

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Sacred Heart Hospital
Centre ID:	OSV-0000549
Centre address:	Old Dublin Road, Carlow, Carlow.
Telephone number:	059 913 6371
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Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Patricia McEvoy
Lead inspector:	Ide Cronin
Support inspector(s):	None
Type of inspection	Unannounced Dementia Care Thematic Inspections
Number of residents on the date of inspection:	74
Number of vacancies on the date of inspection:	3

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:
21 February 2017 09:30	21 February 2017 16:30
22 February 2017 08:20	22 February 2017 14:00

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	Substantially Compliant	Non Compliant - Moderate
Outcome 02: Safeguarding and Safety	Substantially Compliant	Compliant
Outcome 03: Residents' Rights, Dignity and Consultation	Substantially Compliant	Substantially Compliant
Outcome 04: Complaints procedures	Substantially Compliant	Compliant
Outcome 05: Suitable Staffing	Compliance demonstrated	Non Compliant - Moderate
Outcome 06: Safe and Suitable Premises	Substantially Compliant	Substantially Compliant

Summary of findings from this inspection

As part of the dementia care thematic inspection process, providers were invited to attend information seminars given by the Health Information and Quality Authority (HIQA). 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 provider completed the self-assessment document by comparing the service provided with the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013 and the National Standards for Residential Care Settings for Older People in Ireland (2016).

The centre is divided into three units. For the purpose of this inspection, the inspector focused on the care and welfare of residents in St. Claire's unit. St Claire's unit is not a dementia specific unit. However, residents experiencing dementia,

mental health difficulties and other medical conditions lived in this unit. The unit accommodated 22 residents, 20 of whom had a definitive diagnosis of dementia. All actions required from the last inspection of the centre in February 2016 were found to be satisfactorily completed.

Residents' accommodation in the centre was provided at ground floor level and residents with dementia integrated with the other residents. The inspector found that the management team and staff were committed to providing a quality service for residents with dementia. This commitment was clearly demonstrated in work done to date to optimise the physical and mental health and quality of life for residents with dementia living in the centre. A high standard of nursing care was found to be delivered to residents in a respectful and person-centered manner.

Staff were knowledgeable of residents and their abilities and responsive to their needs. Safe and appropriate levels of supervision were in place to maintain residents' safety in a calm and supportive manner. Residents had access to general practitioner (GP) services and to a range of other allied health services. The inspector met with residents, a relative and staff members during the inspection. The journey of residents with dementia within the service was tracked. Care practices and interactions between staff and residents were observed using a validated observation tool. This observation evidenced that staff engaged positively with residents with dementia.

The inspector reviewed documentation such as care plans, medical records and medication records. Residents' physical and mental health needs were met to a good standard. Quality of life and wellbeing were promoted by supporting residents to continue to do as much as possible for themselves and by encouraging residents to remain stimulated by actively engaging in their care pathways and in social activity.

A sample of staff files were examined by the inspector and were found to contain all of the necessary information required by Schedule 2 of the regulations with the exception of one file which did not have photographic identification in place.

The provider confirmed that there were seven staff employed before 29 April 2016, whose Garda vetting was currently being processed.

The Action Plan at the end of this report identifies areas where some improvements are required to comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Standards for Residential Care Settings for Older People in Ireland (2016).

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:

There were 22 residents in this unit on the days of inspection. Twenty residents had a formal diagnosis of dementia. There were suitable arrangements in place to meet the health and nursing needs of residents with dementia. The centre implemented an effective admissions policy which included a pre-admission review. There were processes in place to ensure that when residents were admitted, transferred or discharged to and from the centre, that relevant and appropriate information about their care and treatment was readily available and shared between providers and services.

There was evidence that the wellbeing and welfare of residents was being maintained through the provision of a high standard of nursing, medical and social care. Residents had access to general practitioner (GP) services and there was evidence of medical reviews at least three monthly and more frequently when required. A review of residents' medical notes showed that GPs visited the centre to review residents and medications on a regular basis. Medicines were also reviewed by the pharmacist to ensure optimum therapeutic values.

Access to allied health professionals such as speech and language therapists, dietitians, occupational therapists and staff from mental health services for older people was timely when referrals were made. There was also access to onsite clinics such as diabetes and memory clinics. Residents and staff informed the inspectors that they were satisfied with the current healthcare arrangements and service provision.

Residents either diagnosed with dementia or presenting with impaired cognition had appropriate assessments around communication needs in place. Each care plan viewed by the inspector had a communication care plan in place. A communication policy was available to inform residents' communication needs, including residents with dementia.

A copy of the common summary assessments (CSARs), which details pre-admission assessments undertaken by the multidisciplinary team for residents admitted under the 'Fair Deal' scheme, was available in addition to pre-assessment documentation. Comprehensive assessments were carried out with care plans developed based on

assessments within 48 hours of admission and in line with residents' changing needs thereafter. Care plans were person-centred, clearly directed the care interventions to be completed by staff and were in line with residents' changing needs.

The assessment of need process involved the use of validated tools to assess each resident for risk of malnutrition, falls, cognitive impairment and skin integrity. Residents' progress was closely monitored and recorded, and the daily nursing notes outlined the health, condition and treatments given for each resident and were in accordance with relevant professional guidelines. Staff members were observed to provide care in a respectable and sensitive manner and demonstrated a comprehensive knowledge of residents' individual needs and preferences. There was documented evidence that some residents and their families, where appropriate, were involved in the care planning development and reviews thereafter.

The nutrition and hydration needs of residents with dementia were met. A policy document was in place. Residents were screened for nutritional risk on admission and reviewed regularly thereafter. A nutritional audit had been completed in November 2016 which indicated a compliance rate of 96.2%. Residents' weights were checked on a monthly basis and more frequently where residents experienced unintentional weight loss. Nutritional assessment and care plans were in place that outlined the recommendations of dietitians and speech and language therapists where appropriate. The inspector saw that residents had a choice of hot meals for lunch. Residents who spoke with the inspector said the food was very good.

There were arrangements in place for communication between nursing and catering staff to support residents with special dietary requirements. The inspector spoke with a catering assistant on the unit who was very knowledgeable regarding the culinary requirements of residents. The inspector saw that a resident helped her in the morning to give out breakfast to the other residents. The inspector found that residents on weight-reducing, diabetic and fortified diets, and residents who required modified consistency diets and thickened fluids, received the correct diets. There were brightly coloured table cloths available to assist residents to distinguish between table and cutlery. Residents received discreet assistance with eating where necessary as observed by the inspector. The inspector recommended that interventions such as pictorial menus would further support residents' communication needs.

There were written policies and procedures in place for end-of-life care. Staff provided end-of-life care to residents with the support of their GP and the community palliative care team. There were no residents at active end-of-life stage on the day of the inspection. A pain assessment tool for residents, including residents who were non-verbal was available and in use to support pain management. A system was developed to ensure residents with a do not attempt resuscitation (DNAR) status in place have the status regularly reviewed to assess the validity of the clinical judgment on an ongoing basis. While there were end-of-life care plans in place these required further development to ensure that the end-of-life needs and wishes of all residents with dementia were discussed with them and or their next of kin as appropriate and documented in a care plan.

Staff outlined how residents' religious and cultural practices were facilitated. Members of

the local clergy from various religious faiths provided pastoral and spiritual support to residents as necessary. Mass took place during the inspection and the inspector saw all residents were facilitated to attend if they wished.

There were arrangements in place to review accidents and incidents within the centre, and residents were assessed on admission and regularly thereafter for risk of falls. There was a falls prevention policy in place. There was a serious reportable incident policy in place. A system was in place to highlight and communicate the risk rate to all staff which included the safety pause. Procedures were put in place to mitigate risk of injury to some residents assessed as being at risk of falling including increased staff supervision/assistance, hip protection, low level beds and sensor alarm equipment. All vulnerable residents were appropriately supervised by staff as observed by the inspector on the days of inspection.

There were written operation policies relating to the ordering, prescribing, storing and administration of medicines to residents and disposal of unused or out-of-date medicines. The policies were in the process of being reviewed with input from the pharmacist. The inspector saw that the pharmacist also monitored medication safety incidents. Medication prescriptions and administration records for the most part were complete in accordance with professional standards.

The inspector reviewed a sample of residents' individual medicine prescription charts and there was evidence that residents' prescriptions were reviewed at least three monthly by a medical practitioner. The pharmacist reviewed regular medicines on a monthly basis and a three monthly review of all p.r.n medicines (a medicine only taken as the need arises). The pharmacist, GP, management and nursing team attended three monthly multidisciplinary team reviews in relation to medicines management. There was a community intervention team available to residents to administer subcutaneous fluids to treat dehydration and administer intravenous medication in order to avoid unnecessary hospital admissions. Regular medication management audits were carried out as observed by the inspector.

However, it could not be demonstrated that medicines were administered to residents as prescribed. The inspector noted that medicines were administered by nurses where prescriptions were incomplete or ambiguous. For example, medicines that were administered in a modified form (crushed) were not individually prescribed as such to ensure safe administration and to prevent potential adverse effects if medicines were inappropriately modified.

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 all reasonable measures were in place to safeguard all residents from abuse.

There was a policy in place to inform prevention, recognition, reporting and responding to allegations or suspicions of abuse. Staff had all attended training on protection of vulnerable adults. There were designated safeguarding trainers on site. Staff spoken with by the inspector were knowledgeable regarding abuse and were aware of their responsibility to report any incidents, allegations or suspicions of abuse. The provider and person in charge ensured that there were no barriers to disclosing incidents or allegations of abuse. Residents spoken with on the days of the inspection said that they felt very safe in the centre and complimented the staff looking after them. All staff interactions with residents observed by the inspector were respectful, supportive and kind.

The person in charge clearly demonstrated her knowledge of the designated centre's policy and was aware of the necessary referrals to external agencies. There were systems in place to ensure that allegations of abuse were investigated, and that pending such investigations measures were in place to ensure the safety of residents as observed by the inspector. The inspector saw that the person in charge involved external advocacy services such as SAGE for residents.

There were policies in place on responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) and the use of restrictive practices. Supporting assessment tools were available. Staff spoken with were familiar with appropriate interventions to use to respond to residents' behaviour. The inspector was informed that changes in behaviour were analysed through a reflective cycle for possible trends which would inform reviews by the GP or psychiatric team. The use of the reflective cycle also helped staff to understand the progressive nature of dementia. There was evidence that residents with dementia and responsive behaviours were appropriately referred and reviewed by specialist psychiatric services.

Staff had received training in responsive behaviours. The inspector observed that by the end of April 2017, 44% of staff will have completed a two-day course on enhancing and enabling wellbeing for people with dementia. It was anticipated that all staff will have completed this course by the end of August 2017.

Through observation and review of care plans it was evidenced staff were knowledgeable of residents' needs and provided support that promoted a positive approach to with physical and psychological symptoms of dementia (BPSD). Staff were seen to reassure residents and divert attention appropriately to reduce anxieties. No p.r.n psychotropic medications were administered to residents for management of symptoms of their dementia.

There was a policy on the management of restraint which was based on national policy. A restraint-free environment was promoted in the centre. A restraint register was in

place. The inspector noted that throughout the previous year bed rail use was constantly decreasing with a reduction in bed rail use in 24% of residents in the unit.

Risk assessments had been completed for all bedrails in use and alternatives trialled were also documented. Bedrail safety checks were in place and the inspector saw that these were consistently recorded. Restraint assessments were reviewed on a regular basis as observed by the inspector. There was evidence that alternatives to bedrails, such as low-level beds and sensor alarms, were trialled in consultation with residents or their families as indicated.

Management of residents' finances were reviewed as part of this inspection. The inspector spoke with the administrator and found that the process was transparent. Residents were provided with a lockable space in their bedrooms to facilitate them to independently store personal possessions securely if they wished.

Judgment:
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:
The inspector found that residents were consulted regarding the planning and organisation of the centre. There was a residents' forum in place and a meeting was scheduled on the second day of inspection. The inspector also reviewed minutes of previous meetings. 'This is me' and personal life histories were completed for all residents as observed by the inspector. Choice was respected and residents were asked how they wished to spend their day. Control over their daily life was also facilitated in terms of times of rising or returning to bed and whether they wished to stay in their room or spend time with others in the communal rooms.

Staff were observed to interact with residents in a warm and personal manner, using touch, eye contact and calm reassuring tones of voice to engage with those who became anxious, restless or agitated. The inspector also observed that where residents required supervision in communal areas that staff used these opportunities to engage in a meaningful and person-centred way. Residents appeared to be familiar with staff. At meal times staff were observed speaking to residents, and where support to eat and drink was being provided, it was done in a discreet way. Where residents were able to eat by themselves they were encouraged and supported to do so.

The inspector saw that staff rotated on an hourly basis in the communal room to supervise and conduct an activity with residents. The go for life pals activity programme had been completed by 21 staff members. The programme had commenced roll out

with both group and individual sessions depending on the needs of each resident. The inspector saw some staff members engaging in exercise programmes with residents where a window of opportunity was available. The centre had a part-time activities coordinator supported by two healthcare assistants who managed a programme of activities and also organised special events and celebrations.

However, the inspector found that the activity programme was not adequately resourced to meet the needs of all residents at the time of inspection. The healthcare assistants supporting activities were on leave and had not been replaced. Therefore activities on St. Claire's unit were dependent on staff to provide as part of their daily routine. The activity coordinator provided 24 hours of activities over a seven day period. The inspector spoke with the activity coordinator and found that she was knowledgeable regarding the social care needs of residents with dementia. She told the inspector that she would not see all residents over a three day period.

Aside from routine observations, as part of the overall inspection, a standardised tool was also used to monitor the extent and quality of interactions between staff and residents during discrete 5 minute periods in a block of 30 minutes. The observation tool used was the quality of interaction schedule or (QUIS) Three episodes were monitored in this way both during the morning and afternoon in the sitting/ dining area. The observations returned a positive result in that staff had engaged positively and meaningfully with residents on a regular basis. Residents with dementia were seen to receive care in a dignified way that respected their wishes. The inspector observed staff interactions with residents that were appropriate and respectful in manner.

There were no restrictions on visitors and there were some areas in the centre where residents could meet visitors in private. Visitors were observed visiting throughout the day. A relative who spoke with the inspector expressed their satisfaction with the care their relative received in the centre. Staff told the inspector that family members were encouraged to take residents out and maintain contacts with their community. Some residents went out with their family on a weekly basis. Residents had access to national and local newspapers, televisions, radios and telephones. Voting was facilitated and organised by the activity coordinator.

Judgment:
Substantially Compliant

Outcome 04: Complaints procedures

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:

Policies and procedures which comply with legislative requirements were in place for the management of complaints. Formal complaint procedures and appeals details were outlined in the HSE complaints policy 'your service your say'. Residents and a relative told the inspector that they would have no hesitation reporting an issue to the nurse manager.

On review of the record of complaints there was evidence that all complaints were documented, investigated and outcomes recorded. Complainants were notified of the outcomes and a review was conducted to ascertain the satisfaction of the complainant further to issues being resolved.

All complaints were found to be resolved in a timely way. The independent advocacy service was advertised and utilised as observed by the inspector. Staff members spoken with could explain how complaints were reported and logged and also how learning from complaints was communicated through management and team meetings.

Judgment:
Compliant

Outcome 05: Suitable Staffing

Theme:
Workforce

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

Findings:

The inspector formed the judgement through observation, speaking with staff and review of documentation that there was an adequate complement of nursing and care staff with the required skills and experience to meet the assessed needs of residents taking account of the purpose and size of the unit. Residents spoken with confirmed that staffing levels were good stating they never had to wait long for their call bell to be answered or their requested needs to be met. A staff rota was maintained with all staff that worked in the unit identified. Actual and planned rosters were in place.

A daily communication system was established to ensure timely exchange of information between shifts which included updates on residents' conditions. There was evidence of regular staff meetings taking place. The inspector was informed that staff appraisals took place. Good supervision practices were in place with the nurses visible on each floor providing guidance to staff and monitoring the care delivered to residents. Residents told the inspector that they were very well cared for by staff.

There was a varied programme of training for staff. A training needs analysis had been sent to each staff member to identify their training needs for 2017. Records viewed confirmed there was an ongoing program of mandatory training in areas such as

safeguarding vulnerable adults, fire safety evacuation and safe moving and handling. Staff also had access to a range of education, including training in specific dementia related courses that explained the condition, human rights and effective communication strategies.

Staff demonstrated to the inspector their knowledge in a number of areas for example, infection control, fire safety, adult protection and caring for residents with dementia or responsive behaviours. Staff who spoke with the inspector confirmed that they were well supported to carry out their work by the nurse manager and management team. A staff member told the inspector that the clinical nurse manager provided excellent leadership to the staff.

The inspector found staff to be confident, well informed and knowledgeable regarding their roles, responsibilities and the standards for care of residents with dementia living in residential care. The inspector observed that residents were at ease in their surroundings and content with staff.

Staff recruitment procedures were in place and included vetting of staff. Evidence of current professional registration for nurses was available. A sample of staff files were examined by the inspector and were found to contain all of the necessary information required by Schedule 2 of the regulations with the exception of one file which did not have photographic identification in place. The provider confirmed that there were seven staff and two volunteers whose Garda vetting was currently being processed; these staff had been employed before 29 April 2016.

Judgment:

Non Compliant - Moderate

Outcome 06: Safe and Suitable Premises

Theme:

Effective care and support

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

No actions were required from the previous inspection.

Findings:

The centre is a single-storey premises located within close proximity to the local town centre. For the most part, the design and layout of the centre met the individual and collective needs of residents with dementia. Residents' accommodation consists of 21 designated long-stay beds and there was one respite bed on this unit. There are five multi-occupancy rooms which comprise three four-bedded rooms and two four-bedded rooms. There are two single bedrooms with en suite, shower and wash-hand basin. Apart from the en-suite facilities there are 10 toilets. Communal toilets and bathroom and shower facilities were located within convenient proximity to bedrooms and communal areas.

The use of colour and natural light was optimised to support the quality of life of

residents with dementia. For example, large windows were fitted in bedrooms and in communal rooms. However, in the multi-occupancy bedrooms televisions were partially blocking the natural light. The inspector also observed that storage space for personal belongings was limited. Wardrobes were very small and as a result clothes were stored in plastic storage boxes underneath wardrobes. This had also been highlighted as an issue in satisfaction surveys viewed by the inspector.

Floor covering on corridors were a neutral colour and toilet seats were in contrasting colours. There was good use of signage to support residents to identify key areas. Two courtyard areas had been developed as enclosed gardens with access from the unit. There was a 'memory matters' library room, which was a designated room providing a dementia-specific resource to relatives and staff. The inspector saw that there was a large range of assisted technologies on display in this room. A further small sitting room was in the process of being redecorated on the unit. The day room was the focal point of activities, so sofas and individual chairs of varying height had recently been purchased to make this space more homely and comfortable for residents. These combined actions optimised residents' independence.

Residents had access to appropriate assistive equipment to meet their needs which was appropriately stored when not in use. The corridors were wide which allowed easy access for residents using wheelchairs and other assistive equipment. Grab rails were fitted in toilets and showers and other areas. During this inspection the premises were noted to be clean, well maintained and there were measures in place to control and prevent infection. Staff were noted to take appropriate infection control precautions that included the use of personal protective clothing while attending to residents' care needs and adhering to hand hygiene precautions displayed in the centre. Hand- washing or sanitising facilities were strategically placed throughout the centre and readily accessible for staff and visitors.

Judgment:

Substantially Compliant

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:

Ide Cronin
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:	Sacred Heart Hospital
Centre ID:	OSV-0000549
Date of inspection:	21/02/2017
Date of response:	09/03/2017

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:

Ensure that the end-of-life needs and wishes of all residents' with dementia were discussed with them and/or their next of kin as appropriate and documented in a care plan.

1. Action Required:

Under Regulation 13(1)(a) you are required to: Provide appropriate care and comfort to

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

a resident approaching end of life, which addresses the physical, emotional, social, psychological and spiritual needs of the resident concerned.

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

The end of life care plans already commenced will be further developed in conjunction with residents and/or next of kin to ensure that the end of life needs and wishes of all residents with dementia are discussed and documented in individual care plans.

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:

Medicines that were administered in a modified form (crushed) were not individually prescribed as such to ensure safe administration and to prevent potential adverse effects if medicines were inappropriately modified.

2. 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:

All modified medications (crushed) will be individually prescribed by the medical officer.

Proposed Timescale: 31/03/2017

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:

The inspector found that the activity programme was not adequately resourced to meet the needs of all residents at the time of inspection.

3. Action Required:

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

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

Following an internal recruitment process, an extra 39 hrs per week has been allocated to ensure residents participate in activities relevant to their individual interests and

capabilities. This commenced on 6 March 2017 and this individual will be working in conjunction with the activities co-ordinator to provide personal activities over the seven day period.

In addition to this a business case will be submitted by April 2017 to management for the approval of an additional resource to support the recruitment of an activities manager to co-ordinate, manage and integrate a multidisciplinary approach to activities at the centre.

Proposed Timescale: 31/12/2017

Outcome 05: Suitable Staffing

Theme:

Workforce

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

A sample of staff files were examined by the inspector and were found to contain all of the necessary information required by Schedule 2 of the regulations with the exception of one file which did not have photographic identification in place.

The provider confirmed that there were seven staff and two volunteers whose Garda vetting was currently being processed; these staff had been employed before 29 April 2016.

4. Action Required:

Under Regulation 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

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

All seven staff have submitted their Garda vetting documentation and we are awaiting confirmation from an Garda Siochana.

Volunteers have voluntarily stepped down for volunteering until Garda disclosures are returned.

Proposed Timescale: 30/04/2017

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:

Storage space for personal belongings was limited. Wardrobes were very small as a

result clothes were stored in plastic storage boxes underneath wardrobes.

5. Action Required:

Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

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

The present storage facilities are currently being reviewed to determine a more suitable alternative which will comply with regulation 17(2) for each individual resident.

Proposed Timescale: 31/12/2017