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:	Esker Lodge Nursing Home
Centre ID:	OSV-0000135
Centre address:	Esker Place, Cathedral Road, Cavan.
Telephone number:	049 437 5090
Email address:	vicky@eskerlodgenursinghome.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Esker Lodge Limited
Provider Nominee:	Vicky McDwyer
Lead inspector:	PJ Wynne
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	70
Number of vacancies on the date of inspection:	0

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 2 day(s).

The inspection took place over the following dates and times

From:	To:
14 July 2015 09:10	14 July 2015 18:00
15 July 2015 09:30	15 July 2015 15:30

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

Outcome	Our Judgment
Outcome 01: Statement of Purpose	Compliant
Outcome 02: Governance and Management	Substantially Compliant
Outcome 03: Information for residents	Compliant
Outcome 04: Suitable Person in Charge	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	Substantially Compliant
Outcome 09: Medication Management	Compliant
Outcome 11: Health and Social Care Needs	Non Compliant - Moderate
Outcome 17: Residents' clothing and personal property and possessions	Compliant
Outcome 18: Suitable Staffing	Non Compliant - Moderate

Summary of findings from this inspection

This report set out the findings of an unannounced monitoring inspection. This inspection took place over two days. The inspector reviewed progress on the action plan from the previous inspection carried out in April 2014. Notifications of incidents received since the last inspection was also considered and reviewed on this visit.

There were 70 residents in the centre at the time of this inspection. All residents were residing in the centre for continuing care. The majority of residents were between 80 and 90 years of age. Forty residents had a diagnosis of dementia. There is a dementia specific unit on the ground floor. The unit accommodates a maximum of 20 residents.

The centre was clean, warm and well decorated with a calm atmosphere. Residents were complimentary of staff and satisfied with care services provided. They had good

access to nursing, medical and allied health care. There was a good quality and variety of food available to residents at each meal time.

The nurse management team and all staff interacted with residents in a respectful, warm and friendly manner. Staff demonstrated a thorough knowledge of residents' needs, likes, dislikes and preferences.

A total of 11 Outcomes were inspected. The inspector found the centre moderately non compliant in outcomes on Governance and Management, Health and Social Care Needs and Suitable Staffing. Six Outcomes were found as compliant with the Regulations and a further two as substantially in compliance with the Regulations.

The action plan at the end of this report identifies these and other areas where improvements must be made to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.

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: Statement of Purpose
There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

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 statement of purpose accurately described the aims, objectives and ethos of the centre and the service that was provided.

The statement of purpose set out the services and facilities provided in the designated centre and contained all the requirements of Schedule 1 of the Regulations. The statement of purpose is kept under review by the provider and had been updated.

Judgment:
Compliant

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):
No actions were required from the previous inspection.

Findings:
There was a defined management structure in place to ensure the effective governance of the service. The inspector found that the management structure was appropriate to

the size, ethos, purpose and function of the centre.

The provider met with the inspector and discussed the governance and operational overview required by her role. However, the organisational structures in place to support the person in charge require review. Due to difficulty in recruitment the deputy to the person in charge was rostered for clinical duty. She had reduced hours to oversee her role and responsibilities in clinical governance. The provider indicated nursing staffing resources have been recruited and are due to commence in post in early September 2015.

There was evidence of quality improvement strategies and monitoring of the services. The inspector reviewed audits completed by the management team. These included hygiene, nutrition, residents' monthly weight checks, the number of residents with two bedrails in use and an audit of the medication prescription and administration charts.

An annual report on the quality and safety of care was compiled for 2014 with copies made available to the residents or their representative for their information as required by the Regulations.

Judgment:
Substantially Compliant

Outcome 03: Information for residents
A guide in respect of the centre is available to residents. Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

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 found that all residents had an agreed written contract. The contract of care was revised as this was an area identified for improvement on the last inspection.

The cost of additional expenses incurred by residents was set out in the revised contract of care. This identified charges payable per items not included in the overall fee.

Judgment:
Compliant

Outcome 04: Suitable Person in Charge
The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of

the service.

Theme:
Governance, Leadership and Management

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

Findings:
The person in charge has not changed since the last inspection.The person in charge is a registered nurse and is noted on the roster as working in the post full-time. She had good knowledge of residents care needs. She could describe in an informed way where residents had specific needs and how staff ensured that their care needs were met appropriately.

She has maintained her professional development and attended mandatory training required by the Regulations. The person in charge is a qualified trainer in safeguarding vulnerable adults.

Judgment:
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 found that there were systems in place to maintain complete and accurate records. Records were stored securely and easily retrievable.

Written operational policies, which were centre specific, were in place to inform practice and provide guidance to staff.

A sample of five staff files were examined to assess the documentation available, in

respect of persons employed. All the information required by Schedule 2 of the Regulations was available in the staff files reviewed. This was an area identified for improvement in the action plan of the previous inspection report.

A copy of the current registration details for all nursing staff was available and provided to the inspector for review.

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):

Findings:
The policy on adult protection was available. This was revised in August 2014. Protected disclosure procedures to guide staff in their reporting of a suspicion of abuse were documented in the policy. Residents spoken with stated that they felt safe in the centre. Access and egress to the centre was monitored. There was a visitors log in place.

No notifiable adult protection incidents which are a statutory reporting requirement to the Authority have been reported since the last inspection. Garda Síochána vetting had been applied for all staff members. This was evidenced by a review of returned Garda Siochana vetting forms examined by the inspector.

Staff spoken with were able to inform the inspector of what constituted abuse and of their duty to report any suspected or alleged instances of abuse. Staff identified a senior manager as the person to whom they would report a suspected concern. The inspector viewed records confirming all staff had up to date refresher training in protection of vulnerable adults.

The model of behaviour management in which staff were being trained was in a process of transition from the Management of Actual or Potential Aggression (MAPA) to the Mulberry training model. At the time of this inspection all staff were not trained.

The policy to guide staff action and intervention in responding to behaviours that challenge requires review. The new model of behaviour management utilised by the

centre and in which staff were being trained was not clearly defined in the policy.

There was a policy on restraint management (the use of bedrails and lap belts) in place. At the time of this inspection 19 residents had two bedrails in use. There was a risk assessment completed prior to the use of the restraint and assessments were regularly revised. Signed consent was obtained by the resident or their representative and the GP. Restraint risk assessments were revised routinely and supported with a plan of care. Crash mats, sensor alarms and ultra low beds were in use to promote a restraint free environment. The rationale for each bed rail was outlined in the risk assessment documentation reviewed.

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:
The inspector was satisfied that the health and safety of residents, staff and visitors in the centre was promoted and protected. The actions in the previous inspection which related to risk, health and safety were satisfactorily completed.

The risk management policy contained the procedures required by the Regulation 26 and schedule 5 to guide staff. The health and safety statement outlined the organisational safety roles and responsibilities. Risk assessments were completed to identify potential hazards. Controls were specified to mitigate risk identified.

On the first day of the inspection it was noted a number of window restrictors were not engaged on the first and second floor windows of the building. A review of the incident reports evidenced a resident exited the building via the window on the ground floor. The situation was responded to quickly by staff. The resident was unharmed and safely returned to his accommodation. An individual strategy was developed to minimise the likelihood of a repeat incident. However, precautions system wide were not ensured on each floor of the building.

Fire safety equipment including the fire alarm, fire fighting equipment, emergency lighting and smoke detectors were provided and were serviced annually. Regular fire safety checks were undertaken by staff. Fire exits were checked daily. Automatic door closers were inspected weekly. A monthly check of the fire extinguishers was undertaken. Evacuation sheets were fitted to each bed. Illuminated fire exit signage was

in place. Action notices detailing the procedures to take in the event of discovering a fire or on hearing the alarm were displayed.

All staff had completed training in fire safety evacuation procedures. Records indicated routine fire drill practices were completed. Records evidenced staff practised both horizontal and vertical evacuation techniques. There was evaluation of learning from fire drills completed to help staff understand what worked well or identify any improvements required. This was an area identified for improvement on the previous visit. Staff were able to explain the fire safety procedures to the inspector.

A risk assessment was completed for all residents who smoke. A plan of care was in place detailing the level of assistance and supervision required. Cigarettes and lighters were held in safekeeping by staff both during the day and at night.

The building, bedrooms and bathrooms were visually clean. A suitable cleaning system was in place to break the cycle of infection and minimise the risk of cross contamination. There were separate cloths and mops to clean each bedroom and ensuite bathrooms. A sufficient number of cleaning staff were rostered. Cleaning staff spoken with demonstrated a good knowledge of the cleaning system.

There were arrangements in place for recording and investigating untoward incidents and accidents. The inspector noted that falls and near misses were well described. In the sample of accident report forms reviewed vital signs for residents were checked and recorded. Neurological observations were recorded where a resident sustained an unwitnessed fall or a suspected head injury. Individual strategies were outlined and utilised to minimise the risk of residents sustaining a fall.

The training records evidenced there was an ongoing program of training in moving and handling. However, a small number of staff required refresher training as their current certificate of training had expired.

There was sufficient moving and handling equipment available to staff to meet residents needs. There were seven hoists provided. There was a contract in place to ensure hoists were serviced and safely maintained. Each resident's moving and handling needs were identified. These were available to all staff at the point of care delivery in bedrooms.

Judgment:
Substantially 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):

No actions were required from the previous inspection.

Findings:
There was a medication management policy in place which provided guidance to staff to manage aspects of medication from ordering, prescribing, storing and administration.

Each resident's medication was dispensed blister packs. The blister packs on arrival were checked against the prescription sheets in the signed kardex to ensure all medication orders received were correct for each resident. Drugs which were crushed prior to administration were prescribed and signed by the GP.

The inspector reviewed a sample of drugs charts. Photographic identification was available on the drugs chart for each resident to ensure the correct identity of the resident receiving the medication and reduce the risk of medication error. The prescription sheets reviewed were legible.

The medication administration sheets viewed were signed by the nurse following administration of medication to the resident and recorded the name of the drug and time of administration. The drugs were administered within the prescribed timeframes. There was space to record when a medication was refused on the administration sheet.

Medications that required strict control measures were kept in a secure cabinet which was double locked in keeping with the Misuse of Drugs (Safe Custody) Regulations. Nurses kept a register of controlled drugs. Controlled drugs were checked by two nurses at the change of each shift. The inspector checked a selection of the balances and found them to be correct.

The temperature of the fridge containing drugs requiring refrigeration was monitored daily. A separate fridge was provided to store specimens prior to transport for analysis.

Judgment:
Compliant

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:
There were 70 residents in the centre at the time of this inspection. All residents were residing in the centre for continuing care. There were 18 residents with maximum care needs. Twenty four residents were assessed as highly dependent and 19 with medium dependency care needs. Nine residents were considered low dependency. There were 15 residents over 90 years of age. The majority were between 80 and 90 years of age. There were seven residents between 60 and 70 years of age and three residents between 50 and 60 years old.

Many residents were noted to have a range of healthcare issues and the majority had more than one medical condition. Forty residents had a diagnosis of dementia. There is a dementia specific unit on the ground floor. The unit accommodates a maximum of 20 residents. There were six residents with a primary diagnosis of intellectual disability.

The arrangements to meet residents' assessed needs were set out in individual care plans. The inspector found a good standard of evidence-based care and appropriate medical and allied health care access. Recognised assessment tools were used to evaluate residents' progress and to assess levels of risk for deterioration, for example vulnerability to falls, dependency levels, nutritional care, the risk of developing pressure sores and cognitive functioning.

The inspector reviewed a range of resident's care plans in detail and certain aspects within other plans of care. These included the files of residents with nutritional issues, behaviour that challenges and those with a high risk of falls and residents recently admitted.

Two of the residents recently admitted to the centre did not have a comprehensive assessment completed to identify all their care needs. Initial assessments to identify their moving and handling, dependency level and continence requirements were completed. The residents' were in the service six and eight weeks respectively.

The risk assessments completed were used to develop care plans that described the current care to be given. There was evidence care plans were updated at the required intervals or in a timely manner in response to a change in a resident's health condition. There was evidence of consultation with residents or their representative in all care plans reviewed of agreeing to their care plan when reviewed or updated.

Care plans for residents with dementia or behaviours that challenge required review to ensure they are more person centred. In some instances the inspector found that while the degree of confusion was outlined for example "severe cognitive decline" there was no information that indicated how this impacted on daily life. Information such as who the resident still recognised or what activities could still be undertaken which guide staff practice was not always evident.

The care plans addressed the medical needs of residents well. There was good linkage between the risk assessments completed and plans of care. However, care plans to meet the psychosocial needs of residents were not well developed. Each resident had an activity plan. These detailed social, cognitive and therapeutic needs based on their past

life histories. The activity plan was filed separately from nursing care plans and utilised by the activity coordinator. Other staff were unaware or unable to locate residents' activity care plans. The social needs of a number of the residents with intellectual disability were not being met adequately.

Residents had access to general practitioner (GP) services and there was evidence of medical reviews at least three monthly and more frequently when required. Medical records evidenced residents were seen by a GP within a short time of being admitted to the centre. A review of residents' medical notes showed that GP's visited the centre regularly.

Access to allied health professionals to include speech and language therapist, dietetic service, and psychiatry was available. The consultant psychiatrist and their team visit the centre as required to review residents. Medication is reviewed to ensure optimum therapeutic values. There was good evidence in care records of reviews and recommendation from the occupational therapist and physiotherapist.

There were three residents with pressure or vascular wounds at the time of this inspection. The inspector reviewed the care plan for one resident. Advice was obtained from a clinical nurse specialist in wound care. There was a plan of care outlining the type and frequency of dressing.

There was ongoing monitoring of residents nutritional and hydration needs. Each resident's weight was checked monthly. Staff monitored the food and fluid intake of residents identified with a nutritional risk. Fluid charts were totalled. Food intake records were well completed consistently. However, the amount of prescribed supplements taken was not recorded in food records.

Jugs of water were left into each bedroom in the morning. A significant number of bedrooms were vacant throughout the day and the water was not consumed. Fresh jugs of water were not provided in the evening for residents on retiring to their bedroom.

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):
No actions were required from the previous inspection.

Findings:
The inspector reviewed a policy for the managing of residents' personal property. It provided guidance to staff on the storage and care of residents' belongings. Property lists were completed.

There was evidence that residents had adequate space for their belongings, including secure lockable storage. Each resident was provided with their own wardrobe.

There was a good system in place to ensure all clothes were identifiable to each resident. The inspector checked items of clothing in residents' wardrobes and noted names were recorded on all clothing.

The laundry was suitable in size. Heavily soiled clothing was delivered in sealed bags. Soiled and washed clothing was segregated at all times. The laundry staff ironed clothes and retuned items in individual baskets to each unit. Care staff returned clothing to each resident's wardrobe.

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):
No actions were required from the previous inspection.

Findings:
The provider employs a whole-time equivalent of 11.77 registered nurses and 34.02 care assistants. In addition, there are catering, cleaning, laundry, maintenance and activity coordinators employed. The inspector viewed the staff duty rota for a two week period. The rota showed the staff complement on duty over each 24-hour period. The person in charge at all times was denoted on the rota. The staff roster detailed their position and full name. The inspector noted that the planned staff rota matched the staffing levels on duty. Throughout the inspection residents appeared to be very content with the staff members on duty. Staff demonstrated a good rapport and knowledge of the residents.

The inspector found there was an adequate complement of nursing and care staff with the proper skills and experience to meet the assessed needs of residents at the time of this inspection taking account of the purpose and size of the designated centre. However, staff levels require continuous review to ensure adequate resources to support residents participate in activities suitable to their capacity and life stage. There was limited sensory/cognitive or physical stimulation for residents in the large sitting room on the first floor particularly between 10:00 hrs and 12:30 hrs. This is the main sitting room utilised by the majority of residents. Residents were observed arriving from their bedrooms to sit in the day room until lunch time. This was observed by the inspector throughout the morning time on the two days of inspection. While there were a plentiful supply of newspapers, not all residents had meaningful engagement. The care staff were busy attending to the physical care needs of residents. As identified previously, the social needs of a number of the younger residents with intellectual disability were not being met adequately.

There was a detailed policy for the recruitment, selection and vetting of staff. It was reflected in practice. Recently recruited staff confirmed to the inspector they undertook an interview and were requested to submit names of referees and complete Garda Siochana vetting. They confirmed as part of their induction they were worked alongside another staff member as extra resource.

There was a training matrix available which conveyed that staff had access to ongoing education and a range of training was provided. In addition to mandatory training required by the Regulations staff had attended training on infection control, falls prevention, cardio pulmonary resuscitation techniques, medication management and food safety.

Judgment:
Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

PJ Wynne
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:	Esker Lodge Nursing Home
Centre ID:	OSV-0000135
Date of inspection:	14/07/2015
Date of response:	15/09/2015

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 deputy to the person in charge had reduced hours to oversee her role and responsibilities in clinical governance.

1. Action Required:
Under Regulation 23(a) you are required to: Ensure the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of

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

purpose.

Please state the actions you have taken or are planning to take:
Additional staffing resources were put in place to support the deputy PIC when she was completing clinical duties during that period. We now have a full quota of staff nurses and the deputy PIC is currently doing less clinical hours. However from time to time the deputy PIC will complete clinical hours to review care practices, identify areas for quality improvement programmes and based on residents and the centre's needs. The deputy PIC has some clinical duties included in her job description and will continue to do this as required.

Proposed Timescale: 15/09/2015

Outcome 07: Safeguarding and Safety

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
At the time of this inspection all staff were not trained in the management of behaviour that is challenging

2. Action Required:
Under Regulation 07(1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.

Please state the actions you have taken or are planning to take:
As discussed during the inspection the centre reviewed our challenging behaviour training programme and had already decided to train the staff in two models of managing challenging behaviour, one of the models being person centred and designed for residents with dementia. The Person Centred Care training was completed in 2014 and the other model, prior to the inspection, was scheduled to be completed between September and November 2015. This will proceed as planned.

Proposed Timescale: 30/11/2015

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The policy to guide staff action and intervention in responding to behaviours that challenge requires review as the model of behaviour management utilised by the centre and in which staff were being trained was not clearly defined in the policy.

3. Action Required:
Under Regulation 04(1) you are required to: Prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.

Please state the actions you have taken or are planning to take:
The challenging behaviour policy has been reviewed and now includes specific references to the model of behaviour management utilised by the centre and is linked to the training being delivered.

Proposed Timescale: 30/09/2015

Outcome 08: Health and Safety and Risk Management

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
On the first day of the inspection it was noted a number of window restrictors were not engaged on the first and second floor windows of the building

4. Action Required:
Under Regulation 26(1)(b) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the risks identified.

Please state the actions you have taken or are planning to take:
A full system wide review of window restrictors was conducted on each floor, some restrictors were replaced and all restrictors were checked to ensure they were properly installed.

Proposed Timescale: 15/09/2015

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:
Two of the residents recently admitted to the centre did not have a comprehensive assessment completed to identify all their care needs.

5. 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 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:
The assessments required on admission have been reviewed and a full comprehensive assessment is being completed for every new resident.

Proposed Timescale: 15/09/2015

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Care plans for residents with dementia or behaviours that challenge required review to ensure they are more person centred.

Care plans to meet the psychosocial needs of residents were not well developed.

6. Action Required:
Under Regulation 05(1) you are required to: Arrange to meet the needs of each resident when these have been assessed in accordance with Regulation 5(2).

Please state the actions you have taken or are planning to take:
Action 1: Care plans for residents with dementia or behaviours that challenge have been reviewed and are currently being updated.
Action 2: We have also reviewed how challenging behaviour is recorded and linked to daily records.

Proposed Timescale: Action 1 Jan 2016 and Action 2 15/09/2015

Proposed Timescale: 31/01/2016

Theme:
Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Fresh jugs of water were not provided in the evening for residents on retiring to their bedroom.

7. Action Required:
Under Regulation 18(1)(a) you are required to: Provide each resident with access to a safe supply of fresh drinking water at all times.

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

During the evening supper round staff will refresh the water jugs as required.

Proposed Timescale: 15/09/2015

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The social needs of a number of the residents with intellectual disability were not being met adequately.

8. 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:
There is a plan for both these residents to return to day care subject to discussions with relevant third party service providers.

Proposed Timescale: 30/11/2015

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The amount of prescribed supplements taken was not recorded in food records.

9. 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 relevant staff will be reminded to complete records on a timely basis to ensure that all prescribed supplements taken are recorded in food records.

Proposed Timescale: 31/10/2015

Outcome 18: Suitable Staffing

Theme:
Workforce

The Registered Provider is failing to comply with a regulatory requirement in

the following respect:
Staff levels require continuous review to ensure adequate resources to support residents participate in activites suitable to their capacity and life stage. There was limited sensory/cognitive or physical stimulation for residents in the large sitting room on the first floor.

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

Please state the actions you have taken or are planning to take:
We have reviewed the activity programme and revised it to increase the level of group activities in the morning. There are two additional groups for activities and one care assistant is now allocated to morning activities in the first floor sitting room.

Proposed Timescale: 15/09/2015