

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Kilcolgan Nursing Home
Centre ID:	OSV-0000351
Centre address:	Kilcolgan, Galway.
Telephone number:	091 776 446
Email address:	kilcolgannursinghome@mowlamhealthcare.com
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Mowlam Healthcare Limited
Provider Nominee:	Pat Shanahan
Lead inspector:	Mary McCann
Support inspector(s):	Marie Matthews
Type of inspection	Unannounced
Number of residents on the date of inspection:	45
Number of vacancies on the date of inspection:	3

About monitoring of compliance

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

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

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

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

The inspection took place over the following dates and times

From:	To:
17 February 2016 17:00	17 February 2016 22:00
18 February 2016 09:30	18 February 2016 18:00

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

Outcome	Our Judgment
Outcome 14: End of Life Care	Compliant
Outcome 01: Health and Social Care Needs	Non Compliant - Moderate
Outcome 02: Safeguarding and Safety	Substantially Compliant
Outcome 03: Residents' Rights, Dignity and Consultation	Non Compliant - Moderate
Outcome 04: Complaints procedures	Compliant
Outcome 05: Suitable Staffing	Substantially Compliant
Outcome 06: Safe and Suitable Premises	Non Compliant - Moderate

Summary of findings from this inspection

This was an unannounced inspection with a special focus on the provision of dementia care. Inspectors also considered information received by the Health Information and Quality Authority (HIQA) in the form of unsolicited receipt of information and notifications since the last inspection. Some aspects of the unsolicited information were substantiated. These areas included lack of meaningful activities for residents with dementia and inadequate completion of fluid balance charts.

Inspectors focused on six outcomes that had direct impact on dementia care and followed up on the eight actions from the previous inspection. Five actions had been completed, two were partially complete (these related to care planning and behaviour support plans) and one was not actioned – this related to provision of meaningful activity for residents with dementia.

The Person in Charge and her deputy had attended information seminars given by HIQA regarding dementia inspections. The centre did not have a dementia specific unit. At the time of this inspection, of the 48 residents accommodated, 11 had a formal diagnosis of dementia and nursing staff stated that approximately a further 11

had a cognitive impairment. No resident was under 65yrs of age.

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. The results reflect the effect of the interactions on the majority of residents. This is discussed further throughout the report.

A Mental State assessment is completed on all residents on admission and repeated at regular intervals. This 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. The centre was also using the Cohen-Mansfield Agitation Inventory (CMAI). The purpose of this rating scale is to assess the frequency of manifestations of agitated behaviours in elderly persons. The CMAI was developed for use in nursing homes. While it is impossible to include all possible examples, it is intended to capture a group of closely related behaviours. The objective is not to try to judge if the behaviour can be explained, but to rate the frequency at which it actually occurs.

At the request of HIQA, the provider had submitted a completed self-assessment on dementia care to the HIQA together with relevant policies and procedures prior to the inspection. The provider had assessed the compliance level of the centre and had rated the centre to be substantially compliant with three outcomes and moderate non-compliance with three outcomes.

Inspectors found that the residents were well known by staff, and while the care needs of residents with dementia were met, improvements were required to activity provision and the environment. There was good availability of small sitting rooms. However, these were not been utilized for dementia specific 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 lobby area. This is discussed further throughout the report.

Six nurses (50%) and 16 (66%) care staff had undertaken dementia specific training including training in behaviour and psychological symptoms and signs of dementia (BPSD). One staff member who worked part-time as an activities coordinator had completed Sonas (a therapeutic activity for residents who are cognitively impaired) training. However, only one-to-one Sonas activity was available twice a week, thereby limiting the number of residents who were availing of this service. Staff reported that when residents had an opportunity to engage in Sonas they 'really enjoyed it'. Most residents spoken with by the inspectors stated they had choice regarding their day-to-day living in the centre.

At the feedback meeting at the end of the inspection, the findings were discussed with the provider nominee, person in charge, regional manager and deputizing person in charge. Matters requiring improvement are discussed throughout the

report and set out in an action plan at the end of this report in order to comply 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.

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

Outcome 14: End of Life Care

Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.

Theme:

Person-centred care and support

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

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

Findings:

At the time of the last inspection end-of-life preferences had not been consistently recorded for all residents. This had been addressed.

Staff provided end-of-life care to residents with the support of their General Practitioner (GP) and community palliative care services. Evidence was available that residents were regularly reviewed by their GP. End-of-Life care plans which outlined the physical, psychological and spiritual needs of residents, including residents' preferences regarding their preferred setting for delivery of care, had been completed with residents and there was evidence of family involvement.

Staff outlined how religious and cultural practices were facilitated within the centre.

Judgment:

Compliant

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:

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

No actions were required from the previous inspection.

Findings:

This outcome relates to assessments and care planning, access to healthcare and also encompasses nutritional care. The self-assessment tool (SAT) completed by the provider was rated moderate non-compliant. Areas for improvement included training for staff in BPSD (behaviour and psychological symptoms and signs of dementia) and training for

staff on medications in the treatment of dementia and Alzheimer's disease. Both of these had been completed.

Inspectors followed the pathway of 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.

Pre-admission assessments were completed to identify residents' individual needs and choices. There was evidence of communication with family members and the referring agency/person. An admission policy was available and inspectors found that this was reflected in practice. On review of residents' care files, inspectors found that their hospital discharge documentation was available. However, most files of residents admitted under the 'Fair Deal' Support Scheme did not include a copy of the Common Summary Assessments (CSARS) which details the assessments undertaken by a geriatrician, a medical social worker and a comprehensive nursing assessment. The provider informed the inspectors that the CSAR forms are not available to the centre and are kept in the Fair Deal office.

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. 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 the majority of residents and staff had developed care plans based on the risks and care needs identified. However, some care plans reviewed lacked sufficient detail to guide staff in the delivery of care. Care plans with regard to catheter care did not provide sufficient guidance to staff regarding the daily care of the catheter or detail when the catheter was last changed.

While arrangements were in place to evaluate care plans every four months, the evaluation failed to ensure the care plan was revised to reflect the residents' changing needs. There was evidence available that residents and or family, where appropriate, participated in reviews of the care plans.

There was one resident who had a wound on the day of inspection. Inspectors reviewed the management of wound care and found that the wound was improving but the resident had been prescribed antibiotics and there was no indication that a swab had been taken as per best practice prior to the introduction of the antibiotic. There was a pain assessment tool in place and inspectors noted that residents who were administered analgesia had a pain assessment completed. However, there was no procedure in place for monitoring the effectiveness of the analgesia administered.

Residents were screened for nutritional risk on admission and reviewed regularly thereafter. Improvement was required to the management of residents' nutritional needs. While residents were being weighed monthly and their weights were recorded, some nutritional care plans had not been updated to reflect current requirements and interventions, such as, modified consistency diets, updated recommendations of the speech and language therapist and whether the resident was on a fortified diet or what type of supplements had been prescribed. Some residents choose to dine in their own bedrooms, and this was facilitated.

Food and Fluid intake charts were being completed for residents assessed as being at risk of nutritional deficit. However, they were not sufficiently detailed to contain adequate information to provide a reliable therapeutic record for staff. Inspectors observed residents having their lunch in the dining room. Adequate staff were available to assist and monitor intake at meal times. 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 and dining room staff. This was not up to date and did not reflect recent changes from consultations with speech and language therapy services. For example, all residents, whether they had been prescribed texture A, B or C, were being given texture C. Additionally they did not have the same choice of food as residents on normal diets. There was poor evidence of clear lines of communication between the catering and the nursing staff. One of the inspectors met with the chef on duty who displayed limited knowledge of the specific nutritional needs of the residents and was not clear with regard to whether there was a choice for persons on coeliac.

Residents had access to the psychiatry of later life team who visited the centre as required. There was also good access to GPs and residents were facilitated to keep their own GP on admission to the centre. Inspectors found that residents had good access to allied healthcare professionals including dietitians, speech and language therapy and chiropody. A physiotherapist came to the centre every week and an occupational therapist on a monthly basis. A system was in place to ensure that residents with glasses had their eyesight tested on an annual basis. Dental referrals were actioned as required.

Arrangements were in place to review accidents and incidents. Residents at risk of falling were assessed using a validated falls assessment tool. The outcome of these assessments was communicated to all staff and a care plan specific to the identified falls risk was in place. 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 in relation to transfers and discharge of residents and hospital admissions. Inspectors examined the files of residents who were transferred to hospital from the centre. There was poor evidence available of effective communication between the centre and acute care services when a resident was being transferred for care. Staff informed the inspectors that they forwarded a care printout from their computerized

system to the hospital and the doctor who recommends admission completed a transfer letter, but no copies of these are kept in the centre. Additionally there was no narrative note maintained to indicate that this occurred.

Judgment:

Non Compliant - Moderate

Outcome 02: Safeguarding and Safety

Theme:

Safe care and support

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

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

Findings:

The self-assessment tool (SAT) completed by the provider for this outcome was rated substantially compliant. Policies and procedures were in place regarding safeguarding residents from abuse. All staff had completed training, and were knowledgeable about the steps they would take if they witnessed, suspected or were informed of any abuse taking place. Policies were also in place regarding managing responsive and psychological behaviour, and using methods of restraint in the service. Although behaviour support plans were in place they were not adequately detailed to ensure staff knew how to respond and to ensure the response was appropriate and consistent. For example, a behaviour support plan did not describe the type of behaviour exhibited, was not linked to any behavioral assessment, and failed to identify the diagnoses of the resident. Care plans also failed to identify what triggers the residents' responsive challenging behaviour so that staff could be aware of the triggers and try and ensure that distraction or de-escalation techniques could be utilized. Some residents were prescribed p.r.n. medicines (a medicine only taken as the need arises). However, when this was administered, the effectiveness was not monitored. Staff had received training in behaviour and psychological symptoms and signs of dementia.

A visitors' record was available by the reception area to monitor the movement of persons in and out of the building to ensure the safety and security of residents. The centre had adapted the national policy on a restraint-free environment. Restraints in use included bed rails. Before implementing a restraint measure, an assessment was completed to determine the suitability of the restraint for the specific resident and alternatives to the use of restraint had been trialled prior to the introduction of the restraint measure.

There were systems in place to safeguard residents' finances. There was a secure and transparent system for recording financial transactions regarding residents' finances. These transactions were clearly recorded with signatures of staff and or residents available for all transactions. There were five residents for whom the centre managed their finances. These residents' monies were held in client accounts by the organization.

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:

Most residents spent the day of inspection in the lobby area. This environment was unsuitable as it was not possible to control stimuli and space was confined and did not support free mobility for residents. 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.

Observations of the quality of interactions between residents and staff in communal areas 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. While residents were supervised at all times, Inspectors noted on some occasions that when staff accompanied residents to the dining room there was no interaction between the staff member and the resident.

Resident's quality of life was enhanced by visitors and by external entertainers and musicians. Inspectors observed that 70% of the observation period that the interaction for the majority of residents was neutral care for 70% of the observation period.

Care assistant staff, in conjunction with the activity co-ordinator, supported residents with social activities. Inspectors found that the provision of regular dementia specific therapeutic activities in small groups was not scheduled. At the time of the last inspection while there were opportunities for residents to engage in social care, inspectors found this was not sufficient to meet residents' needs. The provider responded by stating, 'the additional care assistant from 16:00 to 22:00 hrs was available to provide activities early evening'. Inspectors noted that this extra care staff member was available in the lobby on their arrival and thereafter until 22:00hrs. However, he was not available to provide meaningful activity to residents as he was supervising residents and providing nutritional care to residents. He was noted to engage positively with residents as he completed tasks. Inspectors spoke with other staff who confirmed that the main focus of this staff's allocated tasks was supervision to ensure the safety of residents and ensuring all residents had fluids as requested. Inspectors observed that when activities were taking place, the lobby area was noisy

and was not protected from external stimuli, for example, noise, television, radio and other residents.

While life stories were available, these required further input to make them more meaningful for residents. There was no linkage between the information that was available in the life stories 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. The activity schedule included

ball games, music and reading the newspaper. There was poor evidence of reminiscence or dementia-specific activities. Sonas was available, however, the only person trained in Sonas (a therapeutic activity for residents who are cognitively impaired) was the activity co-ordinator who worked part-time. This was offered twice a week on a one-to-one basis for residents with more severe dementia, therefore a limited number of residents were availing of this service. Residents were observed to spend time watching TV and while this is a meaningful activity for some residents, inspectors observed that some residents who were seated watching TV were not engaged.

There was a detailed communication policy in place that stated: 'The nursing home uses three communication techniques to communicate with the residents with dementia, reminiscence, reality orientation, and validation (acknowledges and empathizes with the person's feelings and reality. These to be documented in care plans'. Inspectors noted that there was no evidence available of this in the care plans or activity programme.

Residents' meetings were held; however, on checking residents who were diagnosed as having dementia, inspectors noted that none of these were recorded as having attended residents' meetings. No family members or advocate were in attendance to represent residents with dementia. 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 lobby and small sitting room area.

Staff addressed residents in a respectful manner. There were notice boards available throughout the centre providing information to residents and visitors. However, most communications were not in an accessible format for residents with dementia. Radio, television and newspapers were available for information about current affairs and local matters. Hairdressing arrangements were available to support residents' personal care and choices. An independent advocate was available to ensure the rights of residents are upheld. Residents were facilitated to exercise their civil, political and religious rights. The person in charge confirmed that arrangements were in place for residents to vote.

Judgment:

Non Compliant - Moderate

Outcome 04: Complaints procedures

<p>Theme: Person-centred care and support</p>
<p>Outstanding requirement(s) from previous inspection(s): No actions were required from the previous inspection.</p> <p>Findings: The person in charge advised inspectors that most complaints were managed at a local level. There was a complaints policy in place. Complaints that could not be resolved locally were escalated up to management. Complaints were detailed in the complaints log on the centre's computer system. One of the inspectors reviewed the complaints records and details were maintained about each complaint, details of any investigation into the complaint and whether or not the complainant was satisfied with the outcome</p>
<p>Judgment: Compliant</p>

<i>Outcome 05: Suitable Staffing</i>

<p>Theme: Workforce</p>

<p>Outstanding requirement(s) from previous inspection(s): The action(s) required from the previous inspection were satisfactorily implemented.</p> <p>Findings: Inspectors observed that staff delivered care in a respectful and timely manner. Staff were supervised appropriate to their role. There were appropriate staff numbers and skill set to meet the care needs of residents at the time of the inspection; however, consideration is required with regard to adequate staffing to provide meaningful activity to residents. An action with regard to this area is contained under Outcome 3.</p> <p>There was a planned staff roster in place, with any changes clearly indicated, and the staffing in place on the day of inspection was reflected in this roster. With regard to the direct delivery of care to residents, inspectors found there was two staff nurses and the person in charge plus six carers on duty up to 14:00hrs, two nurses and four care staff up to 20:00hrs and two nurses and three carers from 20:00hrs until 22:00hrs and two nurses and two carers from 22:00hrs to 08:00hrs. From a review of the working staff roster this was the usual levels. From review of additional rosters past and planned, inspectors noted that these were the standard staffing levels. This was also confirmed by staff. Household, kitchen, catering and activity staff were also available. Staff had up to date mandatory training in place. Seven nurses and 14 care assistant staff had attended a dementia care training day that incorporated training on behaviour and psychological symptoms and signs of dementia.</p>

There were effective recruitment procedures in place, and a random selection of staff files were checked by the inspectors who found that all the requirements of Schedule 2 of the Regulations had been met including Garda Vetting and appropriate references. Management confirmed that there were no volunteers working in the centre.

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:

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

No actions were required from the previous inspection.

Findings:

There was no designated dementia care unit in the centre. While the provider, person in charge and key management staff voiced the view that they were very committed to providing a high quality service for residents with dementia, improvements were required.

The entrance lobby opens in to an open plan area where all residents were accommodated sitting in different groups. There was one area partitioned off, but this partition did not provide a private quiet area. Inspectors found that the lobby did not provide a therapeutic setting for residents with dementia as it was noisy, it was impossible to limit stimuli and was not homelike in character. It was not conducive to residents moving around as they wished due to the layout of chairs which posed an obstacle to this.

The environment provided for residents to utilize was not in keeping with the centre's policy on creating a calm soothing environment by minimizing distractions and noises. The policy on communication stated that when staff are communicating with residents 'staff shall turn off background noise where possible and avoid having competing noises for example television and radio on at the same time'. This was not possible due to the open plan style of the lobby where most residents were generally accommodated during the inspection.

Elsewhere in the centre there was a sitting room, visitors' room and activities room and an oratory, but these were not being utilized effectively. Utilization of these areas would support more person-centred care and more therapeutic time spent with residents. While there was some signage and use of colours to support residents to be orientated

to where they were, this was not universal throughout the premises. There was a lack of fixtures and fittings that could aid and promote reminiscence.

The design of the building contributed positively to dementia care practice. Hallways were wide and unobstructed and there was contrast in the colours used for floors, walls and handrails. En-suite facilities in bedrooms were visible from beds and chairs to prompt residents to use these facilities. There are secure gardens available to residents. Access to areas that may pose a risk to residents such as the sluice room is restricted.

Inspectors 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 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:

Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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:	Kilcolgan Nursing Home
Centre ID:	OSV-0000351
Date of inspection:	17/02/2016
Date of response:	07/04/2016

Requirements

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

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

Outcome 01: Health and Social Care Needs

Theme:

Safe care and support

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

Some care plans reviewed lacked sufficient detail to guide staff in the delivery of care. Care plans with regard to catheter care did not provide sufficient guidance to staff regarding the daily care of the catheter or detail when the catheter was last changed.

1. Action Required:

Under Regulation 05(1) you are required to: Arrange to meet the needs of each

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

resident when these have been assessed in accordance with Regulation 5(2).

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

All care plans are being reviewed and updated to include more specific detail to guide staff in the delivery of care, particularly with regard to catheter care. The PIC and CNM will monitor clinical documentation and encourage staff nurses to ensure that care plans are based on the assessed care needs of each individual resident and that they accurately reflect the care being delivered in practice.

Proposed Timescale: 30/04/2016

Theme:

Safe care and support

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

A resident with a wound had been prescribed antibiotics but there was no indication that a swab had been taken as per best practice prior to the introduction of the antibiotic.

There was no procedure in place for monitoring the effectiveness of analgesia administered to residents.

2. Action Required:

Under Regulation 06(1) you are required to: Having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care for a resident, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais.

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

Antibiotic treatment was started by the GP based on prior knowledge of typical signs and symptoms of infection in this resident. The resident has 2 Vac wound drains in situ and has historically responded well to the introduction of antibiotic treatment if there are early signs or symptoms of local infection, without waiting for a wound swab to be sent for culture and sensitivity. It is otherwise usual practice to send a wound swab.

There is a documented pain assessment in place for all residents who may suffer from pain and a care plan in place for residents who receive regular and/or 'prn' analgesia, outlining the indications for its use. The effects of analgesia are also monitored and documented.

Proposed Timescale: 30/04/2016

Theme:

Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement

in the following respect:

There was poor evidence available of effective communication between the centre and acute care services when a resident was being transferred for care.

3. Action Required:

Under Regulation 06(2)(c) you are required to: Provide access to treatment for a resident where the care referred to in Regulation 6(1) or other health care service requires additional professional expertise.

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

All residents who require treatment in an acute hospital will have a transfer letter from the centre which will be sent to the acute hospital as part of the referral documentation, along with the GP's referral letter. All nursing staff are aware.

Proposed Timescale: 30/04/2016

Theme:

Safe care and support

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

Food and Fluid intake charts were being completed for residents assessed as being at risk of nutritional deficit, however they were not sufficiently detailed to contain adequate information to provide a reliable therapeutic record for staff.

Nutritional care plans had not been updated to reflect current requirements and interventions, such as, modified consistency diets, updated recommendations of the speech and language therapist and whether the resident was on a fortified diet or what type of supplements had been prescribed. All residents whether they had been prescribed texture a, b or c were being given texture c and they did not have the same choice of food as residents on normal diets.

There was poor evidence of clear lines of communication between the catering and the nursing staff with evidence of poor knowledge of the specific nutritional needs of the residents including whether there was a choice for persons on coeliac.

4. Action Required:

Under Regulation 18(1)(c)(iii) you are required to: Provide each resident with adequate quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietetic staff, based on nutritional assessment in accordance with the individual care plan of the resident concerned.

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

All care plans are currently being reviewed and updated to reflect current specific nutritional requirements and interventions such as modified consistency diets. Those residents on a Focused Nutrition care plan will have SALT and/or dietitian recommendations and details of nutritional supplements included in care plan. Staff education regarding modified consistency diets will be provided by the dietitian;

this education session will include nurses, carers and catering staff.
The PIC has introduced a record detailing the specific dietary requirements of all residents. This record includes the recommended texture of diet, fluid consistency and resident MUST score. The PIC will ensure that there is effective communication between nursing and catering staff regarding the dietary requirements, choices and preferences of all residents and that the record of this information is updated regularly as required. All staff have demonstrated a good understanding of different diet textures.

Proposed Timescale: 30/04/2016

Outcome 02: Safeguarding and Safety

Theme:

Safe care and support

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

Behaviour support plans in place were not adequately detailed to ensure staff knew how to respond and to ensure the response was appropriate and consistent.

Care plans failed to identify what triggers the residents' responsive challenging behaviour so that staff could be aware of the triggers and try and ensure that distraction or de-escalation techniques could be utilised.

Some residents were prescribed PRN (as required) medication however, when this was administered, the effectiveness was not monitored.

5. Action Required:

Under Regulation 07(2) you are required to: Manage and respond to behaviour that is challenging or poses a risk to the resident concerned or to other persons, in so far as possible, in a manner that is not restrictive.

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

Responsive Behaviour care plans are currently being reviewed and updated to include triggers that may provoke behaviours that are challenging and individualised approaches to de-escalate such behaviours. This information is also currently captured on ABC charts and the information gleaned from a 3-day ABC chart record will be included within individual care plans.

A record is maintained of the effectiveness of all PRN medications prescribed for residents on an individual basis. This evaluation record is kept with Medication Administration Records of residents for whom PRN psychotropic medication is prescribed and is regularly reviewed by nursing staff with the resident's GP.

Proposed Timescale: 30/04/2016

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

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

The provision of regular dementia specific therapeutic activities in small groups was not scheduled.

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:

Those residents with dementia will attend scheduled activities of their choice in the dayroom of the Tribes wing. A separate schedule of activities is currently being developed for these residents and will include but is not limited to group Sonas, reminiscence therapy, foot massage. There will be a range of small group activities and one to one activities offered to residents with cognitive impairment and/or a diagnosis of dementia with respect to individual choices and preferences.

Proposed Timescale: 30/04/2016

Theme:

Person-centred care and support

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

Residents meetings were held but residents who were diagnosed as having dementia were recorded as having attended residents meetings. No family members or advocate were in attendance to represent the views of residents with dementia.

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:

Residents' meetings are held regularly and they are open to all residents to attend. All residents including those with a diagnosis of dementia attend meetings by choice. Family members are also welcome to attend the residents' meetings; the date and time of meeting is always posted in the foyer at least 2 weeks in advance.

Proposed Timescale: 30/04/2016

Theme:

Person-centred care and support

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

the following respect:

On some occasions where there were negative interactions, between staff and residents; for example, where staff accompanied residents to the dining room there was no interaction noted between the staff member and the resident.

8. Action Required:

Under Regulation 09(1) you are required to: Carry on the business of the designated centre with regard for the sex, religious persuasion, racial origin, cultural and linguistic background and ability of each resident.

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

All staff are actively encouraged to interact regularly in a positive and meaningful manner with residents. This will be monitored continuously by the PIC and CNM on an on-going basis. Staff education on Dementia Care has been scheduled for all staff to enhance their understanding of the individual communication needs of residents with cognitive impairment and/or a diagnosis of dementia.

Proposed Timescale: 31/05/2016

Outcome 06: Safe and Suitable Premises

Theme:

Effective care and support

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

The lobby did not provide a therapeutic setting for residents with dementia as it was noisy, it was not possible to limit stimuli and was not homelike in character. It was not conducive to residents moving around as they wished due to the layout of chairs which posed an obstacle to this.

While there was some signage and use of colours to support residents to be orientated to where they were, this was not universal throughout the premises. There was a lack of fixtures and fittings that could aid and promote reminiscence.

9. Action Required:

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

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

Some residents who have lived in the centre for a long while have indicated a preference to sit in the main atrium of the centre and the PIC, CNM and staff are working with residents and their families on an individual basis to ascertain their preferences and choices about how they prefer to spend their time and in which dayroom facility. Residents who have a cognitive impairment and/or a diagnosis of dementia are encouraged to attend scheduled activities in the dayroom of Tribes wing and this facility will also be suitable for residents as a quieter alternative to the main

atrium of the building. This facility also reduces loud noise and stimuli and provides a more homelike setting.

The removal of some furniture from the main atrium, including a large table and chairs, will provide an obstacle free area for residents to move around more freely.

The bedroom doors of residents with dementia currently have a colourful sign with a picture that depicts past occupations or personal interests/hobbies and their name to make rooms more easily identifiable.

Proposed Timescale: 30/04/2016