Health Information and Quality Authority
Regulation Directorate

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

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

Centre name:	Parke House Nursing Home
Centre ID:	OSV-0000083
Centre address:	Boycetown, Kilcock, Kildare.
Telephone number:	01 610 3585
Email address:	alanshaw@parkehouse.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Parke House Nursing Home Limited
Lead inspector:	Sonia McCague
Support inspector(s):	Mary McCann
Type of inspection	Unannounced Dementia Care Thematic Inspections
Number of residents on the date of inspection:	139
Number of vacancies on the date of inspection:	6

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 1 day(s).

The inspection took place over the following dates and times

From:	To:
26 July 2019 08:30	26 July 2019 19:30

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	Substantially Compliant	Non-Compliant - Moderate
Outcome 02: Safeguarding and Safety	Substantially Compliant	Compliant
Outcome 03: Residents' Rights, Dignity and Consultation	Substantially Compliant	Non-Compliant - Moderate
Outcome 04: Complaints procedures	Compliance demonstrated	Non-Compliant - Moderate
Outcome 05: Suitable Staffing	Compliance demonstrated	Substantially Compliant
Outcome 06: Safe and Suitable Premises	Compliance demonstrated	Compliant

Summary of findings from this inspection

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

Prior to the last inspection 7 March 2018, the provider had completed a self-assessment and scored the service against the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Standards for Residential Care Settings for Older People in Ireland. The previous table outlines the self-assessment and the inspectors' current rating for each outcome.

The centre provides a service for up to 145 residents with 139 residents in

occupancy during the inspection. The centre provides short and long stay services, intermediate care, rehabilitation and respite care. The centre has a dedicated unit for up to 24 residents diagnosed with dementia. On the day of the inspection there were 51 (37%) residents confirmed with a diagnosis of dementia and one suspected as having dementia.

The inspectors met with residents, relatives and staff members during the inspection. The journey of a number of residents with dementia was tracked. Care practices and interactions between staff and residents including those with dementia were observed. Policies and documentation such as care plans, medicine and service records, rosters and staff training records were reviewed.

Residents who spoke with the inspectors were mainly positive about the centre and the staff team, and relatives spoken with shared this view. But some areas for improvement were conveyed and affirmed by inspectors.

While some opportunities for occupation and recreation were available, improvements were required based on the size and layout of the centre, interests and varying dependency levels of residents.

Inspectors were not assured that there was adequate skilled staff on duty at all times to ensure the assessed needs of residents were met. While there were rostered staff numbers available during the inspection, a review of staffing was required to ensure a sufficient number of appropriately skilled staff to meet the needs and preferences of residents.

Deficiencies in staffing levels, skill mix and meaningful activity provision had a negative impact on the daily routine, preferences and wishes of residents. Opportunities for engagement and positive interaction with residents were not optimised by some staff observed.

While staff were observed speaking to residents in a respectful manner and some choice was offered when snacks and drinks were being served, observations of the quality of interactions between residents and staff in communal areas for selected periods of time indicated there was a high level of task orientated care and neutral care in instances observed.

Residents had good access to medical and health care professionals. The review of care records showed residents' needs were being assessed and considered, however, some care plans had not been developed for identified needs and others had not been implemented or reviewed on a regular basis and updated accordingly. Gaps within the assessment, planning and evaluation process were evident in some units.

Residents confirmed to the inspectors they felt secure and safe, and care staff confirmed they knew the policy and procedure to ensure residents were safeguarded in the centre. The implementation of approved policies and procedures such as restraint usage was promoted in practice. Risk assessments and consultation with relevant parties informed decisions made in relation to restrictive measures.

Residents' were able to provide feedback on the service they received either directly to staff, in surveys or during a forum via residents meetings. However, a low representation (3.5%) of residents had attended the last meeting and the process and management of complaints required improvement.

The premise was purpose built, and it supported residents' individual privacy and communal needs. There were four distinct units and a range of rooms for sitting, dining, relaxation, prayer and social gatherings. Residents had good access to outdoors with enclosed courtyards, sensory gardens and raised flower beds.

The findings are discussed within the body of the report and areas for improvement required by the registered provider and person in charge are outlined within the 17 action plans at the end for response. During feedback with management, inspectors were told that similar deficiencies had recently been detected by management who had met with the provider to develop and deliver a plan to address all

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

Findings:
Arrangements were in place to promote resident's health, wellbeing and welfare by management and staff, and appropriate medical care and allied health care professionals. However, some improvement was required in relation to the care and nursing process in association with staff provisions to ensure a comprehensive assessment was consistently undertaken, and recommendations made by allied health professionals and medicines in use were accurately reflected in the resident's care plan for implementation and to aid evaluation. Some residents told inspectors of delays encountered when seeking the assistance and support of staff, examples of this were also observed by inspectors during the inspection. Improvements were required in relation to the prevention and management of falls, and assessment and development of an individualised behavioural support plans.

An admission policy was in place to guide practice. A selection of care records and plans were reviewed with staff. An assessment prior to a resident admission formed part of the centre's admission policy and practice. Documented assessments of activities of daily living, including communication, personal hygiene, continence, eating and drinking, mobility, spirituality and sleep, were maintained. Social and recreational assessments and plans were also completed in the sample reviewed.

There was evidence of a range of assessment tools being used to monitor areas such as the risk of falls, malnutrition, cognition, depression, pain, mobility and skin integrity.

From an examination of a sample of residents' records and care plans and discussions with residents and staff, the inspectors found that the nursing, health and medical care needs of residents were assessed and interventions outlined, however, some identified needs had not been comprehensively assessed and recommended treatment plans were not managed or implemented accordingly or consistently. This had a negative impact on residents concerned. Examples found were communicated to management during the inspection to be addressed.

There were processes in place to ensure that when residents were admitted, transferred

or discharged to and from the centre, relevant and appropriate information about their care and treatment was available, maintained and shared between providers and services.

The development of care plans was carried out in consultation with residents or their representatives and information received on admission. Each resident's care plan was subject to a formal review at least every four months.

The assessment of residents' views and wishes for the end of life were recorded and outlined in a related care plan and subject to regular reviews. Care plans that included details and information known by staff regarding religious, spiritual and cultural practices or named persons to assist residents in decisions to be made were noted in the sample of residents records reviewed. Family and friends were encouraged to be involved, where appropriate.

Residents had access to a general practitioner (GP) and physiotherapist contracted by the provider. Other allied health care professionals that included psychiatry of later life, palliative care services, speech and language therapy, audiology, occupational therapy and chiropody were available on a referral basis. Records reviewed and staff confirmed allied health care support was provided. For example, a tissue viability specialist and dietician had assisted in the promotion of pressure ulcer and wound healing. Specialist equipment, mobility aids and adaptations were made available to residents following assessments completed. A number of residents had motorised chairs that promoted their independence and functioning. Mobility and regular exercises were encouraged and incorporated in the activity programme. Hand rails on corridors and grab rails in facilities used by residents were available to promote independence.

Communication aids and systems were in place to ensure that residents' nutritional and care needs were known by staff supporting residents to eat and drink and by those preparing and serving food. Procedures were in place to guide practice and clinical assessment in relation to monitoring and recording of weights, nutritional intake and risk of malnutrition. Staff were knowledgeable and described practices and communication systems in place to monitor residents and prevent malnutrition. However, some improvements were needed to ensure the dining experience for some residents was person centred, interesting and pleasant.

Changes to the menu were reported and evident, however, the four week menu advertised and displayed in dining rooms had not been updated to reflect the changes. Residents who spoke with the inspectors reported they were provided with food and drink at times and in quantities adequate to their needs. Some residents stated that the menu and meals lacked variety and dinner vegetables were mainly always broccoli and carrots. A limited choice as a hot tea option was also reported.

Medicine management procedures relating to the ordering, prescribing, storing and administration of medicines were appropriate and subject to regular review by staff, the GP and pharmacist.

Judgment:
Non-Compliant - Moderate

Outcome 02: Safeguarding and Safety

Theme:
Safe care and support

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

Findings:
Measures were in place to protect residents from being harmed or abused.

There was a policy in place which gave guidance to staff on the prevention, detection, assessment, reporting and investigation of allegations or suspicion of abuse. It incorporated the principles of the national policy on safeguarding vulnerable persons at risk of abuse. Staff involved in the delivery of care to residents confirmed that they had received training on recognising abuse and were familiar with the reporting structures in place. However, some auxiliary staff were unclear if they had attended this training and this required improvement is referenced under the staffing outcome.

A reduction in the use of bedrails was reported and staff spoken with confirmed that some residents had requested the use of bedrails despite the availability of alternatives devices such as wedges, levers, low low beds, sensor alarms and mats. Inspectors spoke with residents and confirmed this. Risk assessments had been undertaken for the use of bedrails and regular checks of residents were completed when in rails were used. A policy was in place which guided practice and decision making processes that incorporated consultation and consensus by relevant parties.

Because of their medical conditions, some residents' behavioural and psychological well-being fluctuated at times. The inspectors saw that possible triggers and proactive interventions were known by staff and recorded in residents care plans within the dementia unit. Staff spoken with were familiar with appropriate interventions to use in relation to responsive behaviours and to record episodes of behavioural changes for possible trends to ensure an appropriate response and referral to specialists.

Inspectors were informed that there were no residents being monitored via behaviour logs. However, the inspectors observed, and received feedback from other residents, in relation to the behaviour of a resident that negatively impacted on them. Staff spoken with were aware of the behaviours but had not carried out a comprehensive assessment or recorded the episodes to identify the antecedents, specific behaviours and consequences or impact on others to ensure a plan care with behavioural supports were put in place. This was considered a deficiency within the assessment and care planning process and is included within the findings in outcome 1.

The management of resident finances was not inspected during this inspection.

Judgment:

Compliant

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:
Person-centred care and support

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

Findings:
Inspectors tracked the journey of a number of residents with dementia within the service. An observational tool (QUIS) in which social interactions between residents and care staff are coded as positive social, positive connective care, task orientated care, neutral, protective and controlling or institutional care/controlling care was used by the inspectors. Inspectors utilised this tool and spent periods of time observing the quality of interactions between staff and residents. While staff were observed speaking to residents in a respectful manner and choice was offered when snacks and drinks were being served, observations of the quality of interactions between residents and staff in communal areas for selected periods of time indicated there was a high level of task orientated care (completion of tasks only with poor engagement between the staff member and staff) and neutral care (a lack of positive social interaction) in instances observed.

Staff were not using opportunities for positive connective care for example when supervising in the sitting room, when transporting residents or assisting residents with their meals. Some residents who did not require immediate assistance were observed going for long periods of time without any interaction from staff. Some staff that were observed assisting residents with nutritional intake during the lunch time period, they did not encourage a conversation with the resident. While staff were going about their work they did not chat with residents in an informal way and on frequent occasions the inspector observed staff walking through the sitting room in the dementia unit who failed to acknowledge staff by greeting them or enquiring were they ok as they went about their work. Inspectors also observed when residents were sitting in the communal areas and while staff were available at times for supervision, inspectors noted on some occasions where there were negative interactions, for example, where staff walked into the sitting room using a mobile phone (supplied by the centre for contacting staff) or spend time supervising in the sitting room with no interaction with residents.

A social care assessment was completed on admission which gathered information on each resident's hobbies, interests, preferences and background interests before admission. Staff also discussed with the resident and family members what other activities residents might be interested in trying after their admission. Activity staff described how they try to look at activities which residents may be interested in but have not participated in, in the past. A recreational care plan was devised for each resident utilising this information.

Two full-time and one part-time activity co-ordinators were in place. On the day of inspection one of the full-time activity co-ordinators was on leave. Inspectors were informed that the part-time activity co-ordinator was primarily responsible for 1:1 activities for residents who spent long periods of time in their bedrooms. However given the number of residents the centre can accommodate and taking into consideration annual leave, together with the high percentage of residents who spent long periods of time in their bedroom, it was difficult to see how the part-time activity co-ordinator (21 hours per week) could effectively support this level of residents with meaningful activities. Inspectors noted that twenty three residents were accommodated on the day of inspection in the dementia unit. Eight residents had remained in their room for the duration of the morning and were still in their rooms at 14:00hrs. As a consequence of this they did not avail of the social occasion of having lunch in the dining room, or attend the live music group or access the garden on the sunny day. The activity therapist confirmed that approximately 21to 25 residents stay in their bedrooms for long periods during the day but this did not correlate with the number that was observed by inspectors on the day of inspection. In another unit 17 residents (36%) were in bed at 11am.

No activity other than the delivery of the provision of care was observed by the inspector to these residents. While two staff was trained in Sonas the activity co-ordinator informed one of the inspectors that activity staff were taking a break from running sonas sessions and no sonas sessions were occurring in the centre at the time of inspection. An activities programme was displayed. Inspectors noted that newspapers was recorded as one of the morning activities on the dementia unit, but observed that one resident was brought the newspaper by a staff member and this was a task orientated interaction. There were no alternative activities organised for other residents except a CD was put on at 11:10am. No activity was recorded on the timetable for the dementia unit on the day of inspection for the day of inspection but inspectors observed that a live music session did occur in the afternoon.

A record of participation of residents in activities programme was made available to residents. This detailed a high dependence on the option 'TV, film/radio'. It was hard to track from this document the level of meaningful activity an individual resident engaged in. An additional daily charge for activities was included as part of the contract of care. The person in charge explained that residents could opt out of paying this fee. Inspectors were told contracts of care were in the process of being reviewed following recent best practice guidance.

Two resident's forum meetings had occurred in 2019. Inspectors reviewed minutes of these meetings. Minutes of these meetings were very similar. There was a very low attendance rate (5 residents) and inspectors were informed that no resident had attended from the dementia specific unit. Three staff attended. The activity coordinator stated in the past an advocate attended these meetings and there was a greater attendance by residents. Given the low number of residents, the level of staff may be a bar to residents discussing issues of concern, also there was no independent person in attendance. It was difficult to track how issues raised by residents were followed up on as no quality improvement plan was developed post the meeting detailing action to be completed, who was responsible and a timescale for completion. The activity co-

coordinator confirmed that an independent advocacy service was available by referral if required. She confirmed that no resident was availing of this service at the time of inspection.

Residents' rights, privacy and dignity were respected with personal care delivered in their own bedroom, all of which had shower and toilet en-suites with privacy locks.

Residents were facilitated to exercise their civil, political and religious rights. Mass was celebrated weekly in the centre. There were no restrictions on visitors and residents could meet visitors in private. On the days of inspection visitors were observed spending time with residents. Hairdressing and beautician arrangements were available to support resident's personal care, grooming and choices.

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 complaints process was in place in relation to the receipt and management of complaints of residents or their representatives including those with dementia.

The complaints procedure prominently displayed in the reception area was reviewed by inspectors. This procedure included the names of three personnel involved in management of the centre but it was unclear who was the nominated person for handling and investigating complaints, who was responsible for overseeing the management of complaints by the nominated person and what the appeals process was prior to contacting the ombudsperson. The timeframes were excluded also. A review of this procedure was required to ensure all functions and steps were clearly outlined and understood by all.

A high level of complaints had been received by management of the centre and a significant number of concerns were received by The Health Information and Quality Authority (HIQA) via unsolicited information since the last inspection. The complaints records reviewed did not consistently show the actions taken or complainants satisfaction level and while some were recorded as closed, it was not established if all steps of the process were followed to demonstrate this.

Inspectors confirmed with management that an audit of complaints had not been completed to identify themes or recurrent matters or establish the association with either long or short stay residents or unit to bring about improvements and learning

opportunities.

Judgment:
Non-Compliant - Moderate

Outcome 05: Suitable Staffing

Theme:
Workforce

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

Findings:
Due to the observations by inspectors and from the findings of this inspection as documented under the outcomes on health and social care and privacy dignity, inspectors were not assured that there was adequate staff on duty at all times to ensure the assessed needs of residents are met.

An assessment of staffing levels and review as to whether staff require further training to ensure they have the required skills relevant for their role and responsibilities was required. Additionally staff need to be supervised to ensure that they are utilising opportunities to ensure holistic person centred care is delivered to residents in accordance with their assessed needs. Furthermore a staffing needs analysis is required to ensure there is adequate staff on duty at all times to ensure the assessed needs of residents are met. The dementia unit had increased their occupancy from 20 to 24 residents at the time of the last inspection. The person in charge confirmed that a corresponding increase in staffing occurred at this time.

The person in charge confirmed that all staff working in the centre has been vetted by An Garda Síochána. Inspectors reviewed a sample of personnel files for different categories of staff and found them to contain all documentation required by Schedule 2 of the regulations, including evidence of a vetting disclosure. All nurses had evidence of active registration with the Nursing and Midwifery Board of Ireland. The centre did not utilise external agency staff, or volunteer care staff. Newer members of staff undergo a period of probation, and all regular staff were appraised annually by the person in charge. Meetings were held between the different categories of staff to discuss matters for example night duty guidelines for health care assistants.

A training matrix was in place. Most Staff were all up to date in the mandatory fire safety and manual handling training. Some gaps in staff knowledge of safeguarding training were identified. All nurses had received in-house training in medication management and all nurses had up to date training in cardio pulmonary resuscitation.

Most staff had completed training on caring for residents with dementia. There was a good range of supplementary training provided to care for residents' needs, such as

infection control and wound management.

Judgment:
Substantially Compliant

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 was found to be well maintained, warm, comfortably furnished and visually clean. All walkways were clear and uncluttered to ensure resident safety when mobilising. The premises and grounds were clean and well maintained.

The centre is designed as four separate units. One of the units is a dementia specific unit. Residents are accommodated in single and twin occupancy bedrooms. From a dementia design perspective, the dementia care unit was well laid out, consisting of circuit corridors, lined on both sides with handrails, which would allow a resident to walk around the premises without approaching dead ends. While there was directional signage on entry to the centre this could be enhanced by using bright colour and simple pictorial signage to direct residents to areas around the unit. Communal rooms had a dementia friendly clock. Resident bedroom doors were equipped with names, photos of visual memory triggers to help give a resident who may get confused assurance that they were at the correct bedroom. The centre encompassed rest and quiet areas along the corridors to allow a resident to stop when tired or to have a quiet space away from the communal areas. Each unit in the centre had a safely enclosed and attractive well maintained garden. While the door to this was not locked, it was noted by the inspector to be only used by residents who could independently access it on the day of inspection in the dementia unit.

There were rooms available other than the resident bedrooms for visitors to be received in private. A coffee dock and spa area is available to residents. An indoor smoking room was available which had large glass windows to assist with observation by staff. There was no odour of smoke in the premises.

There was sufficient space in all bedrooms for residents, and residents were facilitated to decorate their bedrooms to their preferences, including bringing items of sentimental value from home. All bedrooms had adequate storage space including the option of lockable storage for valuables. Bedrooms accommodating more than one resident had appropriate privacy screening between the bed spaces. En-suite toilet and shower facilities were suitably equipped for residents' needs, including assistive grab rails, wet room flooring and appropriately levelled bathroom ware for residents with reduced

mobility or who used a wheelchair. Bathrooms and toilets were easily identifiable by pictorial signage and colour as all doors were painted blue throughout the centre.

All bedrooms, bathrooms and communal areas were equipped with call bells and service records for equipment such as air mattresses and hoists were available.

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:

Sonia McCague
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	Parke House Nursing Home
Centre ID:	OSV-0000083
Date of inspection:	26/07/2019
Date of response:	26/08/2019

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 (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Some residents told inspectors of delays encountered when seeking the assistance and support of staff, examples of this were also observed by inspectors during the inspection.

Improvements were required in relation to the prevention and management of falls, and assessment and development of an individualised behavioural support plans.

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

1. 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:
1) Parke House Nursing Home aims to ensure that each resident is appropriately supervised and provided with assistance at all times as deemed required based on the individual residents identified needs. In order to enhance and promote effective supervision, the Management Team have implemented additional controls to ensure safe and effective care is provided in a timely manner. Additional controls implemented include, but are not limited to:

• Supervisory duties including supervision of communal areas are assigned to individual members of the care team following morning handover. Each specific duty is allocated by the Senior Healthcare Assistant, communicated to members of the care team and documented in the duties book. A review of the allocated duties is completed during mid-shift handover – Completed 01/08/2019;
• A new designated nurse's station has been erected in the Blackwater Unit. This focal point allows for direct access to members of the nursing staff team by residents and additional supervision on the floor – Completed 01/08/2019;
• The replacement and instillation of additional call bell screens has been completed which allows for staff to respond to assistance requirements in a timely manner – Completed 01/08/2019.
• Call bell pagers have been ordered and will be installed for staff use, tnhis will give immediate notification of a bell call -21/9/19
• Call bell response time audit will be conducted to monitor and manage any delays with residents seeking the assistance of staff.
• Call bell software will be added to the Management Team's PCs -21/9/19

2) All residents are assessed for their risk of falls upon admission to Parke House and on an ongoing basis. All residents are provided with information and advice to reduce the risk of falls, based on their assessed risk from members of the nursing team and in-house Physiotherapist. Supervisory duties are specifically allocated to those residents deemed high risk of falls following assessment. Fall Prevention Strategies are employed for residents at High Falls Risk following consultation with residents and their representatives – 01/08/2019.

3) Residents with behaviour that is challenging including behaviour which is a high risk to the individual themselves and others, are managed and responded to effectively within Parke House Nursing Home. To ensure appropriate behavioural support plans are developed and implemented, a senior nurse has been allocated to complete a specific review of all resident behavioural support plans. This review will include an evaluation of effectiveness of the recorded interventions that are implemented to prevent escalation of the residents behaviour. – Completed 26/08/2019.

Following initial feedback immediate intervention were implemented in order to address specific behavioural supports required on the day of inspection.

Proposed Timescale: 26/08/2019

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some improvement was required in relation to the care and nursing process in association with staff provisions to ensure a comprehensive assessment was consistently undertaken, and recommendations made by allied health professionals and medicines in use were accurately reflected in the resident's care plan for implementation and to aid evaluation.

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:
1) An internal care plan, weekly audit schedule has been developed by the Director of Care and Assistant Director of Care. The weekly care plan audit will be completed by members of the Senior Nursing team and will focus on individual specific health care areas based on the assessed needs of each individual resident – Commenced 19/08/2019.

2) This care plan review will ensure that all residents have individual care plans that takes into account all aspects of their physical and mental health, personal and social care needs and any supports required to meet those needs, as identified by initial and ongoing assessment – Commenced 19/08/2019

Proposed Timescale: 19/08/2019

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some identified needs had not been comprehensively assessed and recommended treatment plans were not managed or implemented accordingly or consistently.

3. 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:
1) As outlined in action 2 - an internal care plan, weekly audit schedule has been developed by the Director of Care and Assistant Director of Care. A comprehensive assessment of the resident's physical, psychological and social needs is completed within 3 days following each residents admission as outlined in the internal policy and procedure "Management of Admission, Assessment and Care Initiation", which is distributed to all nursing team members. This care plan review will ensure that all residents have individual care plans that takes into account all aspects of their physical and mental health, personal and social care needs and any supports required to meet those needs, as identified by initial and ongoing assessment – Commenced 19/08/2019.

Proposed Timescale: 19/08/2019

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The provision of choice at mealtimes was identified as an area in need of improvement.

4. Action Required:
Under Regulation 18(1)(b) you are required to: Offer choice to each resident at mealtimes.

Please state the actions you have taken or are planning to take:
1) All residents in Parke House Nursing Home are provided with a balanced, nutritious and varied diet, of adequate quantity, which meets their individual dietary needs. To ensure that all resident specific preferences are addressed, the Catering Supervisor has completed a full review of the menu provided. This review incorporated specific views and opinions of residents based on their likes, dislikes and preferences – Completed 12/08/2019.

2) The reviewed menu is displayed in a suitable format and in appropriate locations so that the residents know what is available at each mealtime – Completed 12/08/2019.

3) The nutritional value of the menu developed has been review and approved by the relevant Health and Social Care Professional – Scheduled for 16/9/19

Proposed Timescale: 12/08/2019

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some improvements were needed to ensure the dining experience for some residents was person centred and an adequate number of staff available.

5. Action Required:
Under Regulation 18(3) you are required to: Ensure that an adequate number of staff are available to assist residents at meals and when other refreshments are served.

Please state the actions you have taken or are planning to take:
1) The Management of Parke House Nursing Home recognise that meals must be unhurried social occasions where staff participate in and view mealtimes as an opportunity to communicate, engage and interact with residents. Nursing staff and care staff induction workbooks have been updated in order to effectively outline and address team members on commencement of employment the importance of ensuring mealtimes are utilised as an opportunity to communicate, engage and interact with residents – Completed 13/08/2019
2) A staff dining audit experience will be undertaken, to give staff a better understanding of the resident's experience, this will help monitor all staff interactions. – Scheduled 2/9/19

Proposed Timescale: 13/08/2019

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:
Person-centred care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
There were insufficient opportunities for residents to participate in activities in accordance with their wishes and preferences.

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:
1) Parke House Nursing Home is committed to facilitating each resident to exercise choice and to continue a lifestyle that is consistent with their previous routines, expectations and preferences and satisfies their social, cultural, language, religious and recreational interests and needs. A Key to Me assessment and corresponding Recreational and Social Care plan is completed for all residents following admission which includes each resident specific preference. The weekly care plan audit scheduled will incorporate a full review of individual Key to Me assessments and corresponding care plans, to ensure that each resident is provided with the opportunity to participate in activities in accordance with their interests and capacities – Commenced 19/08/2019.

2) Parke House Nursing Home are actively recruiting the position of an Activities and Social Care Leader. The purpose of this role is to oversee the development and facilitation of programmes which meet the assessed needs of the entire resident population in Parke House Nursing Home and to ensure the implementation of a

holistic, person-centred activities programme while catering for the individual choices and preferences of residents. The Activities and Social Care Leader will direct and oversee the delivery of an activity programme by both the activities with the appropriate involvement of all care staff. Upon appointment a full departmental review will be undertaken. – To be completed 30/08/2019.

Proposed Timescale: 30/08/2019

Theme:
Person-centred care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Suitable arrangements were not in place to ensure all residents had an opportunity to be consulted with and participate in the organization of the centre.

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:
1) A clearly defined teams and committees' structure is developed in Parke House Nursing Home which incorporates specifically a Residents Committee to allow for residents and their representatives where appropriate to discuss any concerns or suggestions they may have. A specific role of the Activities and Social Care Leader is to encourage involvement from the residents and relatives in attending in house residents committee meetings in order to assist in the ongoing quality improvement of the activities programme and additional social care opportunities and development. In conjunction with the residents committee meetings, localised unit resident meetings will be scheduled and incorporated as part of the weekly activities schedule developed. Each scheduled meeting including, time, date and location will be displayed prominently throughout the nursing home – To Commence 30/08/2019.

2) The Activities and Social Care Leader will have responsibility for ensuring all quality improvements identified at meetings are documented, actioned, closed out and communicated to the relevant Departments. All feedback will be provided to the residents – To Commence 30/08/2019.

3) Resident's Meeting of 22/8/19, was much better attended by nursing home residents and minutes reflect the discussion at same.

Proposed Timescale: 30/08/2019

Theme:
Person-centred care and support

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

Observations and findings did not demonstrate evidence of person-centred care with due regard to the rights of all residents.

8. Action Required:
Under Regulation 09(4) you are required to: Make staff aware of the matters referred to in Regulation 9(1) as respects each resident in a designated centre.

Please state the actions you have taken or are planning to take:
1) As previously outlined, Parke House Nursing Home are actively recruiting the position of an Activities and Social Care Leader. The purpose of this role is to oversee the development and facilitation of programmes which meet the assessed needs of the entire resident population in Parke House Nursing Home and to ensure the implementation of a holistic, person-centred activities programme while catering for the individual choices and preferences of residents. - Scheduled 23/9/19

2) Supervisory duties including supervision of communal areas are assigned to each members of the care team following morning handover. Each specific duty is allocated by the Senior Healthcare Assistant, communicated to members of the care team and documented in the duties book. A review of the allocated duties is completed during mid-shift handover – Completed 01/08/2019;

3) All supervisory duties and resident participation in activities is recorded by members of the care and nursing team on the Epicare system in real time. All – Completed 01/08/2019.

Proposed Timescale: 30/08/2019

Outcome 04: Complaints procedures

Theme:
Person-centred care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The effectiveness of the complaints procedure required review and was to include an obvious appeals process.

9. Action Required:
Under Regulation 34(1) you are required to: Provide an accessible and effective complaints procedure which includes an appeals procedure.

Please state the actions you have taken or are planning to take:
1) The accessible version is displayed in prominent locations of Parke House Nursing Home's. The Responding to Complaints process has been updated to reflect an obvious appeals process. It is now identified specifically that where a Complainant is not satisfied with the handling or decision of the complaint, the Office of the Ombudsman may be contacted. The displayed process includes the role of the Ombudsman and specific contact details. This process is displayed prominently throughout Parke House Nursing Home – Completed 16/08/2019.

Proposed Timescale: 16/08/2019

Theme:
Person-centred care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
It was unclear from the complaints procedure who the nominated person was who was separate from the subject matter.

10. Action Required:
Under Regulation 34(1)(c) you are required to: Nominate a person who is not involved in the matter of the subject of the complaint to deal with complaints.

Please state the actions you have taken or are planning to take:
1) The Management team have completed a full review of the internal Responding to Complaints policy and procedure. This policy and procedure now outlines that the Director of Care shall act as the Nominated Person for Complaints in Parke House Nursing Home – Completed 16/08/2019.

2) The accessible version is displayed at prominent locations within Parke House Nursing Home's. The Responding to Complaints policy and process has also been updated to specifically outline the role of the Director of Care as the Nominated Person for Complaints in Parke House – Completed 16/08/2019.

3) The Responding to Complaints policy and procedure has been re-distributed to all staff for acknowledgement – Completed 16/08/2019.

4) The updated Responding to Complaints policy and procedure will be communicated to all residents and relatives via Resident Committee meetings - To Commence 30/08/2019.

Proposed Timescale: 30/08/2019

Theme:
Person-centred care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The actions taken, investigation process and satisfaction level of the complainant were not consistently recorded in the records reviewed.

11. 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:
1) A full review of the complaints report utilised in Parke House has been completed by the Management team. The updated complaints report now specifically includes:
- Acknowledgement;
- Interventions;
- Investigations;
- Action Plan;
- Outcome;
- Satisfaction details, and;
- Lessons learned – Completed 30/08/2019.

Proposed Timescale: 30/08/2019

Theme:
Person-centred care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
It was unclear if the complainant was informed of an appeals process in complaints reviewed.

12. Action Required:
Under Regulation 34(1)(g) you are required to: Inform the complainant promptly of the outcome of their complaint and details of the appeals process.

Please state the actions you have taken or are planning to take:
1) The satisfaction details section of the updated complaints report now includes specific options including, if the complainant was;
- Satisfied;
- Not Satisfied;
- Informed of Independent Appeals Process.
This is a mandatory section of the updated complaints report and requires specific information including, who this was recorded by and the recorded date – Completed 30/08/2019

Proposed Timescale: 30/08/2019

Theme:
Person-centred care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
It was unclear who was responsible to oversee the management and recording of all complaints.

13. Action Required:

Under Regulation 34(3) you are required to: Nominate a person, other than the person nominated in Regulation 34 (1)(c), to be available in a designated centre to ensure that all complaints are appropriately responded to and that the person nominated under Regulation 34 (1)(c) maintains the records specified under in Regulation 34 (1)(f).

Please state the actions you have taken or are planning to take:
1) The Management team have completed a full review of the internal Responding to Complaints policy and procedure. This policy and procedure now outlines that the Director of Care shall act as the Nominated Person for Complaints in Parke House Nursing Home, responsible for the review, verification and management of all complaints – Completed 16/08/2019.

Proposed Timescale: 16/08/2019

Theme:
Person-centred care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
An audit of all complaints was required to inform quality improvement measures.

14. Action Required:
Under Regulation 34(1)(h) you are required to: Put in place any measures required for improvement in response to a complaint.

Please state the actions you have taken or are planning to take:
1) The internal audit schedule for Parke House Nursing Home has been reviewed and a complaints audit is scheduled for August 2019. This audit will be completed by the Director of Care with all quality improvements communicated to the Management Team – To be completed 29/08/2019.

2) A monthly report including complaints received and type of complaints received is completed on a monthly basis as a component of Key Performance Indicators data collection. Lessons learned will be discussed at all relevant team meetings in Parke House to reduce the risk of re-occurrence where issues of concern are identified – Commenced 02/08/2019.

Proposed Timescale: 29/08/2019

Outcome 05: Suitable Staffing

Theme:
Workforce

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Inspectors were not assured that there was adequate staff on duty at all times to

ensure the assessed needs of residents are met.

An assessment of staffing levels and review as to whether staff require further training to ensure they have the required skills relevant for their role and responsibilities was required.

15. 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:
1) The Management team completed an immediate review and assessment of the staffing levels. This review outlined satisfactory staffing levels in meeting the identified needs of individual residents. – Completed 16/08/2019
2) Ongoing reviews of workflows, appropriate allocation of staff and prioritisation of workload in each unit.-Commenced 02/08/2019

3) Parke House Nursing Home ensures that all staff are appropriately educated and trained and that any needs are identified and addressed. The education and training provided is relevant to each staff member's ability to meet resident needs and improve resident's outcomes. Individual training needs are reviewed on an ongoing basis specifically at 6 monthly probationary reviews and annual reviews. Where deficits are identified Performance Improvement Plans will be developed and implemented by each relevant Line Manager – Commenced 02/08/2019.

4) Members of the Senior Nursing Team have commenced focus group sessions with members of the nursing and care team. These focus groups sessions include discussion on relevant topics including, but not limited to safeguarding, end of life and wound management. Each focus group shall be completed in line with the relevant internal Parke House policy and procedure – Commenced 16/08/2019.

Proposed Timescale: 16/08/2019

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Improvement were required in relation to staff supervision to ensure that they are utilising opportunities to ensure holistic person centred care is delivered to residents in accordance with their assessed needs.

16. Action Required:
Under Regulation 16(1)(b) you are required to: Ensure that staff are appropriately supervised.

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

1) Supervisory duties of all ADL's, including supervision of communal areas are assigned to individual members of the care team following morning handover. Each specific duty is allocated by the Senior Healthcare Assistant, communicated to members of the care team and documented in the duties book. A review of the allocated duties is completed during mid-shift handover – Completed 01/08/2019;

Proposed Timescale: 01/08/2019

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some gaps in staff knowledge of safeguarding training were identified.

17. 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) All staff employed in Parke House Nursing Home have received the relevant Safeguarding training. Gaps identified as part of the inspection have been addressed with additional Safeguarding training scheduled for the 5th September to ensure staff will be able to recognise and report any suspicion of abusive behaviour appropriately. This will be utilised as a refresher course to those staff who already have received the training however require further assistance – To be completed 05/09/2019.
2) Senior Nursing Team have commenced focus groups on relevant topics such as safeguarding Vulnerable adults, pain management and end of life care amongst other topics – Commenced 16/08/2019

Proposed Timescale: 05/09/2019