

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Elm Hall Nursing Home
Centre ID:	OSV-0000034
Centre address:	Loughlinstown Road, Celbridge, Kildare.
Telephone number:	01 601 2399
Email address:	admin@elmhallnursinghome.com
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Springwood Nursing Homes Limited
Provider Nominee:	Mairead M Byrne
Lead inspector:	Sheila McKeivitt
Support inspector(s):	Deirdre Byrne
Type of inspection	Unannounced Dementia Care Thematic Inspections
Number of residents on the date of inspection:	56
Number of vacancies on the date of inspection:	5

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.

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor compliance with specific outcomes as part of a thematic inspection. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 27 July 2016 09:00 To: 27 July 2016 20:00

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

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

Summary of findings from this inspection

This was an unannounced inspection conducted by two inspectors over one day. The purpose of this inspection was to determine what life was like for residents with dementia living in the centre. In order to determine this inspectors focused on six outcomes and followed up on three outcomes from the last monitoring inspection which took place in October 2014. There were 56 residents in the centre and one resident in hospital. 52 of the 56 residents in the centre had a diagnosis of cognitive impairment, Alzheimer's disease or dementia. The centre did not have a dementia specific unit.

Prior to this inspection the provider had submitted a completed self-assessment document to the Authority along with relevant policies and inspectors reviewed these documents prior to the inspection. The judgments in the self assessment stated five were in compliance and one in substantial compliance with the six outcomes.

Inspectors found the provider was in moderate non compliance with three outcomes and in substantial compliance with three outcomes.

Inspectors found the care needs of residents with dementia were met. However, assessment and care plan records required improvement. There was a decrease in the use of restraint and behaviours that challenged were well managed with minimum use of psychotropic medications. However, alternatives trialled prior to restraint been used was not always recorded. The staffing levels were good however the skill mix required review. Staff had received training which equipped them to engage and care for residents who had dementia. However, further training was required around medicines management. The premises required some review to ensure it enabled residents with dementia to flourish. Residents with dementia had choices in relation to all aspects of their life and their personal choices were respected by all staff. However, records pertaining to activities they participated in required review. The management of complaints was robust although an overseer of the process was not evident.

The action plans at the end of this report reflect where improvements need to be made.

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

Outcome 01: Health and Social Care Needs

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

The wellbeing and welfare of residents with a diagnosis of dementia, alzheimers and those with cognitive impairments were being met. There was a detailed admissions policy which was reflected in practice. The nursing, medical and social care needs of these residents were being met. However, as detailed below records including assessments, care plans, activities reflecting activities, medicine prescriptions' and the directory of residents required improvement.

All residents had chosen a general practitioner and pharmacist from practices close by to care for them. The centre had access to a geriatrician lead community outreach team provided by a local acute hospital. In addition, they had access to a consultant psychiatrist. There was no delay in referring residents for assessment to any of the allied health care team members. Inspectors saw evidence of referrals made, assessments completed and recommendations made in resident files. The provider sought external companies to come in and routinely assess resident's eyesight and dental hygiene/needs. The general practitioner chosen by most of the residents routinely visited the centre. There was evidence that all residents had their medical needs including their medications reviewed on a four monthly basis by their general practitioner and the person in charge. The pharmacist delivered medications when required and an audit of medication management practices was completed every month by the management team.

A sample of residents' nursing, medical and medicines prescription charts were reviewed. Residents had comprehensive assessments completed pre-admission and on admission. Some but not all assessments were reviewed on a four monthly basis and those reviewed were not completed in a comprehensive manner. For example, staff wrote "R/V" dating and signing the previous assessment document rather than completing a new assessment form. This led to updated assessments such as risk of pressure ulcers not reflecting residents' current risk status. Residents had a corresponding care plan in place to reflect each identified need. However, these were not always detailed enough to direct care to residents. For example, one resident who was identified as at high risk of falls had a falls alarm mat in use however, this was not

referred to in the residents' care plan. Inspectors noted that one resident had not been reassessed after readmission post a stay in the local acute hospital. Residents at high risk of falls had a falls diary in place. However, these diaries were not reflecting all falls sustained by residents, they were not kept up-to-date.

Staff provided end-of-life care to residents with the support of the general practitioner and the palliative care team if required. There was no resident receiving end-of-life care at the time of this inspection. All current residents' had their own bedroom this ensured their privacy and dignity was maintained at the time of death. Relatives had access to a visitors room which contained furniture which enabled them to sleep overnight in the nursing home. The centre had a small chapel which was used by many families to wake their loved one. An end-of-life symbol was placed on the door of the chapel at this time. Inspectors were informed that staff provided a guard of honour when the residents' remains were being removed from the chapel. Residents' end-of-life preferences were not reflected in their admission or four monthly assessment reviews. Each resident did have an end-of-life care plan in place, however the content was vague, reflecting the residents' preferred resuscitation status and whether they wished to be transferred to hospital or not.

Residents who had been transferred into and out of hospital had copies of their transfer letter from the centre to the acute hospital on file together with nursing and medical transfer letters from the acute hospital back to the centre. However, this data was not reflected in the directory of residents reviewed.

Residents nutritional needs were met and they were supported to enjoy the social aspects of dining. The menu provided a choice of meals, residents told inspectors they were asked on the previous day what they would prefer. The menu was not on display in either of the two dining rooms or made accessible to residents' therefore those residents' identified with a dementia were unable to recall what was for lunch. Those who required support at mealtimes were provided with timely assistance from staff. Inspectors saw this was provided in a quiet, calm and professional manner. Residents' dignity was maintained. Inspectors observed that a number of maximum dependent residents diagnosed with dementia were being assisted with their meal in the sitting room. Inspectors were informed that their chairs took up too much room in the small dining room upstairs and this was why they were not having their lunch in the dining room. This required review to ensure all residents' were given the opportunity to enjoy the dining experience.

Residents had a malnutrition risk screening tool (MUST) completed on admission and this was reviewed three monthly. They were routinely weighted and had their body mass index calculated on a three basis. Those with nutritional care needs had a nutritional care plan in place and those identified as at risk of malnutrition were referred to a dietician when nurses felt their input was required. Inspectors saw that residents' likes, dislikes and special diets were all recorded. All staff spoken with had detailed knowledge of dietary requirements. The management team conducted detailed monthly audits of residents' nutritional status.

There was a medicines management policy in place. Some aspects of practice reflected the policy. The storage of all medications was safe and secure. Opened food

supplements stored in one fridge had the opened date not reflected on the bottle. Medication administration was not always in line with the centres policy or with professional guidelines, one staff was observed signing for medications prior to administering them to the resident. The maximum dose and indications for as required medications was not in place for all residents receiving as required medications. Medication errors were recorded. There was evidence that the person in charge reviewed all errors and took appropriate action to prevent further errors from occurring.

This outcome was judged to be substantially compliant in the self-assessment, inspectors judged it as moderately non compliant.

Judgment:

Non Compliant - Moderate

Outcome 02: Safeguarding and Safety

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

Measures to protect residents with dementia being harmed or suffering abuse were in place. Residents spoken with stated they felt safe in the centre. There was a policy and procedures in place for the prevention, detection and response to abuse which reflected the National Health Service Executive policy and procedures "Safeguarding Vulnerable Persons at Risk of Abuse" 2014. There had been no reported incidences from the centre since the last inspection. However, inspectors were informed of an alleged incidence which had been reported to the person in charge two days prior to this inspection which was in the process of initial investigation to determine if it was an incident of suspected abuse.

Staff demonstrated a good knowledge of what constituted abuse. However, a number of staff did not have up-to-date refresher training in place. Staff did not manage any monies on behalf of the residents.

There was a policy which reflected the use of restraint in the centre. It referenced the National Policy 2011 "Towards a Restraint Free Environment" on the use of restraint. Practice observed reflected policy. However, the provider had invested in alternative equipment used as an alternative to restraint this included fall sensor mats for resident beds and chairs. A small number of residents with dementia had a form of restraint in use including bed rails and psychotropic medications. They had assessments in place to reflect their use. Assessments reviewed reflected how restraint was used only in the resident's best interest. However, alternatives tried prior to using bed rails were not clearly recorded in resident assessment forms. The clinical nurse manager and person in

charge were auditing the use of restraint and psychotropic medications on a monthly basis. These audits showed that the use of restraint had gradually reduced. Residents using a form of restraint had a care plan in place however, they were not detailed enough to direct care for example, they did not reflect if residents had protective padding on the bedrails in place or how frequently they were released when in use.

The policy in place reflected the care provided to manage behaviours that challenge. Residents who intermittently displayed behaviours that challenged had detailed care plans in place which mentioned triggers for the resident, how to avoid them and diversional therapies to try. Some residents were prescribed psychotropic medication on an as required basis to manage these behaviours. These were reflected in the residents' care plan.

This outcome was judged to be compliant in the self-assessment, the inspectors also judged it as being substantially compliant.

Judgment:
Substantially Compliant

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:
Residents with dementia were consulted with and actively participated in the organisation of the centre. Residents' privacy and dignity was respected, including receiving visitors in private. There was a policy providing staff with information on how to communicate with residents with dementia. They had access to meaningful activities and had choice in relation to how they lived their life. However, notices on display were not accessible to residents'.

Inspectors were informed that resident meetings were facilitated by the activities coordinator at least once every month. Residents were in the process of completing a quality satisfaction questionnaire which they had been issued with to gain feedback about the service they were receiving, a small number had been returned to date. Residents had access to an independent advocate who as mentioned under outcome 13 was named on the complaints policy.

Residents were treated with dignity and respect. Residents with dementia spoken with confirmed this to the inspectors. Also, the inspectors observed staff treat residents with the utmost respect. Staff appeared to know the residents well and they took time to communicate with residents in a kind and patient manner.

Residents privacy was respected. They received personal care in their own bedroom or a bathroom which could be locked. Bedrooms and bathrooms had privacy locks in place. There were no restrictions on visitors and residents could receive visitors in private in different areas of the centre. All residents were offered the choice to register to vote and a number of residents had chosen to do so. Residents' from all dominations had independent access to the centres chapel. Mass was said in the centre 2-3 times per month and residents were offered anointment of the sick on a monthly basis. The televisions were connected to the local parish church so residents could connect into live Masses. Residents had access to some local and daily newspapers. They had access to the internet on one communal computer accessible to them in the well stocked library. However, inspectors were informed that wifi was not accessible throughout the centre.

A Health Care Assistant was responsible for coordinating activities on the day of this inspection as the activities coordinator was on leave. Inspectors saw that a wide variety of activities were available to residents'. The activities schedule was on display on the notice boards in the two large sitting rooms. These notice boards were not easily accessible to residents and the activity timetables did not reflect the times activities were taking place. Hence, they did not enable residents to plan their day independently of staff. Records of activities provided and attendees were recorded however, these were not individualised and did not reflect their level of participation. Records did not reflect if activities specific to meeting the needs of dementia residents' were taking place. Although staff were trained to deliver activities to meet the needs of dementia residents and staff told inspectors these classes were provided there were no records to reflect this. One to one activities did not reflect what this entailed.

This outcome was judged to be compliant in the self-assessment, the inspector judged it as substantially compliant.

Judgment:
Substantially Compliant

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:
There was a complaints policy in place which met the regulatory requirements. A copy was on display in the centre.

Residents with dementia told the inspector that they would complain to the person in charge or any of the staff. A review of the two complaints recorded over a two year

period showed that they were all dealt with promptly by the designated complaints officer, the outcome of the complaint and the level of satisfaction of the complainant were all recorded. There was an appeals process, none on file had been appealed. The complaints policy included contact details of an independent advocate available to complainants.

The person named to oversee complaints was not named on the complaints policy.

This outcome was judged to be compliant in the self-assessment, the inspectors judged it as substantially compliant.

Judgment:
Substantially Compliant

Outcome 05: Suitable Staffing

Theme:
Workforce

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

No actions were required from the previous inspection.

Findings:

There was an appropriate number of staff on duty. However, a review of the skill mix was required to ensure that residents' needs were assessed and met and to ensure health care assistants received adequate supervision.

The centres statement of purpose stated that the requirement was for twelve whole time equivalents in addition to the person in charge. However, there were currently nine employed. The management team were in the process of recruiting additional staff nurses to fill the vacant posts. Inspectors were informed that the person in charge was on duty Monday to Friday, together with a clinical nurse manager and two staff nurses working on the floor each day. However, on review of the staff rosters inspectors found that a full complement of qualified staff was provided on 2 days out of a fourteen day period reviewed. This meant that the other days there was a deficit 1 nurse. This reduction in the availability of qualified staff on the floor had contributed to the non compliances outlined in outcome 11. In addition, inspectors found that there was no supervision by a qualified member of staff in the dining room at mealtimes. On days where an additional qualified staff nurse could not be provided an additional HCA had not been scheduled. No review of skill mix had occurred. Inspectors noted that the number of health care assistants employed was as per that stated on the statement of purpose. It was evident from the constant request for help from health care assistants to the activities co-ordinator on the day of inspection that an additional health care assistant was required when a third qualified member of staff was not available.

Inspectors were informed that staff had three monthly supervisory meetings. However,

there was no evidence of these in staff files.

Records reflecting registration details of staff nurses for 2016 were available for review. Staff had up-to-date mandatory training in place. They also had access to other education and training to meet the needs of residents with dementia. This had been provided to some staff and was planned for others. Staff had also received training on how to manage responsive behaviours. This was clearly evident in the manner staff interacted with residents with dementia and included them in all aspects of their care. Some staff nurses required refresher training in medicines management as evidenced under outcome 11.

There was an actual and planned staff roster which reflected the staff on duty. Staff files reviewed contained all the required documents. However, the hours worked by the person in charge were not reflected on the rosters provided to inspectors.

This outcome was judged to be compliant in the self-assessment, the inspector judged it as non compliant moderate.

Judgment:

Non Compliant - Moderate

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:

The location, design and layout of the centre was suitable for its stated purpose and met residents' individual and collective needs in a comfortable and homely way. The premises took account of the residents needs and was in line with Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. However, colour or points of interest were not used to enhance the environment for residents' with a dementia and they did not have independent access to the garden.

Inspectors saw that each of the four sluice rooms in the centre had wash hand basins installed since the last inspection.

The centre was clean tidy, well light and well heated. Bedrooms contained all the furniture they required including adequate storage facilities. They were encouraged to personalise their bedrooms and inspectors saw that most residents did so. Bedrooms were ensuite. There were several communal areas and all were decorated in a homely manner.

The corridors were wide and had handrails in place. There was seating areas along the corridors which gave residents a place to rest when walking. Inspectors noted that there were several communal areas on both floors including two large sitting rooms, a library, visitors rooms, activities room and a smaller quite room. However, although over half of the residents' had a diagnosis of dementia there were no specific areas of interest throughout the corridors or in the communal rooms used by residents. For example, residents who were benefiting from doll therapy had access to dolls but there was no specific area designed for them to potter or to enjoy this therapy.

The ensuite bathrooms were large with grab rails throughout and all had un-slip flooring in place. The sanitary wear, wall tiles, flooring, handrails and toilet seat cover were all white. Colour was not used to enable those with dementia to remain independent when using their bathroom.

Residents had access to equipment required to meet their needs and inspectors saw that equipment such as pressure relieving mattresses, high-low beds and hoists had been serviced within the past year. Inspectors noted that some residents had personalised name signs on their bedroom door. However, there was a lack of signage throughout the centre and the signage in place was not dementia friendly. For example, signs on a number of doors was in small black font on a silver background making it difficult for residents with a diagnosis of dementia to read. In addition, there was a lack of directional signage at eye level which would enable those residents living with a dementia to orientate their way around the centre.

Some aspects of the interiors were dementia friendly such as the plain curtains and non slip plain coloured flooring. Colour was not used to enhance the environment for residents, its use may assist residents with dementia to maintain their independence for longer as their disease progresses.

Residents' could access the enclosed garden via double doors leading from some communal rooms. It was safe and secure containing a circular walking path and seating which residents were free to use. The garden contained flower beds and points of interest such as bird boxes and a variety of pots and window boxes some sown by residents and positioned outside their bedroom window. Inspectors noted that residents' could not access this area independently they had to request staff to release the door in order to enter the enclosed garden.

All fire servicing documents were reviewed. There was evidence that the fire alarm and emergency lighting was reviewed on a quarterly basis and fire extinguishers on an annual basis. Fire drills were also been practiced on a frequent basis.

This outcome was judged to be compliant in the self-assessment, the inspector judged it as moderately non compliant.

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:

Sheila McKeivitt
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 report¹

Centre name:	Elm Hall Nursing Home
Centre ID:	OSV-0000034
Date of inspection:	27/07/2016
Date of response:	19/09/2016

Requirements

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

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

Outcome 01: 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:

Resident assessments were not comprehensively reviewed on a four monthly basis.
Resident assessments did not reflect their end-of-life preferences.

One resident had not been reassessed post return from an acute hospital stay.

1. Action Required:

Under Regulation 05(2) you are required to: Arrange a comprehensive assessment, by

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

an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to the designated centre.

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

To adequately reflect and evidence the 3 - 4 monthly review of all Care Plans & Assessments - Nursing Staff facilitating reviews have been instructed on Best Practice and requested to re-write the Assessment Profile rather than simply noting a review has taken place. This will also include re-assessment post-return from hospital stay.

Senior Nursing Staff have commenced reviewing all Assessment files during the internal documentation auditing process to ensure reviews are comprehensively recorded and necessary changes/interventions implemented by relevant nursing staff. The Documentation Audit process will now take place on a Bi-monthly basis.

The Nursing Home is involved in the 'Think Ahead' Programme - and is a member of the Irish Hospice Foundation, utilising their Training Materials and 'End of Life Care Tool Kit'. Staff also have access to their on-line and other Training Programmes.

Assessment Documents are in the process of being updated and adapted to give residents a choice of formally documenting/recording their relevant End of Life Care preferences in addition to current records which indicate preferences in relation to medical intervention and resuscitation.

Proposed Timescale:

Commenced - Completion by 30th October 2016

Proposed Timescale: 30/10/2016

Theme:

Safe care and support

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

Residents' care plans were not always detailed enough to direct care required for the resident.

2. Action Required:

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

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

Current Care Plans are being reviewed to include additional detail particularly in relation to Social Care Activities and Hazards/Risks. This will also be addressed within the phased process of electronic records.

Proposed Timescale:
Commenced - Completion by 30th October 2016

Proposed Timescale: 30/10/2016

Theme:
Safe care and support

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

A number of maximum dependent residents with a dementia were not given the option to dine in either of the two dining rooms.

3. Action Required:

Under Regulation 18(1)(b) you are required to: Offer choice to each resident at mealtimes.

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

Some Residents for social, behavioural, and other reasons do not wish to be accommodated in the Dining area and it is for this reason that they may choose to eat in their bedrooms or another area of the Nursing Home.

Relevant Care Plans of these Residents are currently being updated to reflect this preference.

Proposed Timescale: 30/09/2016

Theme:
Safe care and support

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

Details of those transferred in and out of the acute hospital were not entered in the directory of residents.

Activity records did not reflect the residents' level of participation in the activity they attended.

Activity records did not reflect what one to one activities was done with the resident in question.

Activity records did not reflect if dementia specific classes such as sonas were being done in the centre.

4. Action Required:

Under Regulation 21(3) you are required to: Retain the records set out in Schedule 3 for a period of not less than 7 years after the resident has ceased to reside in the designated centre.

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

The transfer of one resident in and out of hospital was not recorded in the Directory of Residents. This error was immediately rectified when it was brought to the attention of staff.

A nominated person has been appointed to check the Register on a daily basis to reduce risk of further errors/omissions.

Activity records are currently being reviewed by social care staff and individual documents updated to enhance recording methods and evidence each individuals' participation in social activities.

Proposed Timescale:

Commenced 14th September - Completion By 17th October 2016

Proposed Timescale: 17/10/2016

Theme:

Safe care and support

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

Medications were not always administered as per professional guidelines and the centres policy.

The maximum dose for administration of as required medications was not always entered on the residents' prescription chart.

The indications for use of as required medications was not always entered on the residents' prescription chart.

5. Action Required:

Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.

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

*Following notification from Inspectors that a member of nursing staff did not follow professional guidelines or internal policy as they 'signed for medication in advance of administering same' - this issue was immediately addressed and the individual nurse cautioned.

Re-Assessment and additional Training has also been facilitated for the member of staff and evidence of same will be maintained on their personnel file.

*The Person in Charge will continue to direct Nursing staff in ensuring that they adhere to their regulatory role in relation to all prescribed medication being administered in accordance with the directions of the prescriber and with any advice provided by the dispensing Pharmacist.

*All nurses have been tasked to review internal Medication Policy and An Bord Altranais Medication Administration Guidelines.

*All Nurses are up to date with their Medication Management Certification and possess Certificates for 2016.

Findings regarding maximum dose for administration or indications of use of as required medications - has previously been addressed by Nursing Home Management and re-discussed with the G.P. following the recent Inspection.

The G.P. has indicated that they will not change their prescribing process.

*At the request of the Person In Charge, the Pharmacist regularly attends the Nursing Home to review individual prescriptions/medication and to provide Training to Nursing Staff in relation to Medication Administration.

Proposed Timescale: *Completed 28th / 29th July 2016

Proposed Timescale: 29/07/2016

Outcome 02: Safeguarding and Safety

Theme:

Safe care and support

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

Restraint assessments reviewed did not reflect the alternatives used prior to bedrails being used as a form of restraint.

6. Action Required:

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

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

The Nursing Home has a policy of not utilising Bedrails as restraint and we have a comprehensive policy in relation to managing Behaviour that Challenges. Our Risk Assessment documentation does not include consideration of the use of Bedrails as a means of restraint.

An external Consultant has been engaged to review our Assessment Tools and advise on changes which may be required to enhance Best Practice Guidelines. Following this review - changes will be made as appropriate.

Proposed Timescale: 27/10/2016

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:

The activities timetable did not include the times that activities were scheduled for.

The notice boards were not accessible to residents'.

7. 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:

Specific Activity Times are now displayed on a daily basis.

A more accessible Activity Plan/Time-Table is currently being implemented and will be easily accessible to all Residents.

Relevant Notice Boards and contents have been made more visually accessible and User Friendly.

Proposed Timescale: Commenced 09/08/2016 - Completion 30/09/2016

Proposed Timescale: 30/09/2016

Outcome 04: Complaints procedures

Theme:

Person-centred care and support

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

A person was not nominated to ensure that all complaints were appropriately responded to and that the person nominated under Regulation 34 (1)(c) maintained the records specified under in Regulation 34 (1)(f).

8. Action Required:

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

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

Our internal complaints Policy was updated immediately following the Inspection and a nominated person is now responsible for reviewing complaints.

Complaints files have been reviewed by the nominated person and will continued to be reviewed by this person on a 3 monthly basis.

Proposed Timescale: 28/07/2016

Outcome 05: Suitable Staffing

Theme:

Workforce

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

The two qualified staff working on the floor on the day of inspection and on two of fourteen days in July was not adequate to meet the comprehensive needs of residents'.

9. Action Required:

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

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

*The skill-mix and numbers of staff have been reviewed and changes made as considered appropriate. An additional member of HCA staff has been allocated to assist and supervise Residents during social and other activities.

*Skill mix review takes place on a daily basis to ensure appropriate allocation changes are made in the event of unplanned absences which may affect the staffing skill mix.

*Following a successful recruitment process, an additional three (3) Nursing Staff have been employed to augment the current staff complement. This will enable us to progress towards the re-implementation of allocated additional supervisory Nursing Staff.

Two (2) Pre-Registration Nurses have also been recruited and employed.

Proposed Timescale: *Commenced 29th July 2016 - Completion 19th September 2016

Proposed Timescale: 19/09/2016

Theme:

Workforce

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

Records did not reflect evidence of three monthly supervisory meetings.

10. Action Required:

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

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

The Registered Person In Charge has daily supervisory meetings with all Nursing Staff. There are records on file of individual formal IPR Meetings – which, as agreed with relevant Unions take place on an annual basis.

A review of the records process is taking place to ensure that records are maintained on individual staff files rather than in corporate HR records.

Proposed Timescale: 24/10/2016

Theme:

Workforce

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

Some staff nurses required refresher training in medicines management as evidenced under outcome 11.

11. Action Required:

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

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

All Nurses employed in the Nursing Home have current Medication Management Certification dated between October 2015 and June/August 2016 with the exception of one nurse who is on extended Maternity Leave.

Nurses Medication Management Certificates are maintained on individual files to evidence their current certification status.

The Pharmacist continues to provide education and training in relation to Medication Management issues.

Re-assessment competency of one Nurse has been facilitated as was considered necessary following the Inspection process.

Proposed Timescale: 10/08/2016

Theme:

Workforce

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

Care staff were not appropriately supervised in the dining rooms.

12. Action Required:

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

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

Senior HCA Staff are allocated on duty during all shifts and are responsible under the direction of nurses for supervising during meals and other care intervention activities.

Following a review of staffing rosters and the successful recruitment of Nursing Staff which has enabled us to fill unanticipated vacancies - the full complement of clinical staff is now re-instated to ensure appropriate supervision.

Additional staff have also been allocated to the roster.

Proposed Timescale: 02/08/2016

Theme:

Workforce

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

The roster did not reflect the hours worked by the person in charge.

13. Action Required:

Under Regulation 21(3) you are required to: Retain the records set out in Schedule 3 for a period of not less than 7 years after the resident has ceased to reside in the designated centre.

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

The Person In Charge is employed on a full time basis.

Staff rosters indicate the days the Person In Charge is On-Duty - and times may be adapted to meet families and/or residents as required.

Biometric roster records are maintained and available in relation to the times the Person In Charge is working and on the premises.

Allocation records have been adapted to further evidence attendance and working hours.

All computerised and paper records pertaining to staff and residents are retained as required under Regulation 21(3).

Proposed Timescale: 30/07/2016

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:

The use of additional signage, points of interest and colour required review to ensure the premises continually met the needs of the residents living in the centre with dementia.

14. 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:

Some 'points of interest' - areas have been introduced on a trial basis to ascertain suitability and/or acceptance by Residents and their families.

Temporary signage has been provided on some communal rooms to allow residents/families to consider permanency of same.

Additional signage has been provided on individual bedroom doors.

The issue of 'signage' has been previously addressed with residents and/or their families at forum meetings and there was resistance to the suggestions made in relation to signage as residents and families considered it to be 'too institutional'.

A combined Family/Resident Forum Meeting has been scheduled to take place in October and the issue of signage will be further addressed to ascertain current views relating to the erection of suggested signage or to consider alternatives after which any proposed/accepted signage will be sourced and erected.

Proposed Timescale: 16/11/2016

Theme:

Effective care and support

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

Residents' did not have independent access to the secure garden.

15. 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:

Facilitation of access to external gardens is provided for all Residents as/if required.

Exit doors to external Courtyard are open during daylight hours to facilitate access.

In the event of doors being inadvertently closed - Residents who do not require supervision are aware that access is facilitated by any member of staff at all times.

Residents who, for health and safety reasons require supervision have access to the external gardens but must be supervised by a member of staff or accompanying family member.

Display notices have been provided to indicate access facilities.

Resident Assessment records are in the process of being updated to reflect Hazard Risk Analysis regarding individual Residents who are not safe to independently access the gardens. It is anticipated that all Risk Analysis Records will be updated/completed by October 2016.

Proposed Timescale: 20/10/2016