision of meaningful activities available. One resident said it was often ‘boring’ and others concurred with this view.

For people with dementia there were little activities that focused on the senses, for example sonas, reminiscence sessions and music.

On the first day of inspection there was no evidence of social engagement or meaningful activity. This was communicated to management and staff. As a result, an improvement in the provision of social interaction was made at periods throughout day two.

The Inspector observed the quality of interactions between staff and residents using a validated observational tool to rate and record at five minute intervals, and the quality of interactions between staff and residents during mealtimes on both days and during an organised activity on day two. The scores for the quality of interactions during the organised activity on day two was high with positive connective care observed, however, the overall experience for the majority of residents during all other observation periods was neutral care and task focused.

While staff engaged with individual residents on request or momentarily, interactions were generally needs based or mainly task orientated and passive where staff were reactive rather than proactive. At times the communal environment arrangements did not support therapeutic or quality interactions for structured periods to engage residents in meaningful activities in accordance with their interests or capacities. This was reflected in findings of the informal and formal observation periods carried out over the two days.

All residents with dementia did not have a record or summary of their life story completed to assist staff in understanding there lifelong occupation, hobbies, likes and significant events and to inform their activities

Visiting was unrestricted and a record of those visiting was maintained, as required. The provider and person in charge had recently developed a system to seek feedback by questionnaires and they described plans to hold a relative forum within the next two months.

Staff addressed residents in a respectful manner. Staff were courteous and responsive with residents and visitors. Staff were seen knocking on resident’s bedroom doors before entering. Residents’ right to vote in the upcoming presidential election was to be facilitated. The person in charge told the inspector the option to vote in the centre or to attend a polling booth externally was to be confirmed with residents.
Residents’ clothing, hygiene and regard to their state of dress was reasonably good, however, during the inspection some residents had not been adequately supported to ensure their dignity was maintained at all times.

There were religious services for those residents who chose to attend.

Some residents had private telephones for their personal use, while others were facilitated by staff to use the centres mobile telephone to communicate with their relatives. Some residents had access to newspapers, radios, TV, DVDs and books if they chose. Each resident had a TV in their bedroom and in the main residents rooms were personalised with family photographs and memorabilia brought in.

There were notice boards available throughout the centre providing information to residents and visitors. The absence of appropriate signage for residents with communication difficulties was recognised by the provider and person in charge in the completed SAT. An improvement in assessing and implementing an individualised care plans detailing the communication abilities and needs of residents was also required.

There was access to advocacy services, with contact details on display.

**Judgment:**
Non Compliant - Moderate

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**Outcome 04: Complaints procedures**

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

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

**Findings:**
A complaints policy, procedure and process were in place for the management of complaints and concerns.

The complaints process included an appeals procedure which was prominently displayed throughout the centre. The complaints procedure outlined and displayed met the regulatory requirements.

Written or verbal complaints and concerns expressed by residents including those with dementia and others representing residents interests were recorded and responded to. All recorded complaints and concerns were reportedly resolved to the satisfaction of the complainant.

The person in charge and provider representative said all complaints and concerns about the service were listened to, recorded and acted upon accordingly. Both were known to
residents and relatives as the persons to raise concerns with.

However, the management of complaints and expressions of dissatisfaction about the service was considered an area in need of improvement based on the volume of unsolicited information submitted to HIQA and information received from residents, relatives and staff during this inspection.

Judgment:
Substantially Compliant

**Outcome 05: Suitable Staffing**

**Theme:**
Workforce

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

**Findings:**
Residents and relatives who spoke with the inspector were complimentary of the staff and the care they provided, but many said they were always busy and that there was not enough staff at all times to provide daily activities or timely support.

An actual and planned roster was maintained in the centre with changes clearly indicated. The inspector reviewed the roster which reflected the staff on duty. From a review of rosters, discussions with staff, residents and relatives the inspector confirmed that nursing staff were on duty over a 24 hour period and at all times. In the past week staff nurse levels had increased to a minimum of two nurses each day and night.

While this was a welcomed increase in skill mix noted, the overall staff numbers and skill mix available and on duty to meet the assessed needs of residents, and in particular residents with a dementia, needed improvement.

The provision and allocation of staff did not consistently ensure a sufficient number and skill mix of staff were deployed to ensure appropriate care and adequate supervision of residents. Care and support was observed to be generally reactive and task orientated with little pro-active planning. Staffing provision was also depleted during planned leave.

The inspector observed that all staff were not supervised on an appropriate basis which negatively impacted on residents. For example, residents from all parts of the centre were grouped into one communal room due to the limited availability of staff on the first day. In addition, some records required and maintained by staff were unreliable and this was attributed to a lack of available time to complete records.

A lack of meaningful activity or individualised person-centre care approach was evident
due to the lack of suitably skilled staff. Other examples where the limited availability of staff negatively impacted on resident included the poorly organised mealtime experience observed where residents did not have timely support or assistance by staff due to the lack of staff available.

A recruitment drive was reported as on-going. The inspector examined a sample of staff files of those employed since the previous inspection and found that all files were complete as required. The inspector saw that an audit list was in place to ensure that all staff files included the requirements of the Regulations. A Garda Vetting disclosure was present in the staff files reviewed. The provider representative and person in charge confirmed that all staff were Garda Vetted prior to commencement.

Following the selection and vetting process, all staff received an induction period that was confirmed by staff and seen in records within the files examined. Annual appraisals formed part of the staff training and development plan to be implemented in full by the new management team. There was a varied programme of training for staff. A plan to support staff to develop expertise in specific areas such as palliative care, responsive behaviour and dementia was being prioritised in the training planned.

A Training Matrix was available, and systems were in place to evaluate if all staff had attended the required mandatory training. The training plan showed exiting staff had completed relevant training, however, in conversations with some staff the training confirmed differed from the record seen.

Records confirmed that all staff had completed mandatory training in areas such as safeguarding and prevention of abuse, manual handling, fire safety, and dementia or responsive behaviours that challenge.

Other training provided included training in medicine management, cardio pulmonary resuscitation, food hygiene and infection control. However, training gaps were found and communicated to the person in charge and registered provider representative in feedback.

The person in charge told the inspector that no volunteers were involved in or with the centre.

**Judgment:**
Non Compliant - Moderate

**Outcome 06: Safe and Suitable Premises**

**Theme:**
Effective care and support

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

This is single storey purpose built nursing home that is spacious and laid out in three wings.

All bedrooms (75 single and two twin/double) have full en-suite facilities that are wheelchair accessible with suitable assistive devices, call bells and aids. The detail of the premises has been outlined within previous inspection reports.

The location, design and layout of the centre is suitable for its stated purpose and can meet residents’ individual and collective needs in a comfortable and homely manner.

On arrival, the inspector found the atmosphere in the centre to be calm and welcoming. It was warm, well ventilated, furnished and decorated throughout to a high standard. Some ceiling stains were noted and were identified for repair.

The main dining room adjoined the kitchen where meals were prepared onsite. There was ample communal space throughout which included day spaces and sitting rooms, a smoking room, an equipped hair salon, staff and visitor facilities and a sensory room in development within one wing.

There was a large spacious oratory used for religious services, prayers and recreational events.

Residents had access to a variety of secure well maintained outdoor garden courtyards with raised beds, paved patios and seating areas.

Improvements needed and discussed between the inspector and management, included the display of appropriate signage to orientate residents to specific locations such as the outdoor areas and in the use of contrasting colours to optimise functioning and support way finding within the centre. The lack of windows for natural ventilation in one wing’s communal area was also noted along with the limited outlook available outdoors from the fire exit doors. This requires review.

Corridors and door entrances used by residents were wide and spacious to facilitate movement and aids used and required by residents. The flooring throughout was safe and appropriate. There were plenty of seating areas where residents congregated or relaxed. Handrails and grab rails were provided where required in circulating areas and in bathrooms.

Communal rooms had a call bell facility and all rooms were spacious enough to accommodate personal equipment and devices required by existing residents. Residents had a locked facility for safe storage in their rooms and could choose to lock their bedroom door which some availed off.

Staff had identified improvements such as signage in the SAT (previously referenced in Outcome 3) for improving a dementia friendly environment and the provision of other tactile items were discussed with the staff and management during the inspection.
Judgment:
Substantially Compliant

Outcome 08: Governance and Management

Theme:
Governance, Leadership and Management

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

Findings:
This outcome was partially inspected due to the change in person in charge and management team.

The registered provider representative, person in charge and the management staff demonstrated that they were engaged in the governance, operational management and administration of the centre to bring about improvements.

Governance arrangements were in place for oversight, monitoring and control of the operational activities and resource provision, but improvements were required. The designated centre did not have sufficient and consistent staff resources to ensure the effective delivery of care in accordance with the statement of purpose.

A communication and management system of weekly, monthly and quarterly reporting and auditing by the person in charge and management team supported the oversight and control function by the registered provider. Staffing as a resource was scarce at times when resident activity and occupancy levels increased. It was noted in the weekly communication report records that the replacement cover for staff sickness/absence was not provided in the previous two weeks. The rationale for this was not recorded in the reports.

A review of staff rosters showed that in the previous month (August 2018) a notable number of externally contracted nursing and care staff workers had been required, rostered and had worked in the centre due to the absence and availability of staff resources. From a review of the directory of residents the inspector confirmed that seven residents were admitted to the centre in August 2018 and admissions had occurred on weeks where up to eight externally contracted carers were required to work shifts to complete the staffing compliment required.

Feedback from residents, relatives, management and staff confirmed that staffing resources were stretched and depleted in the previous months and that external staff were contracted to address the shortage of staff. The inspector was informed by management that the recruitment of staff was on-going and they had recently recruited staff that were seen on induction during this inspection. There were no externally
contracted staff rostered for the week of the inspection; however, staff on planned absences were not replaced as noted on this inspection.

Overall and to ensure the centre was effectively monitored and safe, the recruitment of suitably skilled staff as a resource was described as a priority that was on-going to enhance the existing compliment. The previously high turnover of staff and lack of staff resources was a recurrent feature for the provider which was acknowledged by the provider representative who gave assurance and a verbal commitment that it had and would continue to improve. The provider representative and person in charge were informed in feedback of the options available to the Chief Inspector should they fail to implement the necessary improvements required.

The judgment for this outcome was rated substantially compliant as the provider and person in charge had completed the self-assessment tool in advance of this inspection and had identified that areas of non-compliance existed requiring action.

They described plans to address the areas and of a plan to review the overall governance and management arrangements to ensure the service was safe and appropriately resourced, and consistently monitored going forward. The oversight arrangements, reporting structures, communication arrangements and performance of staff were to be part of the review to bring about improvements impacting negatively on residents as discussed in the outcomes examined.

**Judgment:**
Substantially Compliant

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**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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<th>Centre name:</th>
<th>Maynooth Lodge Nursing Home</th>
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<tr>
<td>Centre ID:</td>
<td>OSV-0004593</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>18/09/2018 and 19/09/2018</td>
</tr>
<tr>
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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 01: Health and Social Care Needs

Theme:
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The care plans of residents with dementia did not include interventions to be used to de-escalate behaviour such as effective individualised social activities or divisional therapies to direct staff or guide care practices.

Some residents at risk of developing pressure ulcers did not have a care plan to guide necessary interventions or to mitigate against the risk.

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 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:**
The Management Team & Nursing Staff are reviewing and updating all care plans. Responsive behaviour training is ongoing in Maynooth Lodge, records demonstrate this. Additional training was delivered on 11.09.2018 and a second date secured for the 26.10.2018. Residents that display responsive behaviours have specific care plans to guide practice to de-escalate behaviours that may challenge. In addition a comprehensive assessment including a Key to me, PAL assessment & care plan are completed for social engagement. Families & residents are part of the care planning process and meetings at a minimal interval of every 4 months & sooner if presenting needs change. A multisensory room is now in place in Oghill to provide a quite space for residents.

We have access to Psychiatry of Old Age who supports residents with advancing dementia. ABC charts reviewed at this meetings for any potential trends of antecedents. All residents are assessed using the Waterlow Tool to determine risk of pressure ulcers. New pressure relieving cushions have been purchased for residents that spend periods of time in their wheelchairs. Positional change for residents is encouraged frequently. Tissue Viability Training is scheduled to take place for staff. A Tissue Viability Audit is in place.

**Proposed Timescale:** 30/11/2018

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Gaps in the assessment procedures prior to and following the admission of residents were found.

Some assessments were not complete or carried out as required or when a risk or need was identified.

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

**Please state the actions you have taken or are planning to take:**
A comprehensive Pre admission Assessment form is completed for each resident prior to admission. All pertinent information including CSAR is also requested prior to admission, whilst all documents are requested where these are not made available this will be noted on Pre Admission Form. Upon admission a clear plan is now in place to ensure that all necessary assessments, care plans and follow ups are completed within 48 hours of admission in line with our Policy on admissions. Each resident has a named
nurse upon admission. The PIC & PPIM will audit care plans including new admissions to ensure this is completed.

**Proposed Timescale:** 30/11/2018  
**Theme:** Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Gaps in the care planning process and in the recording of required interventions was found.

Some care plans did not contain sufficient information to specify the actual needs of residents and guide the necessary care interventions to be evaluated.

**3. Action Required:**
Under Regulation 05(3) you are required to: Prepare a care plan, based on the assessment referred to in Regulation 5(2), for a resident no later than 48 hours after that resident’s admission to the designated centre.

**Please state the actions you have taken or are planning to take:**
Upon admission a clear plan is now in place to ensure that all necessary assessments, care plans and follow ups are completed within 48 hours of admission in line with our Policy on admissions. In addition to named nurses we are rolling out a named carer for each resident to complement the care planning process and assist in continuity of care. A review of all care plans is ongoing, a clear plan is now in place.

**Proposed Timescale:** 30/11/2018  
**Theme:** Safe care and support

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
Medicines reportedly given earlier in the day were not recorded as administered until a review of the kardex was sought by the inspector over four hours after the prescribed time.

The actual time that medicines were administered at was not consistently recorded by staff.

**4. 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:**
Scope of Practice Training was delivered on 06.09.2018 by the PIC. A second session is being held on 26.10.2018. Nu-life EMAR is being rolled out in the home on 01.11.2018, this will ensure that medications are administered and documented at the prescribed time. Pharmacist to deliver training on 23.11.2018 & 30.11.2018. All Nurses complete the Yearly medication management online with HSELand.ie. Medication competencies with staff nurses are in progress.

**Proposed Timescale:** 08/12/2018

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
A gap in the documentation of those involved in decisions related to a resident's end of life was found.

A lack detail of the resident’s end of life preferences or wishes was evident in some of the records examined.

**5. Action Required:**
Under Regulation 13(1)(a) you are required to: Provide appropriate care and comfort to a resident approaching end of life, which addresses the physical, emotional, social, psychological and spiritual needs of the resident concerned.

**Please state the actions you have taken or are planning to take:**
Upon admission an Advanced Care Directive in relation to Resuscitation, hospital transfer and interventions is completed for each resident after discussion with resident, representative, GP and nurse. In addition a new form is being rolled out to capture personal preferences around funeral planning, wishes & desires regarding approaching end of life. Quarterly assessment also includes Review of Advanced Care directives. All residents approaching end of life or those who wish to engage in end of life discussions will have their wishes known. A review of all existing care plans is underway, this will be overseen by the PIC & PPIM. The home has access to Specialist Community Palliative Care Services and the PIC has a Masters in Palliative Care. Palliative Care training is conducted in house, another training session is planned for the 6th November, 2018 this is category I approved from NMBI.

**Proposed Timescale:** 15/12/2018

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The meal time experience in both dining areas needed improvement to ensure an organised approach was adopted where all residents were served and supported in a timely manner, and monitored and assisted appropriately by all staff.
**6. Action Required:**
Under Regulation 18(1)(c)(i) you are required to: Provide each resident with adequate quantities of food and drink which are properly and safely prepared, cooked and served.

**Please state the actions you have taken or are planning to take:**
All Residents receive adequate food & fluid intake and are monitored by staff. Meal choice is consistent and received well by residents, there are no complaints or concerns regarding availability/choice of food. The catering staff together with the PIC and care team have designed a new layout of the dining room and for serving tables together. In addition, Picture menus are available. All staff are present in the dining room for mealtimes & to assist with meals.

**Proposed Timescale:** 31/10/2018

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
An adequate number of staff was not available to assist residents at mealtimes.

**7. Action Required:**
Under Regulation 18(3) you are required to: Ensure that an adequate number of staff are available to assist residents at meals and when other refreshments are served.

**Please state the actions you have taken or are planning to take:**
The catering staff together with the PIC and care team have designed a new layout of the dining room and for serving meals together. All staff are present in the dining room for mealtimes & to assist with meals

**Proposed Timescale:** 31/10/2018

**Outcome 02: 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:**
Staff working and allocated to care and support residents with dementia, responsive behaviours or behavioural and psychological signs of dementia (BPSD) were not sufficiently equipped, skilled or trained appropriately.

The delivery of care was mainly reactive care rather than pro-active.

Interventions to be used to de-escalate behaviour such as effective individualised social activities or divisional therapies were not reflected in an appropriate care plan for residents with dementia to direct or guide care.
A structured activity programme was not evident in practice.

**8. 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:**
Responsive behaviour training is ongoing in Maynooth Lodge, records demonstrate this. Additional training was delivered on 11.09.2018 and a second date secured for the 26.10.2018. Residents that may display behaviour that is challenging are discussed at handover, all aspects of care are discussed and a plan of care in place. Policies and procedures are discussed and used as direction to guide practice. Staff always utilise the least restrictive practice in addressing these occurrences. We have access to Psychiatry of Old Age and this includes a review of ABC forms to identify trends in antecedents. Together with the PIC, the Assistant Director of Nursing and 2 Clinical Nurse Managers & 3 Senior Health Care Assistants they ensure that supervision for residents and staff is in place.

A clear structured timetable is in place in both the main house and in Oghill to allow for activities appropriate to the resident’s needs & expressed wishes including the findings from the individual PAL assessments.

**Proposed Timescale: 31/10/2018**

**Outcome 03: Residents’ Rights, Dignity and Consultation**

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

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
There was limited opportunity for occupation, social engagement and meaningful activities.

The arrangements within the communal environment and lack of skilled staff attributed to the lack of meaningful activities in accordance with residents interests or capacities.

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

**Please state the actions you have taken or are planning to take:**
A clear structured timetable is in place in both the main house and in the Secure Unit to allow for activities appropriate to the resident’s needs & expressed wishes. The Social Care Team will be working closely with carers also to offer support & guidance on activities for residents with varying needs. Our Assistant Social Care Practitioner is booked onto the next Sonas Training Programme, Day 1 Friday 2nd November, Day 2
Friday 7th December, Day 3 Friday 18th January, 2019. This 3-day course provides training in the use of the Sonas programme, a therapeutic communication activity for people with dementia.

**Proposed Timescale:** 30/11/2018

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

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The overall experience for the majority of residents during the observation periods was neutral care and task focused.

10. **Action Required:**
Under Regulation 09(4) you are required to: Make staff aware of the matters referred to in Regulation 9(1) as respects each resident in a designated centre.

**Please state the actions you have taken or are planning to take:**
The Management Team has changed in recent months, we now have a full time PIC & PPIMs in place. An additional Senior Health Carer has been recruited bringing this compliment to 3 full time Senior Health Care Assistants to embed our ethos of care that encourages person centred care with regard for the sex, religious persuasion, racial origin, cultural and linguistic background and ability of each resident. The PIC/PPIM meets with the Senior Health Carers monthly. The PIC & Social Care Team ensured that residents who wanted to vote in the referendum/presidential election casted their vote on 12.10.2018.

**Proposed Timescale:** 30/11/2018

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

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The absence of appropriate signage for residents with communication difficulties existed.

An individualised care plan detailing the communication abilities and needs of residents was not in place for residents with communication difficulties.

11. **Action Required:**
Under Regulation 10(2) you are required to: Where a resident has specialist communication requirements record such requirements in the resident’s care plan prepared under Regulation 5.

**Please state the actions you have taken or are planning to take:**
The Management team & Nursing staff are reviewing and updating all care plans. We are designing communication passports for resident’s that have difficulty communicating.
their needs.
Decals have been fitted on doors into and out of the Secure Unit. Red toilet seats are in place in the Secure Unit. Signage is planned throughout the home to direct residents to pertinent areas in the home. Staff are available to redirect residents that may have difficulty finding their way.

Proposed Timescale: 15/12/2018

Outcome 04: Complaints procedures
Theme:
Person-centred care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The management of complaints was an area in need of improvement based on the volume of unsolicited information submitted to HIQA and information received from residents, relatives and staff during this inspection.

12. Action Required:
Under Regulation 34(1)(h) you are required to: Put in place any measures required for improvement in response to a complaint.

Please state the actions you have taken or are planning to take:
The complaints procedure is displayed throughout the home in prominent positions. The PIC has rolled out new documentation for resident’s and family feedback with satisfaction surveys in relation to all aspects of care. This facilitates overall learning and improvements for practice and compliments for staff & facilities. The Provider is assured there is a robust system in place for managing complaints. There are no open complaints currently. Complaints management training will be rolled out to all staff by end of December 2018.

Proposed Timescale: 31/12/2018

Outcome 05: Suitable Staffing
Theme:
Workforce

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Residents and relatives who spoke with the inspector said there was not enough staff at all times and that an absence of daily activities existed.

The overall staff numbers and skill mix available and on duty was not sufficient to meet the assessed needs of residents with dementia.

The provision and allocation of staff did not consistently ensure a sufficient number and skill mix of staff were deployed to ensure appropriate care and adequate supervision of
The limitations in staff numbers available to residents impacted negatively on the care and support provided to residents.

**13. Action Required:**
Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

Please state the actions you have taken or are planning to take:
Recruitment and induction is ongoing and is overseen by the Provider and the PIC. New staff are buddied up with senior staff for induction. Staffing and skill mix has been reviewed and a new system of work implemented to ensure sufficient resources during peak times in the home. The Provide & PIC regularly review the Barthel Index of all residents to determine care needs with consideration for the layout & size of the home.

**Proposed Timescale:** 30/11/2018

**Theme:** Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Gaps in staff training and development existed.

**14. Action Required:**
Under Regulation 16(1)(a) you are required to: Ensure that staff have access to appropriate training.

Please state the actions you have taken or are planning to take:
Training is ongoing. Additional staff training is booked in the following areas: Palliative Care, Dementia & BPSD training, TVN & SALT training, Pharmacy Training & CPR training. All staff receive training on safeguarding of vulnerable adults.

**Proposed Timescale:** 31/12/2018

**Theme:** Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff were not supervised on an appropriate basis.

Staff supervision in the delivery of direct care to resident required review and improvement.

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

**Please state the actions you have taken or are planning to take:**
The PIC/PPIMs are on daily together with a Senior health Care Assistant. In addition each nurse is allocated an area within the home on any given day to oversee the delivery of care. An afternoon handover is occurring to ensure continuity of care. The PIC & PPIMs have a schedule of annual appraisals to ensure staff receive formalised feedback in relation to their role within the home.

**Proposed Timescale:** 31/12/2018

### Outcome 06: Safe and Suitable Premises

**Theme:**
Effective care and support

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
The lack of windows for natural ventilation and limited outlook to outdoors in the communal area of one unit was also noted and highlighted to management.

#### 16. **Action Required:**
Under Regulation 17(1) you are required to: Ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.

**Please state the actions you have taken or are planning to take:**
The Registered Provider is in active discussions with our Design Engineer to investigate the various possibilities in providing additional window space and natural ventilation. We are mindful of the different potential regulatory requirements such as Planning etc and would hope to have a solution in place within 6 weeks.

**Proposed Timescale:** 10/12/2018

### Outcome 08: Governance and Management

**Theme:**
Governance, Leadership and Management

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
The designated centre did not have sufficient and consistent staff resources to ensure the effective delivery of care in accordance with the statement of purpose.

#### 17. **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 purpose.
Please state the actions you have taken or are planning to take:
The home has a new management team in place. The home has a full complement of nurses to manage the care of the cohort of residents in the home. Recruitment and induction is ongoing and is overseen by the Provider and the PIC/PPIMs. New staff are buddied up with senior staff for induction. Staffing and skill mix has been reviewed and a new system of work implemented to ensure sufficient resources during peak times in the home.

Proposed Timescale: 31/10/2018

Theme: Governance, Leadership and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The oversight arrangements, reporting structures, communication arrangements and performance of staff required review to bring about improvements impacting negatively on residents, as outlined in the outcomes inspected.

The provider and person in charge were to implement the described plans to improve the overall governance and management arrangements to ensure the service is safe and appropriately resourced, and consistently monitored.

18. 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 PIC/PPIMs are on daily together with a Senior Health Care Assistant. In addition each nurse is allocated an area within the home on any given day to oversee the delivery of care. The PIC & PPIMs have a schedule of annual appraisals to ensure staff receive formalised feedback in relation to their role within the home. Monthly department/team meetings occur with all staff. The Provider has regular contact with the home and attends the home weekly to meet with the PIC. A robust audit schedule is in place.

Proposed Timescale: 31/10/2018