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:	Caherciveen Community Hospital
Centre ID:	OSV-0000562
Centre address:	Caherciveen, Kerry.
Telephone number:	066 947 2100
Email address:	Caherciveen.CommunityHospital@hse.ie
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Ber Power
Lead inspector:	John Greaney
Support inspector(s):	None
Type of inspection	Unannounced Dementia Care Thematic Inspections
Number of residents on the date of inspection:	30
Number of vacancies on the date of inspection:	3

About Dementia Care Thematic Inspections

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

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

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

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

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

The inspection took place over the following dates and times

From:	To:
25 October 2016 10:15	25 October 2016 17:45
26 October 2016 08:30	26 October 2016 15:45

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

Summary of findings from this inspection

Caherciveen Community Hospital is a 33 bedded facility situated on the outskirts of the town. It is a single storey facility and 25 of the 33 residents are accommodated in multi-occupancy bedrooms of two, three and four beds.

This inspection report sets out the findings of a thematic inspection which focused on six specific outcomes relevant to dementia care. The purpose of this inspection was to focus on the care and quality of life for residents with dementia living in the centre. Seven of the thirty three residents who were living in the centre on the days of the inspection had a formal diagnosis of dementia and another seven residents were suspected of having dementia.

As part of the inspection the inspector also reviewed actions required from the

previous inspection to determine if they were implemented. Since the last inspection the directory of residents was updated to include the cause of death for deceased residents, which had not been included previously. Personal emergency evacuation plans had been developed for residents to identify the most appropriate means of evacuation in the event of an emergency. Records demonstrated that the fire alarm was tested weekly and processes were in place to ensure that an evacuation sheet that previous had been incorrectly fitted to the bed, was now fitted appropriately.

The provider had submitted a completed self assessment on dementia care to HIQA with relevant policies and procedures prior to the inspection. The judgements from the self assessment and inspection findings are set out in the table above.

Overall, residents' healthcare and nursing needs were met to a high standard. As part of the inspection, the inspector spent a period of time observing staff interactions with residents. The inspector used a validated observational tool (the quality of interactions schedule, or QUIS) to rate and record at five minute intervals the quality of interactions between staff and residents in a sitting room and dining room. Overall, the inspector observed staff interacting with residents in a positive and caring manner.

Residents had access to general practitioners (GPs) of their choice, and to allied healthcare services including physiotherapy, dietetics, speech and language therapy, psychiatry, dental, chiropody and occupational therapy. Staff provided end of life care to residents with the support of their GP and the community palliative care team to a good standard.

Improvements were noted in the care planning process and care plans were generally more person-centred and provided guidance on the care to be provided to residents on an individual basis. A sample of complaint records viewed indicated that action was taken in response to complaints and appropriate records were maintained.

Some improvements, however, were required. For example, there was inadequate communal and dining space. The dining room was also the sitting room and there was inadequate space for all resident to have their meals there, should they so wish. There was inadequate space for residents to meet with visitors in private. This was compounded by the fact that 25 of the 33 residents were in multi-occupancy rooms, so the option of meeting visitors in private in their bedrooms was not always available. While there was a programme of activities, these were usually in the mornings and there was no structured programme of activities in the afternoon. Other required improvements included:
• there was no accessible advocacy service
• residents meetings were infrequent and there were no records to indicate the minutes were reviewed and addressed
• not all staff had up-to-date training in responsive behaviour.

The action plan at the end of this report identifies where improvements are needed to meet 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.

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

Outcome 01: Health and Social Care Needs

Theme:
Safe care and support

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

Findings:
This outcome sets out the inspection findings relating to healthcare, nursing assessments and care planning. The social care of residents with dementia is comprehensively covered in Outcome 3.

The inspector focused on the experience of residents with dementia and tracked the journey of a number of residents with dementia. The inspector also reviewed specific aspects of care such as wound care and restrictive practices in relation to other residents.

Residents were usually admitted through the public health nursing service. A common summary assessment report (CSAR) was completed by a placement coordinator and other relevant healthcare professionals, detailing the health needs of each resident. A copy of this report was available in each resident's record. Pre-admission assessments were not routinely carried out on all residents prior to admission to the centre, however, many of the residents had spent some time in the centre on respite prior to becoming permanent residents and therefore staff were usually familiar with the residents.

Residents had access to general practitioners (GPs) of their choice. Medical notes indicated that residents were reviewed regularly by their respective GPs. Out-of-hours GP services were also available and readily accessible, as they were based adjacent to the centre. Residents had good access to allied healthcare services due to the co-location of the centre with a day hospital and a mental health day centre. A physiotherapist visited the centre, usually for one hour each day. A dietician visited the centre for one day each month but was accessible at other times should the need arise. Speech and language therapy and occupational therapy were available on a referral basis. A dentist had visited the centre in the recent past and all residents had an oral exam. A mobile optician also visited the centre recently. Other services available include psychiatry, geriatric medicine, palliative care and chiropody.

The inspector viewed a sample of residents' records, some of whom had been

transferred to hospital from the centre and found that appropriate information about their health, medications and their specific communication needs were shared with the admitting hospital. Records of residents' assessments reviewed included comprehensive biographical details, medical history, and nursing assessments.

The inspector primarily focused on the experience of residents with dementia and tracked the journey of a number of residents with dementia. Aspects of care such as wound care, access to activities and restrictive practices in relation to other residents was also reviewed.

Comprehensive nursing assessments were carried out that incorporated the use of validated assessment tools for issues such as the risk of falling, risk of developing pressure sores and for the risk of malnutrition. Care plans were developed for issues identified on assessment. New care plan documentation had recently been introduced and staff were in the process of developing new care plans for all of the residents. Improvements were seen since the most recent inspection in January 2015 and care plans were now more personalised and provided good guidance on the care to be provided. For example, the care plan for one resident described how she liked to have a hot drink at 8pm prior to going to bed. She also liked to listen to her music and have a dim night light to assist her go the sleep. There was a comprehensive care plan on the management of wounds, which detailed the type and frequency of the dressing to be applied. Some improvements, however, were required in the record of dressing changes and the wound assessment tool. For example, where there was evidence of a significant change in the status of the wound, a new assessment record was not completed. Additionally, each wound did not have a separate record detailing the type of dressing applied and as a result it was difficult to decipher what dressing was applied to each wound.

There were written policies and procedures in place for end-of-life care. Staff provided end of life care to residents with the support of their GP and the community palliative care team. There were no residents at active end of life stage on the days of inspection. The inspector reviewed the record of a deceased resident and was satisfied that end-of-life care was provided to a good standard. Records indicated the involvement of the family and the support of the palliative care team. There was ongoing assessment of pain using a recognised pain assessment tool and medicines were titrated to support the resident to be pain free. The care plan used, however, was generic and did not provide guidance on the care to be provided on an individual basis. The inspector was informed that a new person-centred care plan would be created as part of the introduction of new care plans.

Records indicated that end-of-life preferences were discussed with residents and/or their relatives and these were documented in residents' records. There were two palliative care rooms in a separate wing of the centre. Each room was en suite with toilet, shower and wash hand basin. There were also two en suite bedrooms for use by relatives, which were adjacent to the residents' bedrooms. There was a small sitting room for relatives to make tea and coffee, should they so wish.

There were policies and procedures to guide practice in relation to the management of nutrition. There were systems in place to ensure residents' nutritional needs were met,

and that they did not experience poor hydration. Residents were weighed regularly and were assessed for the risk of malnutrition on admission and at regular intervals thereafter. There was an effective system of communication between nursing and catering staff to support residents with special dietary requirements. Inspectors found that residents who required modified consistency diets and thickened fluids received the correct diet and modified meals were attractively served. Residents that were identified as having unintentional weight loss were assessed by a dietician and advice to increase calorific intake had been appropriately communicated to catering staff.

Most residents had breakfasts in their bedrooms, which was served at 08:15hrs. There were no separate dining facilities and residents had their meals in the main day room, which also served as a dining room. This room was insufficient in size should all residents wish to have their meals here. For example on one of the days of the inspection there were 16 residents having their lunch in the dining room. Nine of these residents were sitting at small dining tables and seven were sitting in either armchairs of speciality chairs with trays tables. All other residents had their meals in their bedrooms.

Fluids were available throughout the day and tea/coffee and snacks were served between meals and in the evening. On the day of the inspection there were adequate numbers of staff on duty to assist residents with their meals. Residents requiring assistance were assisted by staff in a respectful and dignified manner.

The centre had operational policies relating to the ordering, prescribing, storing and administration of medicines to residents. There were processes in place for the handling of medicines including controlled drugs, which were safe and in accordance with current guidelines and legislation. Medication administration practices observed by the inspector were in compliance with relevant professional guidance. A review of a sample of medication prescription and administration charts indicated that practices employed were in compliance with the centre's policies on medication management.

A health service executive (HSE) pharmacist visited the centre weekly. The pharmacist carried out a detailed review and medication reconciliation for all new residents and also reviewed residents' prescriptions on an ongoing basis. The pharmacist also monitored stock levels and provided advice to staff in relation to medication management. Medication management practices were audited, however, there was no action plan associated with the most recent audit to identify how required improvements would be achieved. There were appropriate procedures in place for the management of unused or out-of-date medication. Medication requiring refrigeration were stored appropriately and the fridge temperature was monitored and recorded.

This outcome was judged to be substantially compliant in the self assessment, and the inspector judged it as substantially compliant.

Judgment:
Substantially Compliant

Outcome 02: Safeguarding and Safety

Theme:
Safe care and support

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

Findings:
There was an up-to-date policy in place that addressed prevention, detection, reporting and investigating allegations or suspicions of abuse. Records available indicated that all staff had up-to-date training in recognising and responding to abuse. Staff members spoken with by the inspector were knowledgeable of what action to take if they witnessed, suspected or had abuse disclosed to them. Residents spoken with were complimentary of the care provided and stated that they felt safe. There were no reported allegations of abuse.

There were policies in place about meeting the needs of residents with responsive behaviour (also known as behavioural and psychological signs and symptoms of dementia) and restrictive practices. Policies were seen to give clear instruction to guide staff practice. Training records reviewed by inspectors indicated that staff were facilitated attend training related to the care of people with dementia and responsive behaviour, however, not all staff had attended this training. There were no residents at the time of inspection that presented with responsive behaviour. Staff spoken with were knowledgeable of individual resident's behaviour including how to avoid the situation escalating. The inspector reviewed incident reports in relation to resident's behaviour and records confirmed the information given to inspectors that there were no recent significant behavioural related incidents.

There were residents who required or requested the use of bed rails and there were risk assessments completed prior to the use of bedrails. There were records available of safety checks while restraint was in place.

There were adequate systems in place to safeguard residents finances. The centre managed the finances of a small number of residents and adequate records were maintained of lodgements and expenditure.

This outcome was judged to be compliant in the self assessment and the inspector judged it as compliant.

Judgment:
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:
Residents were consulted about how the centre was planned and run through residents' meetings. The meetings had been chaired by a resident advocate, however, the advocate was no longer available and the meetings had become infrequent. For example, the most recent meeting was held in May 2016 and the previous meeting was in October 2015. In addition to the frequency of meetings, there was no associated action plan to demonstrate that issues raised were addressed or reviewed. While an advocate had visited the centre on one occasion, the provider had failed to adequately support residents to avail of an independent advocate on a regular basis.

Religious preferences were documented and there was evidence that they were facilitated. The centre had a small oratory. Religious ceremonies were celebrated in the centre, including daily prayers and monthly mass for Catholic residents. Residents were facilitated to vote in local and national elections and the returning officer had visited the centre to facilitate residents to vote in the general election.

Improvements were required in the premises in relation to supporting the privacy and dignity of residents. For example, there was inadequate communal space for residents and inadequate space for residents to meet with visitors in private or to spend time alone, should they so wish. As will be discussed in more detail under Outcome 6, 25 of the 33 residents were accommodated in multi-occupancy bedrooms of two, three and four beds. There was inadequate communal space for residents and inadequate space for residents to meet with visitors in private or to spend time alone, should they so wish.

Staff were knowledgeable of individual residents needs and preferences, addressed residents by their name and conversed with them on issues that appeared to be of interest or relevant to the resident. The inspector observed staff interacting with residents in an appropriate and respectful manner. The inspector observed staff knock on bedroom doors before entering.

Residents choose what they liked to wear and inspectors saw residents looking well dressed, including jewellery and makeup. Care plans identified what residents liked to wear and advised staff to consult with residents about what they would like to wear and to give them adequate time to choose their clothes.

Positive interactions between staff and residents were observed during the inspection. As part of the inspection, inspectors spent a period of time observing staff interactions with residents. Inspectors used a validated observational tool (the quality of interactions schedule, or QUIS) to rate and record at five minute intervals the quality of interactions between staff and residents in two communal areas. The scores for the quality of interactions are +2 (positive connective care), +1 (task orientated care, 0 (neutral care), -1 (protective and controlling), -2 (institutional, controlling care). An overview of these observation periods is detailed below

Observations were recorded in the sitting room/dining room. The total observation period was 90 minutes, which comprised three 30 minute periods. For rating purposes,

there were 18 five minute observation periods. 13 scores of +2 were given predominantly when activities were taking place and when staff were seen to assist residents to the dining room and assist with meals. Staff were also seen to sit with residents and chat with them while making good eye contact. Four scores of +1 were given when there were minimal staff in the sitting room. One score of 0 was given when residents were seen to be left alone in the sitting room without any stimulation.

Activities were facilitated by external personnel and predominantly took place in the morning. An activities person visited the centre on Monday and Wednesday from 10am to 12 noon to provide a range of activities to residents in groups and one-to-one, based on residents' interests. For example, on the second day of the inspection some residents were doing a crossword, another resident was knitting, some residents were playing board games and a number of residents were watching a DVD of scenic views while listening to music. On Tuesdays an organisation visited, also from 10am to 12 noon, to provide art and craft based activities, such as painting, making greeting cards, and working with clay. A musician visited on Thursdays, usually from 10.30am to 12 noon and on Friday a massage therapist visited for two hours. There were no organised activities in the afternoon. While the inspector was informed that staff try to spend one-to-one time with the residents in the afternoon, the absence of a schedule of activities for the afternoon meant that this was unlikely to occur on a daily basis.

This outcome was judged to be substantially compliant in the self assessment, and the inspector judged it as moderate non-compliant .

Judgment:
Non Compliant - Moderate

Outcome 04: Complaints procedures

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:
There was a system in place to ensure that the complaints of residents or their representative were listened to and acted upon. There was a complaints policy that identified the person responsible for managing complaints and also included an appeals process. The complaints procedure was on prominent display in the centre, and summarised in the residents guide.

Throughout the inspection it was clear that residents were familiar with all members of management including the person in charge and the clinical nurse manager. It was apparent to inspectors that residents would find staff easy to approach with any concerns or complaints.

Inspectors viewed the complaints log that contained details of complaints, the investigation of each complaint, the outcome of the investigation and whether or not the complainant was satisfied with the outcome of the complaint.

This outcome was judged to be compliant in the self assessment, and the inspector judged it as compliant.

Judgment:
Compliant

Outcome 05: Suitable Staffing

Theme:
Workforce

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

Findings:
Inspectors observed staff providing care in a respectful and caring manner. Residents appeared to be familiar with staff. An actual and planned roster was maintained in the centre, with any changes clearly indicated. The person in charge was supported in her role by a clinical nurse manager. There was a regular pattern of rostered care staff.

The staffing complement on the day of inspection comprised two staff nurses from 08:30hrs until 20:30hrs, one staff nurse from 08:30hrs until 17:30hrs and one staff nurse from 09:00hrs until 17:00hrs. There were three healthcare assistants on duty, one from 08:00hrs to 20:00hrs, one from 08:30hrs to 17:30hrs and one from 09:00 to 17:00hrs. There were three catering staff, a staff member in the kitchenette, one laundry staff, two housekeeping staff, one administrator and a general operative.

There was a varied programme of training for staff. In addition to mandatory training the training programme included training on issues such as nutrition, palliative and end-of-life care, wound care and use of the syringe driver. Some improvements, however, not all staff had not attended up-to-date training in on responsive behaviour or on dementia care.

Inspectors reviewed a sample of staff files and found that all of the requirements of Schedule 2 of the regulations were met in the sample of files viewed. There were adequate records in relation to volunteers with their roles and responsibilities set out in writing, supervision arrangements and satisfactory garda vetting.

This outcome was judged to be substantially compliant in the self assessment and inspectors judged it as substantially compliant.

Judgment:
Substantially Compliant

Outcome 06: Safe and Suitable Premises

Theme:
Effective care and support

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

Findings:
Caherciveen Community Hospital is a 33 bedded facility situated on the outskirts of the town. Bedroom accommodation comprises eight single bedrooms, three twin bedrooms, one triple bedroom and four four-bedded rooms. Two of the single bedrooms were reserved for palliative care purposes and are self-contained in a separate wing that also include two bedrooms for relatives and a small sitting room with tea/coffee making facilities. The palliative care rooms and the relatives rooms are en suite with shower, toilet and wash hand basin.

Sanitary facilities for the rest of the centre comprise one bathroom with assisted bath, toilet and wash hand basin; two bathrooms with assisted showers, toilet and wash hand basin; two toilets with two cubicles in each and two wash-hand basins; three single toilets with wash-hand basins; and a staff toilet. There were also three sluice rooms, each one with a bedpan washer, sluice sink, wash-hand basin and adequate racking for storing urinal bottles and commode pans.

Most bedrooms had overhead tracking hoists. Records were available demonstrating the preventive maintenance of equipment such as beds and overhead hoists. Records of preventive maintenance was available for two of the three portable hoists.

The centre was generally well maintained, bright, clean and comfortable, however, it was not designed to meet the needs of residents with dementia. There was some signage to assist residents and visitors to navigate around the centre, however, further enhancement was required. There was also a distinct lack of contrasting colours to distinguish various areas of the centre. Some other issues identified included tiles missing from the wall in one of the bathrooms and a rusted pipe and damaged ceiling in another bathroom.

Communal facilities comprised a sitting room that also served as a dining room. There was also a smaller sitting room adjacent to the sitting/dining room with comfortable seating. Even though this smaller room was suitably decorated, comfortable and was also used for some activities, it did not have an external facing window and hence had minimal natural light. The dining room/sitting room had large windows providing plenty of natural light and scenic views of the surrounding area. However, it was insufficient in

size to meet the needs of all residents living in the centre.

Since the last inspection combined wardrobe and bedside locker units were purchased and provided for each residents. While it was an improvement from what was previously available, the wardrobe section was quite small and could only store a small amount of clothes.

There was a small enclosed courtyard with high walls containing appropriate furniture and raised plant beds. This area was accessible to residents, however, it was not sufficient in size to allow for free movement of residents. Additional external space was available at the front of the centre, however, due to the low boundary railing and proximity to the car park and the main road, it was unsuitable for residents with a cognitive impairment without staff supervision.

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:

John Greaney
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:	Caherciveen Community Hospital
Centre ID:	OSV-0000562
Date of inspection:	25/10/2016
Date of response:	25/11/2016

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 Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The care plan used for end of life care was generic and did not provide guidance on the care to be provided.

1. 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

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

that resident's admission to the designated centre.

Please state the actions you have taken or are planning to take:
The end of life care plan will be revised to facilitate more person centred care

Proposed Timescale: 30/04/2017

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some improvements, however, were required in the record of dressing changes and the wound assessment tool. For example:
• where there was evidence of a significant change in the status of the wound, a new assessment record was not completed
• each wound did not have a separate record detailing the type of dressing applied and as a result it was difficult to decipher what dressing was applied to each wound.

2. Action Required:
Under Regulation 05(2) you are required to: Arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to the designated centre.

Please state the actions you have taken or are planning to take:
Education sessions will be provided to staff on the use of new wound care documentation by 31/1/2017

Proposed Timescale: 31/01/2017

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents were consulted about how the centre was planned and run through residents' meetings, however, the meetings had become infrequent.
In addition to the frequency of meetings, there was no associated action plan to demonstrate that issues raised were addressed or reviewed.

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

Please state the actions you have taken or are planning to take:
Resident meeting will take place on a 12 week basis and action plans will be written as and when issues arise.

Proposed Timescale: 31/12/2016

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
An advocate from a national advocate agency visited the centre on one occasion who stated that he could be contacted should residents require advocacy, however, there was no independent advocate available to meet with residents on a regular basis.

4. Action Required:
Under Regulation 09(3)(f) you are required to: Ensure that each resident has access to independent advocacy services.

Please state the actions you have taken or are planning to take:
There is access to an independent advocacy service, contact numbers are displayed in the unit, for residents, family/relatives/staff to contact and an independent advocate will visit the centre, more posters will be displayed within the centre with the contact details available. Because of the geographical location it can be difficult to have an advocate visit on a regular basis.

Proposed Timescale: 30/11/2016

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Improvements were required in the premises in relation to supporting the privacy and dignity of residents. For example, there was inadequate communal space for residents and inadequate space for residents to meet with visitors in private or to spend time alone, should they so wish.
25 of the 33 residents were accommodated in multi-occupancy bedrooms of two, three and four beds.

5. Action Required:
Under Regulation 09(3)(b) you are required to: Ensure that each resident may undertake personal activities in private.

Please state the actions you have taken or are planning to take:
There are currently 3 areas that can be identified for residents if they wish to meet family in private, small sitting room, kitchenette area, and oratory.

In each of the rooms there are screens that can be pulled if the residents wish privacy in their rooms

The overall accommodation will be addressed in the reconfiguration plans by 2020

Proposed Timescale: 31/12/2020

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were no organised activities in the afternoon. While the inspector was informed that staff try to spend one-to-one time with the residents in the afternoon, the absence of a schedule of activities for the afternoon meant that this was unlikely to occur on a daily basis.

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:
There will be a schedule of activities for the afternoon, taking into consideration person centred care and choice

Proposed Timescale: 31/01/2017

Outcome 05: Suitable Staffing

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some improvements were required in relation to staff training as not all staff had not attended up-to-date training in on responsive behaviour or on dementia care.

7. 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:
The national dementia training was commenced in 2016 and training date are scheduled for 2017 and staff will be facilitated to attend these training days on dementia care including responsive behaviour.

Proposed Timescale: 30/11/2017

Outcome 06: Safe and Suitable Premises
Theme: Effective care and support **The Registered Provider is failing to comply with a regulatory requirement in the following respect:** There was some signage to assist residents and visitors to navigate around the centre, however, further enhancement was required. There was also a distinct lack of contrasting colours to distinguish various areas of the centre. **8. Action Required:** Under Regulation 17(1) you are required to: Ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3. **Please state the actions you have taken or are planning to take:** Signage will be provided to assist residents to find their way around the centre
Proposed Timescale: 31/01/2017
Theme: Effective care and support **The Registered Provider is failing to comply with a regulatory requirement in the following respect:** Improvements were required in relation to the premises. For example: • there was inadequate communal space • there was inadequate dining space • there was inadequate access to safe and suitable outdoor space • there were tiles missing from one bathroom wall • there was a rusted piped and damaged ceiling in one of the bathrooms. **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:** Bathroom tiles will be replaced and the pipe and ceiling will be amended by 31/12/2016 The dining, communal, and outdoor space will be addressed in the proposed plan for completion by 2020
Proposed Timescale: 31/12/2020