

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	D'Alton Community Nursing Unit
Centre ID:	OSV-0000643
Centre address:	Claremorris, Mayo.
Telephone number:	094 936 2727
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Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Julie Silke Daly
Lead inspector:	Mary McCann
Support inspector(s):	None
Type of inspection	Unannounced Dementia Care Thematic Inspections
Number of residents on the date of inspection:	26
Number of vacancies on the date of inspection:	4

About Dementia Care Thematic Inspections

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

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

Please note the definition of the following term used in reports:
responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor compliance with specific outcomes as part of a thematic inspection. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
20 February 2017 11:00	20 February 2017 19:30
21 February 2017 11:00	21 February 2017 15:00

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

Outcome	Provider's self assessment	Our Judgment
Outcome 01: Health and Social Care Needs	Non Compliant - Moderate	Non Compliant - Moderate
Outcome 02: Safeguarding and Safety	Substantially Compliant	Substantially Compliant
Outcome 03: Residents' Rights, Dignity and Consultation	Substantially Compliant	Non Compliant - Moderate
Outcome 04: Complaints procedures	Substantially Compliant	Substantially Compliant
Outcome 05: Suitable Staffing	Substantially Compliant	Non Compliant - Moderate
Outcome 06: Safe and Suitable Premises	Substantially Compliant	Substantially Compliant
Outcome 07: Health and Safety and Risk Management		Substantially Compliant
Outcome 09: Statement of Purpose		Compliant

Summary of findings from this inspection

This was an unannounced inspection with a special focus on the provision of dementia care. The inspector focused on six outcomes that had direct impact on dementia care and followed up on the seven actions from the previous inspection which was completed in March 2015. All actions detailed from the last inspection had been reviewed however actions with regard to the risk management policy and the provision of meaningful activities required further input.

The centre does not have a dementia specific unit. At the time of this inspection, of the 26 residents accommodated, nine had a formal diagnosis of dementia and five

others had a mild to moderate cognitive deficit. No resident was under 65yrs of age. As part of the inspection, the inspector spent a period of time observing staff interactions with residents using a validated observational tool (the quality of interactions schedule, or QUIS) to rate and record the quality of interactions between staff and residents in the sitting and dining room. Overall, the inspector observed staff generally interacted with residents in a positive and caring manner. However, there were also a number of neutral, task orientated activities where staff did not utilise the time accompanying residents to the dining room or as they passed through the sitting room to positively engage with residents. Additionally staff were not available at all times for supervision in the sitting room. There was no organisational process in place to ensure that a staff member was available for supervision in the sitting room even though this was the only communal area in operation on the days of inspection.

Residents spoken with by the inspector were complimentary of the service provided and stated "we are well looked after, the food is good, staff are good to us, they help me".

A Mental State assessment is completed on most residents on admission. This assessment looks at memory or other mental abilities and helps to diagnose dementia and assess its progression and severity. It is also used to assess changes in a person who has already been diagnosed with dementia and can help to give an indication of how severe a person's symptoms are and how quickly their dementia is progressing.

At the request of the Health Information and Quality Authority (HIQA), the person in charge had submitted a self-assessment on dementia care together with relevant policies and procedures. This documented the compliance level to be moderately non compliant with regard to provision of Health and social care needs, substantially complaint with regard to safeguarding and safety, premises, staffing, residents rights dignity and consultation and complaints management.

Residents were well known by staff, and while the care needs of residents with dementia were met, improvements were required to activity provision, the environment and documentation regarding the delivery of care. While an activities room, a spiritual room, and a quiet day room were available these were not been utilized for activities. These would provide a quiet calm area which is more conducive to good dementia care, than the current arrangements of all residents accommodated for most of their day in the sitting room area. This and other areas which are not in compliance with the Health Act 2007 (Care and Welfare of residents in Designated Centres for Older People) Regulations 2013 are discussed further throughout the report, and areas which need to be addressed are contained in an action plan at the end of this report.

Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

Outcome 01: Health and Social Care Needs

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

This outcome relates to assessment and care planning, access to healthcare and also encompasses nutritional care and end of life care. The inspector followed the pathway of four residents with dementia and tracked the journey from referral, to admission, to living in the centre. All aspects of care provided to include physical, psychological, social and emotional care was reviewed. An admission policy was available. Pre-admission assessments were completed to identify residents' individual needs and choices and to plan an orderly admission to the centre. The centre would accept emergency admissions in exceptional circumstances. Residents' hospital discharge documentation was available and there was evidence of communication with family members and the referring agency/person. Observations such as blood pressure, pulse and weight were assessed on admission and according to assessed need thereafter.

Comprehensive assessments and a range of additional risk assessments had been carried out for residents on admission. Care and medical records and other records, relating to residents and staff, were maintained but on review, the inspector found that some care records were poorly completed and some care plans lacked sufficient detail to guide care and conflicted with other care plans. For example, when care plans were reviewed and changes made to the care regime, the previous care plan was not amended or discontinued. There were examples of where there were two care plans in place for the same identified need but both were very different. On regular occasions, narrative notes were recorded under the intervention section of the care plan which showed a misunderstanding of the care plan process.

While a care plan audit had been completed and deficits identified no quality improvement plan was enacted to address the deficits. Additionally the audit did not evaluate the content of the care plan and whether it was comprehensive enough to address the need identified. The person in charge informed the inspector that additional time was being arranged for nurses to spend more time on care planning and a mentorship approach was being put in place to assist some staff.

There were no designated care plans in place with regard to dementia care for example

detailing the abilities of residents' and ensuring that independence was maintained and nurtured. Also care plans did not detail the effect the dementia had on the functioning of the resident or what process should be adapted to mitigate this.

While arrangements were in place to evaluate care plans every four months, this was not consistently occurring and the evaluation failed to ensure the care plan was revised to reflect the residents' changing needs. For example, there was some documentation in place where end of life decisions had been changes but it was difficult to illicit which decision was current. Additionally, there was poor evidence available that residents and or their family, where appropriate, participated in reviews of the care plans. In some files reviewed personal calendar were poorly completed or blank and narrative noted were medical in nature with poor recording of social or psychological care.

Where residents were identified as been at risk nutritionally they were referred to a dietician and those who had an impaired swallow were reviewed by a speech and language therapist. Care was provided according to the recommendation of the specialist although this information was often not included in the nutritional care plans. There was poor linkage between some assessments completed and the care plan. There was a choice of meals provided and residents on modified diets were given the same choice as other residents. Staff sat beside the resident to whom they were giving assistance and were noted to chat and interact well with the resident and gently encourage the resident throughout their meal. A list of residents on special diets including diabetic, high protein and fortified diets, and also residents who required modified consistency diets and thickened fluids was available to catering staff.

Residents had access to the psychiatry of later life team who visited the centre as required. There was also good access to General Practitioners (GP) and residents were facilitated to keep their own GP on admission to the centre. The inspector found that residents had good access to allied healthcare professionals including dieticians, speech and language therapy and chiropody. A physiotherapist came to the centre every week and an occupational therapist also attended as required. A system was in place to ensure that residents with glasses had their eyes tested two years. Dental referrals were actioned as required. No residents had a wound on the days of inspection.

Residents at risk of falling were assessed using a validated falls assessment tool. Care plans were developed, however on talking with staff the care did not reflect the care that was in place for the resident. For example, the care plan often did not identify that a chair alarm was in place or what procedures staff should enact on assisting a resident to bed. Evidence was available that post-fall observations, including neurological observations, were undertaken to monitor neurological function after a possible head injury as a result of a fall.

Systems were in place to prevent unnecessary hospital admissions. Staff had been trained in sub-cutaneous fluid administration and the centre described good links with the palliative care team. Transfers and discharge of residents and hospital admissions were well managed with good evidence available of effective communication between the centre and acute care services when a resident was being transferred for care. Staff informed the inspector that they forwarded a transfer letter and a copy of the

medication chart.

There was a comprehensive medication management policy in place which provided guidance to staff to manage aspects of medication from ordering, prescribing, storing and administration. The inspector reviewed a sample of medication charts. Photographic identification was available on the medication 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 clear and legible. The maximum amount for (PRN) medication (a medicine only taken as the need arises) was indicated on the prescription sheets examined. There was space to record when medication was discontinued and these were signed and dated on the sample reviewed. 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.

All medicines were stored safely and the temperature of the medicine refrigerator was monitored and temperatures recorded. The prescription sheets were pre-printed by the pharmacist and signed individually by the General Practitioner.

Medications that required strict control measures were kept in a secure cabinet which was double locked. A controlled drugs register was maintained.

Some medication was being crushed for some residents. Alternative liquid or soluble forms of the drugs were sought where possible through consultation with the pharmacy. Drugs being crushed were signed by the prescribing doctor as suitable for crushing.

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:

Measures to protect residents from being harmed or suffering abuse were in place.

A policy on safeguarding and procedures for the prevention, detection and response to allegations of abuse, were in place. Staff spoken to by the inspector confirmed that they had received training in adult protection. Staff spoken with displayed good knowledge of the different types of abuse and what they would do if they witnessed any type of abuse.

There were systems in place to ensure allegations of abuse were fully investigated, and that pending such investigations measures were in place to ensure the safety of residents. Staff confirmed that there were no barriers to raising issues of concern. There were policies in place with regard to managing behavioural and psychological signs and symptoms of dementia.

The inspector reviewed the use of restraint within the centre. A policy on enabler/restraint use was in place to guide practice. There were risk assessments completed for residents who had bed rails in place and all bedrails were in use as enablers. Care plans were not in place detailing the enabling function of the bedrail.

All staff did not have up to date manual handling training. The action with regard to this deficit is detailed under the outcome on Staffing.

Judgment:
Substantially Compliant

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:
Person-centred care and support

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

Findings:
There was some evidence available that residents were consulted on the organisation of the centre. Two resident meetings were held during 2016. Minutes of these meetings supported that residents were involved in discussing activities, the food and their views of the service provided. The Inspector found that the provision of regular dementia specific therapeutic activities in small groups required development. There was only one communal area utilised for residents throughout the inspection even though there were two other alternative areas that could have been used. The inspector observed that when activities were taking place the sitting room area was noisy and was not protected from external stimuli for example staff walking through. The inspector noted that while a care assistant was engaged with residents playing bingo, she was the only staff available and was also supervising residents and assisting residents to attend the toilet. While staff engaged therapeutically with individual residents on occasions the environment did not support quality interactions for the group as a whole. This was reflected in findings of the formal observation periods when completing the QUIS tool.

There was no designated activity therapist. Care assistant staff supported residents with social activities. The Inspector found that the provision of regular dementia specific therapeutic activities in small groups was not scheduled. At the time of the last inspection an action was included in the action plan with regard to lack of meaningful

activities for residents. This is repeated in the action plan at the end of this report.

Social care assessments and personal calendars were not detailed and there was no linkage between the information that was available with regard to interests or past activities with the activity schedule which provided limited choice for residents. There was poor availability of social care plans to ensure person centred social care. Staff explained to the inspector that Sonas (a therapeutic activity for residents who are cognitively impaired) was available occasionally. While the person in charge had completed a resident satisfaction survey, the results of this had not been collated and any deficits identified with a corresponding quality improvement plan enacted.

Staff explained to the inspector that they completed 1:1 activities for residents with more severe dementia and residents who chose to spend long periods in their bedroom. Residents in the day room were observed to spend time watching the news on the TV, which was an activity that many residents were interested in.

Residents were facilitated to exercise their civil, political and religious rights. Residents could attend Mass in the centre. There were no restrictions on visitors and residents could meet visitors in private in the visitors' room, and on the day of inspection visitors were observed spending time with residents in the sitting room area.

Observations of the quality of interactions between residents and staff in communal areas of the centre for selected periods of time indicated there were a number of positive interactions between staff and residents. However, there were also a number of neutral, task orientated activities. There were a number of negative interactions when residents were sitting in the communal areas and staff walked through the sitting room.

Staff addressed residents in a respectful manner. Radio, television and newspapers were available for information about current affairs and local matters. An independent advocate was available.

Judgment:

Non Compliant - Moderate

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:

A centre specific complaints policy was available.

The inspector reviewed the complaints procedure and noted this was displayed. The

policy detailed timelines to be adhered to, the requirement to carry out a thorough investigation and to inform the complainant of the outcome of the investigation. An independent appeals process was also detailed so that if the complainant was not satisfied with the outcome of their complaint they could utilise this procedure.

No complaints were being investigated at the time of inspection. A complaints log was in place which contained a record of all relevant information about complaints. There was evidence that when complaints were made, the policy was enacted and complaints reviewed were resolved. However there was poor evidence available to show whether the complainant was satisfied with the outcome of their complaint.

Complaints were recorded in a communal book. Consideration should be given to recording complaints individually.

Judgment:
Substantially Compliant

Outcome 05: Suitable Staffing

Theme:
Workforce

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

Findings:
The inspector found evidence that the allocation and deployment of staff was not adequately meeting the needs of residents. The inspector observed during the inspection that the sitting room was regularly unsupervised and when a staff member was delivering an activity to residents she was also supervising other residents and assisting residents with toileting. A copy of the staffing roster was reviewed by the inspector. The normal allocation of staff on duty was three nurses and five care assistants during the day from 08.00 until 16:30. This reduced to two nurses and two care assistants in the evening until 20:00. At night time there was one nurse and two care assistants until 22:00hrs and one nurse and one care assistant from 22:00hrs until 08:00hrs. Additional catering, administration and cleaning staff were available.

A training plan for 2016 was available and it included mandatory training and clinical care updates and dementia care. Not all staff had up to date mandatory training in moving and handling. The inspector reviewed a sample of staff files and found that the required documentation was in place in line with the requirements of Schedule 2 of the Regulations. An Bord Altranais agus Cnáimhseachais na hÉireann registration numbers for all nursing staff were available.

Judgment:
Non Compliant - Moderate

Outcome 06: Safe and Suitable Premises

Theme:

Effective care and support

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

No actions were required from the previous inspection.

Findings:

The centre is a community nursing unit under the management of the Health Service Executive (HSE). It is a purpose built single-storey building and is registered with the Health Information and Quality Authority (HIQA) to provide care to 30 residents. As a result of the recent refurbishment to ensure that a maximum of two residents are accommodated in any twin bedroom, the maximum occupancy is 29.

It is situated approximately one kilometre from the town of Claremorris, Co. Mayo. The D'Alton Community Nursing Unit provides long stay residential care and respite care, with day care provided one day per week. The unit provides nursing care to those whose healthcare needs cannot be met through community services, families or carers. The accommodation includes single rooms with a wash-hand basin and twin rooms with en-suite facilities. Other facilities include sitting rooms, visitors rooms including accommodation for overnight, recreation rooms, oratory, dining room, store room, offices and shower/bath and toileting facilities. Two enclosed courtyard gardens are available. Plans are in place to transform one of these into a sensory garden. The centre was warm, clean and comfortably furnished and residents had access to two courtyard gardens which were safe secure outdoor areas.

While the centre was recently refurbished and was clean and comfortable, there was minimal use of contrasting colours. The main day room was used for all activities throughout the inspection. The design and layout is not conducive to dementia friendly activities. Some equipment was stored inappropriately in this area such as Christmas decorations and a nebulizer machine.

The corridors were clean and free of clutter and provided a safe environment for residents to mobilise. Handrails were provided and the layout allowed for circular movement for residents with dementia who like to actively walk around. Plans were in place to turn one of the courtyard gardens into a sensory garden.

The inspector observed that a number of residents had personalised their rooms with personal items including photos. Signage had been provided within the centre using lettering and pictures to identify toilets, and some residents with dementia had signs on their bedroom door to make their room more easily identifiable.

There was a functioning call bell system in place within the centre, and hoists and pressure relieving mattresses were available, with records available to indicate servicing

at appropriate intervals.

Judgment:
Substantially Compliant

Outcome 07: Health and Safety and Risk Management

Theme:
Safe care and support

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

Findings:
All residents had emergency evacuation plans in place. At the time of the last inspection the directory of residents did not contain all information specified in Schedule 3 of the regulations; this had been addressed prior to this visit.

There were systems in place to maintain complete and accurate records. Records were stored securely and easily retrievable. The risk management policy and procedures to guide staff in the event of violence, aggression and self harm and arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents staff or visitors was available.

Records were maintained of accidents and incidents. While factual details of the accident/incident, date event occurred, name and details of any witnesses and whether the general practitioner (GP) and next of kin had been contacted, there was poor evidence of review by the person in charge or her deputy. The area related to action plan to prevent reoccurrence was blank on some incidents reviewed. Evidence of risk prevention strategies, for example the use of sensory alarms or provision of hip protectors, was available.

Judgment:
Substantially Compliant

Outcome 09: Statement of Purpose

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 had been reviewed in May 2016. It set out the services and facilities provided in the designated centre and contained all the requirements of Schedule 1 of the regulations.

Judgment:

Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Mary McCann
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	D'Alton Community Nursing Unit
Centre ID:	OSV-0000643
Date of inspection:	20/02/2017
Date of response:	18/04/2017

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non-compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 01: Health and Social Care Needs

Theme:

Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

While arrangements were in place to evaluate care plans every four months, this was not consistently occurring and the evaluation failed to ensure the care plan was revised to reflect the residents' changing needs.

1. Action Required:

Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding

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

4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.

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

A regular schedule which will enable four-monthly reviews is being compiled in consultation with the CNM11 who has recently taking up this post. This will ensure that all Care Plans will be audited within the appropriate time-frame. Further formal training in Care Plan documentation was already being organized for any Nurse requiring this additional support. This formal education will be underpinned by local mentorship in order to strengthen the Care Plan process where required. Additionally, a review of electronic care plan systems is taking place in May 2017 for units across Galway, Mayo and Roscommon to review three electronic systems to assist in meeting care planning process.

Proposed Timescale: 31/07/2017

Theme:

Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Some care plans lacked sufficient detail to guide care. Some care plans conflicted with other care plans. For example when care plans were reviewed and changes made to the care regime the previous care plan was not amended or discontinued. There were examples of where there were two care plans in place for the same identified need but both were very different.

2. 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:

Where obsolete documentation is identified this will be discontinued, and clearly placed within an "obsolete" file. This is the normal practice which occurs, however it is acknowledged that the Care Plan which reflected this non-compliance did not have an "obsolete" file available. As a result a discontinued Care plan and a current Care Plan remained within the DML file. This practice will be prevented in future through audit, training and mentorship. The use of DMLs in paper format has proven challenging in terms of the quantities of paper organisation required. As previously stated we are now reviewing electronic version.

Proposed Timescale: 30/06/2017

Theme:

Safe care and support

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

In some files reviewed, personal calendar were poorly completed or blank, and narrative noted were medical in nature with poor recording of social or psychological care.

3. 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:

Nurses had already begun the inclusion of Social and Psychological Care as part of their Care Plan documentation. This enabled an accurate reflection of the day to day practices pertaining to Social and Psychological care, which occurs within the unit. However an audit of personal calendars will now take place which will ensure that this aspect of the Care Plan file is addressed more fully.

Proposed Timescale: 31/05/2017

Outcome 02: Safeguarding and Safety

Theme:

Safe care and support

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

Care plans were not in place detailing the enabling function of the bedrail.

4. Action Required:

Under Regulation 07(3) you are required to: Ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.

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

Each Primary Nurse will review her cohort of Resident files with a view to compiling Care Plans where bedrails are used as an Enabler. This documentation will be evaluated on Audit.

Proposed Timescale: 31/07/2017

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

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

the following respect:

There was only one communal area utilised for residents throughout the inspection and when activities were taking place the sitting room area was noisy and was not protected from external stimuli, for example staff walking through it .

5. Action Required:

Under Regulation 09(2)(a) you are required to: Provide for residents facilities for occupation and recreation.

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

Activity Room will be utilized more effectively and residents will be facilitated to use this area. Residents will also be facilitated to continue to join Day Care in the front lounge each Tuesday for the beneficial Activity programme which takes place and is very popular with the residents. Staff will be advised that the Day room is not to be used as means of getting to other parts of the building. The lay out and placement of seating within the day room will be re-assessed in order to promote a more "sitting room" effect.

Proposed Timescale: 30/04/2017

Theme:

Person-centred care and support

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

There was a lack of meaningful activities for residents. Social care assessments and personal calendars were not detailed and there was no linkage between the information that was available with regard to interests or past activities with the activity schedule, which provided limited choice for residents.

6. Action Required:

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

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

A "Buddy system" has been established which will provide HCA support to each Primary Nurse. In consultation with the Nurse, it is proposed that the HCA staff allocated to the Primary Nurse will assist with gaining further insight into what each resident's preferred activities are. This Team approach will enable a more detailed schedule to be then drawn up in order that each resident is having his/her particular interests addressed, and as a result this will aid with the provision of greater meaningful activities.

Proposed Timescale: 30/06/2017

Theme:

Person-centred care and support

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

While the person in charge had completed a resident satisfaction survey, the results of this had not been collated and any deficits identified with a corresponding quality improvement plan enacted.

7. Action Required:

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

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

Resident satisfaction surveys and resident meetings are viewed by the D.O.N. As a result the information gained is cascaded to staff via meetings, handovers and Notice Boards. An area identified for improvement is Resident outings to places of interest. Recent improvement to staffing levels will now enable this identified need to be actioned. An interior designer is being engaged to review the finishes of the centre and to enhance the environment using contrast to meet residents with dementia needs.

Proposed Timescale: 31/05/2017

Outcome 04: Complaints procedures

Theme:

Person-centred care and support

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

There was poor evidence available to show whether the complainant was satisfied with the outcome of their complaint.

8. Action Required:

Under Regulation 34(1)(f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.

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

Monthly audit identifies if there has been any complaint, and whether the complaint has been formally or informally addressed, or if same still remains open. Audit results are forwarded to Manager of Older Persons services in a timely manner. However in future more detailed information on the specific outcome of any complaint will also be maintained locally in order to clearly demonstrate that same has been satisfactorily resolved from the point of view of the person raising the complaint.

Proposed Timescale: 30/04/2017

Outcome 05: Suitable Staffing

Theme:
Workforce

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

The allocation and deployment of staff was not adequately meeting the needs of residents. During the inspection, the sitting room was regularly unsupervised and when a staff member was delivering an activity to residents she was also supervising other residents and assisting residents with toileting.

9. 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:

Application for the filling of vacant posts has already been made. Rosters are also being reviewed. The post of CNM11 has recently been filled. Improved staffing levels will enable more assistance to be available to the day room, and as a support to the staff member delivering activities. A review of the activity schedule is underway following update of social activities requested by residents and entered in their care plans.

Proposed Timescale: 30/09/2017

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Not all staff had up to date mandatory training in moving and handling.

10. 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:

Further Staff are in the process of completing the theory aspect of Manual Handling training. The previous planned training for February 2017 was deferred due to adverse weather conditions. Training is due to re-commence in May 2017

Proposed Timescale: 31/07/2017

Outcome 06: Safe and Suitable Premises

Theme:

Effective care and support

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

There was minimal use of contrasting colours in the centre.

The main day room was used for all activities throughout the inspection. The design and layout is not conducive to dementia friendly activities. Some equipment was stored inappropriately in this area such as Christmas decorations and a nebulizer machine.

11. Action Required:

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

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

Shelving within the day room, with it's contents, has been removed to a more suitable location. Plans are underway to incorporate Murals as part of the interior design of the unit. However we are currently investigating the Fire retardant properties of Murals before proceeding with same. When there is definite clearance on the safety aspect of this project, we will then be in a position to proceed. As previously stated an interior designer is being engaged to review all finishes and colours.

Proposed Timescale: 30/09/2017

Outcome 07: 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:

Records were maintained of accidents and incidents but there was poor evidence of review of these by the person in charge or her deputy.

12. Action Required:

Under Regulation 26(1)(c)(iii) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control accidental injury to residents, visitors or staff.

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

Due to a particularly busy period, prioritization was required in other areas which created a delay in completing this documentation, however D.O.N was informed of any accidents and incidents which would be addressed at daily handover in consultation with Nursing Staff. This enabled actions to be discussed in order to reduce risk. However going forward due to the provision of additional support to the D.O.N review of accidents/ incidents will also be demonstrated through documented Action Plans .

Proposed Timescale: 30/04/2017