Health Information and Quality Authority
Social Services Inspectorate

Inspection report
Designated centres for older people

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	Maple Court Nursing Home
Centre ID:	0062
Centre Address:	Dublin Road
	Castlepollard
	Mullingar
	Co. Westmeath
Telephone number:	04496 62918
Fax number:	04496 62701
Email address:	caroday@eircom.net
Type of centre:	☒ **Private** ☐ **Voluntary** ☐ **Public**
Registered provider:	Tom Ryan for Ryan Argue Partnership
Person in charge:	Aoife Brady
Date of inspection:	09 and 10 November 2010
Time inspection took place:	**Day 1: Start:** 09:30hrs **Completion:** 17:00hrs **Day 2: Start:** 09:00hrs **Completion:** 14:45hrs
Lead inspector:	Catherine Connolly Gargan
Support inspector(s):	PJ Wynne
Type of inspection:	☒ **Registration** ☐ **Scheduled** ☒ **Announced** ☐ **Unannounced**

About inspection

The purpose of inspection is to gather evidence on which to make judgments about the fitness of the registered provider and to report on the quality of the service. This is to ensure that providers are complying with the requirements and conditions of their registration and meet the standards; that they have systems in place to both safeguard the welfare of service users and to provide information and evidence of good and poor practice.

In assessing the overall quality of the service provided, inspectors examine how well the provider has met the requirements of the Health Act 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland* under the following topics:

1. Governance and leadership: how well the centre is organised.
2. The quality of the service.
3. How well the healthcare needs of residents are met.
4. Premises and equipment: appropriateness and adequacy.
5. Communication: information provided to residents, relatives and staff.
6. Staffing: the recruitment, supervision and competence of staff.

This report summarises the findings of the inspection under some or all of these topics, highlighting areas of good practice as well as areas where improvements were required as follows:

Evidence of good practice – this means that an acceptable standard was reached and the provider demonstrated a culture of review and improvement and aimed to drive forward best practice.

Some improvements required – this means that practice was generally satisfactory but there were areas that need attention.

Significant improvements required – this means that unacceptable practice was found.

The report also identifies minor issues, where applicable, to which the provider should give consideration to enhance the quality of the service.

Registration inspections are one element of a process to assess whether providers are fit and legally permitted to provide a service. The registration of a designated centre is for three years. After that the provider must make an application for registration renewal at least six months before the expiration date of the current registration. New providers must make an application for first time registration 6 months prior to the time the provider wishes to commence.

In controlling entry to service provision, the Chief Inspector of Social Services is fulfilling an important regulatory duty under section 40 of the Health Act 2007. Part of this duty is a statutory discretion to refuse registration if the Chief Inspector is not satisfied about a provider's fitness to provide services, or the fitness of any other person involved in the management of a centre.

The registration inspection is one element for the Chief Inspector to consider in making a proposal to the provider in respect of registration. Other elements of the process designed to assess the provider's fitness include the information provided in the application to register, the Fit Person self-assessment and the Fit Person interviews. Together these elements are used to assess the provider's understanding of, and capacity to, comply with the requirements of the regulations and the Standards. Following assessment of these elements, a recommendation will be made to the Chief Inspector and the formal legal process for registration will proceed. As a result, this report does not outline a final decision in respect of registration.

The report is available to residents, relatives, providers of services and members of the public, and is published on our website www.hiqa.ie.

About the centre

Description of services and premises

Maple Court is a purpose built single-storey, bungalow style facility with accommodation for 21 residents. Older people who need long term care, people aged over 65 years with dementia care needs and those who need respite or convalescent care are admitted.

There are 21 bedrooms, seventeen of which have en suite toilet handwashing and shower facilities and four have en suite toilet and handwashing facilities. There is one twin room with en suite toilet and shower. Additionally, there is an assisted bathroom and assisted shower suitable for residents with physical disabilities.

Residents have access to a spacious dining area. There is a large sitting area to the front of the centre opposite the dining room. It opens out into an enclosed yard via ramped access

Location

Maple Court Nursing Home is located on the perimeter of the village of Castlepollard, Co Westmeath. It is within close proximity to the centre of the village, shops and other amenities.

Date centre was first established:	May 2001
Number of residents on the date of inspection	18 + 1 resident in hospital
Number of vacancies on the date of inspection	2

Dependency level of current residents	**Max**	**High**	**Medium**	**Low**
Number of residents	2	5	11	0

Management structure

The centre is owned by the Ryan Argue Partnership, the partners of which are Tom Ryan, Raymond Argue and Kieran Argue. Tom Ryan is the nominated person on behalf of the partnership.

Caroline Day, Operations Manager, reports directly to Tom Ryan on all operational aspects of the centre.

The Person in Charge is Aoife Brady who manages and oversees the delivery of care and supervises a team of nurses, carers, administration, catering, cleaning and caretaker staff.

Staff designation	Person in Charge	Nurses	Care staff	Catering staff	Cleaning and laundry staff	Admin staff	Other staff
Number of staff on duty on day of inspection	1	1	3	2	2	1	2*

*1 Activity and 1 Maintenance person

Summary of findings from this inspection

This was an announced registration inspection which took place over two days. The providers had applied for registration under the Health Act 2007 and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2009 (as amended). An essential aspect of the registration process is the requirement that the provider satisfies the Chief Inspector of Social Services that he is fit to provide the service and that the service will comply with the *National Quality Standards for Residential Care Settings for Older People in Ireland* and the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

In order to assess the fitness of the provider and the person in charge, separate fit person interviews were held. The provider and the person in charge demonstrated good knowledge of the legislation and standards.

As part of the application for registration the provider was requested to submit documentation to the Authority including completion of the fit person self assessment. This documentation was reviewed by the inspector to inform the inspection process. Since completion of the fit person entry programme, a number of improvements have been made. This included provision of pictorial cues to assist residents with cognitive impairment, commencing review of the health and safety statement and developing a hazard identification risk assessment tool with the aid of an external company and staff had engaged in a comprehensive program of training to meet the needs of residents. In addition to mandatory training required by the legalisation, staff were facilitated to attend training relevant to residents care cardio pulmonary resuscitation techniques, infection control and hand hygiene, continence care, care planning and documentation and palliative care.

While areas for improvement were identified, overall the inspectors found that the provider and person in charge led out on a service that met the majority of the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*. Although not in attendance every day, the provider had strengthened the management structure by employing an operations manager who attends Maple court Nursing Home five days per week. A robust risk management process and review of the quality and safety of care and the quality of life for residents was in place.

Daily routines and care practices provided residents with capacity to exercise autonomy and make choices. Residents could practice their religious beliefs freely. There was a good choice and a high quality of food available to residents. The dining experience was pleasant and residents were treated with respect and dignity by staff.

The health needs of residents were met. Residents had access to general practitioner (GP) services and to a range of allied health professionals. Evidence based nursing care was provided. Inspectors observed staff providing care for the residents in a knowledgeable, competent and respectful manner.

The building was well maintained and had a feeling of homeliness and warmth which was commented on by residents and their relatives in the pre inspection questionnaires. Residents had access to a range of assistive equipment and specialist beds appropriate to their needs. While all equipment was serviced on a contract basis, maintenance procedures were supported by an on-site maintenance person.

While there were two areas where significant improvements was required, namely, medication administration practices and elder abuse training and recognition.
The inspectors identified other aspects of the service that required improvement.
Care staff provided recreational activity in the centre, this aspect of their roles would benefit from formal training to enable them to develop activity programmes to meet the interests and capacities of all residents. Some improvement was required to the directory of residents; their finance management procedures, the emergency policy and procedures if a resident leaves the centre unaccompanied.

These and some other areas that required improvement were identified for address to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended). They are discussed in the body of the report and are included in the action plan at the end of this report.

Comments by residents and relatives

Two residents and three relatives completed pre inspection satisfaction questionnaires. A member of the inspection team conducted in-depth interviews with five other residents and spoke about areas of the service with a number of others.

While most residents and relatives stated that they did not want any aspect of the service changed as what was in place “worked well” for them, this was an area identified as needing some improvement. Some residents had experienced security worries in their homes prior to coming to the centre and commented positively about this aspect of the service.

All residents spoken with complimented staff and management. They confirmed they were well cared for and could get the doctor if necessary. Food was “the best in the area” “really good” and mealtimes were a highlight of the day. A number of residents and relatives spoke about the cleanliness of the centre.

Overall findings

1. Governance: how well the centre is organised

Outcome: The centre is well organised and managed and complies with the requirements of the Health Act 2007, the regulations and standards.

Good governance involves the effective and efficient deployment of resources in accordance with the stated purpose and function of the centre. Governance includes setting clear direction for the service, a commitment to continual improvement and having a system in place to effectively assess and manage risk.

Evidence of good practice

A strong organisational structure was in place. The provider visits the centre approximately seven times per month. There were robust arrangements to support the person in charge in her day to day management practices from the company's operational manager. The operations manager attended the centre four to five afternoons each week; this was documented on the duty rota. The person in charge placed a strong emphasis on being easily accessible to residents. She had organised her working day whereby she provided 'hands on' care up to 14:00hrs each day. While much of the governance activities were done in the afternoons, further 'management time' was scheduled on the staff rota to give the person in charge adequate time to fulfil all the requirements of her role.

Fit person interviews were held with the provider, operations manager and person in charge who demonstrated knowledge and awareness of the Health Act 2007(Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland.*

Each resident had a signed contract of care which accurately reflected the services provided to them in the centre.

Fire policies and procedures were reviewed by inspectors and were found to meet legislative requirements. Inspectors were provided with written evidence from a suitably qualified person confirming the building meets all the statutory requirements of the fire authority in relation to the use of the building as a residential centre for older people. Fire records indicated that fire safety training took place regularly and fire escape routes and fire fighting equipment was checked in line with best practice. Risk assessments were completed to identify evacuation needs of dependent residents in the event of a fire. Fire evacuation sheets were also held on reserve in the event of resident dependency levels increasing or new admissions.

Comprehensive risk management processes were found and regular auditing of staff training, medications, food safety and falls, amongst others had occurred. These audits identified trends, deficits in practice, actions required and outcomes. For example, a letter was sent to the GPs to request three monthly medical reviews and weekly reviews of wounds. All of the residents in the centre were either in their eightieth and ninetieth years of age. Management of resident falls has been given high priority so as to balance risk of falling with residents' quality of life. Each fall is analysed in detail and contingency plans are put in place immediately, resulting in a robust falls prevention programme.

Insurance for residents' property in the centre met all the legislative requirements.

Residents' safety and security was protected through the use of a keypad operated security system on the main door. On arrival at the centre the inspectors were asked to sign the visitor's book. Residents confirmed they felt safe in the centre.

Improvements made further since completion of the fit person entry programme self assessment were observed and included completion of cardio pulmonary resuscitation training, ensuring appropriate skill mix on every shift with senior carer and senior staff nurse on duty, improving pictorial signage within the centre.

Some improvements required

A record of all complaints was maintained in the centre. All verbal and written complaints were recorded. Inspectors found that all complaints were investigated and responded to in an appropriate and timely manner. However, the procedure directed complainants to make their complaints to the operations manager as the first point of contact rather than the person in charge.

Although some hazard identification audits had been carried out, a complete risk assessment of all hazards with associated controls including environmental and work systems and practices had not been put in place. However, the operations manager informed inspectors that an external company was scheduled to undertake this task.

Adequate controls were in place to safeguard residents' finances locally. An arrangement for depositing two residents money in the bank was not adequate. However, this had been already identified by the management team and procedures were taking place to rectify this area.

A directory of residents was maintained. However, it did not fully meet the legislative requirements in that it did not include clear details of all periods where residents went out of the centre to another facility and their re-admissions, e.g. if hospitalisation was necessary.

A documented procedure was not in place informing staff what they should do in the event of fire, flood or loss of light. However, no reference was made in the emergency policy to tell staff of contingency plans to safeguard residents in the event of loss of heat or water. There was also no procedure advising actions to take in the event of a resident causing themselves self-harm.

Minor issues to be addressed

A policy was also in place referencing procedures to take in the event of a vulnerable resident leaving the centre unaccompanied. However, a profile of the residents had not been completed that might assist with expediting their recovery. A drill had not been conducted to inform staff of the procedures to follow and test the effectiveness of the procedure in place. Although a risk assessment of current residents by the management team confirmed that none of the current residents were at risk of leaving the centre unaccompanied. Windows were not fitted with restrictors to protect future residents.

2. Quality of the service

Outcome: Residents receive a good standard of service, appropriate treatment and are treated with courtesy and respect.

A quality service is one where residents are protected from harm or abuse, where practice is person-centred, where rights are protected, where residents are enabled to play an active part in the centre and where management, staff and residents work together towards continuous improvement.

Evidence of good practice

There was a homely atmosphere in the centre complimented by the location of the sitting and dining room to the front of the centre. Both these rooms were decorated to a good standard with domestic style furniture. Some residents sat in seating in the lobby and said they liked to watch the 'comings and goings'. A fireplace was the focal point of the sitting room. Chairs were comfortable and some were arranged in clusters promoting conversation between the residents which was observed by inspectors. Four residents opted to remain sitting in the dining room after lunch finished, having a cup of tea which was facilitated and encouraged by staff.

The kitchen was spacious, clean and bright. It was well equipped and was well stocked with fresh meat, vegetables and fruit. There was a plentiful supply of prune and cranberry juices. The chef kept records of the dietary requirements of residents on special and modified consistency diets, and these were updated following consultation with the dietician and the speech and language therapist.

Residents were provided with nutritional meals which offered them choice of diet. They confirmed that they were satisfied with portion sizes and presentation. 77% of the residents choose to come to the dining room for their meals. Modified consistency diets were plated in a way whereby residents could taste the vegetables and meat separately. Diabetic, high protein and low fat diets were also provided. An inspector examined records of previous menus which were organised on a four weekly plan. The menus were varied, offered choice and were nutritional. The chef made breads, pastries and deserts which many of the residents complimented. On the day of inspection, home-made apple pie, brown bread and scones was available for their enjoyment.

The dining room was spacious and clean. Tables had a range of condiments to suit individual tastes. The menu was clearly displayed on a large notice board hanging in the dining room. Printed menus were also provided on tables. Residents' menu choices were confirmed by staff prior to serving food. They were encouraged by staff to maintain their independence where possible and those who needed assistance were offered it discreetly. Residents were offered napkins and clothes protectors were not used.

Snacks were available to residents outside of mealtimes and drinks were available throughout the day. Inspectors observed staff offering refreshments to residents in communal areas and jugs of water and orange squash were available in communal areas to compliment regular fluids. Kitchen staff were available from 07:30hrs to 20:00hrs each day. The kitchen was accessible to night staff to meet residents' needs in this area during the night.

Residents' privacy was respected and promoted by staff and inspectors observed staff members always knocking before entering residents' bedrooms and seeking consent before entering rooms. Residents' dignity and independence was also promoted by staff who asked for consent prior to intervening with assistance for daily activities. Residents were facilitated to get up in the mornings at their own pace and make decisions regarding the times they retired.

Residents' religious and spiritual needs were met. Mass was celebrated daily by a resident priest and fortnightly by the local priest. Arrangements were also in place for residents of other religions. Although residents had access to an oratory, those spoken with by the inspector said they liked to pray in their bedrooms.

An activities board on the wall close to the dining and sitting room displayed the programme for the day. This referenced a variety of activities including sonas sessions, bingo, arts and crafts and hand massage provided on a seven-day basis. Care assistants co-ordinated the activities for residents and had completed individual assessments for each resident in an effort to ascertain their interests and capabilities. The care assistant who would co-ordinate the recreational activities each day rotated between the team and was indicated on the duty rota. This arrangement meant that all carers had knowledge o providing activities. Even though all residents didn't attend the main activity provided, other care staff could provide activities suitable to their capabilities. Staffing numbers and skill mix was revised to incorporate this good practice.

Inspectors observed that some residents had dementia related conditions which caused them to be disorientated and confused at times. Staff ensured that these residents were cared for appropriately and were included in the life of the centre. The inspectors observed staff gently and respectfully reassuring and responding to these residents, and including them in general conversations. Staff had a good knowledge of these residents' backgrounds and used every opportunity to reminisce with them.

Residents were encouraged to maintain their independence and links with the community. Eucharistic ministers delivered copies of the parish bulletin to keep the residents informed of the parish activities. The mass scheduled for the centre by the local priest was included in this bulletin. Residents all had access to the newspaper and two residents purchased a different newspaper of their choice. Inspectors observed residents post being hand delivered by the person in charge. Four residents have mobile phones while two others have a landline directly into their room with their own personal telephone numbers. The legion of Mary came in weekly to say the rosary and led a sing-a-long following prayers. A local musician also visits the centre to entertain the residents on a monthly basis. A resident in her ninetieth years was facilitated to leave the centre three to four days each week. This resident enjoys sewing and maintains a winter and summer wardrobe. Family and friends were observed visiting the centre

throughout the days of inspection. Those spoken with were happy with the care and attention their relatives received in the centre.

Residents were dressed in co-ordinated, well fitting clothing. Many confirmed that they had chosen what to wear themselves. Inspectors visited residents' bedrooms and noted that residents' had suitable space for storing their clothes. Bedrooms were personalized to resident's individual tastes and included displays of photographs and ornaments. Others had pictures of sentimental value hanging on their walls.

A hairdresser comes to the centre every two weeks to a suitable, well equipped hairdresser's salon. One resident's own hairdresser calls to the centre to do her hair while another resident goes out to the hairdresser in the town.

Some improvements required

While residents had ramped access to an enclosed sheltered area, there was no seating available for them to sit and rest on if they wished. A resident had identified access to a suitable area where she could go outside in her response on a care questionnaire.

Significant improvements required

Not all staff had received training in the prevention, detection and reporting of elder abuse. Training in this area was scheduled for 11 November 2010. A policy was in place and reporting procedures including documentation was provided.

Minor issues to be addressed

Inspectors were told that although there were advocacy services available locally, an independent advocate was not calling to the centre routinely. However, this is an area that the operations manager stated she was working to put in place.

Although residents clothing was individually marked, the resident's names had worn off some clothing due to the laundering process and names were not clearly legible in all cases.

Although identified as an area for improvement by the provider and team in the fit person self assessment documentation. Life histories had not been completed with the residents. Activity assessment documentation did not sufficiently capture residents' present and past interests, hobbies and pastimes.

3. Healthcare needs

Outcome: Residents' healthcare needs are met.

Healthcare is integral to meeting individual's needs. It requires that residents' health, personal and social care needs are assessed and reviewed on an ongoing basis, within a care planning process, that is person centred. Emphasis is firmly placed on health promotion, independence and meaningful activity.

Evidence of good practice

Each resident was assessed prior to admission. Comprehensive evidence based, recognised assessment tools were used to promote health and address health issues. Assessment tools such as falls risk, pressure sores, wound care, dependency needs, nutritional assessment, manual handling assessment had been completed as part of a post admission assessment to determine needs. Identified needs were reflected in residents care plans, where risks were noted, an appropriate care intervention was prescribed. Care plans were reviewed on a three-monthly basis by nursing staff; this was confirmed by inspectors who reviewed a sample of care plans.

Care plans were updated to reflect residents changing needs and staff were knowledgeable regarding residents current health status. Efforts to personalise the assessments and care plans were also noted. Residents or relatives signed in agreement of the care plans developed and confirmed discussion had taken place.

Many of the care plans to meet residents needs were supported by care administration recording sheets, for example, change of position record, daily flow charts, restraint monitoring charts. Residents' weight, blood pressure and heart rate were recorded on a monthly basis or more frequently if necessary. There was specialist equipment available to record residents' weights. Residents had access to dietetic services, which assessed and prescribed appropriate food and fluid supplements. Three residents with swallowing difficulties were assessed by a speech and language therapist who prescribed modified consistency diets and fluids as necessary for them. These diets were communicated to kitchen and care staff to ensure appropriate food and assistance was provided at mealtimes for the residents. Discussion of this area took place for each resident on the morning walk around handover. The speech and language therapist contacts the centre weekly and reassesses as necessary.

Some residents had mental health issues. Medical files indicated that the consultant psychiatrist for later life saw these residents regularly. The community mental health nurse also visited the centre regularly.
Inspectors noted that residents had good access to assistive devices with many residents been assessed for particular pieces of equipment suitable to their needs.

Residents had good access to other allied health professionals on referral including the physiotherapist, occupational therapy services and tissue viability specialist services.

Residents also had access to general practitioners of their choice and many were able to retain the services of their own GP. The person in charge told the inspectors that the chiropodist attends the centre regularly. The person in charge organised for residents to attend outpatients appointments if family were unable to accompany them.

Emergency healthcare equipment was available to enable nursing staff to respond to medical emergencies promptly. This equipment included a suction machine, oxygen supplies and masks. Emergency masks were located around the building enabling staff to respond promptly in the event of an emergency. A large number of staff had been trained on cardiopulmonary resuscitation and procedures to take in the event a resident choking. A defibrillator was available in the local fire station and GP surgery. Vaccination programmes were in place for prevention of influenza.

Significant improvements required

All aspects of medication management were not of a good standard. Inspectors observed that residents' medications were being administered from a pharmacy generated medication administration record system (MARS). Although a medication prescription completed by a GP was available in the residents file. It was not consulted each time a medication was administered in line with professional medication administration standards. Photographic identification was available on the drugs chart for each resident and was updated monthly to ensure the correct identity of the resident receiving the medication. This practice reduced the risk of medication error. However, one resident's picture was not in place.

Minor issues to be addressed

Medical files belonging to some residents were not reviewed on a three monthly basis as required by the National Quality Standards for Residential Care Settings for Older People in Ireland. The management of the centre had already identified this issue and they were in the process of resolving it to an adequate standard.

4. Premises and equipment: appropriateness and adequacy

Outcome: The residential care setting provides premises and equipment that are safe, secure and suitable.

A good physical environment is one that enhances the quality of life for residents and is a pleasant place to live. It meets residents' individual and collective needs in a comfortable and homely way, and is accessible, safe, clean and well-maintained. Equipment is provided in response to the assessed needs of each of the residents and maintained appropriately.

Evidence of good practice

The perimeter areas were covered by tarmacadam and grounds were landscaped and accessible to residents. The site boundary was secure and screened with hedging. The external areas were clean and tidy and were adequately illuminated after dark to a standard that promoted good safety. Access to the centre was secured by a keypad entry system. A visitor's book which all visitors were requested to sign was situated in the entrance lobby.

The building was well maintained. Adequate and appropriate assistive equipment was available and supported by an ongoing servicing programme. An external company are contracted and recently attended the centre to service electric beds, air mattresses, hoists, pumps and wheelchairs. In-house maintenance procedures were reviewed by inspectors and found to be well-managed. A maintenance log was in place, which was signed off by the centre's maintenance person, indicating that equipment was ready for use.

Communal space was of a suitable and sufficient standard. All areas were warm and pleasantly decorated. These comforts were confirmed by residents who also said they liked the colour schemes. Toilet facilitates were provided close to communal areas for residents' convenience. Windows were located at a level where residents could sit and look out at the activity outside the centre. All entrance and exit doors were ramped ensuring ease of access for residents with mobility impairment. Handrails were fitted along the corridors to assist the independent movement of residents around the building.

There was a nurse's station located close to the main entrance, providing a central point of contact for residents' and visitors.

Promotion of cleanliness and prevention of infection was evidenced. There was sufficient alcohol rub and/or hand-washing facilities and personal protective equipment available which inspectors noted staff using. Adequate colour coded equipment was available and separate equipment was available if required for cleaning infected areas. Documented cleaning procedures were in place and were supported by signed cleaning schedules. Cleaning staff spoken with were well informed and adequately explained the procedures they complete in cleaning various areas in the centre.

The laundry was clean, well organised and had one industrial sized washing machine and one dryer. A hand washing basin was accessible. The inspector spoke with a staff member who worked in the laundry. She explained the procedures she follows to ensure that clothing is laundered appropriately and returned to residents. She also told the inspectors that staff will undertake minor repairs to residents' clothing e.g. sew on buttons or sew hems.

There was a call bell system in place at each resident's bed with which residents were familiar with and found easy to use. Call bells were responded to in a timely manner during the course of the inspection.

Bedrooms were adequately furnished and equipped to assure the comfort and privacy needs of the residents. Suitable lighting with a dimming facility was provided within easy reach of residents in each bedroom. Some residents liked to have their light dimmed throughout the night as they found it promoted their safety when using the en suite facilities. Grab support rails were fitted alongside all toilets and in showers. Hot water taps were fitted with thermostats preventing scald injury. Radiators were fitted with adjustable thermostats allowing residents to adjust the heat levels to suit their needs.

Some improvements required

Although a sluice room was available and equipped with stainless steel sinks, a wash hand basin, bed pan decontamination unit and storage areas for bedpans. Three commodes stored in this area restricted access to the handwashing sink, this compromised infection prevention procedures.

A storage area was designated for storage of some equipment including hoists wheelchairs and some other equipment for residents when not in use. However, storage space was not adequate for storage of all equipment. The operations manager told inspectors that this was currently under review.

While potentially toxic chemicals and cleaning solutions were stored in a cupboard with locked doors. The locking mechanism was not adequately secured to the frame of the cupboard and access could be achieved even though the lock was engaged on the doors.

Residents did not have exclusive access to a visitor's room to meet their visitors in private if they wished as the designated visitors' room doubled up as an oratory. Although furnished with chairs and an altar, no residents were observed in this room by inspectors during the days of the inspection. The provider told inspectors that plans were in place to improve this facility.

There were inadequate numbers of lockers for staff to place their personal belongings while on duty.

Minor issues to be addressed

An appropriately equipped treatment room was not available in the centre where residents could have clinical examinations and receive therapies.

While colour coded zoning was used to assist with segregation of linen using tape on the floor, which indicated zoning for infected (red area) soiled (black area) or clean laundry (white area). Although no infected linen was in the centre on the days of the inspection, it was unclear how segregation of infected linen could be adequately achieved due to the floor space of the laundry room.

5. Communication: information provided to residents, relatives and staff

Outcome: Information is relevant, clear and up to date for residents.

Information is accessible, accurate, and appropriate to residents' and staff needs. Feedback is actively sought from residents and relatives and this informs future planning and service provision. Information is recorded and maintained in accordance with legal requirements and best practice and is communicated to staff on a need to know basis to ensure residents' privacy is respected.

Evidence of good practice

A multidisciplinary 'walk-around' handover was completed at each change of shift. A morning handover was attended by a member of the inspection team. The person in charge, nurses, carers, catering and household staff were also in attendance. Each resident was reviewed at this time, their health status, care needs and fulfilment needs for the shift was discussed. Residents with appointments outside the centre were noted and plans were established to facilitate these. The hairdresser was also scheduled and both male and female residents' choices were ascertained at this time regarding this activity so they could attend the hairdresser at a time suitable to them.

Notice boards were placed outside the sitting and dining room where residents could readily obtain information in relation to the correct day and date, weather conditions, daily activities.

A suggestion book was located at the front door and residents and visitors were invited to make suggestion for improvement. A care satisfaction survey was sent to relatives and was also given to residents. The operations manager and person in charge meet with families annually on an individual basis to update them and to ascertain their feedback on the service for their loved ones.

Copies of the centre's statement of purpose and residents' guide were available. Each resident had a copy of the residents' guide in their bedroom for their information.

A comprehensive list of centre specific policies and procedures were available and found to be in compliance with relevant legislation. These had been reviewed and updated on a regular basis. Staff spoken with were familiar with the contents. A signing sheet was used to confirm that each staff member had read and understood the contents of the policy. Signing sheets were well populated with staff signatures.

Residents' records were stored in a safe and secure manner. Medical notes and care plan files were maintained in cabinets at the nurse's station which were locked when not in use.

Each staff grade was identifiable by their uniform, and all staff wore name badges. Residents and staff knew each other well and chatted easily.

Information leaflets were available on a wall in individual holders. Leaflets were of interest to the residents in the centre including information on their entitlements and information about nursing homes in general in Ireland.

Some improvements required

There were four residents with cognitive impairment cared for in the centre. Some pictorial signage to guide residents with cognitive impairment was used to assist residents to recognise communal rooms and their function. However, cues to assist communication for residents with dementia required improvement, for example talking mats were not available. A communication policy was available but was not adequate and required development to address all areas of communication in the centre.

Minor issues to be addressed

A residents' forum was established this year but only one meeting was held and although minuted, the minutes were not circulated so residents who were unable to attend could not view the discussion that took place. The person in charge said she planned a further meeting before the end of the year.

6. Staff: the recruitment, supervision and competence of staff

Outcome: Staff are competent and recruited in sufficient numbers to meet residents' needs

Staff numbers and skill-mix are determined by the size and complexity of the service and there should be sufficient competent staff on duty, both day and night, to meet the needs of residents. Robust recruitment and selection procedures ensure the appointment of suitably qualified and experienced staff. Staff are supported in their work by ongoing training and supervision.

Evidence of good practice

All personnel files included qualifications, experience, garda vetting, medical fitness and photographic identification Records contained all of the requirements of Schedule 2 of the (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended). The person in charge maintained a record of An Bord Altranais 2010 PINs (professional identification numbers) for all registered nurses in their files.

Induction and appraisal processes were found to be in place. Induction is undertaken by means of a mentoring process where each staff member is assigned a staff mentor. All new staff are provided with an induction book which they work through. New staff are supernummary for a minimum of 40 hours which may be extended. Competency in various aspects of their role is confirmed by the assigned mentor's signature. All grades work in all areas of the centre for a period during their induction. The person in charge confirmed that this practice provided new staff with an insight into how each area works in the centre.

Staff appraisals commenced in June and were ongoing. All staff had a job description and were clear on their roles and responsibilities.

Ongoing evaluation of staffing numbers and skill mix is done by the management team. Carer hours were increased recently to meet the needs of the resident group in the centre. Dependency levels are reviewed daily. The staffing roster was viewed by the inspectors and confirmed the staff on duty Staff were supported and supervised in the delivery of care by the person in charge and a staff nurse on the days of inspection. The rota indicated there was a registered nurse on duty at all times. Arrangements were in place to address staff absences and a senior nurse deputised for the person in charge when she was absent. Part-time staff did additional hours to cover additional unplanned staff absences

The majority of care staff had received Further Education and Training Awards Council (FETAC) Level 5 training and had completed all modules.

Staff training records viewed confirmed that mandatory training on manual handling attended by all staff. The person in charge is an instructor for this course. All episodes of moving and handling procedures observed with residents were of an adequate standard.

A training matrix summarising training received up to October 2010 also referenced training in palliative care, infection prevention and control, continence promotion, care planning and documentation and use of a NIPPV (Non Invasive Positive Pressure Ventilation) machine. This therapy was in use in the centre on the days of the inspection. Staff spoken with could discuss the principles of using supportive respiratory therapy for residents comfort.

Staff were knowledgeable about residents' needs and had established a good relationship with all the residents. Most of the staff had been working in the centre for a number of years. While staff were not assigned as key workers, staff turnover was very low, with only two staff leaving in the past twelve months ensuing continuity and consistency in care.

Some improvements required

Training records confirmed staff had not received training on the care of residents with dementia while residents with dementia were cared for in the centre. Although all care staff were involved in coordinating activities, training had not been provided for them in this area so they could understand the condition better and be enabled to deliver the appropriate recreational activities and care to support residents with cognitive impairment.

Minor issues to be addressed

Training in challenging behaviour was also not completed by staff. Although there were no incidents of challenging behaviour, this training may be of value in the future to assist staff with approaching and interacting with residents who are confused.

Performance reviews had not taken place but were scheduled for 2011. However, the operations manager indicated that she would be conducting the appraisal interviews. The notice did not indicate that the person in charge would be involved in conducting these staff reviews.

Closing the visit

At the close of the inspection visit a feedback meeting was held with the operations manager and the person in charge, to report on the inspectors' findings, which highlighted both good practice and where improvements were needed.

Acknowledgements

The inspectors wish to acknowledge the cooperation and assistance of the residents, relatives, provider and staff during the inspection.

Report compiled by

Catherine Connolly-Gargan
Inspector of Social Services
Social Services Inspectorate
Health Information and Quality Authority

09 November 2010

Chronology of previous HIQA inspections	
Date of previous inspection	**Type of inspection:**
12 August 2009	☐ Registration ☒ Scheduled ☐ Follow up inspection ☒ Announced ☐ Unannounced
13 May 2010	☐ Registration ☐ Scheduled ☒ Follow up inspection ☐ Announced ☒ Unannounced

Health Information and Quality Authority
Social Services Inspectorate

Action Plan

Provider's response to inspection report*

Centre:	Maple Court Nursing Home
Centre ID:	0062
Date of inspection:	09 November 2010
Date of response:	14 December 2010

Requirements

These requirements set out what the registered provider must do to meet the Health Act 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

1. The provider has failed to comply with a regulatory requirement in the following respect: The complaints procedure directed complainants to make their complaints to the operation manager as the first point of contact rather than the person in charge.	
Action required: Revise the complaints policy to reflect the role of the person in charge of the centre as having responsibility to manage complaints at a local level.	
Reference: Health Act, 2007 Regulation 39: Complaints Procedures Standard 6: Complaints	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**

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

Provider's response: The complaints policy has now been reviewed as per legislation Please see attached document	Completed 11 November 2010

2. The provider has failed to comply with a regulatory requirement in the following respect: All procedures and equipment were not in place to effectively manage risk to residents in the centre. Robust contingency plans for events when an outage of services becomes prolonged were not in place.
Action required: Ensure that the risk management policy covers, but is not limited to, the identification and assessment of risks throughout the designated centre and the precautions in place to control the risks identified.
Action required: Put in place an emergency plan to safeguard residents in the event of loss of heat or water.
Action required: Revise the emergency policy to include actions to take in the event of a resident causing themselves self-harm.
Action required: Place adequate locking facilities on cupboards containing hazardous chemicals and liquids to safeguard vulnerable residents from ingestion.
Reference: Health Act, 2007 Regulation 31: Risk Management Procedures Standard 26: Health and Safety Standard 29: Management Systems

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**

Provider's response: The identification and assessment of risks and precautions in place to control the risks identified. Please see attached contingency plan relating to loss of heat or water The emergency plan now contains action to follow in the event of a resident causing self harm There is now a coded lock on the door of the cleaning room	 Completion date January 27 2011 Completed December 10 2010 Completed December 10 2010 Completed November 17 2010

3. The person in charge has failed to comply with a regulatory requirement in the following respect: The directory of residents was adequately maintained.	
Action required: Put procedures in place where all information relating to residents in the directory meets the legislative requirements.	
Reference: Health Act, 2007 Regulation 23: Directory of Residents Standard 32: Register and Residents' Records	
Please state the actions you have taken or are planning to take following the inspection with timescales:	**Timescale:**
Provider's response: The directory of residents does contain all the information according to the legislative requirements, however the columns are now simpler and user friendly in the new directory of residents, which will ensure that the date of admission of a resident to hospital and the date of return to the nursing home will be entered into the directory of residents.	 Completion date December 30 2010

4. The provider has failed to comply with a regulatory requirement in the following respect:
All arrangements were not in place to safeguard residents' finances.

Action required:
Revise current procedures to ensure each resident has an individual bank account in their name with an individual account number.

Reference:
Health Act, 2007
Regulation 7: Residents' Personal Property and Possessions
Standard 9: The Resident's Finances

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: This process was started in July; we are currently awaiting details from the bank with individual bank account and account number. Unfortunately, since the inspection one of the Residents has now deceased whose banking we were managing, so only the one account is needed presently. The proposed plan going forward is that there will be 2 separate patient accounts and each resident will have their own account	Commenced July 2010 Date of completion January 31

5. The provider has failed to comply with a regulatory requirement in the following respect:
There was not a designated area that was private for residents' to meet visitors.

There was not adequate staff storage facilitates provided.

Seating was not available for residents to sit and rest on if they wished while outdoors in the enclosed garden.
Access to the hand washing sink in the sluice room was obstructed.

The visitors room doubled as an oratory therefore residents did not have exclusive access to a visitor's room where they could take their residents in private other than their bedrooms.

Action required:
Ensure access to the hand washing sink is clear at all times in the sluice room

Action required:
Ensure suitable and sufficient storage is made available in the centre.

Action required: Provide a visitors room for residents to meet their visitors in private if they wish.	
Action required: Provide storage facilities for staff to place their personal belongings while on duty.	
Reference: Health Act, 2007 Regulation 19: Premises Standard 25: Physical Environment	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: All staff have been advised to ensure that commodes are maintained in a single file whilst storing. Notice has been displayed There is currently a storage room where all equipment is stored. There will be more storage room available when building commences. However presently all equipment is stored in a safe and adequate manner. The staff nurse in charge on each shift is responsible in ensuring that this is done and is signed for as part of the checks schedule each day The availability of a visitors room as previously discussed and discussed on the day of inspection indicated to you that the proposed new building will include a visitor's room. Questionnaires have been circulated to residents and their families and the feedback indicates that absolutely no resident or family are inconvenienced by this, due to the layout of the nursing home. However as per regulations there will be a visitor's room prior to 2015. As an interim measure, there is a seating arrangement and tables provided in the oratory, which was actioned following inspection in May 2010. New lockable lockers have been purchased since the inspection and are now in use	Completed November 30 2010 May 30 2015 completion date Completed December 7 2010 Completed December 7 2010

6. The person is failing has failed to comply with a regulatory requirement in the following respect:
Not all staff had been trained in the prevention, detection and response to elder abuse.

Action required:
Make arrangements for all staff in the centre to have elder abuse training.

Reference:
Health Act, 2007
Regulation 6: General Welfare and Protection
Standard 8: Protection

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: There are currently 5 members of staff who have not attended elder abuse training, 2 of whom commenced employment 4 weeks prior to HIQA inspection. The elder abuse training held 3 times in 2010 and the above staff did not attend. Training session now planned for Friday 7 January 2011 and letters have been issued to members of staff requesting their attendance.	Completed by January 31 2011

7. The provider has failed to comply with a regulatory requirement in the following respect:

All aspects of medication management were not of a good standard in that residents' medications were being administered from a pharmacy generated medication administration record system (MARS).

One resident's photograph was not in place.

Action required:
Revise medication administration procedures to ensure that each resident's original prescription is consulted every time a medication is administered.

Action required:
Provide photographic identification for all residents.

Reference:
Health Act, 2007
Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines
Standard 14: Medication Management

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**

Provider's response: As you are aware on the day of inspection the above was rectified immediately. The one photograph that was missing was put in the next day following inspection. All medications are now signed for individually on the MARS sheet on each calendar month. This is as per written policy and procedure in Maple Court for administration of medications in accordance with An Bord Altranais guidelines.	On day of inspection. Completed 11 November 2010

8. The provider has failed to comply with a regulatory requirement in the following respect: A communication policy was not adequate as it did not reference	
Action required: Revise and implement the communication policy to address all areas of communication in the centre.	
Reference: Health Act, 2007 Regulation 11: Communication Standard 18: Routines and Expectations	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The communication policy is currently being reviewed and are currently awaiting input from other health care professionals.	Completion date February 28 2011

9. The person in charge has failed to comply with a regulatory requirement in the following respect: Staff had not received training on the care of residents with dementia while residents with dementia were cared for in the centre. Although all care staff were involved in co-ordinating activities, training had not been provided for them in this area
Action required: Put procedures in place where staff are facilitated to attend training in areas relevant to residents needs.

Reference: Health Act, 2007 Regulation 17: Training and Staff Development Standard 23: Staffing Levels and Qualifications	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The staff that are involved in coordinating the activities are currently completing their FETAC level 5 health care support certificate, which involves the recreation and leisure module, which incorporates activities and coordination of same. There is a staff nurse who has completed a diploma in activity training in DCU and she assists and coordinates the planning and implementing of activities with the care staff. There are currently 6 care staff attending the FETAC level 5 course, when same completed the training proposal will include for some members of staff to undergo sonas training which will ensure residents requiring dementia care will be also provided for.	Completed by July 31 2011

Recommendations

These recommendations are taken from the best practice described in the *National Quality Standards for Residential Care Settings for Older People in Ireland* and the registered provider should consider them as a way of improving the service.

Standard	Best practice recommendations
Standard 3: Consent	Provide independent advocacy services to assist residents to make decisions relating to consent to treatment or care. **Providers Response:** The Citizen Information advice Bureau will now provide advocacy service to the residents of Maple Court. Notice has been displayed to reflect same. Date completed was November 30 2010.
Standard 26: Health and Safety	Complete a profile of each resident to assist with expediting their recovery in the event of them leaving the centre unaccompanied. Conduct a drill to inform staff of the procedures to follow and to test the effectiveness of the procedure in place. **Providers Response:** Profile of each resident will be completed and drill within 6 months May 2011
Standard 25: Physical Environment	Although residents clothing was individually marked, the resident's names had worn off some clothing due to the laundering process and names were not clearly legible in all cases. **Providers Response:** All clothes are now checked fortnightly for remarking of names and a chart is in progress to document same completed on december3 rd 2010.
Standard 15: Medication Monitoring and Review	Put procedures in place where medical files belonging to all residents are reviewed on a three monthly basis. **Providers Response:** As you are aware, the operations manager and the person in charge informed you on the day about the letter that was written to GP the previous week, so this was already actioned. Proposed dates are given to GP, next due week ending 31 January 2011.

Standard 25: Physical Environment	While colour coded zoning was used to assist with segregation of linen using tape on the floor, which indicated zoning for infected (red area) soiled (black area) or clean laundry (white area). Although no infected linen was in the centre on the days of the inspection, it was unclear how segregation of infected linen could be adequately achieved due to the floor space of the laundry room. **Providers Response:** There is more than a separation distance of two foot between each zone. Perhaps, if this was mentioned at time of inspection, this could have been illustrated to yourselves. When the proposed building is completed, this will ensure that there is a adequate sized laundry. In the interim, infection control measures are strictly adhered to at all times, and staff are very knowledgeable with infection control procedure. Expected date of completion will be March 31 2015.
Standard 25: Physical Environment	An appropriately equipped treatment room was not available in the centre where residents could have clinical examinations and receive therapies. **Providers Response:** Residents have clinical examinations in their own rooms, where they are most comfortable in and I am not sure exactly what therapies you are referring to as per regulations there will be a clinical room provided prior to 2016.
Standard 2: Consultation and Participation	Schedule regular residents meetings where residents have a forum to contribute to the running of the centre and future planning. **Providers Response:** Residents meetings are now scheduled for every 6 weeks and a notice is displayed with same information. Completed on December 10 2010
Standard 24: Training and Supervision	Training in challenging behaviour was also not completed by staff. Although there were no incidents of challenging behaviour, this training may be of value in the future to assist staff with approaching and interacting with residents who are confused. **Providers Response:** Training for challenging behaviour is now included in the 2011 training plan. Expected date of completion is April 2011
Standard 24: Training and Supervision	Performance reviews had not taken place but were scheduled for 2011. However, the operations manager indicated that she would be conducting the appraisal interviews. The notice did not indicate that the person in charge would be involved in conducting these staff reviews.

	Providers Response: Of course, the person in charge will be involved in conducting the performance reviews; again this issue could have been clarified at time of inspection if asked. Person in charge was involved in previous performance reviews. The operations mamnager will be in attendance only at performance reviews, whilst Aoife Brady is conducting the performance reviews.
Standard 18: Routines and Expectations	Complete life histories with the residents. Activity assessment documentation did not sufficiently capture residents' present and past interests, hobbies and pastimes. Appraise the information when collated with a view to influencing the activity program. **Providers Response:** Life histories are currently being completed with all residents. However, all activities presently do reflect our residents interests, e.g., playing cards, knitting, singing, bingo, cooking. Completion date is April 2011
Standard 18: Routines and Expectations	Provide suitable equipment to encourage and enable residents with communications difficulties to express themselves. **Providers Response:** There are picture cue cards available, large print books are available, enlarged board games, there are subtitles available on the television, and if residents communication needs changed then our practice would then be to obtain communication aids as per advice from healthcare professionals. talking mats is also being researched presently and speaking books .The equipment is being reviewed concurrent with review of communications policy Date of completion is March 2011

Any comments the provider may wish to make:

Provider's response:

(No response given).

Provider's name: Tom Ryan/ Caroline Day
Date: 14 December 2010