<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Moorehall Lodge</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000147</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Hale Street, Ardee, Louth.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>041 685 6990</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:sean.mccoy@mhliving.ie">sean.mccoy@mhliving.ie</a></td>
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<tr>
<td>Type of centre:</td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
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<td>Registered provider:</td>
<td>Moorehall Lodge Healthcare Services Limited</td>
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<tr>
<td>Provider Nominee:</td>
<td>Sean McCoy</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Siobhan Kennedy</td>
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<tr>
<td>Support inspector(s):</td>
<td>Sonia McCague</td>
</tr>
<tr>
<td>Type of inspection:</td>
<td>Unannounced Dementia Care Thematic Inspections</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>80</td>
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<td>Number of vacancies on the date of inspection:</td>
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About Dementia Care Thematic Inspections

The purpose of regulation in relation to residential care of dependent Older Persons is to safeguard and ensure that the health, wellbeing and quality of life of residents is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer and more fulfilling lives. This provides assurances to the public, relatives and residents that a service meets the requirements of quality standards which are underpinned by regulations.

Thematic inspections were developed to drive quality improvement and focus on a specific aspect of care. The dementia care thematic inspection focuses on the quality of life of people with dementia and monitors the level of compliance with the regulations and standards in relation to residents with dementia. The aim of these inspections is to understand the lived experiences of people with dementia in designated centres and to promote best practice in relation to residents receiving meaningful, individualised, person centred care.

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

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

The inspection took place over the following dates and times

From: 09 March 2016 09:00
To: 09 March 2016 19:00

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

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Provider’s self assessment</th>
<th>Our Judgment</th>
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</thead>
<tbody>
<tr>
<td>Outcome 01: Health and Social Care Needs</td>
<td>Substantially Compliant</td>
<td>Non Compliant - Moderate</td>
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<tr>
<td>Outcome 02: Safeguarding and Safety</td>
<td>Substantially Compliant</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 03: Residents’ Rights, Dignity and Consultation</td>
<td>Substantially Compliant</td>
<td>Non Compliant - Moderate</td>
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<td>Outcome 04: Complaints procedures</td>
<td>Compliance demonstrated</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 05: Suitable Staffing</td>
<td>Compliance demonstrated</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 06: Safe and Suitable Premises</td>
<td>Compliance</td>
<td>Substantially</td>
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</table>
Summary of findings from this inspection

The focus of the inspection was on the provision of dementia care. Inspectors evaluated the quality of care and life for residents with dementia living in two specific dementia care units in the centre.

Prior to the inspection the provider/person in charge had submitted a completed self assessment on dementia care to the Authority, together with relevant policies and procedures. The provider had assessed the compliance level of the centre as compliant or substantially compliant in relation to the six outcomes.

Inspectors met with residents and in particular, reviewed the provision of care for 4 residents. Care practices and interactions between staff and residents using a validated observation tool were observed and documentation such as care plans, complaints, medical records and information regarding staff working in the centre were examined. The findings are detailed under six outcomes in this report.

The matters arising from the previous inspection carried out on 22 October 2013 were followed up and found to be satisfactorily addressed.

In respect of the provision of dementia care the provider/person in charge measured the performance of the centre against the regulations as being compliant or substantially compliant and generated an action plan to achieve full compliance. Some of the actions had not been fully implemented.

On the day of the inspection 41 residents were assessed as having dementia including residents who had a cognitive impairment. Working with dementia care matters the organisation has adopted the “butterfly model” to create an environment and culture which focuses on residents’ quality of life. Accommodation was based on “the household model”.

The findings of the inspection highlighted the following: –

- Health-care needs of residents were primarily met with good access to medical and allied health care and a reduction in fall/accidents. However, improvements were required in relation to medication management, care planning in respect of behaviours that are challenging and record-keeping.
- Measures to protect residents with dementia being harmed or suffering abuse were in place, however, moving and handling practices were not reflective of the training provided and current guidance.
- The quality of interactions/engagement for the periods observed were mixed and ranged from the facilitation of meaningful interaction and engagement with residents to the delivery of services which was passive and not stimulating.
- The management and recording of complaints was satisfactory.
- There were sufficient staff to meet the needs of residents, however, staff did not have appropriate training.
- The household of one of the dementia specific units was undergoing refurbishment, while the environment of the other dementia specific unit was appropriate for
Inspectors found the service to be moderate non compliant in four of the outcomes. The areas of non-compliance are detailed in the action plan 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):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
This outcome sets out the inspection findings relating to healthcare. The social care of residents with dementia is covered in Outcome 3.

Matters arising from the previous inspection which primarily related to documentation had been satisfactorily actioned.

The provider/person in charge had assessed the provision of health and social care to be substantially compliant and were seeking to find additional measures to ensure that residents are able to participate as far as practicable in the care planning process. This matter was in progress.

Overall there were arrangements in place to meet the health and nursing needs of residents with dementia. Pre-admission (with the exception of one) and admission assessments were carried out and care plans developed. These were detailed to support the delivery of consistent care and there was evidence of residents and relatives involvement in the care planning process, however there were gaps in some of the records. The nutritional and hydration needs of residents with dementia were met. None of the residents had pressure sores, incidents of falls were low and appropriate interventions were in place for residents at a risk of weight loss. Medicines were not administered in accordance with the centre’s policy/procedure.

Inspectors focused on the experience of residents with dementia and they tracked the care of four residents with dementia.

Residents had access to general practitioners (GPs) of their choice, and to allied healthcare professionals including dietetic, physiotherapy, speech and language, dental, ophthalmology and podiatry services. Residents had access and onsite visits from the psychiatry of later life team and the community palliative care team. Inspectors noted
that some residents’ seating was not appropriate, however, a seating referral had not been made to the community occupational therapist.

There were systems in place to optimise communications between the resident/families, the acute hospital and the centre. Prospective residents and their families were invited to visit the centre and meet other residents and staff before making the decision to live there. The person in charge visited prospective residents in hospital prior to admission. This gave the resident and their family information about the centre and also to ensure that the service could adequately meet the needs of the resident. Pre assessment documentation (with the exception of one) was available for inspection. These provided good information.

Residents’ records were available and contained copies of discharge letters/correspondence from hospital. Inspectors noted that the files of residents admitted under Fair Deal did not have Common Summary Assessments (CSARS) which detailed the assessments undertaken by a geriatrician, a medical social worker and a comprehensive nursing assessment.

Inspectors examined the files of residents who were transferred to hospital from the centre and found that the transfer letter contained information about the resident’s health, medicines and personal information. Relatives were informed if a resident was transferred to hospital.

On admission, general information had been recorded, under a heading “core resident details” however, the details of a resident’s next of kin and or any person authorised to act on the resident’s behalf had not been fully detailed and in some instances the family member to be contacted during the night was omitted. Residents had a nursing assessment on admission and a property list completed, however, in some instances, the signature of the assessing nurse and the staff member completing the property list had been omitted. A manual handling assessment/chart found in a resident’s bedroom (dated 4 July 2014) did not correspond with the up to date assessment in the resident’s care plan dated 5 December 2015.

The assessment process involved the use of validated tools to assess each resident’s risk of malnutrition, falls, dependency level and their skin integrity. There was also a pain level monitoring tool for residents who were non-verbal. An assessment of residents’ level of cognitive function was undertaken.

A care plan was developed within 48 hours of admission based on the resident’s assessed needs. The care plans contained the required information to guide the care of residents and the relevant records as per the schedule, for example residents’ weights, referrals to allied health professionals and specialist communication needs.

Inspectors did not see the standardised assessment tool entitled the “Cohen Mansfield agitation inventory” (a seven-point rating scale for assessing the frequency with which residents show certain behaviours) referred to in the policy entitled Meeting the Needs of Resident’s with Behaviour that Challenges.

While there was a care plan in place in respect of one of the behaviours displayed by a
resident that was challenging, care plans were not devised for other behaviours identified.

Care plans were in place in respect of residents’ social and recreational activities which identified their preferences and in some cases this was linked to a reduction in the residents’ behaviours that were challenging. However, there was no evidence of the level of involvement by the resident in these social and recreational activities. See also Outcome 3.

Care plans were updated routinely on a four monthly basis. The review in the majority of cases was comprehensive and stated that the review had taken place and were updated to reflect residents' changing care needs to include the amended/new care interventions. However, in some instances there was only the review date with no narrative/information and no evidence that it was revised in consultation with the resident concerned and where appropriate the resident’s family.

There was documentary evidence that some residents and relatives, where appropriate had provided information to inform the assessments and the care plans. Each care plan had a section for the resident’s dietary likes and dislikes and information about resident’s routines.

Staff provided end of life care to residents with the support of their general practitioner and the community palliative care team. No residents were under the care of the community palliative care team at the time of inspection. One of the care plans examined had an end of life care plan that outlined the resident’s preferred setting for delivery of care. Single rooms were available for end of life care.

Residents were risk assessed and measures put in place to prevent pressure sores developing and appropriate treatment plans, including the assistance and advice of specialist tissue viability services were in place for those who were at high risk. Residents with diabetes were managed by the GP and referred to the diabetic clinic where appropriate. Staff described the procedure for measuring residents’ blood glucose levels.

All residents were screened for risk of falls on admission and regularly reassessed thereafter. Care plans were in place based on the assessment and amended following a fall. Interventions were put in place to prevent a reoccurrence and to mitigate the risk of injury from falls and a system was in place to review accidents and incidents within the centre. Inspectors analysed the incident reports and found that the incidence of falls was low. Neurological observations were undertaken when a resident had an un-witnessed fall or if there was any risk of a head injury.

Health was promoted and residents had been offered the flu vaccine. Good hand hygiene practices were observed.

Residents had access to the local pharmacist and the pharmacist was available to meet with residents if required. The pharmacist undertook audits of medication practices. Medicinal products had been secured safely.

There were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents, however medicinal products were not administered in accordance with the directions of the prescriber of the residents concerned as follows: –
• The administration times did not match the prescription times.
• The staff member administering medicines omitted signing the administration sheet.
• Medicines were crushed but had not been prescribed to be taken in this way.
• In all instances, comments were not made in respect of residents who refused medicines.

Systems to ensure residents' nutritional needs were met accorded with the centre’s policy. Records showed that the majority of residents were weighed monthly and more regularly if required. Residents were risk assessed on admission and regularly thereafter. 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. Some residents were on supplements which were prescribed and administered appropriately. Information about dietary intake was reported in the daily nursing notes.

There was an effective system of communication between nursing and catering staff to support residents with special dietary requirements. Inspectors found that residents on weigh reducing, diabetic, high protein and fortified diets, and also residents who required modified consistency diets and thickened fluids received the correct diet.

**Judgment:**
Non Compliant - Moderate

### Outcome 02: Safeguarding and Safety

**Theme:**
Safe care and support

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

**Findings:**
The provider/person in charge had assessed that the service was substantially compliant in relation to safeguarding and safety and aimed to review the policies and procedures and establish opportunities for the staff and family members to explore this area. These matters were in progress.

There was a policy/procedure in place for the prevention, detection and response to abuse which reflected the National Policy ‘Safeguarding Vulnerable Persons at risk of Abuse’ 2014.

Currently there were no ongoing investigations, however, the provider/person in charge were knowledgeable of the investigation process.

Staff who spoke with inspectors were knowledgeable about the various types of abuse, recognising abuse, and were familiar with the reporting structures in place. An examination of the training records identified that staff had access to and participated in
training in the protection of residents from abuse.

There was a policy on behaviour management which emphasises a positive approach to the behaviours and psychological symptoms of dementia (BPSD).

Assessment and care planning in relation to behaviours that challenge are detailed in outcome 1.

From discussions with staff and scrutiny of the training records provided staff had not received sufficient education and training to enable them to manage and respond to behaviour that is challenging in accordance with the designated centre’s policy/procedure on behaviour management.

There was evidence that residents who exhibited behaviours that challenge had been reviewed by the GP and psychiatry of later life.

A restraint free environment was promoted, however all staff did not have a comprehensive understanding of restrictive practices. See outcome 5 for action plan. Risk assessments were carried out prior to the use of bedrails. This included the trial of alternative methods in consultation with a multidisciplinary team. A risk register was in place. Some integrated full length bedrails were used however, inspectors saw that other equipment/devices were used for example enabling bars to assist residents to move in bed, and in some instances these were used in conjunction with a single integrated bed rail. The bedrails had bumpers for protection and safety. On the day of the inspection the majority of residents were up and about during the day and lap belts were used for some residents who were using wheelchairs. A resident who was the focus of the inspection and who was at risk of wandering had free access within the designated centre and could access the garden. Incidents where restraint was used were notified to the Authority in accordance with the regulation. As per the “use of resident restraint policy” a resident had been assessed and was provided with the door code to allow freedom of movement between houses.

Although measures were implemented to prevent accidents and injuries, for example extending the hours that staff work, inspectors saw that staff were not putting into practice the up to date guidance and training in respect of moving and handling residents.

The centre maintained day to day expenses for some residents and there was a policy on the security of resident’s accounts. In respect of those accounts examined transactions were appropriately documented and lodgements and withdrawals were co-signed by 2 staff members or the resident and a staff member. See also outcome 3.

**Judgment:**
Non Compliant - Moderate
**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 provider/person in charge had assessed that the service was substantially compliant in relation to residents' rights and aimed to have a household specific family forum and develop a local independent advocacy service. These matters were in progress. Inspectors saw that meetings had taken place in August and September 2015 and that an advocate had visited the households to communicate with residents.

The philosophy of care was based on the “butterfly model”, (“to create an environment and culture which focuses on quality of life, breaking down institutional barriers and task driven care, focusing strongly on the principle that feelings matter most and that this emphasis on relationships forms the core approach”) however, all staff were not totally familiar with the model.

Staff worked to ensure that residents received care in a dignified way that respected their privacy and were observed knocking on bedroom and bathroom doors prior to entering.

There was evidence that residents were involved in the consultation process and had participated in the organisation of the centre. For example “learning circles” were held which invited residents to participate in a meeting regarding the day-to-day management of the centre.

Inspectors saw that there were 2 choices prepared for the lunchtime meal and residents were verbally asked for their preference. However, for those residents who had communication difficulties the visual options were not presented to the residents so that an informed choice could be made.

The lunchtime meal in the sitting/dining room was a social occasion, however a staff member stood with a resident while providing encouragement and assistance with the meal.

The inspectors reviewed the systems in place to manage residents' personal possessions. A record of residents’ personal processions was available in the residents’ care plans, however, on examination some items of clothing described in the records were not available.

The record did not state whether furniture had been brought by a resident into the bedroom occupied by that resident regulation.
The hanging space in the wardrobes was sufficient for residents to store and maintain their clothes. Residents were able to receive visitors in private either in their own bedrooms or in a designated visitor’s area. There were no restrictions on visitors. There was an up to date current directory of visitors available.

There were opportunities for religious practices.

Inspectors noted that meaningful activities assessment was carried out in respect of residents and for one of the residents who was the focus of the inspection this entailed participating in bus trips, attending music and art sessions, visiting neighbours in nearby households, flower arranging and household activities. Inspectors did not see evidence of the resident's participation in these activities and therefore could not judge if the charge for social and recreational activity provision had a good outcome for the resident.

Inspectors noted in the contract of care/written agreement record that residents were not presented with a choice to opt out of the charge for social and recreational activity provision.

The development of life story work was an area for improvement.

Some residents had opportunities to participate in meaningful activities, appropriate to their interests and preferences, however other residents did not have these opportunities. Inspectors observed the quality of interactions between staff and residents using a validated observational tool to rate and record the quality of interactions between staff and residents at five minute intervals, in the sitting/ dining room at various times.

The definition of the scoring for the quality of interactions for the period observed is as follows: –

• +2 positive connective care – the facilitation of meaningful interaction and engagement with residents.
• +1 task orientated care – the provision of kind physical care, whereby interactions/conversation is more instructive.
• 0 neutral care – the delivery of services is passive and not stimulating.
• -1 protective and controlling-provision of individual care with the emphasis on safety and risk aversion.
• -2 institutional, controlling care – regarding residents as a homogeneous group who will fit into the established routine of the designated centre/home.

The scores reflect the effect of the interactions on the majority of residents for the period observed. While there was evidence of positive connective care with residents (58% of this was for a period of 40 minutes in a household where residents were involved in a variety of activities including making cards for St Patrick's Day, and other arts and crafts), 25% was neutral care and 17 % of the time staff provided good quality task oriented care, which mostly related to assisting with food or drinks or personal care (this related to a one hour period in a household).
**Outcome 04: Complaints procedures**

**Theme:**  
Person-centred care and support

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

**Findings:**  
There was a system in place to ensure that the complaints of residents with dementia or their representatives were listened to and acted upon, and they had access to an appeals procedure.

There was a complaints policy and procedure. This detailed the process. The information was publicised and there was a summary available in the resident’s guide.

In addition, to the designated complaints officer there was a designated person who would review the complaint and investigation process should a complainant be dissatisfied with the outcome.

Residents who communicated with the inspectors were familiar with the management team and could approach any staff member with any concern or complaint.

Inspectors reviewed the complaints records on file since the last inspection and found that details were maintained about each complaint, the investigation into the complaint and the action taken as a result of the complaint. There was documentation regarding the satisfaction or otherwise of the complainant with the outcome of the investigation.

At the time the inspection a complaint was being investigated.

**Judgment:**  
Compliant

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**Outcome 05: Suitable Staffing**

**Theme:**  
Workforce

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

**Findings:**
The provider/person in charge had assessed staffing to be compliant.

The recruitment procedures in place were satisfactory. This process included induction and probationary periods for staff. An examination of randomly selected documentation in relation to staff working in the designated centre found that all of the information identified in schedule 2 was available.

Inspectors examined the duty roster for the day of the inspection and found that the staff numbers and skill mix was adequate to meet the needs of residents. There was a planned staff roster in place, with changes clearly indicated. The staffing in place on the day of inspection was reflected in the roster. This consisted of carers, homemakers, housekeeping staff and registered nurses.

There were a variety of meetings scheduled in order to ensure that staff of various grades had appropriate knowledge to deliver services to residents. This included handover meetings at the change of shifts, staff meetings and performance management meetings.

Inspectors found that while there were opportunities for staff to participate in education and training relevant to their role and responsibility some staff had not completed necessary training or required refresher training for example in the philosophy of care based on the “butterfly model”, moving and handling, dementia training, falls prevention, restrictive practices and first aid/CPR.

There was evidence of good verbal communication between staff, residents and relatives and staff who communicated with the inspectors were knowledgeable of residents’ conditions and preferences.

Management were familiar with the regulations in respect of having volunteers working in the designated centre.

**Judgment:**
Non Compliant - Moderate

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**Outcome 06: Safe and Suitable Premises**

**Theme:**
Effective care and support

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

**Findings:**
In general, the design and layout of the centre was suitable for its stated purpose and met residents’ individual and collective needs in a comfortable and homely way.

However one of the households was being refurbished. Inspectors saw that aspects of the premises had deteriorated since the previous inspection for example:
- Chipped paint on the walls and furnishings in residents’ bedrooms and communal areas were worn.
- A toilet facility was ill-equipped for residents’ use.

Management informed the inspectors that it is anticipated that the refurbishment work will be completed by Easter 2016.

The 2 households which formed the focus of the inspection each have their own front door, domestic style kitchen with open plan sitting and dining room. The living environment is centred around the kitchen. Areas have been developed for sonas (sensory) activation programmes. The majority of bedrooms are single with some or full ensuite facilities. There were sufficient bathrooms, clinical and sluicing facilities.

The lack of storage was identified in one of the households, particularly in relation to the following: –
- Residents’ records were stored in a secure system, however, this was located in an area where it necessitated moving residents who were in wheelchairs in order to access the records.
- The corridors were not kept clear in accordance with the designated centre’s “use of resident restraint policy” as the hoist was stored in the corridor and obstructed access to reminiscent items and could possibly be a trip hazard.
- Communal bathrooms/toilet facilities were used for storage.

There was evidence to show that equipment was routinely serviced.

Each resident had a lockable storage space/secure facility for the safekeeping of residents’ personal valuables. The bedrooms had profiling beds and in some bedrooms there were pressure relieving mattresses. The inspectors visited a number of bedrooms and found that they were personalised with residents’ mementos.

**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:**

Siobhan Kennedy  
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

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<td>OSV-0000147</td>
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<tr>
<td>Date of inspection:</td>
<td>09/03/2016</td>
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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 Registered Provider is failing to comply with a regulatory requirement in the following respect:
The standardised assessment tool entitled the “Cohen Mansfield agitation inventory” (a seven-point rating scale for assessing the frequency with which residents show certain behaviours) referred to in the policy entitled Meeting the Needs of Resident’s with Behaviour that Challenges was not being used.

1. Action Required:

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
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 Cohen Mansfield inventory which is in our policy now replaces the behavioural assessment tool previously used. Briefings and training in usage and scoring are being undertaken by staff nurses.

**Proposed Timescale:** 30/04/2016

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Pre assessment documentation was not available for one resident.

**2. 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:**
It is our practice to undertake pre assessments on all new admissions. In this instance a pre assessment was completed prior to admission however due the length of stay for that particular resident the pre-assessment form was archived. Never the less, we have audited all of our care records and as a result all pre admission forms are now in current care records.

**Proposed Timescale:** 22/03/2016

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
While there was a care plan in place in respect of one of the behaviours displayed by a resident that was challenging, care plans were not devised for other behaviours identified.

**3. 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:**
This issue was reviewed and discussed with all nurses 22nd March 2016. Further development of care plans were discussed and agreed to ensure a more comprehensive
detailing of behaviours that challenge.

PIC/Care Manager to audit and spot check care plans to ensure compliance.

**Proposed Timescale:** 31/05/2016

**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 evidence of the residents' level of involvement in the social and recreational activities following assessment.

In some instances, the care planning review documentation only showed the review date with no narrative/information and no evidence that it was revised in consultation with the resident concerned and where appropriate the resident’s family.

**4. 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:**
1. Care plan audits completed. A new template evidencing individual involvement in social and recreational activities developed and implemented.
2. We do evidence Care plan review outcomes and comments in communication section of care records. As a result of this inspection a new template for care plan review has been implemented to evidence the outcome of the care plan review and the participation of the resident and family members.
3. Practice change required by Nurses from the 1st April 2016 and all care plan reviews will be updated by the 1st August 2016.

Proposed Timescale:
1. To be completed by the 30th April 2016
2. Completed 21st March 2016
3. To be completed by the 1st August 2016

**Proposed Timescale:** 01/08/2016

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
A seating referral had not been made to the community occupational therapist for assessment of specialised and general.
5. **Action Required:**
Under Regulation 06(2)(c) you are required to: Provide access to treatment for a resident where the care referred to in Regulation 6(1) or other health care service requires additional professional expertise.

**Please state the actions you have taken or are planning to take:**
We make referrals to community occupational therapists as the need emerges. Since the day of the inspection a review of residents including general seating needs was initiated and due to be completed 30th April 2016.

**Proposed Timescale:** 30/04/2016

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The files of residents admitted under Fair Deal did not have Common Summary Assessments (CSARS) which detailed the assessments undertaken by a geriatrician, a medical social worker and a comprehensive nursing assessment.

The details of a resident’s next of kin and or any person authorised to act on the resident’s behalf had not been fully detailed and in some instances the family member to be contacted during the night was omitted.

In some instances, the signature of the assessing nurse completing the admission assessment and the staff member completing the property list had been omitted.

A manual handling assessment/chart found in a resident’s bedroom (dated 4 July 2014) did not correspond with the up to date assessment in the resident’s care plan dated 5 December 2015.

6. **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:**
1. CSARS now forms part of our preadmission information pack.
2. Staff to complete fully all parts of the contacts list and to include 2nd & 3Rd significant others contact addresses.
3. Property inventory template update. All staff briefed through nurses meetings, team leader meetings and team meetings of the proper application of our policy and procedure for Management of Residents Personal Belongings.
4. All manual handling assessment charts are now stored in one place in the residents care records.

**Proposed Timescale:**
1. Effective from the 1st April 2016.
2. To be completed by 30th May 2016
3. To be completed by the 30th May 2016
4. Completed 1st April 2016

**Proposed Timescale:** 30/05/2016

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Medicinal products were not administered in accordance with the directions of the prescriber of the residents concerned as follows: –
- The administration times did not match the prescription times.
- The staff member administering medicines omitted signing the administration sheet.
- Medicines were crushed but had not been prescribed to be taken in this way.
- In all instances, comments were not made in respect of residents who refused medicines.

7. **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:**
1. We attempt to balance being person centred and compliance every day. Where appropriate and in discussion with GP’s prescription times and MAR sheet have been changed to reflect resident and compliance needs/requirements.
2. Staff member on duty administering medications at the time of the inspection has had supervision to reflect on practice. A reassessment of competency assessment completed. Outcomes of inspection also discussed at staff nurses meeting.
3. It is our policy to only administer crushed medicines following prescription from a GP. In this instance crushed medicines were prescribed together with rationale for being crushed however individual medicines requiring crushing had not been signed by the GP. This omission was corrected within 24 hrs of the inspection. To prevent a repeat, this issue was discussed at the staff nurses meeting on the 22nd March 2016. PIC/Care Manager to undertake regular audits undertaken to monitor adherence to our policy.
4. Record of resident refusing medication is recorded on the MAR Sheet however comments had not been recorded in the daily progress notes. This issue was discussed in staff nurses meeting on the 22nd March. A new template record of residents right to refuse will be implemented by 30th April 2016.

Proposed Timescale:
1. Completed 28th March 2016
2. Completed by 22nd March 2016
3. Completed by 22nd March 2016
4. 22nd March 2016 and the 30th April 2016
**Proposed Timescale:** 30/04/2016

<table>
<thead>
<tr>
<th><strong>Outcome 02: Safeguarding and Safety</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theme:</strong> Safe care and support</td>
</tr>
<tr>
<td><strong>The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:</strong></td>
</tr>
<tr>
<td>Staff had not received sufficient education and training to enable them to manage and respond to behaviour that is challenging in accordance with the designated centre’s policy/procedure on behaviour management and the regulations.</td>
</tr>
<tr>
<td><strong>8. Action Required:</strong></td>
</tr>
<tr>
<td>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.</td>
</tr>
<tr>
<td>Please state the actions you have taken or are planning to take:</td>
</tr>
<tr>
<td>Training in the management and responding to behaviours that challenge is part of our annual training plan. There is a rolling programme in place which commenced for 2016 on the 22nd February 2016 and continues planned dates throughout 2016.</td>
</tr>
</tbody>
</table>

**Proposed Timescale:** 31/12/2016

| **Theme:** Safe care and support |
| **The Registered Provider is failing to comply with a regulatory requirement in the following respect:** |
| Staff were not putting into practice the up to date guidance and training in respect of moving and handling residents. |
| **9. Action Required:** |
| Under Regulation 08(1) you are required to: Take all reasonable measures to protect residents from abuse. |
| Please state the actions you have taken or are planning to take: |
| 1. This issue was discussed with staff in the days immediately after the inspection and again formally on the 22nd March 2016. Practice and techniques as per our training and policy reinforced. |
| 2. To ensure compliance with our policy observations undertaken by the PIC and care manager on at least four occasions since the date of the inspection. We plan to continue with these across the 24hr clock and into other households. |
| Proposed Timescale: |
| 1. Completed 22nd March 2016 |
| 2. To be completed by 30th April 2016 |
Proposed Timescale: 30/04/2016

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:
There were 2 choices prepared for the lunchtime meal and residents were verbally asked for their preference. However, for those residents who had communication difficulties the visual options were not presented to the residents so that an informed choice could be made.

10. Action Required:
Under Regulation 09(3)(a) you are required to: Ensure that each resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.

Please state the actions you have taken or are planning to take:
We are very conscious of our responsibility to ensure we do not make assumptions regarding individual resident capacity to make decisions and express choice. All staff are reminded of the importance of this and to always facilitate informed choice. Through observations adherence to this is monitored.

Proposed Timescale: 10/03/2016

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some residents did not have opportunities to participate in meaningful activities, appropriate to their interests and preferences.

Life story work was an area identified for further development.

11. 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:
1. This issue we believe relates to a small number of residents who experienced neutral care on the day of the inspection. Our model of care approach reinforced to all staff and through observations validation of improvements evidenced.
2. Following an audit on life stories two residents did not have a completed life story. For one resident it was a stated preference of the family and for the 2nd resident it is now completed. All other residents had a life story either outside their rooms and/or in the care records.
Proposed Timescale:

1. Completed 22nd March 2016
2. Completed 1st April 2016

Proposed Timescale: 01/04/2016

Theme:
Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A record of residents’ personal processions was available in the residents’ care plans, however, on examination some items of clothing described in the records were not available.

12. Action Required:
Under Regulation 12(a) you are required to: Ensure that each resident uses and retains control over his or her clothes.

Please state the actions you have taken or are planning to take:
1. Property inventory template updated. All staff briefed through nurses meetings, team leader meetings and team meetings of the proper application of our policy and procedure for Management of Residents Personal Belongings.
2. Through Household family forums and through direct communication, all families to be reminded of the importance to inform staff when residents receive new or remove any existing personal belongings.

Proposed Timescale: 31/05/2016

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The record of residents’ personal processions did not state whether furniture had been brought by a resident into the bedroom occupied by that resident.

The charge for activity provision was not clearly defined in the written contract and it was not clear if residents had a choice to opt out of this part of the agreement.

In respect of a resident who was the focus of the inspection the evidence was not available to determine the resident's participation in social and recreational activities.

13. 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:
1. Property inventory template updated. All staff briefed through nurses meetings, team leader meetings and team meetings of the proper application of our policy and procedure for Management of Residents Personal Belongings.
2. The Contract of Care does clearly set out the activity fee and this was pointed out the day of inspection. On previous inspections it was judged that our Contract of Care was compliant and it has not been amended since the previous inspection.
3. A revised individualised evidence template has been created.

Proposed Timescale:
1. To be completed by the 31st May 2016
2. Completed 10th March 2016
3. To be completed 31st May 2016

Proposed Timescale: 31/05/2016

Outcome 05: Suitable Staffing

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some staff had not completed necessary training or required refresher training for example in the philosophy of care based on the “butterfly model”, moving and handling, dementia training, falls prevention, restrictive practices and first aid/CPR.

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

Please state the actions you have taken or are planning to take:
1. We are reviewing our annual training plan to redefine where appropriate what we classify as core mandatory training and best practice training. As a minimum all staff to undergo core mandatory training.
2. We have a rolling training programme which incorporates Butterfly model (dementia training), restrictive practices, enablers, moving and handling and falls prevention. These topics will form part of monthly team meetings.
3. As a core part of management team function together with the training lead, unannounced spot checks to be undertaken to assess staff’s comprehension, understanding and resulting practice.

Proposed Timescale:
1. 30th April 2016
2. 31st August 2016
3. 30th April and quarterly thereafter.
## Proposed Timescale: 31/08/2016

### 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:**
Aspects of the premises had deteriorated since the previous inspection for example:
- Chipped paint on the walls and furnishings in residents’ bedrooms and communal areas were worn.
- A toilet facility was ill-equipped for residents’ use.

The lack of storage was identified as the following was noted: –
- Residents’ records were stored in a secure system, however, this was located in an area where it necessitated moving residents who were in wheelchairs in order to access the records.
- The corridors were not kept clear in accordance with the designated centre’s “use of resident restraint policy” as the hoist was stored in the corridor and obstructed access to reminiscent items and could possibly be a trip hazard.
- Communal bathrooms/toilet facilities were used for storage.

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

**Please state the actions you have taken or are planning to take:**
1. On the day of the inspection refurbishment of one of the households assessed was being undertaken. The refurbishment and decoration of the immediate area including furniture has been completed. Monthly audits of buildings and furnishing in place.
2. The toilet facility identified was repaired on the day after the inspection.
3. Due to the refurbishment of the household, the storage space for the care records was relocated temporarily. This was explained on the day of the inspection and was relocated back once refurbishment was completed.
4. Hoists are stored in designated areas.
5. On the night before of the inspection, night staff had removed “butterfly stuff” ready for decorating and were temporarily stored in a bathroom. This was resolved on the day of the inspection.

**Proposed Timescale:**
2. Completed 11th March 2016
5. Completed 9th March 2016
Proposed Timescale: 25/03/2016