Health Information and Quality Authority
Regulation Directorate

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

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

Centre name:	Connolly Hospital (Silver Birch & Woodland Units)
Centre ID:	OSV-0000528
Centre address:	Blanchardstown, Dublin 15.
Telephone number:	01 646 5560/646 5510
Email address:	margaret.boland1@hse.ie
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Margaret Boland
Lead inspector:	Sheila McKevitt
Support inspector(s):	Jim Kee
Type of inspection	Unannounced
Number of residents on the date of inspection:	34
Number of vacancies on the date of inspection:	6

About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

▪ Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
▪ Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

▪ to monitor compliance with regulations and standards
▪ to carry out thematic inspections in respect of specific outcomes
▪ following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
▪ arising from a number of events including information affecting the safety or wellbeing of residents.

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.

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

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

The inspection took place over the following dates and times

From:	To:
12 May 2016 10:00	12 May 2016 17:00

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

Outcome	Our Judgment
Outcome 02: Governance and Management	Substantially Compliant
Outcome 05: Documentation to be kept at a designated centre	Compliant
Outcome 07: Safeguarding and Safety	Non Compliant - Moderate
Outcome 08: Health and Safety and Risk Management	Compliant
Outcome 09: Medication Management	Non Compliant - Moderate
Outcome 11: Health and Social Care Needs	Non Compliant - Moderate
Outcome 12: Safe and Suitable Premises	Non Compliant - Moderate
Outcome 17: Residents' clothing and personal property and possessions	Compliant
Outcome 18: Suitable Staffing	Substantially Compliant

Summary of findings from this inspection

This inspection was an unannounced follow-up inspection. The purpose of the inspection was to determine if the provider had addressed the non compliances within the proposed timescale as outlined in the response to the last inspection report from 05 May 2015.

The centre is registered to accommodate 40 residents'. The provider nominee and person in charge was available on inspection. Inspectors found a number of improvements had been made since the last inspection. Improvements made had improved the quality of care delivered to residents'. The 2014 annual review of the quality of care provided had been completed. The annual review for 2015 was due to be completed in June 2016.

Access to a dental service had not been sourced to date, the management team were still working on the provision of a routine service to residents'.

The premises state of repair had improved externally and internally since the last

inspection as outlined in the body of this report. The Authority was provided with written confirmation that Connolly Hospital Residential Services had been approved for a new 100 bedded Older persons residential unit by the Department of Health (DOH) and Health Services Executive (HSE). Once completed the number of residents' sharing a bedroom will be reduced further.

The fire exit on Silver Birch unit had been addressed by the provider. The fire exit was now accessible to residents' and appeared safe to use.The amount of personal space available to residents within the multiple occupancy rooms had increased with the overall reduction in resident numbers from 48 to 40. Assistive equipment had been purchased, inspectors saw that some alternative non restrictive equipment was now available to use together with appropriate chairs for the transfer of dependent residents' to the shower rooms. However, there was still no assisted bath available to residents'. Appropriate personal storage space had been provided for resident to store their personal belongings. An increase in communal space was available in Woodlands unit with the provision of a new dining room space for residents. The shower room in Silverbirch had been refurbished and some maintenance work had been completed in both gardens.

Medicines management practices had improved in the centre since the last inspection. However non-compliances were identified relating to certain aspects of medicines management including information included on the prescription sheets, authorisation to crush medicines and some aspects of the storage of medicines. The use of restraint was being reported and audited however, alternatives trialled, tested and failed prior to restraint being used were not being recorded. Staffing levels were good, agency staff were employed on an infrequent basis as resident numbers had reduced. Volunteers now had Garda vetting in place and had their roles and responsibilities clearly outlined. Residents' were being consulted with. Activities provided was much improved, with an additional staff member in place, increased variety and a schedule covering seven days per week. Policies had been reviewed and maintenance of records improved.

The action plans at the end of this report reflect the non-compliances.

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

Theme:
Governance, Leadership and Management

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

Findings:
There was a clearly defined management structure that identified who was in charge, accountable and what the reporting structure was. Management systems were now in place to ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored.

The provider nominee, person in charge, and two of the three clinical nurse managers were on site on the day of inspection. The provider nominee was appointed since the last inspection and had been deemed fit to hold this post. The clinical nurse managers manage the day to day running of the centre and report to the person in charge. The management team together with members of the multi-disciplinary team met on a quarterly basis to discuss the quality of care being delivered to residents. Minutes of meetings held since the last inspection were available for review. They showed clinical and non clinical issues were discussed and action plans put in place had been actioned or were in process.

An annual review had been conducted in June 2015. It reviewed the quality of care delivered to residents in 2014. The content was comprehensive, it included plans for quality improvement. The inspector saw a number of these quality improvement plans had already been completed. For example, the plan to improve the provision of activities in the centre had been implemented as evidenced under outcome 11. The inspector noted that there was no evidence of consultation with residents or their families in the annual review.

A system to monitor the quality of care being delivered to residents' had been implemented in the centre. The nursing metrics tool used covered a number of areas of nursing practice including aspects of medication management, nursing documentation including assessments and care plans, pressure ulcer care, falls and restraint use. These

areas were being audited on a monthly basis by clinical nurse managers and feedback was presented to staff at staff meetings. There was evidence that some areas of practice such as medication management had improved with the introduction of consistent monitoring.

Judgment:
Substantially Compliant

Outcome 05: Documentation to be kept at a designated centre
The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:
Governance, Leadership and Management

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

Findings:
The inspector was sent a copy of the updated restraint policy, personal property policy and recruitment, selection & vetting policy. They had all been updated in May 2015 and reflected current practices.

Judgment:
Compliant

Outcome 07: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe care and support

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

Findings:
Inspectors saw that alternative equipment to restraint had been purchased and this equipment was available for use in both units within the centre.

Each of the two units had two low, low beds and four crash alarm mats on each unit. Inspectors were informed a small number of residents' on both units were using bedrails as a form of restraint and up to 15 on each unit were using bedrails as an enabler at night time. However, inspectors found that assessment forms completed for residents' with bedrails in use did not clearly outline how staff were differentiating the use of bed rails as a form of restraint or as an enabler. The completed bedrail assessment forms did not consistently outline what alternatives had been trialled, tested and failed prior to bedrails being used as a form of restraint. This practice was not in line with the National Policy.

Staff on both units had up-to-date training in place on the detection, prevention of and response to abuse. Two clinical nurse managers had completed train the trainer course and were now providing training to staff.

Clinical nurse managers had put safe systems in place to ensure petty cash held on behalf of residents was safe and secure. Two staff signed all inputs and outputs, receipts were available for all expenditures. Clinical nurse managers were completing an audit on all petty cash held in the centre on a monthly basis.

Judgment:
Non Compliant - Moderate

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

Theme:
Safe care and support

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

Findings:
Inspectors saw that the outstanding issue with the ramp leading from one of the two fire exit doors on Silver Birch, had been addressed and no longer posed a potential risk to residents in the event of a fire. This issue had been addressed in May 2015. The fire exit door now lead on to a cemented ramp which lead on to a cemented footpath which lead around to the front of the building.

Judgment:
Compliant

Outcome 09: Medication Management
Each resident is protected by the designated centre's policies and procedures for medication management.

Theme:
Safe care and support

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

Findings:
There were written operational policies and procedures in place in the centre relating to the ordering, prescribing, storing and administration of medicines. The centre had made improvements in medicines management practices since the last inspection including the introduction of an audit system for medicines management practices in the centre. The inspectors found that certain aspects of medicines management practice required further improvement including certain aspects of documentation relating to the prescribing of medicines, and storage of medicines. During the inspection of the centre on 5/5/2015 inspectors had identified issues relating to the crushing of medicines in the centre. The action plan submitted to address this issue had not been fully implemented.

Medicines were supplied to the centre by the pharmacy department located on the hospital campus. The inspectors were informed that a pharmacist did not routinely visit the centre to conduct reviews of the residents' medicines but was available if requested. All medicines were stored securely within the centre on medication trolleys or securely within a locked clinical room. There was a fridge available for all medicines or prescribed nutritional supplements that required refrigeration. However the temperature of this fridge was not monitored on a daily basis to ensure the temperature of the fridge was maintained between two and eight degrees Celsius. All controlled (MDA) medicines were stored in a secure cabinet, and a register of these medicines was maintained with the stock balances checked and signed by two nurses at the end of each working shift. The inspectors observed that dates of opening were not consistently recorded on prescribed nutritional supplements with limited expiry periods once opened, and that nutritional supplements that required refrigeration once opened were not being stored in the fridge.

The inspectors observed nursing staff administering medicines to residents as part of one of the medication rounds in the centre. The inspectors reviewed the processes in place for administration of medicines, and were satisfied that nurses were knowledgeable regarding residents' individual medication requirements and followed professional guidelines. Nursing staff were observed to safely administer medicines and in a person centred manner. There were procedures in place for the handling and disposal of unused and out of date medicines.

The inspectors reviewed a number of the prescription and administration sheets and identified the following issues that did not conform with appropriate medicines

management practice:
-The indication for use of PRN (as required) medicines was not consistently documented on the prescription sheet. In some cases residents had been prescribed psychotropic medicines on a PRN basis but the prescription did not indicate when the medicine was to be used. There was no information included in care plans reviewed by inspectors to guide practice to ensure appropriate consistent administration of these medicines, and to provide assurance that if these medicines were being used as part of the management of responsive behaviours that it was part of an overall strategy that included less restrictive alternatives if appropriate.
-The maximum daily dosage for PRN (as required) medicines was not consistently indicated on the prescription sheet.
-A number of residents required their medicines to be crushed prior to administration and this was documented at the front of the prescription charts. The prescriber had not consistently indicated that crushing was authorised for each individual medicine on the prescription sheet.

There were systems in place within the centre for reviewing and monitoring medication management practices, including medication management audits completed on a monthly basis as part of the nursing metrics system in place in the centre. The medication audits made available to the inspectors reviewed the storage of medicines in the centre including controlled drugs, and also included review of the prescription and administration sheets. The audit process was subject to peer review and discussion.

Medication incidents including medication errors were recorded and reviewed within the centre. Medication errors and near misses were recorded on clinical incident forms and discussed with the person In charge. The clinical incidents reports are discussed at the quality of care meetings, and also submitted to the risk manager for the hospital to ensure that any risks identified are appropriately managed.

Residents' prescribed medicines were reviewed as part of the medical reviews conducted by the doctors.

Judgment:
Non Compliant - Moderate

Outcome 11: Health and Social Care Needs
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

Theme:
Effective care and support

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

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

Findings:
The provision of activities for residents' had improved since the last inspection. A second person had been employed to assist the activities coordinator to deliver activities across both units. There was written evidence that 1:1 activities and group activities were provided to all residents. Activities were now provided to residents' seven days per week. A weekly timetable of activities was on display in both units and included a variety of activities,1:1 and group for residents' to chose from. Records of activities attended were now being kept in individual resident files.

Residents were not routinely reviewed by a dentist. This service was only provided outside of the centre on an as required basis and it was found that the level of service was not adequate to meet the needs of maximum dependent residents' living in the centre. A dental service had not been sourced to date. Residents did not have a routine dental assessment. They were only referred to the dentist when they had dental pain. The proposed timescale for this to be actioned was 30 June 2015. However, inspectors were informed that there had been issues with securing this service.

Nursing records had improved somewhat from the previous inspection. However, they needed further improvement as mentioned under Outcome 7 the records around use of restraint were not comprehensive enough. HIQA had been notified of a number of incidents where residents' had developed pressure ulcers in the centre. Inspectors observed that repositioning charts were not being used to record when residents' were repositioned. Although, a number of residents' care plans stated requires repositioning two or four hourly. However, there were no records to reflect that this care was being provided.

Inspectors read a sample of residents' personal hygiene care plans. Those reviewed did were not clearly identify why residents were refusing showers and some were contradictory stating offer resident choice of shower or bath but staff stated that the resident could not have a shower and there was no bath in the centre. A clear rationale was not always recorded as to why a number of residents' were not having a shower.

Judgment:
Non Compliant - Moderate

Outcome 12: Safe and Suitable Premises
The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:
Effective care and support

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

Findings:
Improvements had been made to the premises since the last inspection. HIQA have been informed that funding has been approved for a new 100 bedded unit.

There were now just four residents' in each multiple occupancy bedrooms. Hence, each resident had a greater amount of personal space available to them. The amount of communal space available to residents in Woodlands (one of the units) had increased, a new dining room space had been provided and was being used by residents' at meal times.

The amount of storage space available to residents' had also improved. Each resident had been provided with a more appropriate sized individualised storage space for their personal belongings, which included a lockable storage space.

The up keep of the outdoor space around the Woodlands Unit had improved. The grass and flowerbeds were maintained to a higher standard. The paved pathways were clear and appeared safe for residents' to use. The handrails on either side of the two sloped pathways leading from the veranda to the garden had been re-painted. The outdoor space outside Silver Birch, was now safe or secure for residents to use, the fence had been repaired.

The centre did not have a bath suitable to meet the needs of maximum dependent residents'; each unit had assisted showers and although, shower trolleys had been purchased staff told the inspector that they were not used as residents' found them too uncomfortable and were unable to sit on the standard shower chairs. Two tilt chairs had been purchased to enable staff to transfer residents from maximum dependent residents from their bed to a shower. Records reviewed showed that maximum dependent residents were being offered a shower and if a shower was not their preference this was recorded in their personal hygiene care plan. Staff told the inspector and written evidence reviewed showed that these residents' were not receiving a bath or a shower instead they had a full bed bath and their hair washed once per week.

The shower room in Silver Birch which had been identified as being in a poor state of repair during the last inspection had been repaired and was now safe for residents' to use.

The number of assisted toilets was now adequate to meet the needs of maximum dependent residents' in each unit as the maximum number of residents on each unit had been reduced to twenty.

Judgment:
Non Compliant - Moderate

Outcome 17: Residents' clothing and personal property and possessions
Adequate space is provided for residents' personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.

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:
Storage space available to residents' for personal items had improved since the last inspection. Each resident now had a storage facility by their bed which enable them to maintain control of their personal items. Each storage space contained a lockable storage space.

Judgment:
Compliant

Outcome 18: Suitable Staffing
There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

Theme:
Workforce

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

Findings:
The staffing levels and skill mix met the needs of residents'.

Inspectors were informed that the centre now had a full complement of staff employed to meet the needs of 40 residents'. There was minimum use of agency staff reflected on rosters reviewed.

As mentioned under outcome 7, all staff had up-to-date elder abuse training in place.

Clinical nurse managers had begun completing annual appraisals/supervisory personal development meetings with staff nurses. Inspectors were informed that these would be completed by July 2016. Inspectors were shown a competency assessment document created to assess Health Care Assistants competencies, this was completed on a once only occasion with health care assistants and was not re-visited. They or household staff did not have annual appraisals or supervisory personal development meetings.

There were a number of volunteers coming into the centre to assist residents'. They provided assistance to residents at meal times and also assisted with the provision of activities. Inspectors reviewed a sample of volunteers' files and found evidence of Garda vetting and an outline of their roles and responsibilities.

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:

Sheila McKevitt
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

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

Provider's response to inspection report[1]

Centre name:	Connolly Hospital (Silver Birch & Woodland Units)
Centre ID:	OSV-0000528
Date of inspection:	12/05/2016
Date of response:	09/06/2016

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 02: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The annual review did not include evidence of consultation with residents and their families.

1. Action Required:
Under Regulation 23(e) you are required to: Prepare the review referred to in regulation 23(1)(d) in consultation with residents and their families.

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

Please state the actions you have taken or are planning to take:
Currently the residents are participating in a resident satisfaction survey. During the June 2016 Annual Review of Quality of Care meeting the Designated Residential Centre Committee will discuss the satisfaction survey results and review the minutes from meetings held during the year with residents and relatives. This is to ensure that residents and families views and opinions are discussed and actioned at the Annual Review of Quality of Care meetings. Feedback will be made available to relatives and families at upcoming meetings and information will be placed on the resident & relative notice boards.

Proposed Timescale: 30/06/2016

Outcome 07: Safeguarding and Safety

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The completed bedrail assessments forms did not reflect what alternatives had been trialled, tested and failed prior to bed rails being used as a form of restraint, in line with National policy.

2. 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:
Currently an RGN (with Masters in Gerontology) has been assigned to review the residents care plans in relation to bed rail assessments and what alternatives had been trialled prior to the decision to use bed rails. This review will inform education & training needs of staff in relation to carrying out comprehensive assessments on the need for use of bed rails. The Clinical Nurse Managers will provide education sessions to up skill staff to ensure that assessments are in line with the National Restraint Policy. Overall findings and action plans will be discussed at the June Annual Review at Quality of Care meeting. The Designated Residential Centre Multidisciplinary Team will be involved in the quality improvement action plans that are required.

Proposed Timescale: 31/07/2016

Outcome 09: Medication Management

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The following issues did not conform with appropriate medicines management practice:
-The indication for use of PRN (as required) medicines was not consistently documented on the prescription sheet. In some cases residents had been prescribed psychotropic medicines on a PRN basis but the prescription did not indicate when the medicine was to be used. There was no information included in care plans reviewed by inspectors to guide practice to ensure appropriate consistent administration of these medicines, and to provide assurance that if these medicines were being used as part of the management of responsive behaviours that it was part of an overall strategy that included less restrictive alternatives if appropriate.
-The maximum daily dosage for PRN (as required) medicines was not consistently indicated on the prescription sheet.
-A number of residents required their medicines to be crushed prior to administration and this was documented at the front of the prescription charts. The prescriber had not consistently indicated that crushing was authorised for each individual medicine on the prescription sheet.
- The temperature of the fridge used to store medicines and prescribed nutritional supplements was not monitored on a daily basis with the temperature recorded to ensure the temperature of the fridge was maintained between two and eight degrees Celsius.
-Dates of opening were not consistently recorded on prescribed nutritional supplements with limited expiry periods once opened, and nutritional supplements that required refrigeration once opened were not being stored in the fridge.

3. 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:
The CNMs are discussing with the Medicine for the Elderly prescribing team the requirement to document the indication for use of PRN medications on prescription sheets. Core care plans are being activated, reviewed and updated in relation to regular and PRN psychotropic medication use. These are based on the Resident Assessment Instrument in relation mood communication & behaviour (N1& N3). This will ensure that the care plans are brought up to the required standard.
Care plan review to be completed by 20/06/2016

The education & training needs of staff identified during this review will be actioned. The education sessions will be delivered by the CNMs locally to improve overall staff knowledge to improve standards of care.
Up skilling of staff to be completed by 31/07/2016

The maximum daily dose of PRN medication is now indicated on prescription sheets.
Action completed: 27/05/2016

All medication prescription that requires crushing are now being prescribed as required.

Action completed: 27/05/2016
The pharmacy fridge temperature in both residential units is being monitored and recorded daily.
Action completed: 15/05/2016

All prescribed nutritional supplements are dated once opened are now being stored in the pharmacy fridge.
Action completed:13/05/2016

All medication prescribing issues will be discussed at the June Annual Review of Quality of Care meeting to ensure there is a consistent approach to medication prescribing.

Proposed Timescale: 31/07/2016

Outcome 11: Health and Social Care Needs

Theme:
Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Personal hygiene care plans did not reflect care been given or visa versa.

There were no records to show that residents' were repositioned as outlined in their repositioning care plan.

4. 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:
Records around use of restraint were not comprehensive enough (also in Outcome 7). Currently an RGN (with Masters in Gerontology) has been assigned to review the residents care plans in relation to restraint and bed rail assessments and what alternatives had been trialled prior to the decision to use bed rails. This review will inform education & training needs of staff in relation to carrying out comprehensive assessments on the use of bed rails. The Clinical Nurse Managers will provide education sessions to up skill staff to ensure that assessments are in line with the National Restraint Policy. Overall findings and action plans will be discussed at the June Annual Review at Quality of Care meeting. The Designated Residential Centre Multidisciplinary Team will be involved in the quality improvement action plans in relation to use of bed rails.

Residents' personal hygiene care plans are currently being reviewed by the CNMs and being updated by the RGNs to clearly indicate residences preference and residents reason for that preference in relation hygiene matters.

All residents that required repositioning charts (in line with skin care bundles) now have these in place. Frequency of repositioning is being documented throughout each twenty four hours of care. Action completed 17/05/2016.

Proposed Timescale: 31/07/2016

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Maximum dependent residents did not have routine dental check-ups as they did not have access to a dentist for non urgent treatments.

5. Action Required:
Under Regulation 06(1) you are required to: Having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care for a resident, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais.

Please state the actions you have taken or are planning to take:
In April 2015 the Registered Provider and Person in Charge met with the Principal Dental Surgeon for Dublin North City to explore solutions around the provision of routine dental examinations to residents. It was agreed that the service would be facilitated by a local dental surgery and residents would be visited on site. Meetings and discussions took place throughout the year and service provision was at an advanced stage of agreement. Unfortunately the service has not commenced as routine dental check up is no longer covered by the Health Services Executive (HSE) General Medical Card Scheme. The Registered Provider has contacted the Principle Dental Surgeon Dublin North City to arrange a meeting to explore further who is approved and permitted to provide a service on site that would meet the needs of residents in relation to routine dental examination.

Proposed Timescale: 30/09/2016

Outcome 12: Safe and Suitable Premises

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were no assisted baths available to meet the needs of the maximum dependent residents living in the designated centre.

There were four residents' sharing a bedroom.

6. 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 residential services are part of the Department of Health & HSE capital development plan. A new build is due for completion by end of 2021. This new 100 bed residential unit will be fully compliant with outcome 12. Once built there will be sufficient numbers single rooms for residents and sufficient numbers of assisted baths to meet needs of maximum dependant residents.

Proposed Timescale: 31/12/2016

Outcome 18: Suitable Staffing

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Health care assistants and household staff were not having any form of formal supervision.

7. 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:
CNMs and Nurse Practice & Quality Department are reviewing documentation that will be used to carry out annual appraisals on healthcare assistants in line with their current role and responsibilities. Once this document is developed the appraisals will be carried out by the CNMs on an annual basis.
The Person in Charge has discussed with the Catering Manager that an annual appraisal needs to be carried out in relation to catering staff to ensure competence and understanding in meeting residents' nutrition and hydration needs. The Catering Manager is currently developing an appraisal form in relation to this. The staff appraisals will be carried out by the Catering Manager/Supervisors.

The Person in Charge has informed the Household Services Manager that an annual appraisal needs to be carried out in relation household staff to ensure that household staffs are competent in their roles. The staff appraisals will be carried out by the Household Services Manager/Supervisors.

A training need analysis will be carried out following these appraisals and a quality improvement plan will be put in place to up skill staff where required.

Proposed Timescale: 30/09/2016