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:	Ferbane Nursing Home
Centre ID:	OSV-0004690
Centre address:	Main Street, Ferbane, Offaly.
Telephone number:	090 645 4742
Email address:	info@ferbanenursinghome.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Maracrest Ltd.
Provider Nominee:	Denis McElligott
Lead inspector:	Sheila Doyle
Support inspector(s):	None
Type of inspection	Unannounced Dementia Care Thematic Inspections
Number of residents on the date of inspection:	42
Number of vacancies on the date of inspection:	9

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 2 day(s).

The inspection took place over the following dates and times

From:	To:
02 August 2016 11:00	02 August 2016 18:00
03 August 2016 09:30	03 August 2016 18:00

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	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	Substantially Compliant	Non Compliant - Moderate
Outcome 06: Safe and Suitable Premises	Non Compliant - Moderate	Non Compliant - Moderate
Outcome 12: Notification of Incidents		Compliant

Summary of findings from this inspection

As part of the thematic inspection process, providers were invited to attend information seminars given by the Authority. In addition, evidence-based guidance was developed to guide the providers on best practice in dementia care and the inspection process.

The person in charge completed the provider self-assessment and scored the service against the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland. The previous table outlines the centre's and inspector's rating for each outcome.

The inspector met with residents and staff members during the inspection. She tracked the journey of a number of residents with dementia within the service. Care practices and interactions between staff and residents who had dementia were observed using a validated observation tool. Documentation such as care plans, medical records and staff training records were reviewed. An interview was carried out with the recently appointed assistant director of nursing.

The inspector also followed up on some unsolicited information received by the Authority relating to routine practices and standards of care. While improvements were required there was limited evidence to support this information.

Approximately 38% of residents in this centre have dementia. The atmosphere was homely, comfortable and in keeping with the overall assessed needs of the residents who lived there.

Each resident was assessed prior to admission to ensure the service could meet their needs and to determine the suitability of the placement. Residents had an assessment undertaken and care plans were in place, however some gaps were noted in this documentation.

Improvement was required to ensure that medication management practices were safe and in line with national guidelines. The health needs of residents were met to a high standard although additional work was required to ensure that residents had ample opportunity to express their wishes and preferred options for care at end of life. Residents had access to general practitioner (GP) services and to a range of other health services.

Safe and appropriate levels of supervision were in place to maintain residents' safety. There were policies and procedures in place around safeguarding residents from abuse. There was appropriate staff numbers and skill mix to meet the assessed needs of residents. There was a recruitment policy in place which met the requirements of the Regulations but some improvement was required to ensure staff files met the requirements of the Regulations. In addition there were gaps in the required documentation for volunteers.

The dining experience was pleasant and residents' nutritional needs were met. There was a range of interesting things for residents to do but some improvement was required to ensure that the activities reflected the capacities and interests of each individual resident. The provider discussed plans for additional changes to the premises to create a more homely and dementia friendly environment.

While the results from the observations were encouraging, additional work is required to ensure that the majority of staff interactions with residents promote positive connective care and eliminates routine practices.

These are discussed further in the report and included in the Action Plan at the end of this report

Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National 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 inspector was satisfied that each resident's wellbeing and welfare was maintained by appropriate evidence-based nursing, medical and allied health care. However improvements were required to ensure that medication management practices were safe. In addition, improvement was required to the care planning process. The arrangements to meet each resident's assessed needs were not consistently set out in an individual care plan and end of life documentation and assessment required improvement.

The inspector reviewed a sample of administration and prescription records and noted that some improvement was required around medication management practices.

Some residents required medication as and when required (PRN). However the maximum dose that could safely be administered in a 24 hour period was not consistently recorded.

Some residents also required their medication to be crushed. However this was not consistently prescribed this way in line with national guidelines.

Improvement was also required around the storage of medications that required strict controls. The inspector checked the stock balance of some medications. Although the balances were correct unsafe practices were observed. The practice was that the controlled drugs were supplied for individual residents with the resident's name on the label and box. In two samples reviewed, the medication patches had been removed from their original containers and put with other similar medications. This meant that medications were being dispensed with different batch numbers and expiry dates and therefore increased the risk of medication error.

The inspector saw that a fridge was provided for medications that required specific temperature control. The inspector noted that the temperatures, which were checked daily, were within acceptable limits at the time of inspection. The inspector saw that the medication fridge was not locked. Staff told the inspector they did not have the key.

These issues were discussed with the provider and person in charge to ensure that practices were in line with national guidelines.

Written evidence was available that three-monthly medication reviews were carried out. Support and advice were available for the supplying pharmacy.

The inspector reviewed a sample of clinical documentation including nursing and medical records. The inspector saw that improvement was required to the care planning documentation to ensure that it contained sufficient detail to guide practice. A new computerised system had been introduced and some care plans were comprehensive and person centred. However some had not been updated and did not include details the assessments undertaken or the care provided. This was discussed with the person in charge who outlined her plans to introduce a more person centred approach.

There was no documented evidence that residents and their families, where appropriate, were involved in the care planning process.

Although there were several examples of good practice in relation to end of life the inspector found that in some cases, there was no documented evidence to show that residents were afforded the opportunity to outline their wishes regarding end of life. These wishes and preferred priorities of care could then direct the care provided. The person in charge told the inspector that plans were in place to introduce detailed assessments in this regard and the inspector saw that the documentation was ready for this.

Otherwise the inspector was satisfied that caring for a resident at end-of-life was regarded as an integral part of the care service provided. The practices were supported by an end-of-life policy. The person in charge stated that the centre received advice and support from the local palliative care team.

The inspector was satisfied that there were suitable arrangements in place to meet the health and nursing needs of residents with dementia. Residents were satisfied with the service provided. Residents had access to GP services and out-of-hours medical cover was provided. A full range of other services was available on referral including speech and language therapy (SALT) and occupational therapy (OT) services. Physiotherapy services were available on site. Chiropody, dental and optical services were also provided. The inspector reviewed residents' records and found that some residents had been referred to these services and results of appointments were written up in the residents' notes.

There were systems in place to ensure residents' nutritional and hydration needs were met. Residents were screened for nutritional risk on admission and reviewed on a monthly basis thereafter. Residents' weights were also checked on a monthly basis or more frequently if required. Nutritional care plans were in place that detailed residents' individual food preferences and outlined the recommendations of dieticians and speech and language therapists where appropriate. The inspector also noted that individual preferences and habits around mealtimes were recorded.

The inspector was satisfied that each resident was provided with food and drinks at times and in quantities adequate for his/her needs. Food was properly prepared, cooked and served, and was wholesome and nutritious. Assistance was offered to residents in a discreet and sensitive manner. Residents told the inspector that they enjoyed the food with some residents describing it as ' hotel quality' and all acknowledging that staff would get you anything you wanted to eat.

Validated nutrition assessment tools were used to identify residents at potential risk of malnutrition or dehydration on admission and were regularly reviewed thereafter. Weights were also recorded on a monthly basis or more frequently if required. Records showed that some residents had been referred for dietetic review. Medication records showed that supplements were prescribed by a doctor and administered appropriately. The person in charge told the inspector that following on from a complaint received; they had examined their existing practice in relation to recording of food and fluid intake on residents. Formal records were now maintained when required.

The inspector saw that residents had been reviewed by a speech and language therapist when required. The inspector observed practices and saw that staff were using appropriate feeding techniques as recommended.

The inspector visited the kitchen and noticed that it was well organised and had a plentiful supply of fresh and frozen food which was stored appropriately. The chef on duty discussed the special dietary requirements of individual residents and information on residents' dietary needs and preferences. The catering staff discussed on-going improvements in the choice and presentation of meals that required altered consistencies. The inspector saw that residents who required their meal in an altered consistency had adequate choices available to them. The chef discussed plans to introduce pictorial menus to assist residents with choosing their meal.

The inspector saw that snacks and drinks were readily available throughout the inspection. The inspector observed and residents confirmed that the chef continued to produce a wide range of home-baking including a variety of scones, cakes and home-made desserts.

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 measures were in place to protect residents from being harmed or abused.

Staff had received training on identifying and responding to elder abuse and this had been an action required from the previous inspection. There was a policy in place which gave guidance to staff on the assessment, reporting and investigation of any allegation of abuse. At the time of inspection, this was being updated to reflect the national policy. The person in charge and staff spoken to displayed sufficient knowledge of the different forms of elder abuse and all were clear on reporting procedures.

Some residents showed behavioural and psychological signs of dementia (BPSD). The inspector noted that specific assessments to include details of possible triggers and interventions were undertaken for residents. The inspector also noted that staff spoken with were familiar with appropriate interventions to use. During the inspection staff approached residents with behaviour that challenged in a sensitive and appropriate manner and the residents responded positively to the techniques used by staff.

Ongoing improvements were noted in the use of restraint. Risk assessments had been undertaken and safety checks were completed when in use. Staff spoken with confirmed the various alternatives that had been tried prior to the use of bedrails. Additional equipment such as low beds and sensor alarms had also been purchased to reduce the need for bedrails.

Some residents' monies were managed within the centre. Balances checked on inspection were correct. There was a policy in place to guide the practice. The inspector was satisfied that the system was sufficiently robust.

Judgment:
Compliant

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:
Person-centred care and support

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

Findings:
The inspector was satisfied that residents were consulted on the organisation of the centre, and that their privacy and dignity was respected. However some improvement was required to ensure that feedback was sought from residents with dementia and the activities available were not dictated by the routine and resources and reflected the capacities and interests of each individual resident.

There was limited evidence that feedback was sought from residents with dementia on

an ongoing basis regarding the services provided. The person in charge had already identified this as an area for improvement.

As part of the inspection, the inspector spent a period of time observing staff interactions with residents with a dementia. The observations took place in the day rooms. Observations of the quality of interactions between residents and staff for selected periods of time indicated that 38% of interactions demonstrated positive connective care, 24% reflected task orientated care while 38% indicated neutral care. The inspector noted that during one half hour interval that the activity underway was interrupted by other staff enquiring what residents would like for dinner the following day and a second staff member giving out drinks. As the activity was bingo, residents were being distracted from listening to the numbers called to answer routine questions regarding dinner choices. The inspector noted that some residents lost interest in the activity. Three residents fell asleep. These results were discussed in detail with the provider and person in charge at the end of inspection. The provider and person in charge who undertook to monitor care practices on an ongoing basis.

Despite this the inspector saw that the activity coordinator was very committed to meeting the needs of the residents. 'A Key to me' was completed for each resident and this included details of residents' likes and dislikes, previous interests and hobbies. Some dementia appropriate activities were available and a programme of activities was on display. This included music, games and crafts. One to one activities such as hand massage were carried out for residents who did not wish to engage in group activities. The person in charge told the inspector that they were currently reviewing the activity programme to ensure it met the needs of residents.

Staff worked to ensure that each resident with dementia received care in a dignified way that respected their privacy. Staff were observed knocking on bedroom and bathroom doors. Adequate screening was available in shared rooms. The inspector observed staff interacting with residents in an appropriate and respectful manner, and it was clear that staff knew the residents well. The inspector noted good humoured banter between the residents and staff.

Independent advocates were available and contact details were on display in the front hall. There were no restrictions to visiting in the centre and many residents were observed spending time with family or friends. During the day residents were observed to move around the centre freely.

The inspector saw that the residents' guide was available in both standard and large print versions to assist residents. The person in charge stated that she was currently getting this document put on a CD for residents who may have difficulty reading or understanding the written word.

Residents were facilitated to exercise their civil, political and religious rights. Residents confirmed that their rights were upheld. Residents' right to refuse treatment or care interventions were respected. Residents were satisfied with opportunities for religious practices. Arrangements were in place for residents to vote in the recent election.

There was a residents’ committee in operation. The inspector viewed the minutes of

some meetings and saw that suggestions made by residents had been taken on board. For example the inspector saw where suggestions regarding activity choices had been acted upon. In addition the inspector saw that residents were reminded about the complaints policy and advocacy services at each meeting.

The inspector heard a resident discussing the proposed colour scheme for his room. The person in charge undertook to bring in some colour charts to help with this.

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:
The complaints procedure in the designated centre was found to be appropriately managed and reviewed.

The inspector noted that the complaints log was currently being updated to ensure compliance with the regulations and standards.

The procedures in place to deal with complaints were clearly set out and understood staff members spoken to. The complaints' procedure and complaint forms were available in the reception area together with comment cards should residents or visitors wish to comment of the service provided.

Judgment:
Compliant

Outcome 05: Suitable Staffing

Theme:
Workforce

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

Findings:

The inspector was satisfied that at the time of inspection there were appropriate staff numbers and skill mix to meet the assessed needs of residents for the size and layout of the centre.

All staff were supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. However some gaps were noted in the staff files reviewed. Improvement was also required to documentation relating to volunteers.

The inspector reviewed a sample of staff files and saw that efforts had been made to ensure that all documents required by Schedule 2 were in place. However the inspector noted that three of the four files reviewed did not contain a satisfactory history of any gaps in employment as required by the regulations.

Several volunteers and outsourced service providers attended the centre and provided very valuable social activities and services which the residents said they thoroughly enjoyed and appreciated. However some had not been vetted appropriate to their role. In addition their roles and responsibilities were not set out in writing as required by the regulations.

The staff rota was checked and found to be maintained with all staff that worked in the centre identified. Systems were in place to provide relief cover for planned and unplanned leave. Up to date registration numbers were in place for nursing staff. The inspector discussed the ongoing need to review the staffing levels to ensure that adequate staff were available at all times of the day and night to meet the needs of the residents.

The inspector saw that a robust induction programme was in place for new staff which included the safety, a review of policies and mandatory training.

The provider and person in charge promoted professional development for staff and were committed to providing ongoing training to staff. Previous action relating to the provision of training had been addressed. A training matrix was maintained. Training records showed that extensive training had been undertaken and staff spoken with confirmed this. This included training in dementia care and nutritional care. The inspector saw that a training plan was in place for the coming year and included topics such as infection control, restraint and medication management.

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:
Improvements were required to ensure that 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 including residents with dementia.

Ferbane Nursing Home is a 51 bedded facility set in mature grounds. It is a three storey building and a lift and stairs provide access to each floor. It consists of 37 single rooms and seven twin rooms some of which are en suite.

The bedrooms were comfortable and had bright, fresh curtains and bed linen. Many of the residents had personalised their bedrooms with family photographs, pot plants and favourite ornaments.

The inspector found the parts of the premises that residents had access to, were visibly clean and well maintained. However improvements were required to ensure that the premises meets residents' individual and collective needs in a comfortable and homely way in particular for residents with dementia. A baseline audit had been undertaken to explore the required improvements to make the premises more dementia friendly. Some of these had taken place, for example, the day room was redecorated and new chairs had been provided. However some outstanding work remained and the person in charge stated that plans were in place to address some of the areas. This included the provision of suitable dementia friendly signage, the use of contrasting colours and cues and a variety of other dementia friendly initiatives.

The provider and person in charge outlined plans to further develop the centre including the provision of additional bedrooms and complete renovation of the kitchen areas. Several of the old outhouses and sheds will be removed at that time which will make the area both safer and aesthetically pleasing. This will also include the provision of secure garden areas as currently, although there are extensive grounds there was no secure garden area for residents with dementia. There is a proposed start date of early next year.

In the interim, some improvements will take place. This will include the provision of additional furniture such as tables in the day rooms, the relocation of a sluice room to the ground floor and the provision of additional toilets near residents' bedrooms. The flooring in the upstairs dining room also requires attention.

Appropriate assistive equipment was provided to meet residents' needs such as hoists, seating, specialised beds and mattresses.

A high level of cleanliness and hygiene was maintained throughout the building. Staff spoken with were knowledgeable as regards infection control measures and the safe use and storage of cleaning chemicals and disinfectant agents.

Adequate arrangements were in place for the disposal of general and clinical waste. Ample parking was available at the front of the building. There are spacious grounds to the front of the building and the inspector saw several residents walking in that area

during the inspection. However as stated earlier there was no secure garden area for residents to wander freely.

Judgment:
Non Compliant - Moderate

Outcome 12: Notification of Incidents

Theme:
Effective care and support

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

Findings:
A record of incidents and accidents occurring in the designated centre was maintained and, where required, notified to the Chief Inspector in accordance with statutory requirements.

Judgment:
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 Doyle
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	Ferbane Nursing Home
Centre ID:	OSV-0004690
Date of inspection:	02/08/2016
Date of response:	18/08/2016

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:
Improvement was required to the care planning documentation to ensure that it contained sufficient detail to guide practice

1. Action Required:
Under Regulation 05(2) you are required to: Arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of

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

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:
Pre-assessment visits are arranged to assess the care needs of the proposed resident, which includes a Mini Mental State Examination (M.M.S.E.) assessment. In addition, where a visit is not warranted a comprehensive report is requested from the referring agency – usually from the hospital Ward Manager.
A comprehensive pre-assessment is carried out on all new residents to the nursing home. A new computerised system is in operation. All residents' care plans are being reviewed and updated in a new format, which is person centred and comprehensive in detail to guide practice. This commenced in mid July 2016.

Proposed Timescale: 30/11/2016

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was no documented evidence that residents and their families, where appropriate, were involved in the care planning process.

2. Action Required:
Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.

Please state the actions you have taken or are planning to take:
A more formal approach to meeting with the resident and where appropriate the resident's family/representative is planned to commence on 1st September 2016. This will involve consultation with the resident and where appropriate their family/representative, in the review and evaluation of the resident's care plan and will be carried out by the staff nurses. These meetings will be held at four monthly intervals or more frequently if there is any change in the condition of the resident concerned. These meetings will be documented and kept in the resident's file.

Proposed Timescale: 30/11/2016

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was no documented evidence to show that residents were afforded the opportunity to outline their wishes and priorities of care regarding end of life.

3. Action Required:
Under Regulation 13(1)(a) you are required to: Provide appropriate care and comfort to 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 nursing home works closely with the local palliative care services and receives support and advice accordingly. An End of Life policy is in place and as part of the overall review of our End of Life care, this will be re-evaluated by the team of nurses headed up by the Assistant Director of Nursing and the Person-in-Charge.
As part of the formal review of the resident's care plan and meeting with the resident and their family/representative, a new document will be discussed and completed. This document is called "Think Ahead" and it is a planning document for thinking, discussing and recording the resident's preferences regarding all aspects of end of life care. Other initiatives are planned in conjunction with the other Persons-in-Charge from our sister nursing homes, including a family handover bag and a bereavement pack.

Proposed Timescale: 20/11/2016

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some residents required medication as and when required (PRN). However the maximum dose that could safely be administered in a 24 hour period was not consistently recorded.

Some residents also required their medication to be crushed. However this was not consistently prescribed this way in line with national guidelines.

4. 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 "as and when required (P.R.N) "analgesic medication had a maximum dose in 24 hours recorded on their current medication records. This has now been updated to include the maximum dose in 24 hours for all remaining "as and when required (P.R.N.) medications".
The medication prescription for those residents who require their medication to be crushed has now been updated as per national guidelines. We will continue to record any advice from the resident's pharmacist re the appropriate use of the medication to be crushed, in the designated section of the resident's medication chart.

Proposed Timescale: 18/08/2016

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some medications that required strict controls had been removed from the original container and were stored with other similar medications.

The key to lock the medication fridge was missing.

5. Action Required:
Under Regulation 29(4) you are required to: Store all medicinal products dispensed or supplied to a resident securely at the centre.

Please state the actions you have taken or are planning to take:
In conjunction with the nursing home's pharmacist, a suitable container and label for each of the two medication patches mentioned in the Inspector's report, were immediately put in place. This included the batch number and expiry date of the medication.
All nurses have reviewed the medication policies, which are in line with national guidelines and have been informed that this is an unsafe practice. Medication error forms have been completed and this will be discussed at the next staff nurses meeting to ensure that this practice will not occur again.
A new lock and key has been fitted to the medication fridge

Proposed Timescale: 18/08/2016

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:
Some improvement was required to ensure that the activities were not dictated by the routine and resources and reflected the capacities and interests of each individual resident.

6. 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:
The Person in Charge is currently reviewing the nursing home's activity programme.
An audit has been completed looking at the quality of interactions of staff with residents

and its findings will be used to generate a plan of action and implement change. Staff practices are currently being monitored to ensure that unnecessary distractions do not occur during the activities programme.
The nursing home will be looking at the models currently in place in our sister nursing homes, where visiting specialists in areas such as art and music, complement the existing activities programme. Following internal review by the management team, we will be creating an activities team with more specialised training in order to meet the needs of our residents.
"A Key to Me" has been completed for all residents and included information of individual resident's previous interests and hobbies. This has helped to guide the activities programme.
Currently if a resident wishes to have privacy or to not partake in a particular activity, this is facilitated. One to one activities are ongoing and will now be documented for each resident availing of them.
A new care plan is being put in place for each individual resident reflecting their capacities and interests.
As discussed with the inspector on the day of the inspection, longer term plans include the creation of an additional new facility, which will be designed with residents with dementia specifically in mind. This facility will be designed based on a similar one in our sister nursing home in Limerick.

Proposed Timescale: 30/11/2016

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was limited evidence that feedback was sought from residents with dementia on an ongoing basis regarding the services provided.

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

Please state the actions you have taken or are planning to take:
There is a policy in place which guides the active seeking out of our residents' feedback to assist in the ongoing improvement of the care and services provided.
All residents' meetings will have a plan of action generated to ensure that the residents' wishes will be incorporated into the organisation of the nursing home. For those residents who do not wish to attend meetings, feedback and consultation will be facilitated through the formal meetings with the resident and/or their family/representative, which will be held a minimum of four monthly. This feedback will be included in any plan of action required.
A resident's satisfaction survey will be conducted by staff in September 2016 and the Person-in-Charge will collate and generate a plan of action where required. In addition Residents' comment cards are available in the nursing home and alternative communication tools e.g. Talking Mats, will be used where required to facilitate

residents with dementia making their wishes known.

Proposed Timescale: 30/10/2016

Outcome 05: Suitable Staffing

Theme:
Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Three of the four files reviewed did not contain a satisfactory history of any gaps in employment as required by the regulations.

8. 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:
A review of all staff files is nearly completed and updated curriculum vitas requested from those staff members who contained gaps in their employment history. The Induction checklist which is in operation to ensure that all staff records met with the requirements, has been updated to ensure that all gaps in employment history are covered. We are embarking on reviewing Gardai vetting for all staff who have been employed in the nursing home for a period of over 3 years.

Proposed Timescale: 07/09/2016

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The roles and responsibilities of volunteers were not set out in writing as required by the regulations.

9. Action Required:
Under Regulation 30(a) you are required to: Set out in writing the roles and responsibilities of people involved on a voluntary basis with the designated centre.

Please state the actions you have taken or are planning to take:
The roles and responsibilities of volunteers are currently being reviewed by the Person in Charge and the HR department and will be set out in writing. Each individual volunteer will receive their roles and responsibilities and sign accordingly.

Proposed Timescale: 07/09/2016

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some volunteers had not been vetted appropriate to their role.

10. Action Required:
Under Regulation 30(c) you are required to: Provide a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 for people involved on a voluntary basis with the designated centre.

Please state the actions you have taken or are planning to take:
A new checklist has been generated as a result of this requirement, to ensure that all volunteers have been vetted appropriately to their role in the nursing home. Any outstanding Garda vetting forms have been completed on 17th August 2016 and forwarded to the National Vetting Bureau. There is a waiting period of approximately 8 weeks for vetting to be received by the nursing home.

Proposed Timescale: 15/10/2016

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:
Improvements were required to ensure that 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 including residents with dementia.

11. Action Required:
Under Regulation 17(1) you are required to: Ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.

Please state the actions you have taken or are planning to take:
Following feedback on the day of the inspection the Registered Provider has identified a suitable location for a sluice room, that will meet the needs of the staff and the building. Work on this will commence on or about the 12th September where our group maintenance team will commence this work.
Secondly, the store room identified on Floor 1 will be converted into toilet facilities to accommodate male and female residents, thereby ensuring their privacy. Work on this will commence about the same time and it is envisaged that this will be completed in approximately 4 weeks. This timescale is approximate due to the nature of the works

i.e. mechanical and electrical, plumbing, installation of a nurse call system and construction.
Proposed Timescale: 10/10/2016