

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Maypark House Nursing Home
Centre ID:	OSV-0000249
Centre address:	Maypark House, Maypark Lane, Waterford.
Telephone number:	051 301 848
Email address:	info@mayparkhouse.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Maypark Lane Limited
Provider Nominee:	Michael Dwyer Snr.
Lead inspector:	Gemma O'Flynn
Support inspector(s):	Mary O'Donnell
Type of inspection	Unannounced
Number of residents on the date of inspection:	28
Number of vacancies on the date of inspection:	14

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.

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 Quality Standards for Residential Care Settings for Older People in Ireland.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 06 July 2016 07:30 To: 06 July 2016 16:30

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

Outcome	Our Judgment
Outcome 01: Statement of Purpose	Substantially Compliant
Outcome 02: Governance and Management	Non Compliant - Moderate
Outcome 03: Information for residents	Substantially Compliant
Outcome 04: Suitable Person in Charge	Compliant
Outcome 06: Absence of the Person in charge	Compliant
Outcome 07: Safeguarding and Safety	Compliant
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 09: Medication Management	Non Compliant - Moderate
Outcome 10: Notification of Incidents	Non Compliant - Moderate
Outcome 11: Health and Social Care Needs	Non Compliant - Moderate
Outcome 12: Safe and Suitable Premises	Non Compliant - Moderate
Outcome 13: Complaints procedures	Substantially Compliant
Outcome 14: End of Life Care	Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Compliant
Outcome 18: Suitable Staffing	Non Compliant - Moderate

Summary of findings from this inspection

This inspection report sets out the findings of a triggered, unannounced, inspection of this centre. The inspection was carried out in one day to follow up on the action plans to address non compliances from the previous inspection in March 2016. Inspectors also considered unsolicited information received by the Health Information and Quality Authority (HIQA) which referenced inadequate staffing and nursing levels and inadequate standards for care and poor standards of cleanliness of communal areas in the centre.

Throughout the course of the inspection, inspectors met with residents and family members, the person in charge, the operations manager, nursing staff, healthcare assistants and household staff. Documentation such as staff rosters, training records

and care plans were also reviewed.

The 12 actions required following the previous inspection in March 2016 were reviewed and inspectors found that 8 of these had been satisfactorily completed, however four actions remained non-compliant with the Regulations. The judgements in relation to each outcome inspected are stated in the table above.

Activity provision had improved significantly since the previous inspection and a new staff team were committed to meeting the social needs of residents.

Two vacant nursing posts were unfilled and the provider gave an undertaking to keep admissions below 30 until staff were recruited. This impacted on the supervision of care and mentoring of new staff. The operations manager told inspectors that a senior nurse was recruited and due to begin in post soon. Due to inadequate documentation it was not possible to determine if care delivered was in line with residents' care plans. Audits were conducted but ongoing development was required to fully utilise the audit process for continuous quality assurance purposes.

Non compliances are discussed in detail in the body of the report and in the action plans at the end of the report

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

Outcome 01: Statement of Purpose

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

There was a written Statement of Purpose that consisted of a statement of the aims, objectives and ethos of the designated centre and statement as to the facilities and services which are to be provided for residents. However, this document didn't accurately reflect the current governance and staffing arrangements in the centre and thus required updating.

Judgment:

Substantially Compliant

Outcome 02: Governance and Management

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

Theme:

Governance, Leadership and Management

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

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

Findings:

There was a clearly defined management structure in place, this was an action in the previous report. Since the last inspection, a full time person in charge had been appointed in the centre, to whom nursing and care staff reported. The person in charge

reports to the operations manager. The operations manager is also the person in charge of the provider's sister centre and she supports the person in charge. The operations manager attended the centre on the day of the inspection to support the person in charge. The person in charge confirmed that a senior staff nurse had also been recruited and was due to start working in the centre the week following the inspection. She stated that she planned on delegating some supervisory responsibilities to this senior nurse to ensure that the staff working with residents were appropriately supported and supervised. The General Manager oversaw the running of the non care related aspects of the service and he was in the centre Monday to Friday.

The person in charge told inspectors that management meetings occurred quarterly but it was her intention to increase the frequency of these meetings to monthly. Although the provider wasn't present on the day of inspection, the person in charge confirmed that he was there most week days. Staff who spoke with inspectors were able to identify the person in charge and the provider.

The person in charge confirmed that there were sufficient resources in place to ensure the effective delivery of care. She stated that whilst she didn't have autonomy in regards to financial expenditure, requests for staff, equipment etcetera were discussed with the General Manager for final sign off. She confirmed that this arrangement worked well and that there had been no difficulties procuring what she had required to date. The General Manager confirmed this arrangement.

An annual review of the quality and safety of care delivered to residents had been completed in September 2015. Some learnings were evident as a result, these included ensuring the audit information formed an integral part of staff meetings to ensure learning outcomes and endeavouring to have more community input in 2016. The report required editing to ensure that resident names were not included to ensure confidentiality was maintained at all times.

Audits completed by the person in charge included: medication, falls, restraint and infection control. Some learning were evident, particularly following the falls audit where the times and cause of falls had been analysed and a reduction in falls had been noted compared to the previous quarter. However, other learning had not instigated an improvement in practices, for example, medication management. Significant deviations from NMBI (Nursing and Midwifery Board of Ireland) guidelines were found in the medication audit for quarter 1 of 2016. The person in charge stated that she was in the process of completing the audit for quarter 2, but had noted that issues were still arising and inspectors witnessed poor medication management practices over the course of the inspection.

The infection control audit was found to be inadequate as it was not comprehensive and hadn't found areas of non compliance in the area of infection control that were identified on the day of inspection. These non compliances are discussed under the Health & Safety outcome. Therefore, although audits were being completed, they were not seen to bring about significant improvements in the quality of care and safety and therefore required review to ensure they were more meaningful to the service.

There was evidence of consultation with residents and their representatives via a survey

in February 2016. Individual issues had been acted upon such as feedback about meals, however, the results required further analysis so as to determine any trends in the overall service provided.

Judgment:

Non Compliant - Moderate

Outcome 03: Information for residents

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

A sample of residents' contracts were reviewed and were found to be signed and dated. Some residents had signed their own contracts. However, details of recently introduced fees for social activity and physiotherapy were not stated.

Judgment:

Substantially Compliant

Outcome 04: Suitable Person in Charge

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The centre had appointed a new person in charge in June 2016. She was a nurse with the required experience in the area of nursing the older adult and had been working in the centre as a senior nurse up to the date of her appointment as person in charge. She was able to demonstrate continuing professional development via her attendance on relevant training days and had completed recognised courses in Supervisory Management and Safety Management. She had also completed training such as End of Life Care and Challenging Behaviour in Dementia Care and had obtained a higher

certificate in Gerontology.

She discussed her plans for the centre and stated that she wanted the centre to become a 'hospice friendly nursing home' and said that the operations manager was planning to schedule the relevant training for September. She demonstrated a knowledge of the Standards and had scheduled training for August 2016 to further enhance her knowledge in this area.

She was aware of the findings in the previous inspection reports issued by HIQA and discussed her plans to bring the service into compliance. Her plans included boosting staff morale and focusing on communication between staff and residents. She also stated that she planned to involve her nursing team in the process of auditing care in the centre.

She was knowledgeable of her responsibilities in regards the safeguarding of residents and was up to date on recent changes in the reporting of any allegations of abuse.

She stated that she was well supported by the provider of the centre.

Judgment:
Compliant

Outcome 06: Absence of the Person in charge
The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:
Governance, Leadership and Management

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

Findings:
There were adequate plans in place in the event that the person in charge would be absent from the centre. The person in charge stated that she would be taking extended planned leave in August 2016. During this time, the operations manager was the person nominated to deputise for the person in charge in her absence. She was a nurse with the relevant experience and qualifications for the role.

Judgment:
Compliant

Outcome 07: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or

suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:

Safe care and support

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

Findings:

On the previous inspection care plans for residents who exhibited behaviours that challenge were not consistently completed and they lacked details of possible triggers and strategies to de-escalate or prevent the behaviour from occurring. Inspectors found that there were four residents with behaviours that challenge. These residents had been assessed and behavioural logs completed which identified the antecedents, the behaviour and the consequences of the behaviour. The residents had care plans in place which reflected the assessment findings. Interventions were clearly stated to support a proactive, consistent approach to the management of the residents. Staff interviewed had the relevant information to support them to implement the care plans. The effectiveness of the care plans was evident because many of the behaviours identified had not occurred for a number of months. The person in charge told inspectors that training in 'behaviours that challenge' was now mandatory for all staff. Staff confirmed that they had done the programme on line and the training records showed that many of the staff had completed the training and the competency assessment afterwards.

Inspectors found that measures were now in place to protect residents from harm or suffering abuse and to respond to allegations, disclosures and suspicions of abuse. There was a policy in place covering the prevention, detection, reporting and investigation of allegations or suspicion of abuse. It incorporated the national policy on safeguarding vulnerable persons at risk of abuse. Training records confirmed that staff attended the mandatory training in safeguarding. Staff spoken to by inspectors confirmed that they had received training on recognising abuse and were familiar with the reporting structures in place.

Staff were proactively working to promote a restraint free environment. Inspectors saw that the use of electronic bracelets (2) and bedrails (11) had reduced since the last inspection. Appropriate risk assessments had been undertaken and regular checks were recorded when bedrails were in use. There was documented evidence that alternatives had been tried prior to the use of restraint, as required by the centre's policy. Additional equipment such as low-low beds and crash mats were in use to reduce the need for bedrails.

Judgment:

Compliant

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

Theme:
Safe care and support

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

Findings:

The centre had policies and procedures relating to health and safety. There was a risk management policy in place, however, it didn't meet the requirements of the Regulations. For example, it didn't set out the arrangements for identifying, recording, investigating and learning from serious incidents or the arrangements in place for identifying risks. It also didn't set out the arrangements for specified risks such as abuse or the unexplained absence of any resident as required by the Regulations.

However, the person in charge did carry out regular hazard identification checks and there was documentary evidence of this. Inspectors identified a hazard in a resident's bedroom and the person in charge demonstrated that she had already identified this, however it had been five days since the hazard had been identified and no action had been taken at the time of the inspection.

A risk register was maintained and controls were in place. The ramp leading to the dining room was risk assessed following the previous inspection but the completed risk assessment was insufficient. For example, the hazard itself (the ramp) was listed as a control. Controls the person in charge spoke of such as specific criteria for residents admitted to a bedroom leading off the ramp were not documented and other controls were vague and non specific, for example, 'the ramp will be monitored to ensure safety' but didn't specify as to how it would be monitored.

Suitable fire equipment was provided and service records showed that fire equipment was serviced annually and was due to be serviced in the month of the inspection. Whilst records showed that the fire alarm had been serviced, servicing did not occur four times per year as required.

Fire evacuation procedures were displayed in prominent locations throughout the centre. Staff were trained and regular drills took place. However, staff who spoke with inspectors were not consistent in explaining what they should do in the event of a fire. Fire drill documentation was good overall but could be further developed to enhance learnings. For example, drill records didn't include the time the drill took place and it didn't give detail about what had gone well and what required improving after the drill had taken place.

Procedures for the prevention and control of healthcare associated infections required improvement as they were not in line with the Authority's standards. For example, the person in charge explained the procedure for the management of bedrooms where there

were healthcare associated infections, however, this procedure was not seen to be implemented in practice. For example, these areas were not left until last to be cleaned as the person in charge stated they should be. The cleaning trolley was visibly dirty as were the mop buckets. The inspector was told that the same mop head was used in all bedroom and communal areas downstairs and then the mop was changed for upstairs. There were no spare mopheads on the trolley, the person in charge stated there was ample mopheads available and that they should be changed frequently. Documentary guidance was insufficient as it didn't clearly and comprehensively guide this practice.

Judgment:

Non Compliant - Moderate

Outcome 09: Medication Management

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

Theme:

Safe care and support

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

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

Findings:

Policies and procedures were in place to guide staff in the management of residents' medication. They included information on the prescribing, administering, recording, safekeeping and disposal of unused or out of date medicines. On the previous inspection it was found that faxed medication prescriptions were not transferred into residents' prescriptions within 72 hours in line with the policy. This action had not been fully completed. Inspectors followed up on two recently faxed prescriptions and found that one had been transferred into the residents prescription sheet and the other one had not been written up in the resident's prescription sheet, this meant that the medication were not administered from a valid prescription.

Further improvement was required to ensure that each resident was adequately protected by all medication management practices.

Prior to administering medicines to residents the inspector observed the staff nurse consulting with residents and maintaining hand hygiene between each resident. However, practices associated with the administration of medicines required significant improvement:

- A nurse administering medications, who was deemed to be competent, could not tell the inspector what various medications were for.
- Crushed medications were left unattended on the top of the medicine trolley in the dining room.
- There was no pain chart used to determine levels of pain or the effectiveness of analgesia administered.

There was evidence of GPs reviewing residents' medicines on a regular basis. The person in charge showed inspectors medication audits which had been carried out in order to highlight and subsequently control any risks which may be identified by staff operating it. There was no evidence that the audits led to quality improvements as inspectors noted that the same failings found in the first audit were repeated in the second audit.

Judgment:
Non Compliant - Moderate

Outcome 10: Notification of Incidents
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:
Safe care and support

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

Findings:
A record of incidents occurring in the centre was maintained. Notifications were received by the Authority, however, a record of environmental restraint was not included in the centre's quarterly notification submission as required by the Regulations.

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:

On the previous inspection, not all residents had a care plan to guide person-centred care. On this inspection, residents had care plans informed by comprehensive assessments. Some of the care plans viewed were generic and did not reflect the individual needs of the residents. There was inadequate documentary evidence to determine if the care plans were implemented in practice.

The centre provides care primarily for residents with long-term nursing care needs.

Relatives confirmed that staff informed them of their relatives' health care needs and any changes in their conditions. Residents had access to GP services and out-of-hours medical cover was provided. Psychiatry of later life services were available and provided to residents upon referral. The centre employed a physiotherapist and a full range of other services was available on referral basis including speech and language therapy (SALT) and occupational therapy (OT), dietician, chiropody, dental and optical services. Inspectors reviewed residents' records and found that some residents had been referred to these services and results of appointments were recorded in the residents' notes.

Inspectors found that residents had a comprehensive nursing assessment and care plans developed based on these assessments. For example, there was information which detailed residents' choices with regard to food likes and dislikes, risk assessments such as moving and handling, falls, use of bed rails, nutrition, continence and the risk of pressure sores.

Inspectors found the supervision of care and the documentation of care provided was inadequate to determine if the care provided was in line with the residents' care plan.

Inspectors observed that drinks were not offered to residents who required assistance at dinner time and it was not possible to determine if residents' fluid intake was adequate, as the volume of fluids taken was not consistently recorded.

The day before the inspection a dietician had recommended that resident took 1,200mls fluid daily, this advice was not communicated at handover and there was no fluid chart in place for this resident. The care plan had not been updated to reflect the specialist advice.

Some care plans were generic and did not reflect the wishes/preferences of individual residents. For example, the sample of care plans examined all stated the resident should have a shower/bath at least on a weekly basis. There was no system in place to ensure that care plans were consistently implemented. Staff explained that residents had a daily body wash and a weekly shower/bath. Records showed that the residents had on average, three showers a month. When inspectors queried why a resident did not have a shower/bath for a month, a senior staff member said the resident decided they didn't want one. There was no record to indicate that this resident had been offered and refused a shower and their care plan had not been amended to indicate how their personal hygiene needs would be met. Prior to inspection HIQA had received information of concern about poor standards of personal hygiene and relatives who met inspectors on the day also had reservations about standards of personal care provided to dependent residents.

There were no residents with pressure ulcers care at the time of this inspection. Residents were assessed on a three monthly basis for risk of pressure ulcers and care plans were developed and implemented. There was evidence that residents had their position changed regularly and appropriate pressure relieving devices were provided.

There was a strategy in place to prevent falls. An evidence-based assessment tool was used to assess residents' risk of falls on admission and at least every three months thereafter. A review was completed after each fall incident with preventative measures, such as, ultra low beds and crash mats used to mitigate further risk of injury. Audits showed that the incidence of falls was low. An additional staff member now rostered to work until 22:00 hours to further reduce the number of falls in the centre.

Judgment:

Non Compliant - Moderate

Outcome 12: Safe and Suitable Premises

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

Theme:

Effective care and support

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

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

Findings:

Actions required under this outcome following the last inspection were underway but not completed at the time of the inspection, however, the General Manager advised that the timeline of October 2017 given in the previous report, pertaining to accessible, safe outdoor garden space was still on track. These plans were discussed with the inspector and the person in charge stated that a decision needed to be made between two options before plans could get fully underway.

In the previous report, an inappropriately located sluice room off a residents' toilet room had been identified. The person in charge discussed the plan to address this issue in detail and whilst she and the General Manager were confident that works would be completed in a short timeframe, an actual completion date could not be determined on the day of the inspection.

The ramp leading to the dining room remained an issue and as discussed in Outcome 8, the ramp required a comprehensive risk assessment to mitigate any associated risk.

An action regarding the covering of a frosted glass panel in a toilet door had been completed.

Otherwise, the design and layout of the centre were in line with the Statement of Purpose. Overall, it was adequately maintained, however, some minor decorative repair was required. For example, some walls had holes left where wall hangings had been removed and some wardrobes had sticker residue on the doors. Curtains seen in a resident's bedroom required attention to ensure they were hanging properly. On the day of inspection, the centre was seen to be clean and free from odour.

Some homely features were noted on the day of inspection such as photographs of residents on the walls and wall displays featuring 'my earliest childhood memories', my school day memories. Signage was utilised to direct residents to the chapel, activities room and the dining room.

Bedrooms seen on the day of the inspection contained the requirements set out in the Regulations and twin rooms seen by the inspector had adequate privacy screening with the exception of one unoccupied room. The person in charge stated that this was due to the room being recently decorated and the curtain had yet to come up from the laundry.

There was ample communal space in the centre and lobby areas had plenty of seating should one wish to use it.

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):

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

Findings:

There were policies and procedures for the management of complaints. The complaints process was seen to be user friendly and displayed in a prominent place. However, information regarding the Authority's involvement in centre's complaints was inaccurate and required review.

Complaints were logged and staff who spoke with the inspector clearly explained that they would report all complaints to the nurse in charge so they would be documented.

The person in charge had been nominated at the person to deal with complaints and an appeals process was in place.

However, as required by the Regulations a nominated person to ensure that all complaints were appropriately responded to and records kept had not been nominated. Whether or not a complainant was satisfied with the outcome of a complaint was not always clearly recorded as required by the Regulations. This was discussed with the person in charge on the day and was also identified on the previous inspection.

An audit of complaints had not been undertaken despite the previous action plan stating that they would be audited quarterly.

Judgment:

Substantially Compliant

Outcome 14: End of Life Care

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

Theme:

Person-centred care and support

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

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

Findings:

On the previous inspection, not all residents had a care plan to guide person-centred care in relation to end of life care. Inspectors randomly selected the care plans for five residents and found that four of the five residents had a care plan which detailed their wishes and preferences for end of life care. There was documentary evidence that the resident who did not have an end of life care plan stated that he did not wish to engage in a conversation about his future care needs or his wishes for end of life care. The person in charge said she planned to reopen the discussion at a time when the resident may be more receptive to the conversation.

There was evidence that families represented the wishes and views of residents who did not have the capacity to communicate their wishes.

The care plans viewed were created following multidisciplinary discussion and reflected the residents' wishes regarding their resuscitation status, transfer to hospital, antibiotic treatment for infections and their preferred place of care. Inspectors noted that the white board in the office had a symbol beside each resident to indicate if they were not for resuscitation.

Inspectors saw that a resident who was receiving end of life care had a comprehensive care plan based on the resident's wishes and preferences. The community palliative care

team were actively involved in this resident's care and the care plan was updated accordingly.

The majority of residents had single room accommodation and those who shared a room had a single room available for end of life care. There was a room for families to use if a relative was very ill or approaching end of life.

Judgment:
Compliant

Outcome 16: Residents' Rights, Dignity and Consultation
Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

Theme:
Person-centred care and support

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

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

Findings:

In the previous inspection there were limited opportunities for residents with dementia to engage in activities. The communications policy did not reference the needs of residents with dementia and their communication needs were not adequately addressed by staff.

The communication policy was revised on 23 March 2016. Staff training records showed that staff had participated in training about communicating with people who had dementia. Staff spoken with had a clear understanding of communication strategies relevant to various residents with communication problems and also those with dementia.

A new activity coordinator had been appointed since the previous inspection. She had introduced a breakfast club which was very popular among the residents. Health care staff were actively engaged in meeting the social needs of residents and they facilitated the breakfast club at the weekends. Live music was also provided at the weekends. Residents were seen enjoying various activities during the inspection. Relatives and residents completed a 'Getting to know you' booklet after admission and each resident's preferences were assessed and this information was used to plan an activity programme. Residents who were confused or who had dementia related conditions were encouraged to participate in the activities and many of the activities were suitable for these residents. A programme of activities was available and planned that included current affairs, music, games and a range of both group and individual activities. Daily records showed that residents, including those who were confined to their bedrooms

were provided with social stimulation on a daily basis.

There was evidence that residents were consulted with and had opportunities to participate in the organisation of the centre in that a resident's forum was facilitated and the group met on a regular basis.

Residents had access to independent advocacy services. An independent advocate met with residents weekly and represented their views at the three monthly residents' meetings. In addition an advocate from 'SAGE' was supporting a resident with a particular issue. Residents' independence and autonomy was promoted. For example, the inspector saw residents choosing to participate in activities or not. In the main, residents were able to make choices about how they lived their lives in a way that reflected their individual preferences or abilities.

Residents recently completed a survey of their dining experience and there was evidence of positive changes made in response to this survey.

Inspectors saw that residents' privacy and dignity was respected when care was provided in their bedrooms and they could receive visitors in private. Residents were of an older age range, they were seen occupied in hobbies that interested them such as reading and music. Residents were seen to be dressed in an appropriate manner in their own clothes with personal effects of their choosing.

Judgment:
Compliant

Outcome 18: Suitable Staffing

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

Theme:
Workforce

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

Findings:

On the previous inspection the numbers and skill-mix of staff did not adequately meet the needs of the residents. The provider had difficulty recruiting nurses and had given an undertaking to keep the occupancy levels below 30 until the full complement of staff was in place.

A record of resident dependency levels, the staffing levels and training programmes were maintained and monitored on a regular basis to inform staffing arrangements. The inspectors were told that a recruitment drive had been on-going and that all health care assistants and catering staff vacancies had been filled and a recently recruited nurse was now working full time in the centre but two nursing posts remained vacant.

Inspectors reviewed the actual and planned rosters from the previous two weeks and saw there was no absenteeism in that period. Staff told inspectors that there was very little sick leave but if a staff member was sick another staff member who was off duty would usually cover the shift. The staff numbers on the day of inspection correlated with the roster. Inspectors discussed staffing levels and staff allocation with the person in charge and the staff team. They described how they allocated care of residents to staff teams based on dependency and location of the residents. The ratio of nurses to healthcare staff is approximately 40%:60% which includes the person in charge.

On the day of inspection the dependency levels, determined by use of a validated tool for 28 residents were: Maximum = 16, High = 7, Medium = 4. Low = 1. There was one nurse and the person in charge and five healthcare staff on duty. The activity co-ordinator worked from 9:15 to 5:00pm daily.

Inspectors found from an examination of the staff roster, communication with staff on duty and residents that the levels and skill mix of staff at the time of inspection were sufficient to meet the needs of the 28 residents. However, inspectors were not assured that staffing levels would be suitable and sufficient to meet the needs of residents if the occupancy levels were above 30. While there was the minimum of one registered nurse on duty at all times, the newly recruited nurse, was relatively inexperienced and required mentoring and ongoing support, which the person in charge provided. The person in charge was also responsible for the supervision of care teams, in addition to her responsibilities as person in charge.

Staff supervision and the arrangement of skill mix on duty at all times required review to ensure staff with appropriate training, qualifications and experience were available to maintain residents' needs.

Staff with responsibilities that included medication management and recording required improvement to ensure professional standards were adhered to at all times.

The provider employed a HR manager and the recruitment policies and procedures in place were found to be appropriate. The three staff files examined held all the required documentation and met the requirements of Schedule 2. Training records on file showed that mandatory training had been completed. There was documentary evidence that each new staff member completed a formal induction programme which included fire safety awareness. They shadowed an experienced staff member for a period.

Staff turnover was high. Records for the previous 12 months showed that 15 staff left the service and 11 staff were recruited. Two senior nurses who left the service had not been replaced. This impacted on the quality of mentorship and staff supervision. Much of the training offered to staff was 'on line' and staff completed a written, multiple

choice questionnaire, when they completed an on line training programme. The questionnaires examined showed that the incorrect answers were sometimes ticked but there was no documentary evidence to indicate that further training or support was provided to ensure the staff member fully understood the topic or to ensure that a satisfactory level of competence was achieved. Staff also had annual performance appraisals. While areas for improvement were documented, there was no plan developed to address the areas of unsatisfactory performance or to support the professional development of the staff member. Staff who spoke with inspectors confirmed that they were supported to attend training events they wished to attend.

Staff and residents interviewed were satisfied that there were adequate staff on duty. There was one nurse and two healthcare assistants on night duty. Inspectors noted that an additional healthcare assistant was rostered to work until 10:00pm to support residents who wished to watch television and retire later if they wished to do so. Residents and relatives spoke highly of the calibre of staff but some relatives felt the staff were stretched and expressed reservation about the standard of personal care provided. Inspectors observed that call-bells were answered in a timely way and staff were available to assist residents and the pace did not appear to be rushed. However the person in charge was stretched as she did not have the support of a senior nurse and was responsible for the mentoring of the new staff nurse and the supervision of care provided by the care teams as well as her responsibilities as person in charge.

A daily communication system was established to ensure timely exchange of information between shifts; which included a walk around handover at each resident's room with updates on the residents' condition. Inspectors saw that staff had available to them copies of the Regulations and the Standards.

The two volunteers worked in the centre a regular basis were appropriately vetted and supervised. They had a written agreement which detailed their roles and responsibilities.

Judgment:

Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	Maypark House Nursing Home
Centre ID:	OSV-0000249
Date of inspection:	06/07/2016
Date of response:	26/07/2016

Requirements

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

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

Outcome 01: Statement of Purpose

Theme:

Governance, Leadership and Management

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

The Statement of Purpose had not been revised to ensure it accurately reflected the current governance and staffing arrangements in the centre and therefore did not meet the requirements of the Regulations.

1. Action Required:

Under Regulation 03(1) you are required to: Prepare a statement of purpose containing

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

the information set out in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

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

This will be addressed and information corrected

Proposed Timescale: 01/08/2016

Outcome 02: Governance and Management

Theme:

Governance, Leadership and Management

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

Audits findings were not adequately addressed to ensure improvement in practices e.g. medications management.

Audits were not comprehensive as they didn't always identify areas requiring improvement e.g. infection control.

2. 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:

We are now revisiting the audits and looking to list improvements required, how we make the improvements and look at the outcomes, before the next audit. There will be more regular staff nurse meetings to discuss outcomes. We will be giving further audit training to our nurses and highlighting the audit finding in our appraisals

Proposed Timescale: 01/11/2016

Outcome 03: Information for residents

Theme:

Governance, Leadership and Management

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

Residents contracts were not amended to reflect the recently introduced fees for social activity and physiotherapy was not stated.

3. Action Required:

Under Regulation 24(2)(b) you are required to: Ensure the agreement referred to in regulation 24 (1) relates to the care and welfare of the resident in the designated

centre and includes details of the fees, if any, to be charged for such services.

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

There is a provision in all contracts issued to Residents or nominated representative for a Social Program charge on an 'at cost' basis, although this had not previously been implemented. The charge introduced is below the actual cost of the social program and each resident or their nominated representative was written to two months prior to the introduction of the charges. All subsequent contracts issued to new admissions have the contribution to the Social program stated in the fee section of the contract. A copy of the letter issued has now been included in all resident files.

Proposed Timescale: 01/07/2016

Outcome 08: Health and Safety and Risk Management

Theme:

Safe care and support

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

The risk management policy didn't meet the requirements of the Regulations. For example, it didn't set out the arrangements for identifying, recording, investigating and learning from serious incidents or the arrangements in place for identifying risks. It also didn't set out the arrangements for specified risks such as abuse or the unexplained absence of any resident as required by the Regulations.

4. 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 full review of the risk assessments will take place and arrangements for identifying, recording, investigating and learning will be made clear

Proposed Timescale: 01/10/2016

Theme:

Safe care and support

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

A hazard in a resident's bedroom had been identified but still had not been addressed five days later.

The risk assessment for the ramp leading to the dining room was inadequate as it did not fully outline the controls required to mitigate the risk nor did it clearly identify the ramp as a hazard.

5. 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 hazard is being dealt with currently. As this is a part of the structure, we may not be able to physically change it, but will add it to our risk assessments and assess appropriate residents prior to them being admitted to the room.
Risk Assessments are being reviewed as above.

Proposed Timescale: 01/10/2016

Theme:

Safe care and support

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

Procedures for the prevention and control of healthcare associated infections required improvement as they were not in line with the Authority's standards.

For example:

The cleaning trolley was visibly dirty.

The procedure for the management of cleaning bedrooms where a healthcare acquired infection was present was not consistent with the practice observed nor was it clearly set out in the centre's infection control policy.

The frequency of changing mopheads was unclear and not set out in the centre's infection control policy.

6. 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 cleaning trolley is currently being upgraded

We will review our infection control policy and make changes to ensure it reflects our practices. Housekeeping staff will be taken through the policy to ensure compliance.

Mop heads will be added to the daily check list and this will also be added to the policy

Proposed Timescale: 01/09/2016

Theme:

Safe care and support

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

Not all staff who spoke with the inspector were aware of what to do in the event of a fire.

7. 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:

Staff have had further fire training and the fire drills have been continued, but with more emphasis on roles of staff, response time and time of the drill.

Proposed Timescale: 01/09/2016

Theme:

Safe care and support

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

Servicing records indicated that fire alarm servicing did not take place at the required intervals.

8. Action Required:

Under Regulation 28(1)(c)(i) you are required to: Make adequate arrangements for maintaining all fire equipment, means of escape, building fabric and building services.

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

The alarms are serviced every quarter. The dates when the company attended and provided a service are as follows:

31/12/2014

07/04/2015

25/05/2015

28/09/2016

12/01/2016

Documentation provided

Proposed Timescale: 28/09/2016

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:

Practices associated with the administration of medicines required significant improvement:

- A nurse administering medications, who was deemed to be competent could not tell the inspector what various medications were for.
- Crushed medications were left unattended on the top of the medicine trolley in the dining room.
- There was no pain chart used to determine levels of pain or the effectiveness of analgesia administered.

There was no evidence that the audits led to quality improvements as inspectors noted that the same failings found in the first audit were repeated in the second audit.

9. 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:

Our pharmacist is developing a training programme for nurses to assist us in improving practice.

Reassessment of staff nurse medication competencies will be completed by the senior nurse.

We are looking at completing the Abbey pain scale on a more regular basis if there are pain management issues. This will be started after the first administration of analgesics that day. Pain management training is being looked for to further develop the nurses

Proposed Timescale: 01/10/2016

Outcome 10: Notification of Incidents

Theme:

Safe care and support

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

Environmental restraint was not included in the quarterly returns as required by the Regulations.

10. Action Required:

Under Regulation 31(3) you are required to: Provide a written report to the Chief Inspector at the end of each quarter in relation to the occurrence of any incident set out in paragraphs 7(2) (k) to (n) of Schedule 4.

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

We have now added the keypad on the front door as an environmental restraint and it has been included in quarter two

Proposed Timescale: 15/06/2016

Outcome 11: Health and Social Care Needs

Theme:

Effective care and support

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

Inspectors found the supervision of care and the documentation of care provided was inadequate to determine if the care provided was in line with the residents' care plan.

Inspectors observed that drinks were not offered to residents who required assistance at dinner time and it was not possible to determine if residents' fluid intake was adequate, as the volume of fluids taken was not consistently recorded.

Some care plans were generic and did not reflect the wishes/preferences of individual residents.

11. 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:

Staff nurses are reviewing all the care plans to ensure they are totally resident focused and we will be giving further training to ensure complete understanding.

Drinks are now served to all residents at the beginning of their meals so they have them during the meal. Those residents who are not taking adequate fluids, as noted by staff and or the dietician, will be on fluid balance charts to monitor their intake.

Proposed Timescale: 01/10/2016

Theme:

Effective care and support

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

Care plans were not consistently reviewed in line with the residents' changing needs.

12. 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:

Staff nurses are reviewing all the care plans to ensure they are totally resident focused and up to date reflecting changes in resident care.
The audit will be improved to ensure the care plans reflect the resident and the input from the resident themselves and their family.

Proposed Timescale: 01/10/2016

Outcome 12: Safe and Suitable Premises

Theme:

Effective care and support

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

Inspectors identified areas which did not meet the requirements for a safe and suitable premises such as:

Safe access to a suitable external space
Inappropriately located sluice room
Some minor decorative upgrade

13. 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 external space will be completed by 1st November 2016
The sluice area is being moved to a more appropriate place. This has commenced and will be completed by 30th September 2016
All minor decorative issues have been addressed

Proposed Timescale: 01/11/2016

Outcome 13: Complaints procedures

Theme:

Person-centred care and support

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

Whether or not a complainant was satisfied with the outcome of a complaint was not always clearly recorded as required by the Regulations.

14. Action Required:

Under Regulation 34(1)(f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into the

complaint, the outcome of the complaint and whether or not the resident was satisfied.

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

This has been rectified

Proposed Timescale: 01/07/2016

Theme:

Person-centred care and support

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

As required by the Regulations, a nominated person to ensure that all complaints were appropriately responded to and records kept had not been appointed.

15. 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:

As we have 2 nursing homes the nominated person to audit our complaints will be the PIC from the other home.

Proposed Timescale: 01/10/2016

Outcome 18: Suitable Staffing

Theme:

Workforce

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

Two senior nurses who left the service have not been replaced. This impacted on the quality of mentorship and staff supervision.

Staff had annual performance appraisals. While areas for improvement were documented, there was no plan developed to address the areas of unsatisfactory performance or to support the professional development of the staff member.

Staff with responsibilities that included medication management and recording required improvement to ensure professional standards were adhered to at all times.

16. Action Required:

Under Regulation 16(1)(c) you are required to: Ensure that staff are informed of the Act and any regulations made under it.

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

One of the senior nurses is now the PIC. We have recruited another to replace the second nurse.

Appraisals have now taken place and staff objectives have been set including improvement in their medication management and documentation. Further training will be arranged to develop our nurses and a performance review will take place in 3 months

Proposed Timescale: 01/11/2016

Theme:

Workforce

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

Much of the training offered to staff was on line and staff completed a written, multiple choice questionnaire, when they completed an on line training programme. The questionnaires examined showed that the incorrect answers were sometimes ticked but there was no documentary evidence to indicate that further training or support was provided to ensure the staff member had a clear understanding of the topic and ensure that a satisfactory level of competence was achieved.

17. 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:

Each answer paper will be discussed with the member of staff. If they are still showing lack of knowledge, further training will be given and their performance reviewed there after

Proposed Timescale: 01/10/2016