

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Tralee Community Nursing Unit
<b>Centre ID:</b>	OSV-0000566
<b>Centre address:</b>	Teile Carraig, Killerisk Road, Tralee, Kerry.
<b>Telephone number:</b>	066 719 9250
<b>Email address:</b>	maire.flynn@hse.ie
<b>Type of centre:</b>	The Health Service Executive
<b>Registered provider:</b>	Health Service Executive
<b>Provider Nominee:</b>	Ber Power
<b>Lead inspector:</b>	Mary Costelloe
<b>Support inspector(s):</b>	None
<b>Type of inspection</b>	Unannounced Dementia Care Thematic Inspections
<b>Number of residents on the date of inspection:</b>	43
<b>Number of vacancies on the date of inspection:</b>	0

## **About Dementia Care Thematic Inspections**

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

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

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

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

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

**The inspection took place over the following dates and times**

From:	To:
03 April 2017 08:30	03 April 2017 18:00
04 April 2017 08:30	04 April 2017 14:00

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

<b>Outcome</b>	<b>Provider's self assessment</b>	<b>Our Judgment</b>
Outcome 01: Health and Social Care Needs	Substantially Compliant	Non Compliant - Moderate
Outcome 02: Safeguarding and Safety		Non Compliant - Major
Outcome 03: Residents' Rights, Dignity and Consultation	Substantially Compliant	Non Compliant - Major
Outcome 04: Complaints procedures	Substantially Compliant	Compliant
Outcome 05: Suitable Staffing	Substantially Compliant	Compliant
Outcome 06: Safe and Suitable Premises	Substantially Compliant	Non Compliant - Moderate

**Summary of findings from this inspection**

This inspection report sets out the findings of a thematic inspection which focused on specific outcomes relevant to dementia care.

As part of the thematic inspection process, providers were invited to attend information seminars given by the Authority. In addition, evidence-based guidance was developed to guide the providers on best practice in dementia care and the inspection process. Prior to the inspection, the person in charge completed the provider self-assessment and compared the service with the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

While this centre does not have a dementia specific unit the inspector focused on the care of residents with a dementia during this inspection. 12 residents were formally diagnosed with dementia. The inspector met with residents, relatives, and staff members during the inspection. The inspector tracked the journey of a number of residents with dementia within the service, observed care practices and interactions between staff and residents who had dementia. The inspector also reviewed documentation such as care plans, medical records, staff files, relevant policies and the self assessment questionnaire which were submitted prior to inspection.

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

Residents had access to a variety of communal day spaces and the two enclosed garden courtyards were easily accessible.

The inspector was satisfied that residents' overall healthcare needs were met and they had access to appropriate medical and allied healthcare services and residents had opportunities to participate in meaningful activities.

The collective feedback from residents and relatives was one of satisfaction with the service and care provided.

Staff were offered a range of training opportunities, including a range of specific dementia training courses.

Improvements were required to areas such as restraint management and nursing documentation. The physical environment posed significant challenges when delivering personal care and attending to residents' end of life care needs. Other improvements were required to ensuring that all residents had choices at meal times, all residents were consulted with and adequate personal storage space was provided

These areas for improvement are discussed further throughout the report and in the action plan 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 Standards for Residential Care Settings for Older People in Ireland.**

***Outcome 01: Health and Social Care Needs***

**Theme:**

Safe care and support

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

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

**Findings:**

The inspector found that residents' overall healthcare needs were met and they had access to appropriate medical and allied healthcare services. Residents had opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. However, many improvements were required to the nursing documentation.

The centre had regular and timely services provided by a local general practice. There was an out-of-hours GP service available. Residents received a full review of their medical care and their medications every three months. Residents and relatives spoken with were satisfied with the medical care in the centre. The residents received timely access to speech and language therapy, dietician, occupational therapy and physiotherapy in the centre. The inspector reviewed residents' records and found that residents had been referred to these services, regularly reviewed and results of assessments were written up in the residents' notes.

There was a policy in place that set out how resident's needs would be assessed prior to admission, on admission, and then reviewed at regular intervals. A review of the records showed that this was happening in practice.

Comprehensive up-to-date nursing assessments were in place for all residents. A range of up-to-date assessments were completed for residents including risk of developing pressure ulcers, falls risk, nutritional assessment, dependency, moving and handling, oral hygiene and mental score.

The inspector reviewed a sample of residents files and noted that nursing documentation and care plans were fragmented and difficult to navigate. It was difficult to find the most up to date appropriate information on the residents current care needs. The information in some care plans was generic and not individualised or person centered. Nursing staff spoken with were very familiar with residents current care needs and were clearly able to describe the care being delivered but in many instances this was not reflected in the care plans. The inspector noted that the care plans reviewed did

not guide the care of the resident. Nursing staff spoken with agreed with the inspector stating that it was difficult to find the appropriate up to date information. Some care plans had not been recently updated while other files reviewed had not been updated following recent reviews and changes in recommendations from the SALT. The inspector noted that care plans were not in place for all identified issues such as risk of developing pressure ulcers. While the inspector saw that appropriate pressure relief equipment was in use and staff were providing appropriate care, this was not reflected in the nursing documentation. The person in charge advised the inspector that a new care planning template was due to be put in place shortly and some staff had already received training on its implementation.

Nursing staff spoken with stated that they regularly discussed care needs and care plans with both residents and their families but there was no documentary evidence of relative and resident involvement in the review of care plans.

The person in charge showed the inspector the detailed hospital transfer letter which was completed when a resident was transferred to hospital. The transfer letter outlined the required information to ensure that hospital staff were made aware of residents individual needs. The person in charge told the inspector that should it be necessary for a resident to be admitted to hospital that they were always accompanied by a staff member if a family member was not available or present.

The inspector was satisfied that residents weight changes were closely monitored. All residents were nutritionally assessed using a validated assessment tool. All residents were weighed regularly. Nursing staff told the inspector that if there was a change in a resident's weight, nursing staff would reassess the resident, inform the GP and referrals would be made to the dietician and speech and language therapy (SALT). Files reviewed by the inspector confirmed this to be the case. However, nutrition care plans reviewed were not found to be person centered, comprehensive and did not reflect the most up to date recommendations of the dietician and SALT. Nutritional supplements were administered as prescribed. Staff spoken with were aware of residents likes and dislikes and of those residents who required specialised diets or modified diets and were knowledgeable regarding the recommendations of the dietician and SALT.

The inspector observed the lunch time meal experience and noted that some improvements were required particularly in relation to ensuring residents choice. This action is included under Outcome 3 : Residents rights, dignity and consultation.

A new spacious dining room had been provided to the Lohar ward since the last inspection. Meals were served to residents in the dining rooms in both wards and some residents had their meals in their bedrooms. The dining rooms were bright and spacious. A variety of tables were provided seating from two to six residents. While the tables had table cloths provided, they had no other place settings, cutlery, condiments, sauces or centre pieces.

On the first day of inspection, residents and staff spoken with did not know what choices were available for lunch. There was no daily menu displayed. The main meals were prepared and cooked in the local hospital and transported to the centre each day which were then reheated and served on site. Some residents spoken with stated that

they did not get a choice of meals however, staff stated that meal choices were offered. The inspector spoke with catering staff who advised that residents were asked each day of their preferred meal option for the following day, however, staff were unable to show the inspector records of these meal choices for the previous week. They stated that there was no formal system in place for recording residents preferred meal options. Catering staff had recorded the preferred meal options for some residents on day two of the inspection but advised that residents who required modified diets did not have a choice or option. The daily menu was not displayed. The inspector noted that residents were not offered a choice of drinks or choice of gravy. Milk was served to residents in mugs and all meals were served with gravy.

The inspector noted that staff assisting residents with a dementia were caring and sensitive, they explained what foods were on offer and gently reminded some to swallow. Modified consistency diets were nicely presented and included a variety of texture and colour. Many staff had received training in relation to dysphagia and nutrition.

Residents spoken with stated that the food was generally alright. The inspector observed a variety of drinks and snacks being offered to residents throughout the days of inspection. The person in charge informed the inspector that she had recently reviewed the dining experience had had ordered new table cloths and table ware. She advised that the recently appointed clinical nurse manger 2 (CNM2) had also planned to complete a workplace culture observation audit in the coming week with a view to further enhancing the dining experience.

The inspector reviewed the file of a resident with a wound and noted adequate wound assessment and wound care charts in place. Staff had access to support from the tissue viability nurse if required.

The inspector reviewed the files of residents who had recently fallen and noted that the falls risk assessments, maintaining a safe environment and mobility care plans were in place. The person in charge reviewed falls on a regular basis, there was evidence of learning and improvement to practice. Low-low beds, crash mats, chair/bed sensor alarms and hip protectors were in use for some residents. All falls were logged as incidents and individual resident's falls logs were updated following each fall to assist staff to track individual falls pattern. There was evidence that residents' families and GP were contacted post falls and that neurological observations were recorded following un witnessed falls. The physiotherapist and OT attended weekly handovers and assessed all residents post falls. However, the inspector noted that recent OT recommendations following a post fall review had not been updated in the residents' mobility care plan.

Staff provided end of life care to residents with the support of their GP and the palliative care team. The inspector reviewed a sample of 'end of life' care plans and spoke with and observed staff who were providing end of life care to a resident. The inspector was satisfied that the residents medical, nursing and spiritual needs were being met however, the end of life care plan in place was not informative, person centered or did not describe the care as outlined by staff as actually being delivered.

Many staff had undertaken training in end of life care and some nursing staff had

completed training on advance care planning directive. The inspector saw that end of life decision plans were in place for some residents and discussions on end of life wishes had taken place for others. Residents religious and spiritual needs were met. The local priest visited regularly and mass was celebrated monthly in the centre. Other denominations were catered for when requested. There was a prayer room available to residents. Family and friends were facilitated to be with a resident who was at their end of life stage and there were no restrictions in terms of visiting hours. A visitors room was provided with a sofa and comfortable arm chairs, families could stay overnight if they wished.

While staff continued to try to meet the social care needs of the residents, improvements were required to social care planning documentation to ensure that the individual needs, interests and capacities of residents were met. A rehabilitation assistant was employed full time and coordinated activities in the centre. He worked under the auspices of Kerry General Hospital Occupational Therapy department and worked on individual activities of daily living assessment with residents in conjunction with the occupational therapist and physiotherapist. Three volunteers helped out with a variety of activities. Group activities and one to one activities were provided (e.g. music therapy, doll therapy, film sessions, choir practice, arts and crafts, gardening, knitting, hand massage, nail care, reminiscence). The daily and weekly activities schedule was displayed. During the inspection, the inspector observed residents enjoying a variety of activities including ball game exercises, bingo which had been recently introduced at the request of residents and a SONAS session (therapeutic programme specifically for residents with a dementia).

The inspector noted that recreation and social care plans in place were not informative. Residents individual interests, hobbies and life stories were not documented, the 'help us to get to know you' template provided was not completed in respect of all residents. The person in charge told the inspector that life stories booklets had been ordered and it was planned to complete these for each resident.

**Judgment:**

Non Compliant - Moderate

***Outcome 02: Safeguarding and Safety***

**Theme:**

Safe care and support

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

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

**Findings:**

The inspector found that while measures were in place to protect residents from being harmed or abused, the documentation to support the management of restraint was not in line with the centres own policies or national policy on the use of restraint.

There were comprehensive policies in relation to safeguarding of residents. Staff spoken with confirmed that they had received training in relation to the prevention and detection of elder abuse and safeguarding and were knowledgeable regarding their responsibilities in this area. Information posters outlining the safeguarding policy statements, names of the designated officers and the contact information for the confidential recipient were clearly displayed. The person in charge advised that further safeguarding training was scheduled.

The person in charge advised the inspector that the administrator managed some residents accounts. The administrator was not available on the days of inspection but the systems outlined by the person in charge indicated that residents' finances were managed in a clear and transparent manner. Small amounts of money were kept for safekeeping on behalf of some residents. All money was securely stored. Individual balance sheets were maintained for each resident and all transactions were clearly recorded and signed by two staff members. Receipts were kept for all purchases and expenditure.

The inspector reviewed the policies on the support of residents with responsive behaviour and use of restraint. The policy on the support of residents with responsive behaviour outlined guidance and directions to staff as to how they should respond and strategies for dealing with responsive behaviour. The national policy on the use of restraint 'Towards a restraint free environment' had been adopted and included clear directions on the use of restrictive procedures including risk assessment and ensuring that the least restrictive intervention was used for the shortest period possible.

There were 32 residents using bedrails at the time of inspection. The inspector noted that the documentation to support the use of bedrails was not in line with national policy on the use of restraint. Risk assessments completed were not in line with policies. There was no evidence that alternatives had been tried or considered prior to using bedrails. There was no evidence of multidisciplinary input into the decision to use the bed rails. There was no clear rationale documented for the use of bedrails. The inspector had concerns that bed rails were in use for some residents even though the risk assessment completed indicated that a bed rail should not be used.

Consent for the use of restraints were documented, care plans were in place to guide staff on the use of bedrails, staff carried out regular checks on residents using bedrails and these checks were recorded.

The inspector reviewed a sample of files of residents who presented with responsive behaviour and noted that while care plans were in place they did not clearly outline guidance for staff regarding known triggers and distraction techniques. Staff spoken with were clearly able to describe the care but this was not always reflected in the care plans. Some residents were prescribed psychotropic medicines on a 'PRN' as required basis. These medicines were administered occasionally for some residents. Staff spoken with informed the inspector that these were always administered as a last resort only when other strategies had been trialled and possible underlying causes had been eliminated. However, records were not maintained to indicate the rationale for administration of these medications or what other interventions had been tried to

manage the behaviour.

Staff spoken with and training records reviewed indicated that staff had received training on dementia awareness including the management of responsive behaviour.

The inspector reviewed a sample of staff and volunteers files and noted that safeguarding measures such as Garda vetting were in place. The person in charge confirmed that Garda vetting was in place for all staff, volunteers and persons who provided services in the centre.

The inspector observed staff interacting with residents in a respectful and friendly manner. Residents spoke highly of the staff.

**Judgment:**

Non Compliant - Major

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

**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:**

The inspector noted that staff were sensitive to residents' rights for privacy and dignity. However, the physical environment posed significant challenges when delivering personal care and attending to residents' end of life care needs. Other improvements were required to ensuring that all residents had choices at meal times, all residents were consulted with and adequate personal storage space was provided.

Residents were treated with respect. The inspector heard staff addressing residents by their preferred names and speaking in a clear, respectful and courteous manner. Staff paid particular attention to residents' appearance, dress and personal hygiene and were observed to be caring towards the residents. Residents and relatives spoken with were complimentary of staff and the care provided.

Bedroom and bathroom doors were closed and screening curtains were in place in shared bedrooms when personal care was being delivered. Staff were observed to knock and wait before entering bedrooms.

The inspector observed the lunch time meal experience and noted that some improvements were required particularly in relation to ensuring and facilitating residents choice. This issue was also discussed under Outcome 1: Health and social care needs.

On the first day of inspection, residents and staff spoken with did not know what choice options were available for lunch. There was no daily menu displayed. Some residents

spoken with stated that they did not get a choice of meals. Catering staff had recorded the preferred meal options for some residents on day two of the inspection but advised that residents who required modified diets did not have a choice or option. The inspector noted that residents were not offered a choice of drinks or choice of gravy. Milk was served to residents in mugs and all meals were served with gravy.

Residents' religious and political rights were facilitated. A local priest visited weekly and Mass was celebrated monthly in the centre. The mass from the local hospital was also available by video link. A prayer room was provided for residents of varying religious beliefs. Residents were facilitated to vote and the person in charge explained that residents had been facilitated to vote in-house during past elections.

There was an open visiting policy in place. Residents could meet with family and friends in private if they wished, or could meet in their rooms, or communal areas of the home.

Residents' forum meetings were held on a regular basis and were facilitated by a volunteer advocate. Minutes of meetings were recorded; issues recently discussed included food, activities, ideas for activities and upcoming events. Approximately 10 residents had attended the last number of meetings. The inspector was not satisfied that systems were in place to ensure that the views of residents with a dementia were captured. The person in charge advised that relatives of residents had not been invited to the forum in the past but it was something she was going to consider in the future.

Information on the national advocacy service SAGE was displayed in the centre. The person in charge outlined how she intended to have an information evening for residents and relatives to outline the services provided by SAGE.

While the inspector was satisfied that staff met the communication needs of residents with a dementia, communication care plans in place were generic and did not set out the individual specific needs of residents. Improvements required to care planning documentation has already been discussed under Outcome 1 : Health and social care needs.

Storage space for personal possessions continued to pose to a challenge in shared bedrooms due to the small size of individual wardrobes. Following the last inspection the person in charge told the inspector that staff had in consultation with residents and their families reviewed the amount of personal clothing and other items in storage. Excess clothing and other personal items were removed and new laundry baskets were provided for the storage of soiled clothing. Residents spoken with stated that wardrobe space was small and they were limited in the amount and variety of clothing they could retain. This impacted on residents choice and dignity.

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

**Judgment:**  
Non Compliant - Major

***Outcome 04: Complaints procedures***

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

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

No actions were required from the previous inspection.

**Findings:**

The management team had a positive attitude to receiving complaints and considered them a means of learning and improving the service.

There was a comprehensive complaints policy in place; it included details of the complaints officer and appeals process.

The complaints procedure was displayed in prominent locations in the centre and also included in the residents guide. A comment suggestion box was also available.

The inspector reviewed the complaints log and noted that all complaints including verbal complaints were recorded. There were no open complaints at the time of inspection. Details of complaints, investigations carried out, outcomes, recommendations and complainant's satisfaction or not with the outcome were recorded.

**Judgment:**  
Compliant

***Outcome 05: Suitable Staffing***

**Theme:**  
Workforce

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

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

**Findings:**

There was a clear management structure in place in the centre and lines of accountability were clear to all staff. A new person in charge had been appointed in November 2016 and a new clinical nurse manager 2 (CNM2) had been recently appointed.

The inspector found there were appropriate numbers and skill mix of staff on duty to meet the holistic and assessed needs of the 43 residents on the days of inspection. There were four nurses and six healthcare assistants on duty in the morning and afternoon, four nurses and two healthcare assistants on duty in the evening time and two nurses and two healthcare assistants on duty at night time. The person in charge and CNM2 were normally on duty during the day time Monday to Friday. The staffing complement included a rehabilitation assistant for activities, catering and housekeeping staff. The staffing rosters reviewed indicated that these staffing patterns were the norm.

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

The staff also had access to a range of education, including training in specific dementia care training courses, advance care directives, end of life care, medication management, nursing documentation, dignity at work, incontinence promotion, diabetes and wound management, care planning and person centered care education.

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

There were three volunteers attending the centre, their roles and responsibilities were not set out in writing and Garda Síochána vetting was in place.

**Judgment:**  
Compliant

### ***Outcome 06: Safe and Suitable Premises***

**Theme:**  
Effective care and support

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

**Findings:**  
Tralee Community Nursing Unit consisted of a single storey, purpose built building and its total capacity was 43 residents. There was ample parking for staff and visitors. The centre was clean and well decorated throughout in a homely manner. All areas were bright and well lit, with lots of natural light in the all areas. The atmosphere was quiet, calm and peaceful.

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

The multi occupancy rooms presented challenges to the provision of adequate space, privacy and dignity for each resident. The physical environment posed challenges when delivering personal care; attending to residents' care needs, infection control and communicating in privacy. Residents had limited space for the storage of personal belongings. This was already discussed under Outcome 3: Residents rights, dignity and consultation.

There were ample numbers of toilets and showers in the centre and three single bedrooms had an ensuite shower room and toilet. The toilets and showers had grab rails for safety. There was two assisted specialised baths available in the centre, however, both bathrooms were used to store equipment such as specialised chairs. On the days of inspection both bathrooms were full with equipment and the baths were inaccessible. Staff informed the inspector that the baths were used by some residents and equipment was removed to facilitate bathing. Some wheelchairs were also stored in assisted shower rooms.

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

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

Residents had access to two, secure, enclosed garden areas which were paved and landscaped, they provided a safe space for residents to walk or sit out in the fresh air. The gardens were easily accessible and could be viewed from many areas in the centre. Residents spoken with stated that they enjoyed the gardens and looked forward to some fine weather when they could sit outside. Some residents told the inspector that they enjoyed looking out at the beautiful gardens.

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

The inspector noted good signage and sign posting throughout the centre. Appropriate signage was provided on doors, there was a sign with a word and a picture for bathrooms and other rooms residents would use. However, the inspector noted that bedroom doors were not provided with visual cues to assist residents recognise their own bedroom.

There was a range of equipment in the centre to aid mobility. Overhead ceiling hoists were provided in all bedrooms. Hoists and other equipment seen in the centre were in

working order, and records showed they had been regularly serviced. Staff records showed that staff had completed manual handling training in relation to the equipment available in the centre.

**Judgment:**

Non Compliant - Moderate

**Closing the Visit**

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

**Acknowledgements**

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

***Report Compiled by:***

Mary Costelloe  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority

## Health Information and Quality Authority Regulation Directorate

### Action Plan



### Provider's response to inspection report<sup>1</sup>

<b>Centre name:</b>	Tralee Community Nursing Unit
<b>Centre ID:</b>	OSV-0000566
<b>Date of inspection:</b>	03/04/2017 and 04/04/2017
<b>Date of response:</b>	16/05/2017

### Requirements

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

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

### Outcome 01: Health and Social Care Needs

#### Theme:

Safe care and support

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

Care plans were not in place for all identified issues such as risk of developing pressure ulcers.

The social care needs of residents were not set out in a care plan.

#### **1. Action Required:**

Under Regulation 05(3) you are required to: Prepare a care plan, based on the

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

assessment referred to in Regulation 5(2), for a resident no later than 48 hours after that resident's admission to the designated centre.

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

1. This issue has been addressed in the new documentation- August 2017.
2. Present care plans are to be reviewed to reflect the risk of developing pressure ulcers while awaiting new documentation – June 2017.

**Proposed Timescale:** 31/08/2017

**Theme:**

Safe care and support

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

- nursing documentation and care plans were fragmented and difficult to navigate.
- The information in some care plans was generic and not individualised or person centered.
- Residents current care needs were not always reflected in the care plans.
- Some care plans reviewed did not guide the care of the resident.
- Some care plans had not been recently updated.
- Some care plans had not been updated following recommendations from allied health professional such as SALT and OT.
- There was no documentary evidence of relative and resident involvement in the review of care plans.

**2. 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:**

1. New documentation has been developed to reflect a more person centre approach to care. This documentation is presently at the printers and will be available in the first week in June. Education for staff regarding new documentation will take place in June. All Residents to have new documentation in place by the end of August 2017.
2. All care plans to be reviewed three monthly unless otherwise indicated and to reflect recommendations from allied health professionals- Immediate.

**Proposed Timescale:** 31/08/2017

## Outcome 02: Safeguarding and Safety

### Theme:

Safe care and support

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

There were 32 residents using bedrails at the time of inspection. The inspector noted that the documentation to support the use of bedrails was not in line with national policy on the use of restraint. Risk assessments completed were not in line with policies. There was no evidence that alternatives had been tried or considered prior to using bedrails. There was no evidence of multidisciplinary input into the decision to use the bed rails. There was no clear rationale documented for the use of bedrails. The inspector had concerns that bed rails were in use for some residents even though the risk assessment completed indicated that a bed rail should not be used.

Some residents were prescribed psychotropic medicines on a 'PRN' as required basis. Records were not maintained to indicate the rationale for administration of these medications or what other interventions had been tried to manage the behaviour.

### 3. Action Required:

Under Regulation 07(3) you are required to: Ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.

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

Each resident is to be reassessed regarding their bedrail usage and managed as per Policy on the use of physical restraints in designated residential care units for older people.

**Proposed Timescale:** 30/06/2017

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

### Theme:

Person-centred care and support

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

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

### 4. Action Required:

Under Regulation 09(3)(b) you are required to: Ensure that each resident may undertake personal activities in private.

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

A designated room to provide End of Life care to Residents is planned and will be provided as soon as the Physiotherapy department is relocated to a new premises.

**Proposed Timescale:** 31/12/2017

**Theme:**

Person-centred care and support

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

All residents did not have a daily choice of meal option. There was no menu displayed showing what meal options were available. Residents who required modified diets did not have a choice of meal option. Residents were not offered a choice of drinks or choice of gravy. Milk was served to residents in mugs and all meals were served with gravy.

**5. Action Required:**

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

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

1. Meeting already held with catering Supervisor regarding meal options for all Residents. New menus to be drawn up and daily menus to be displayed by end of May.
2. Choice of drinks and sauces being offered- immediately.

**Proposed Timescale:** 31/05/2017

**Theme:**

Person-centred care and support

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

Systems were not in place to ensure that the views of residents with a dementia were captured. The person in charge advised that relatives of residents had not been invited to the forum in the past but it was something she was going to consider in the future.

**6. Action Required:**

Under Regulation 09(3)(d) you are required to: Ensure that each resident is consulted about and participates in the organisation of the designated centre concerned.

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

1. A relative's forum is being addressed and will be in place by end of June.

**Proposed Timescale:** 30/06/2017

**Theme:**

Person-centred care and support

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

Communication care plans in place were generic and did not set out the individual specific needs of residents.

**7. Action Required:**

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

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

This issue has being addressed in the new documentation and will be in place by end of August 2017.

**Proposed Timescale:** 31/08/2017

**Theme:**

Person-centred care and support

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

Storage space for personal possessions continued to pose to a challenge in shared bedrooms due to the small size of individual wardrobes. Following the last inspection the person in charge told the inspector that staff had in consultation with residents and their families reviewed the amount of personal clothing and other items in storage. Excess clothing and other personal items were removed and new laundry baskets were provided for the storage of soiled clothing. Residents spoken with stated that wardrobe space was small and they were limited in the amount and variety of clothing they could retain. This impacted on residents choice and dignity.

**8. Action Required:**

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

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

1. The Multi-occupancy 4 bedded rooms in the Tralee Community Nursing Unit are 41m<sup>2</sup> and this is meeting the National Standards for Residential Care Settings for Older people in Ireland 2016.

**Proposed Timescale:**

## Outcome 06: Safe and Suitable Premises

### Theme:

Effective care and support

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

There was inadequate storage space for the storage of equipment. On the days of inspection the two assisted bathrooms were full with equipment and the baths were inaccessible. Some wheelchairs were also stored in assisted shower rooms.

### 9. 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:

Wheelchairs are no longer stored in assisted shower rooms. All other equipment not in use is to be stored off site.

Proposed Timescale: Mid May.

## Proposed Timescale: 16/05/2017

### Theme:

Effective care and support

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

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

### 10. 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:

1. The Multi-occupancy 4 bedded rooms in the Tralee Community Nursing Unit are 41m<sup>2</sup> and this is meeting the National Standards for Residential Care Settings for Older people in Ireland 2016.
2. All efforts have been made to ensure efficient use of space, there are overhead hoists in situ and curtains are used appropriately during the delivery of care to protect

resident's privacy and dignity.

3. Alternative enhanced storage facilities have been provided for resident's clothing and laundry following previous inspections. There are no further interventions possible at this time.

**Proposed Timescale:**