

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Carthage Nursing Home
<b>Centre ID:</b>	OSV-0000021
<b>Centre address:</b>	Mucklagh, Tullamore, Offaly.
<b>Telephone number:</b>	057 935 2863
<b>Email address:</b>	info@carthagenursinghome.com
<b>Type of centre:</b>	A Nursing Home as per Health (Nursing Homes) Act 1990
<b>Registered provider:</b>	Anvik Company Limited
<b>Provider Nominee:</b>	Catherine Murphy O'Connor
<b>Lead inspector:</b>	Sonia McCague
<b>Support inspector(s):</b>	Siobhan Kennedy
<b>Type of inspection</b>	Unannounced Dementia Care Thematic Inspections
<b>Number of residents on the date of inspection:</b>	61
<b>Number of vacancies on the date of inspection:</b>	2

## **About Dementia Care Thematic Inspections**

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

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

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

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

**The inspection took place over the following dates and times**

From: 17 February 2016 09:30 To: 17 February 2016 20:00

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

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

**Summary of findings from this inspection**

This inspection report sets out the findings of a thematic inspection which focused on six specific outcomes relevant to dementia care. An additional outcome was partially inspected in relation to health and safety and risk management. The purpose of this inspection was to determine what life was like for residents with dementia living in the centre. The inspection also considered findings from the last inspection carried out on 13 May 2014, notifications submitted and unsolicited information received by the Health Information and Quality Authority (the Authority) since the last inspection.

The centre did not have a dementia specific unit and at the time of inspection there were 29 residents of the 63 that had a formal diagnosis of dementia. Inspectors observed that many of the residents required a high level of support and monitoring due to their individual needs and dependencies.

The provider had submitted a completed self assessment tool on dementia care to the Authority with schedule 5 policies and procedures requested prior to the inspection. The provider had assessed the compliance level of the centre through the self assessment tool but the findings of inspectors did not accord with the provider's judgements.

Although some progress was made by the provider in implementing the required improvements identified on the last inspection in May 2014, one of the findings in relation to meaningful activities was again evident on this inspection.

On the day of inspection the person in charge, who is also the provider nominee was working in the centre. The purpose and function of the inspection was outlined to the person in charge at the commencement of the inspection.

Overall, inspectors found improvements required in five of the six outcomes specific to the thematic inspection with moderate non compliances found under Outcomes 1, 2, 3, 5 and 6. Outcome 4 was found to be compliant. Improvement was also required in Outcome 7 as moderate non compliances regarding fire safety and risk management was found during this inspection.

Improvements in resident assessments and care plans, the management of behaviours that challenge, staff training and staffing levels at night, and medication management. Aspects of the physical environment also required improvement in order to support people with dementia.

Risks associated with fire safety precautions and emergency evacuation plans including fire compartments of the building required attention and was to be addressed by the person in charge and operations manager following feedback.

At the feedback meeting at the end of the inspection, the findings were discussed with the provider nominee/ person in charge and the services manager. Matters requiring improvement are discussed throughout the report and set out in an action plan at the end of the report.

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

***Outcome 01: Health and Social Care Needs***

**Theme:**

Safe care and support

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

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

**Findings:**

This outcome sets out the inspection findings relating to assessments and care planning, access to healthcare, maintenance of records and policies available governing practice. The social care of residents with dementia is reported in Outcome 3.

The self assessment tool (SAT) completed by the provider was rated substantially compliant in this outcome with some areas for improvement highlighted. An improvement outlined in this outcome included establishing each resident's legal status and capacity at the pre-admission stage by May 2016. At the time of inspection, five residents in the centre were represented by a ward of court order. Other areas for improvement identified by the provider are discussed in the body of the report.

Inspectors focused on the experience of residents with dementia and they tracked the journey prior to and from admission of four residents. They also reviewed specific aspects of care such as nutrition, wound care, mobility, access to health care and supports, medication management, end of life care and maintenance of records.

Arrangements were in place to support communications between the resident and family, and or the acute hospital and the centre. The person in charge visited prospective residents in hospital prior to admission. This arrangement gave the resident and or their family an opportunity to meet in person, provide information about the centre and assess or determine if the service could adequately meet the needs of the resident.

An admission policy dated 9 May 2014, in the main reflected in practice. Residents' files held a copy of their hospital discharge letters (medical and nursing). However, the files of residents admitted under 'Fair deal' did not include the copy of the Common Summary Assessments (CSARS), which details assessments undertaken by professionals such as a geriatrician, a medical social worker and nurse. An improvement outlined in the self assessment tool (SAT) included accessing and requesting a copy of the CSARS for future prospective residents.

Residents had a comprehensive nursing assessment on admission. The assessment process involved the use of validated tools to assess each resident's dependency level, risk of malnutrition, falls and their skin integrity. However, an assessment of the level of cognitive impairment of all residents admitted with a diagnosis of dementia was not available or recorded.

An assessment of cognition using a validated tool did not routinely form part of the admission, follow up or review process. An improvement outlined in the self assessment tool (SAT) included access to or completion of an assessment using a validated tool mini mental state examination (MMSE) to assess residents level of cognitive function on admission. This assessment outcome was to be linked to the care plan for review three monthly thereafter.

Arrangements were in place to meet the health and nursing needs of residents with dementia. Access to allied healthcare professionals including physiotherapy, dietetic, speech and language, tissue viability, continence advisor, dental, ophthalmology and podiatry services were facilitated on a referral basis.

Inspectors were informed that residents had access to psychiatry of later life services. From the cases tracked it was evident that this service had been available to some residents prior to their admission. However, it had not been made available to all in residents since admission. Access to psychiatry of later life (POLL) services was on the referral basis. An inspector read in a resident's nursing records of a recommended referral required to POLL following discussions with the GP. However, a copy of correspondence to or from the designated centre relating to each resident including referrals to other services was not maintained in the centre as required. A record or actual update to confirm the referral had been made was not available. Psychology services was available to residents on a referral basis. Referral or access to occupational therapy (OT) was found to limited. Some resident's seating arrangements had not been reviewed by an OT to determine the suitability of the equipment in use.

Clinical observations such as blood pressure, pulse and weight were assessed on admission and as required thereafter. Functional assessments were carried out prior to and on admission of residents. A care plan was developed following admission based on the residents assessed needs. However, care plans had not been put in place for all the identified needs and changing needs of residents. Some care plans did not contain sufficient information to specify the actual problem and guide the necessary care interventions of residents.

Arrangements were in place to evaluate existing care plans routinely on a four monthly basis. However, the evaluation did not ensure the care plan was updated or revised to reflect the residents' changing care needs. Evidence that residents and or family, where appropriate, participated in care plan review meetings at intervals not exceeding four months was not available.

Staff provided end of life care to residents with the support of their GP and community palliative care services. 'End of life' care plans that outlined the physical, psychological and spiritual needs of the residents, including residents' preferences regarding their

preferred setting for delivery of care had not been completed with all residents and or family.

Since the last inspection 13 May 2014 and registration of the centre for 67 residents, the provider and person in charge had reconfigured the four multi-occupancy bed rooms as indicated in their action plan response. The maximum number of residents that can be accommodated in the centre was 63 at the time of this inspection. Four bedrooms had reduced the occupancy to three residents. There were six twin rooms and 39 single rooms available. The choice of a single room or alternative arrangements for residents and those in shared bedrooms was to be determined when residents were approaching their end of life. Relatives or friends would be accommodated in the visitor's room with refreshment facilities available.

Staff outlined how religious and cultural practices were facilitated within the centre. There was an oratory and religious services were held regularly.

Since the last inspection up to five residents had pressure ulcers or wounds, and at least two residents were admitted to the centre with pressure ulcers. Inspectors tracked wound care for residents and found their wounds were either healed or healing. Residents identified at risk of developing pressure ulcers had specific equipment in place to mitigate the risk, such as repositioning regimes, pressure relieving mattresses and cushions. There were two residents with pressure ulcers at the time of inspection. One resident's medical condition had resulted in specialist treatment in hospital.

Arrangements were in place to meet the nutritional and hydration needs of residents with dementia. There were systems in place to ensure residents' nutritional needs were facilitated and monitored. Inspectors were told that residents had been administered subcutaneous fluids to treat dehydration in the past. The person in charge told inspectors subcutaneous fluids was not in use or used on a regular basis. Inspectors confirmed that one of the current residents had a percutaneous endoscopic gastrostomy (PEG) tube in place.

Residents were screened for nutritional risk on admission and reviewed regularly thereafter. Residents' weights were checked on a monthly basis, and more frequently when indicated. Referrals for review by a dietician and or speech and language therapist were prompted following assessment and reviews. However, a record to demonstrate the referral was not consistently maintained in the centre.

Nutritional and fluid intake records when required were appropriately maintained. Procedures and care plans were in place in relation to nutritional care. However, the associated care plans had insufficient detail regarding residents' individual food preferences, and the recommendations of dieticians and speech and language therapists where appropriate.

Inspectors saw that a choice of meals was offered and available to residents. There was the system of communication between nursing and catering staff to support residents with special dietary requirements. Mealtimes in the dining rooms were social occasions with attractive table settings and staff sat with residents while providing encouragement or assistance with the meal. Some residents choose to dine in their own bedrooms, and

this was facilitated.

There were arrangements in place to review accidents and incidents within the centre, and residents were regularly assessed for risk of falls. A system was in place to highlight and communicate the risk rate to all staff. However, a care plan specific to the identified falls risk had not been put in place for all residents and/or updated following 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 and found that appropriate information about their health, medications and their needs in relation to activities of daily living were included in the nurse transfer letter.

An improvement outlined in the self assessment tool (SAT) included the development and implementation of a resident passport by May 2016. The aim of which was to ensure all critical information was available with each resident on transfer to hospital or other appointments.

Residents had access to a pharmacist and general practitioner (GP) of their choice and the majority opted for the services of their previous GP. There were eight GP's attending to residents in the centre.

Arrangements were described that involved the pharmacist, GP and person in charge or clinical nurse manager's participation in a four monthly medication review. However, improvements were required based on the findings from this inspection.

There were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents. However, the policy had not been implemented as inspectors found practices in relation to prescribing, administration, recording and review of medication did not meet with professional or regulatory requirements. Residents were not sufficiently protected by medication practices and procedures found in the sample of resident's records inspected and all medicines had not been administered in accordance with the directions of the prescriber.

Suitable arrangements by an appropriate health care professional to meet the needs of each resident had not been facilitated or maintained as required.

A record of on-going medical assessment, treatment and care provided by a person's medical practitioner was not available.

Inspectors found that psychotropic medication transcribed by nurses (but unsigned) had been commenced and administered to one resident from 29 December 2015. The dose was subsequently increased on two occasions dated 27 January 2016 and 16 February 2016. The medication had been recorded and confirmed as administered in the absence of a record of a GP review and original prescription. Three fax prescriptions were available that coincided with dates the psychotropic medication was commenced and increased. The actual prescription kardex record showed that the last prescription date completed by the general practitioner (GP) was in August 2015. The resident's medical records showed the last review date recorded by the general practitioner was June 2015, on return to the centre from a hospital admission. The medication administration

record showed the medicine had not been administered in accordance with the fax directions of the prescriber. A care plan to include all recommended treatments or medical reviews and or medication adjustments was not developed or maintained.

Records were not consistently maintained in accordance with professional standards and guidelines. Opposing names were recorded for one resident in clinical and medication prescription records reviewed which may compromise resident safety.

Medication administration records showed incorrect and unsafe practices in relation to transcribing and administration practices. A record of each medicine administered, signed and dated by the nurse was not maintained in accordance with relevant professional guidelines.

**Judgment:**

Non Compliant - Moderate

***Outcome 02: Safeguarding and Safety***

**Theme:**

Safe care and support

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

No actions were required from the previous inspection.

**Findings:**

The self assessment tool (SAT) completed by the provider for this outcome was rated compliant and the response included continuing to educate staff about concerning behaviour by means of toolbox talks and open discussions.

The safeguarding policy entitled elder abuse prevention, protection and response dated 6 October 2015 was received along with the SAT.

While the policy did not reference the National Policy 'Safeguarding Vulnerable Persons at risk of Abuse' (2014) it did resemble the overall processes and procedures to be implemented.

The centre's policy included that 'all staff will undertake training prior to the commencement of employment and thereafter on the 2 yearly basis' as the safeguarding measure. Training records available indicated that the majority of staff had completed training on the prevention, detection and response to abuse. However, a small number of staff (one rostered day staff) had no training date to confirm attendance and two rostered staff members (day and night) had not received refresher training in the past two years as per the centre's policy.

Staff who spoke with inspectors were knowledgeable about the various types of abuse, recognising abuse, and were familiar with the reporting structures in place. There were

no reported allegations of abuse notified to the Authority.

The person in charge was well known to residents and relatives. Staff confirmed that there were no barriers to raising issues of concern which were addressed promptly.

A policy entitled concerning behaviours dated 2 February 2016 was received in relation the management of behaviours that challenge. It was a comprehensive policy that included assessment protocols, guidelines for the management of episodes of violence and aggression and use of physical intervention as a means of response. However, this policy was not entirely reflected in the practices found. Staff had not completed training specific to the professional management of aggression and violence and or use of safe and appropriate physical intervention techniques as outlined in the policy.

Training specific to behaviours that challenge and or dementia had not been completed by all staff. Improvements were required to promote a positive behavioural support approach to residents' with behaviours that challenged and or that negatively impacted on others.

A comprehensive assessment of residents' behaviours that challenged had not been completed as outlined within the policy. The antecedents, behaviours displayed and consequences of behaviours had not been fully recognised or detailed to inform an individualised plan of care and aid evaluation of treatment or responses provided. The communal environment, noise, stimuli and activity levels challenged one resident. However, these antecedents and sensitivities had not been assessed in accordance with the centres policy or reflected in an appropriate care plan. Suitable and sufficient care plans were not in place to direct care and promote a consistent approach to care and treatment in order to support those with behaviours that challenged.

The restraint policy and associated procedures required review and improvement to ensure use was in accordance with National policy and used as a last resort when alternative measures had failed. A restraint policy dated 2 October 2014 was in place. While this policy referenced physical, chemical and environmental restraint in its definition, its primary focus was related to physical restraint and the use of bedrails and principles of consent. The use of bedrails by five residents was the only reported form of restraint in quarterly notifications submitted to the Authority. The person in charge told inspectors of concerted efforts made to promote a restraint free environment. Bed rail use had been reduced with the support of devices such as low-low beds, sensor alarms and bedside mats. These measures achieved the goals of care without restricting the residents' freedom.

The policy included that restraint use was not permitted for wandering behaviour. However, the use of a 'wandering tag' was found to be in use by a resident.

Chemical restraint was not reported and not clearly defined or discussed in the centre's policy. However, the use of medication with the intention to modify a resident's behaviour was found to be used in the centre. A record to detail the reason for its use, the alternative measures or interventions tried to manage the behaviour and its duration had not been completed to demonstrate the use of medication was as a last resort. All incidents where restraint is used are to be notified to the Authority accordingly.

The centre maintained day to day expenses for some residents and there was an up to date policy on the security of residents' accounts and personal property. All transactions were appropriately documented with lodgements and withdrawals co-signed by two staff members as observed by an inspector. However, the contracts of care records reviewed did not reflect the current arrangements in place and fees charged. An additional charge for activity provision was not clearly defined in the written contract agreed. The choice to opt out of additional fees or charges was not outlined in the written agreement record.

**Judgment:**

Non Compliant - Moderate

***Outcome 03: Residents' Rights, Dignity and Consultation***

**Theme:**

Person-centred care and support

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

No actions were required from the previous inspection.

**Findings:**

The self assessment tool (SAT) was rated compliant in this outcome. The action plan response included developing a staff support team for residents with dementia and providing mobile or visual internet communication arrangements should residents request this.

A communication policy dated 8 February 2016 was comprehensive and included information to promote communication with residents and relevant others, and provided staff guidelines in relation to the governance and management of communications.

Arrangements for residents to be consulted with and participate in the organisation of the centre on a day-to-day basis were described. A system where each resident had a primary nurse responsible for assessing and reviewing their needs was in place. Staff were allocated to care and support the number of residents on a daily basis. Staff knew residents and their relatives well, and residents were familiar with the person in charge and staff members.

A structured forum for residents to meet and discuss issues was described in the centre's policies and information documents. However, the forum arrangement was infrequent and did not include residents' relatives. Inspectors were informed by managers that a resident satisfaction survey had been undertaken in November 2015. However, the results had not been concluded for review or disseminated within a report.

Arrangements were in place to promote residents' privacy and dignity, and many residents were supported to make choices and to be independent. There were opportunities for residents to participate in group activities that suited their interests.

However, the support needs of individual residents whose journey was tracked by inspectors had not been sufficiently supported or facilitated to its full potential to improve their overall quality of life.

The quality of life for many residents in the centre was enhanced by their engagement with visitors on a regular basis and participation in meaningful activities such as arts and crafts or by external entertainers and musicians.

Facilitating the social needs of residents and their families was fundamental to the values of the centre. There was a variety of group activities available to residents in the centre, organised by the activities staff. The activity schedule included activities arranged for the mornings and afternoons and included music, knitting, board games, quizzes, arts and crafts and exercise to music. A plan for a sale of arts and crafts made by residents was to be arranged to help fundraise to support the development of further activities in the centre.

Care staff supported by activity staff considered residents' wishes when planning activities and events. The daily routine for some residents' was informed by their wishes and preferences communicated to staff. The recently developed communications policy aimed at optimising communications between the resident and relevant others. However, some residents with communication difficulties were unable to verbalise and clearly express their preferences and wishes. Residents had a section in their assessment and care plan that covered communication needs. However, the specific needs, means and methods most appropriate for communicating with residents were not consistently detailed. Strategies, functional aids and devices to support effective communication for residents with dementia required further development and exploration. Staff training in communication was planned for 2016, with the date to be confirmed.

A group activity was seen to be a positive experience for some residents, but a negative experience for others. For example, group activities for some residents were not meaningful or appropriate to those who were sensitive to high levels of noise and stimuli by a crowded area. Whereas, other residents enjoyed the group arrangements and were seen participating fully. In a sample of care plans reviewed and tracked, inspectors found insufficient detail of residents' preferred activities, likes and dislikes or those most suitable or appropriate to meet the social well-being and personal needs of individuals.

While staff engaged with individual residents on request or momentarily, interactions were generally needs based or mainly task orientated and passive where staff were reactive rather than proactive. At times the communal environment did not support therapeutic or quality interactions for structured periods to engage residents in meaningful activities in accordance with their interests or capacities. This was reflected in findings of the formal observation periods carried out over two hours.

Inspectors observed the quality of interactions between staff and residents using a validated observational tool to rate and record at five minute intervals, the quality of interactions between staff and residents in the art room and day room. 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). The

scores reflect the effect of the interactions on the majority of residents. The observation commenced in the morning in the art room where a small group of residents evidenced a high rate of positive connective care with six scores of +2 (26%) awarded when staff provided good quality interaction that demonstrated positive connective care which benefitted the majority of residents. One score of +1 (4%) was awarded to task oriented care from observations in the main communal area before lunch. While, the remaining period and overall later experience for the majority of residents was neutral care for 70% of the observation period.

Staff addressed residents in a respectful manner. Residents' rights were facilitated and promoted in most instances observed. For example, residents had an opportunity and choice to complete an early election vote which was facilitated on the day of the inspection. Staff were courteous and responsive with residents and visitors. Staff were seen knocking on resident's bedroom doors before entering. Residents had an option to lock their bedroom door or had a lockable storage space in their room to ensure privacy. Staff accessed resident's bedrooms with their permission for cleaning purposes. However, during the inspection some residents had not been adequately supported to ensure their dignity and privacy was maintained at all times. Residents' clothing and regard to their state of dress was not appropriately maintained to meet their needs which compromised their dignity and rights.

There were many visitors in the centre on the day of this inspection and there were a number of areas where residents could meet with visitors in private. Family members told inspectors they were welcomed when visiting. A record of visitors to the designated centre was maintained.

Some residents had private telephones in their bedroom for their personal use, while others were facilitated by staff to use the centres mobile telephone to communicate with their relatives.

There were notice boards available throughout the centre providing information to residents and visitors. Radio, television and newspapers were available for information about current affairs and local matters. Staff informed inspectors that every effort was made to provide each resident with the freedom to exercise their choice in relation to their daily activities of living.

Hairdressing arrangements were available on a weekly basis to support residents personal grooming.

Independent advocacy services and contact details were also displayed to support all residents including residents' families to raise issues of concern.

**Judgment:**  
Non Compliant - Moderate

#### ***Outcome 04: Complaints procedures***

<p><b>Theme:</b> Person-centred care and support</p>
<p><b>Outstanding requirement(s) from previous inspection(s):</b> No actions were required from the previous inspection.</p> <p><b>Findings:</b> The complaints policy was prominently displayed in the reception area and was included in the residents guide and statement of purpose.</p> <p>Unsolicited information was received by the authority since the last inspection highlighting issues of concern in relation to housekeeping and decor, medication, mealtimes and management of residents with behaviour that challenge. These issues were communicated to the person in charge who told inspectors that complaints of this nature had not been received. These matters were considered in the overall context of this thematic inspection with some areas for improvement identified.</p> <p>Inspectors were told there had been no formal or written complaints since the last inspection. Verbal complaints had been logged and managed promptly using the complaints process to inform service improvements. Records showed the outcome and satisfaction of the complainant.</p>
<p><b>Judgment:</b> Compliant</p>

<p><b><i>Outcome 05: Suitable Staffing</i></b></p>
<p><b>Theme:</b> Workforce</p>
<p><b>Outstanding requirement(s) from previous inspection(s):</b> The action(s) required from the previous inspection were satisfactorily implemented.</p> <p><b>Findings:</b> The self assessment tool (SAT) action plan response included incorporating dementia awareness in the staff and volunteer induction programme, and developing a specific training programme for staff to include dementia awareness, concerning behaviour and communicating effectively.</p> <p>The inspectors found from an examination of the staff rosters, communication with staff on duty and residents and relatives that the levels and skill mix of staff at the time of inspection were sufficient to meet the needs of residents. A planned and actual staff roster was maintained to clearly identify each staff by name, role and working times. There were appropriate numbers of healthcare assistants and nurses on at the time of the inspection. However, inspectors were not assured that four staff for an eight hour period at night could adequately meet the needs of 63 residents including 46% (29) residents with a diagnosis of dementia</p>

In addition, four staff responsible to respond in the event of an emergency and to evacuate up to 17 residents accommodated in one compartment may compromise residents' safety. The person in charge agreed to review this matter following feedback. Reviews of resident dependency and staffing levels were monitored to inform staffing levels and skill mix. Inspectors were told that a recruitment drive was on-going.

Staff were seen responding, supporting, assisting or supervising residents throughout the inspection. Residents told the inspectors they felt supported by staff who were available to them as required.

Systems of communication were in place to support staff with providing safe and appropriate care. There were hand-over meetings each day to ensure good communication and continuity of care when shifts changed. Staff told the inspectors that they were allocated to work with a number of residents daily under the supervision of the nurse. By means of a daily handover and by working with colleagues and residents, staff became familiar with residents care needs.

Formal meetings between nursing management and staff were reported but infrequent. Staff told inspectors they communicated regularly but that a formal or recorded staff meeting had not occurred for some time.

There was evidence that staff had access to education and training. However, all staff had not demonstrated or completed appropriate training in relevant areas appropriate to their role and responsibilities as highlighted in other sections of the report. For example, staff had not been trained in managing behaviour that is challenging including de-escalation and intervention techniques. Fire safety training and simulated fire evacuation drills had not been completed by all staff. Manual handling training was provided and described by staff. However, some practices observed were not reflective of evidence best and safe practice, including medication management. Therefore the supervision of trained staff required improvement. Training in Cardio pulmonary resuscitation had not been completed or updated by all relevant staff. Training specific to dementia and communication had not been provided to support all care staff supporting 29 residents with a diagnosis of dementia.

The inspectors did not review staff files. However, the person in charge described the records required on recruitment which captured those required by the Regulations and schedule 2. The person in charge told inspectors that Garda vetting clearance may be outstanding for recently employed staff and that a self declaration by all staff was required to be completed while Garda clearance was applied for.

Since the last inspection a system had been introduced to ensure that all volunteers were vetted appropriate to their role and level of involvement. However, the person in charge told inspector there were no persons working on the voluntary basis in the centre at this time.

**Judgment:**

Non Compliant - Moderate

## ***Outcome 06: Safe and Suitable Premises***

### **Theme:**

Effective 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) was rated substantially compliant in this outcome. The action plan response included improvements in directional and visible signage, the colour scheme and the provision of orientation calendars in resident's bedrooms by March 2016.

The centre did not have a dementia specific unit and residents with dementia integrated with the other residents in the centre.

The centre was found to be reasonably well maintained, warm, comfortably and visually clean in most parts. however improvement was required in the following:

- Dust seen on an item stored on a high surface in one bedroom was found and reported
- The wash hand basin removed from a communal toilet in use had not been replaced to support residents' needs
- The sluice on the first floor was reported as out of order
- Rust was observed on the radiator in a residents room
- The light was not functioning in one residents room
- Paint decor in parts was worn and in need of repair

The communal areas such as the dining room and the day room had a variety of comfortable furnishings and were domestic in nature. However, there were a lack of side tables in communal sitting rooms to support residents with tea cups, snacks and drinks.

Heat, lighting and ventilation were adequate and the temperature of the building met requirements in bedrooms and communal areas where residents sat during the day.

Inspectors found that aspects of the layout and design of the centre required improvement to meet its stated purpose in respect of providing accommodation for residents with dementia.

Residents were accommodated on two floors. A passenger lift was in place to support residents move between floors. However, it use was restricted as an apparatus fixed to the exterior call button of the lift prevented normal access to its use and difficulty in operating. Stairways between floors were locked by a key code device. These arrangement discouraged free movement of residents within the centre and between floors.

Parts of the centre included shared bedroom and bathroom accommodation. Residents' accommodation was in 39 single, six twin and four three bedded bedrooms. Since the last inspection, four multi occupancy bedrooms had reduced from four to three bedded rooms, reducing the overall maximum capacity from 67 to 63 residents.

While there was limited personal and communal space in three and two bed bedrooms, there was no infringement on privacy and dignity found on this inspection as a result of the room size and layout.

Of the residents whose journey inspectors tracked:

- One resident shared a bedroom with an en-suite shower facility with two other residents.
- One resident had recently transferred from a shared room to a single room two days before this inspection. In the review of this residents care records the inspector read and later confirmed with staff that the resident had had disturbed sleep patterns most nights when accommodated in the shared bedroom. The night report records included 'up and wandering'. However, a care plan had not been developed. Since the move to the single bedroom with an en-suite facility the resident's daily report stated 'slept well' for both nights.
- The other two residents tracked by inspectors were accommodated in single bedrooms with en-suite facilities.

Inspectors were told that residents were encouraged to personalise their rooms. Some rooms had personal photographs and mementoes, although other rooms did not.

Parts of the centre and along some main corridors had strong contrasting colours. Hand rails along corridors and supports in toilets and bathroom were provided to promote independence.

Communal toilets were easily identifiable by a red door colour. The toilet seat in communal toilets was also red. However, other arrangements found within the premises did not promote orientation and ease of direction for those with dementia.

The centre was not sufficiently laid out to meet the needs of residents with dementia. A lack of functional or picture signage and colour scheme was found in areas and bedrooms occupied by residents with dementia. For example, bedroom door numbers conflicted with resident bed numbers listed within the residents' occupancy record. These records did not correspond making it difficult to figure out where residents were located. This arrangement may compromise timely access to and assistance by others when required to respond in the event of an emergency or unplanned evacuation of the centre.

In some parts of the centre signage that included the name and photograph of a resident identified their bedroom. However, directional and or pictorial signage to or from each resident's room, wing and or communal area used by residents' were not sufficiently available to identify your location or to enhance orientation and direction.

The consistent colour scheme observed on the bedroom walls and doors did not sufficiently highlight or make obvious the exit door from the room or door of the en-suite toilet facility.

Walkways were clear and uncluttered to ensure resident safety when mobilising. However, some resident's en-suite rooms were cluttered with furniture not in use and a household trolley was seen inappropriately stored in the en-suite of one twin bedroom. The centre had windows that optimised natural lighting and view in most parts. However, the natural light and view from one bedroom located within the internal building where three residents resided had poor natural light with the view or outlook into a small enclosed area.

A smoking room was provided within the centre and located centrally near the communal sitting rooms and areas on the ground floor. Residents using the smoking room were visible from the corridor. However, due to the frequent use of this room by up to five residents, inspectors found the odour of smoke migrated into the corridor at times.

Risk assessments for residents who smoked had been maintained. However, a supporting care plan had not been completed relevant to the identified or assessed needs. Wooden furniture seen in use in the smoke room had multiple scorch marks indicating insufficient control measures and supervision of residents at all times.

Calls bells were provided in resident bedrooms and staff confirmed that there was a sufficient supply of assistive equipment such as hoists, specialised beds and mattresses to meet residents' needs.

There were two safe enclosed garden areas available to residents. However, due to the weather conditions access at this time was limited. They were well maintained and had suitable furniture.

Relatives or friends had the use of facilities that included a visitor's room, kitchenette with refreshment facilities available and or oratory.

**Judgment:**  
Non Compliant - Moderate

### ***Outcome 07: Health and Safety and Risk Management***

**Theme:**  
Safe care and support

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

**Findings:**  
This outcome was not inspected in full. However, a number of risks including fire safety were identified from this inspection as follows:

- One compartment containing two corridors within the building accommodated up to 17 residents of varying dependencies and who would need the assistance of staff in the event of an emergency or fire
- Simulated fire evacuation drills from all parts of the building and compartments had not been maintained with the record to inform learning or improve safety arrangements
- Simulated fire evacuation drills had not been completed at varying times of the day or night to test the worst case scenario when the maximum number of four staff were available to residents at night
- Residents' occupancy list bed numbers did not reflect bedroom door numbers. This arrangement may compromise timely access to and assistance by others when required to respond in the event of an emergency or unplanned evacuation of the centre.
- Fire doors inappropriately held in an open position by a snib would not close as intended in the event of the fire alarm
- The resident list had not been updated following a change in room occupancy 2 days previous
- All staff were not familiar with the total number of residents in the centre
- Residents toothbrushes and disposable razors were inappropriately stored together on a wash hand basin or window ledges and accessible

**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:*

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<sup>1</sup>

<b>Centre name:</b>	Carthage Nursing Home
<b>Centre ID:</b>	OSV-0000021
<b>Date of inspection:</b>	17/02/2016
<b>Date of response:</b>	03/06/2016

### 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:**

Operational policies relating to the ordering, prescribing, storing and administration of medicines to residents had not been implemented in practices.

Arrangements in relation to prescribing, administration, recording and review of medication did not meet with professional or regulatory requirements.

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

Residents were not sufficiently protected by medication practices and procedures found.

**1. Action Required:**

Under Regulation 04(3) you are required to: Review the policies and procedures referred to in regulation 4(1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.

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

All prescription kardexs have been audited.

Faxed prescriptions that had been received from GP and transcribed by two nurses, have now been signed by the resident GP.

Prescription kardex will be audited on a weekly basis to ensure compliance with medication management policy.

Medication management training will be refreshed by all nursing staff.

**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:**

Suitable arrangements by an appropriate health care professional to meet the needs of each resident had not been facilitated or maintained as required.

Psychotropic medication had been commenced and administered to one resident from 29 December 2015, the dose was subsequently increased on two occasions dated 27 January 2016 and 16 February 2016 in the absence of a GP review and original prescription.

**2. 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:**

The Person in Charge will ensure that needs of each resident are assessed and reviewed by appropriate health care professionals as required by the resident.

**Proposed Timescale:** 31/03/2016

**Theme:**

Safe care and support

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

An assessment of the level of cognitive impairment of all residents admitted with a

diagnosis of dementia using a validated assessment tool was not maintained, available or recorded.

A care plan to include a comprehensive assessment and recommended treatments or medical reviews and or medication adjustments was not maintained.

### **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:**

We have completed the MMSE assessment with current residents.

The CSAR will be requested from the HSE for all residents prior to admissions that are in receipt of NHSS. This will support our comprehensive assessment.

As part of the admission process the MMSE assessment will be completed with each resident and thereafter at three monthly intervals for those who have been diagnosed or suspected of having dementia.

Care plans will continue to be reviewed to reflect the changing needs of our residents, but giving a more comprehensive view of the resident, upon professional, nursing and/or medical review and assessment.

**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:**

Care plans to address all residents' identified needs were not in place and or reviewed, revised and or updated in line with residents changing needs.

Some care plans did not contain sufficient information to specify the actual problem and guide the necessary care interventions of residents.

### **4. 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:**

Care plans will be updated to include changing needs of our residents upon professional nursing and/or medical review and assessment.

Risk assessments are completed routinely and we will incorporate these assessments more in the care plan development to identify the problem, set goals of care and interventions required.

**Proposed Timescale:** 20/05/2016

**Theme:**

Safe care and support

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

A record to demonstrate resident and or relative involvement in care plans including end of life decisions had not been maintained to reflect the wishes of residents with dementia.

Evidence that residents and or family, where appropriate, participated in care plan review meetings at intervals not exceeding four months was not available.

A care plan specific to the identified risks had not been put in place for all residents and or updated following a review.

**5. Action Required:**

Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.

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

Formal care plan reviews are scheduled on a three monthly basis. Each resident has an allocated primary nurse who is responsible for care plan review with the resident or next of kin. The person in charge will formulate evidence that this review has been implemented with the resident or the next of kin by means of a care plan communication form. This will be audited to ensure compliance.

**Proposed Timescale:** 20/05/2016

**Theme:**

Safe care and support

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

Evidence to confirm a recommended referral of a resident to POLL was not available to demonstrate the completion of the referral as intended.

Access to occupational therapy (OT) was limited. Some resident's seating arrangements had not been reviewed by an OT to determine the suitability of the equipment in use.

**6. Action Required:**

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

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

We have requested and received referrals sent to POLL from the GP and will request same as proof of referral going forward.

Upon admission the resident will be assessed by the admission nurse and if required onward referral will be requested in consultation with the resident and/or next of kin. Changes to resident needs are assessed as required and resident will be referred to appropriate healthcare professional in consultation with the resident and/or next of kin. Copies of all referrals will be kept on residents file.

**Proposed Timescale:** 15/03/2016

**Theme:**

Safe care and support

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

Nutritional care plans had insufficient detail regarding residents' individual food preferences, and the recommendations of dieticians and speech and language therapists where appropriate.

**7. 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 residents are offered a healthy balanced nutritious diet. Our menus have been assessed by a dietitian and same demonstrates that food offer meets daily nutritional requirements.

While recommendations and preferences are documented in resident file we recognise that these need to be reflected in the resident care plan.

**Proposed Timescale:** 20/05/2016

**Theme:**

Safe care and support

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

The files of residents admitted under 'Fair deal' did not include the copy of the Common Summary Assessments (CSARS), which details assessments undertaken by professionals such as a geriatrician, a medical social worker and nurse as required in schedule 3(4)(a).

Records were not consistently maintained in accordance with professional standards

and guidelines as required in schedule 3(4)(c).

Opposing names were recorded for one resident in clinical and medication prescription records reviewed which may compromise resident safety.

A record of each medicine administered, signed and dated by the nurse was not maintained in accordance with relevant professional guidelines as required in schedule 3(4)(d).

A record of on-going medical assessment, treatment and care provided by a person's medical practitioner was not available as required in schedule 3(4)(e).

An assessment of cognition using a validated tool did not routinely form part of the admission, follow up or review process as required in schedule 3(4)(f).

A copy of correspondence to or from the designated centre relating to each resident including referrals to other services was not maintained in the centre as required in schedule 3(6).

### **8. Action Required:**

Under Regulation 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

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

The CSAR will be requested from the HSE for all residents prior to admission that is in receipt of NHSS. This will support our comprehensive assessment.

All documentation will bear the residents actual name and not what they "like to be known as".

Each resident has their choice of GP.

Medical reviews are requested by the Person in Charge on a quarterly basis.

A record of ongoing medical assessment, treatment and care provided by a person's GP will be documented in the resident notes where available. Where medical notes are not provided by the GP, instruction from GP is documented in the nursing notes.

As part of the admission process the MMSE assessment will be completed with each resident and thereafter at three monthly intervals for those who have for those who have been diagnosed or suspected of having dementia.

Correspondence to and from other services and referrals in relation to each resident will be copied and kept on each residents file.

**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:**

All medicines had not been administered in accordance with the directions of the prescriber.

**9. Action Required:**

Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.

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

All prescription kardexs have been audited.

Faxed prescriptions that had been received from G.P and transcribed by two nurses, have now been signed by the resident GP.

Prescription kardex will be audited on a weekly basis to ensure compliance with medication management policy.

Medication management training will be refreshed by all nursing staff.

**Proposed Timescale:** 30/06/2016

**Outcome 02: Safeguarding and Safety****Theme:**

Safe care and support

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

A review of the safeguarding policy entitled elder abuse prevention, protection and response required review to ensure the National Policy 'Safeguarding Vulnerable Persons at risk of Abuse' (2014) was incorporated.

A review of the restraint policy was required to ensure all practices and procedures were defined, included and clearly outlined to guide staff practice and safeguard residents.

A review of the policy entitled concerning behaviours and procedures in relation to the management of behaviours that challenge was required to guide staff practice, ensure adequate training and safeguard residents.

**10. Action Required:**

Under Regulation 04(3) you are required to: Review the policies and procedures referred to in regulation 4(1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.

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

Elder Abuse awareness and Protection policy will be reviewed.

Restraint policy will be reviewed.

Concerning Behaviours policy will be reviewed to include management of behaviours that challenge. Staff training in Concerning/Challenging Behaviour has been scheduled.

**Proposed Timescale:** 30/06/2016

**Theme:**

Safe care and support

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

Training specific to behaviours that challenge and or dementia had not been completed by all staff.

Suitable and sufficient care plans were not in place to direct care and promote a consistent approach to care and treatment in order to support those with behaviours that challenged.

Staff had not completed training specific to the professional management of aggression and violence and or use of safe and appropriate physical intervention techniques as outlined in the policy.

**11. Action Required:**

Under Regulation 07(1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.

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

Care plans will be updated to include changing needs of our residents upon professional nursing and/or medical review and assessment.

Staff training in Challenging Behaviour has been scheduled. This will incorporate management of aggression and violence and safe intervention techniques.

Care plan training will be scheduled for all staff nurses.

**Proposed Timescale:** 31/07/2016

**Theme:**

Safe care and support

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

Improvements were required to promote a positive behavioural support approach to residents' with behaviours that challenged and or that negatively impacted on others.

A comprehensive assessment of residents' behaviours that challenged had not been completed as outlined within the policy.

The antecedents, behaviours displayed and consequences of behaviours of residents had not been fully recognised or detailed to inform an individualised plan of care and aid evaluation of treatment or responses provided.

**12. 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:**

Staff training in Challenging Behaviour has been scheduled.

All residents who display behaviours that challenge will have their care plans reviewed.

This will identify antecedents, type of behaviour and potential consequences or risks.

This will inform staff in relation to managing and responding to behaviours identified.

**Proposed Timescale:** 30/06/2016

**Theme:**

Safe care and support

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

The restraint policy and associated procedures required review and improvement to ensure use was in accordance with National policy and used as a last resort when alternative measures had failed.

The policy included that restraint use was not permitted for wandering behaviour. However, the use of a 'wandering tag' was found to be in use by a resident.

Chemical restraint was not clearly defined or discussed in the centre's policy. However, the use of medication with the intention to modify a resident's behaviour was found to be used in the centre.

**13. Action Required:**

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

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

Restraint policy will be reviewed.

One resident had a "wandering tag" in place. This was documented in the residents care plan titled "exit seeking behaviour". The purpose of the wandering tag being in place is to alert staff that the resident is near an exit and to ensure that the resident's safety is paramount.

**Proposed Timescale:** 30/06/2016

**Theme:**

Safe care and support

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

A small number of staff (one rostered day staff) had no safeguarding training date to confirm attendance and two rostered staff members (day and night) had not received refresher training in the past two years as per the centre's policy.

**14. Action Required:**

Under Regulation 08(2) you are required to: Ensure staff are trained in the detection and prevention of and responses to abuse.

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

All staff will have completed refresher training in Elder Abuse Awareness, Prevention and Protection by the end of March.

**Proposed Timescale:** 31/03/2016

**Theme:**

Safe care and support

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

A record to detail the reason for its use, the alternative measures or interventions tried to manage the behaviour and its duration had not been completed to demonstrate the use of medication was as a last resort as required in schedule 3(4)(g).

The contracts of care records reviewed did not reflect the current arrangements in place and fees charged. An additional charge for activity provision was not clearly defined in the written contract agreed. The choice to opt out of additional fees or charges was not outlined in the written agreement record, as required in schedule 4(4).

All incidents where restraint was used were not notified to the Authority accordingly, as required in schedule 4(7)(2)(k).

**15. Action Required:**

Under Regulation 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

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

All residents who display behaviours that challenge will have their care plans reviewed. This will identify antecedents, type of behaviour and potential consequences or risks. We will document alternative measures/ interventions tried. This will inform staff in

relation to managing and responding to behaviours identified.  
Care plans will continue to be reviewed to reflect the changing needs of our residents, but giving a more comprehensive view of the resident, upon professional, nursing and/or medical review and assessment.  
Contracts of care have been reviewed and schedule amendments have been issued to reflect current arrangements in place and fees charged.  
All incidents where restraint is used will be notified to the Authority.

**Proposed Timescale:** 15/04/2016

### **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:**

Arrangements for residents to be consulted with and participate in the organisation of the centre on a formal basis required improvement.

A structured forum for residents to meet and discuss issues was described in the centre's policies and information documents. However, the forum arrangement was infrequent and did not include residents' relatives.

A resident satisfaction survey undertaken in November 2015 had not been concluded for review or disseminated within a report.

**16. 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:**

While resident meetings do take place and families are invited to participate, we will move forward to having these meeting more frequently. Notice of the residents meetings are advertised in the nursing home central areas a week in advance.

We will organise smaller group forums and invite resident and family participation in same.

Resident satisfaction survey will be reviewed and discussed at next resident meeting scheduled in April.

**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:**

In a sample of care plans reviewed and tracked, inspectors found insufficient detail of residents' preferred activities, likes and dislikes or those most suitable or appropriate to meet the social well-being and personal needs of individuals.

The overall experience for the majority of residents was neutral care for 70% of the observation period.

Staff interactions with residents were generally needs based and passive where staff were reactive rather than proactive.

At times the communal environment did not support therapeutic or quality interactions for structured periods to engage residents in meaningful activities in accordance with their interests or capacities.

**17. 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 is a broad activities programme in the nursing home. Our programme does include activities for residents who have dementia. We do acknowledge the inspectors findings in relation to further developing specific meaningful activities.

We have developed a staff support group for residents with dementia. The aim of this group is to improve the quality of life for residents who cannot participate in group activity by providing meaningful activity on a one to one basis.

**Proposed Timescale:** 15/03/2016

**Theme:**

Person-centred care and support

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

Some residents had not been adequately supported to ensure their dignity and privacy was maintained at all times.

Residents' abilities and their state of dress was not appropriately regarded to meet their needs which compromised their dignity and rights.

**18. 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:**

The privacy and dignity of all our residents are paramount in our home.

We strive to ensure that all residents' dignity and privacy is maintained at all times.

**Proposed Timescale:** 15/03/2016

**Theme:**

Person-centred care and support

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

Residents with communication difficulties were unable to verbalise and clearly express their preferences and wishes.

Strategies, functional aids and devices to support effective communication for residents with dementia required further development and exploration.

Staff training in communication was planned for 2016, with the date to be confirmed.

**19. Action Required:**

Under Regulation 10(1) you are required to: Ensure that each resident, who has communication difficulties may communicate freely, having regard to his or her wellbeing, safety and health and that of other residents in the designated centre.

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

Communication, verbal and non-verbal will be further developed.

Picture signage has been increased to aid residents.

Communication care plans will be audited to ensure effective communication plan is in place for each resident who demonstrates difficulty with same.

Communication training will be scheduled.

**Proposed Timescale:** 31/07/2016

**Theme:**

Person-centred care and support

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

The specific needs, means and methods most appropriate for communicating with residents were not consistently detailed within an assessment or care plan.

**20. Action Required:**

Under Regulation 10(2) you are required to: Where a resident has specialist communication requirements record such requirements in the resident's care plan prepared under Regulation 5.

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

Communication, verbal and non-verbal will be further developed.

Communication care plans will be audited to ensure effective communication plan is in place for each resident who demonstrates difficulty with same

**Proposed Timescale:** 31/07/2016

**Outcome 05: Suitable Staffing**

**Theme:**  
Workforce

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

Inspectors were not assured that four staff for an eight hour period at night could adequately meet the needs of 63 residents including 46% (29) residents with a diagnosis of dementia.

Four staff responsible to respond in the event of an emergency and to evacuate up to 17 residents accommodated in one compartment may compromise residents' safety.

The person in charge agreed to review this matter following feedback.

**21. 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:**

Fire officer has visited our nursing home upon request and we have put in place a schedule to further compartmentalise the nursing home to reduce the number of residents within each compartment. The number of residents accommodated per compartment will range from 3-7 residents.

**Proposed Timescale:** 15/04/2016

**Theme:**  
Workforce

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

All staff had not demonstrated or completed appropriate training in relevant areas appropriate to their role and responsibilities.

Medication management practices observed were not reflective of evidence best and safe practice.

All staff had not been trained in managing behaviour that is challenging including de-escalation and intervention techniques.

Fire safety training and simulated fire evacuation drills had not been completed by all staff.

Manual handling training was provided and described by staff. However, some practices observed were not reflective of evidence best and safe practice.

Training in Cardio pulmonary resuscitation had not been completed or updated by all relevant staff.

Training specific to dementia and communication had not been provided to support all staff supporting 46% (29) residents with a diagnosis of dementia.

**22. 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:**

Medication management training will be refreshed by staff whose training is not current. April 2016

Staff training in Concerning/Challenging Behaviour has been scheduled. June 2016

Fire Safety Awareness training has been completed by all staff. Simulated fire evacuation drills are part of training although not all staff have participated in simulated drills. Simulated fire evacuation drill training will be carried out for both day time and night time. April 2016

All staff have received patient handling and moving training. Supervision in the environment will continue to ensure best practice is adhered to.

Refresher training in CPR will be completed by all nursing staff. April 2016

"Approach to Dementia" training was completed by a number of staff in February 2016. Further training in dementia and communication is planned in April and May 2016.

**Proposed Timescale:** 30/06/2016

**Theme:**

Workforce

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

Manual handling practices observed were not reflective of evidence best and safe practice. Therefore the supervision of staff required improvement.

**23. 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:**

All staff have received patient handling and moving training. Supervision in the environment will continue to ensure best practice is adhered to.

**Proposed Timescale:** 15/03/2016

### **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 centre was not sufficiently laid out to meet the needs of residents with dementia.

A lack of functional or picture signage and colour scheme was found in areas and bedrooms occupied by residents with dementia.

Directional and or pictorial signage to or from each resident's room, wing and or communal area used by residents' were not sufficiently available to identify your location or to enhance orientation and direction.

Access to the lift between floor was restricted. Stairways between floors were locked by a key code device. These arrangement discouraged free movement of residents within the centre and between floors.

The consistent colour scheme observed on the bedroom walls and doors did not sufficiently highlight or make obvious the exit door from the room or door of the en-suite toilet facility.

Bedroom door numbers conflicted with resident bed numbers listed within the residents' occupancy record. This arrangement may compromise timely access to and assistance by others when required to respond in the event of an emergency or unplanned evacuation of the centre, making it difficult to locate residents.

Inappropriate storage arrangements found in some resident's en-suite rooms did not promote freedom of movement and use of facilities.

The natural light and view from one bedroom located within the internal building where three residents resided had poor natural light with the view or outlook into a small enclosed area.

The frequent use of the smoke room resulted in an odour of smoke migrating into the communal corridor at times.

Wooden furniture seen in use in the smoke room had multiple scorch marks indicating repair or replacement, insufficient control measures and supervision of residents at all times.

Improvement was also required in the following:

- Dust seen on an item stored on a high surface in one bedroom was found and reported
- The wash hand basin removed from a communal toilet in use had not been replaced to support residents' needs
- The sluice on the first floor was reported as out of order
- Rust was observed on the radiator in the residents room
- The light was not functioning in one residents room
- Paint decor in parts was worn and in need of repair

There were a lack of side tables in communal sitting rooms to support residents with tea cups, snacks and drinks.

#### **24. 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:**

We acknowledge the inspectors findings and will work on making our nursing home environment more dementia friendly. While we continuously strive to provide a home from home environment for all our residents. We acknowledge that there are improvements to be made.

A lack of functional or picture signage and colour scheme was found in areas and bedrooms occupied by residents with dementia. Proposed Timescale: 30/04/2016

Directional and or pictorial signage to or from each resident's room, wing and or communal area used by residents' were not sufficiently available to identify your location or to enhance orientation and direction. Proposed Timescale: 31/07/2016

Access to the lift between floors was restricted. Stairways between floors were locked by a key code device. These arrangement discouraged free movement of residents within the centre and between floors. Proposed Timescale: 31/03/2016

The consistent colour scheme observed on the bedroom walls and doors did not sufficiently highlight or make obvious the exit door from the room or door of the en-suite toilet facility. Proposed Timescale: 30/04/2016

Bedroom door numbers conflicted with resident bed numbers listed within the residents' occupancy record. This arrangement may compromise timely access to and assistance by others when required to respond in the event of an emergency or unplanned evacuation of the centre, making it difficult to locate residents. Proposed Timescale: 30/04/2016

Inappropriate storage arrangements found in some resident's en-suite rooms did not promote freedom of movement and use of facilities. Proposed Timescale: 31/03/2016.

The natural light and view from one bedroom located within the internal building where three residents resided had poor natural light with the view or outlook into a small

enclosed area. Proposed Timescale: 31/07/2016

The frequent use of the smoke room resulted in an odour of smoke migrating into the communal corridor at times. Proposed Timescale: 30/04/2016

Wooden furniture seen in use in the smoke room had multiple scorch marks indicating repair or replacement, insufficient control measures and supervision of residents at all times. Proposed Timescale: 15/03/2016

Improvement was also required in the following: Proposed Timescale: 31/07/2016

- Dust seen on an item stored on a high surface in one bedroom was found and reported
- The wash hand basin removed from a communal toilet in use had not been replaced to support residents' needs
- The sluice on the first floor was reported as out of order
- Rust was observed on the radiator in the residents room
- The light was not functioning in one residents room
- Paint decor in parts was worn and in need of repair

There were a lack of side tables in communal sitting rooms to support residents with tea cups, snacks and drinks. Proposed Timescale: 15/04/2016

**Proposed Timescale:**

**Theme:**

Effective care and support

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

The reduction in four bedrooms occupancy and the reconfiguration of bedrooms completed had not prompted a review of the Statement of Purpose.

**25. 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:**

Statement of Purpose will be reviewed and updated to reflect reconfiguration of bedrooms.

**Proposed Timescale:** 31/03/2016

**Outcome 07: Health and Safety and Risk Management**

**Theme:**

Safe care and support

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

Risk assessments for residents who smoked had been maintained. However, a supporting care plan had not been completed relevant to the identified or assessed needs. Wooden furniture seen in use in the smoke room had multiple scorch marks indicating insufficient control measures and supervision of residents at all times.

**26. Action Required:**

Under Regulation 26(2) you are required to: Ensure that there is a plan in place for responding to major incidents likely to cause death or injury, serious disruption to essential services or damage to property.

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

Risk assessments have been incorporated into the formation of care plans for residents who smoke. Smoking room has been reviewed and will incorporate improved safety measures.

**Proposed Timescale:** 20/03/2016

**Theme:**

Safe care and support

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

Residents toothbrushes and disposable razors were inappropriately stored together on a wash hand basin or window ledges.

**27. Action Required:**

Under Regulation 27 you are required to: Ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.

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

Individual toiletry containers have been supplied for all residents that are accommodated in shared bedrooms. Personal care items are now stored individually.

**Proposed Timescale:** 15/03/2016

**Theme:**

Safe care and support

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

One compartment containing two corridors within the building accommodated up to 17 residents of varying dependencies and who would need the assistance of staff in the event of an emergency or fire.

Residents' occupancy list bed numbers did not reflect bedroom door numbers. This arrangement may compromise timely access to and assistance by others when required to respond in the event of an emergency or unplanned evacuation of the centre.

Fire doors inappropriately held in an open position by a snib would not close as intended in the event of the fire alarm.

The resident list had not been updated following a change in room occupancy two days previous.

All staff were not familiar with the total number of residents in the centre.

**28. Action Required:**

Under Regulation 28(1)(c)(ii) you are required to: Make adequate arrangements for reviewing fire precautions.

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

Fire officer has visited our nursing home upon request and we have put in place a schedule to further compartmentalise the nursing home to reduce the number of residents within each compartment. The number of residents accommodated per compartment will range from 3-7 residents.

Bedroom numbers have been ordered for doors appropriate to the bed numbers in each room.

Fire precautions will be reviewed to incorporate the removal of snibs and apply alarm triggered door self-closing system.

Resident list will be updated with change of room occupancy.

Occupancy levels are displayed on the communication boards in both nurses' stations. Staff have been informed that it is their responsibility to keep informed of all information displayed on same.

**Proposed Timescale:** 30/06/2016

**Theme:**

Safe care and support

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

Simulated fire evacuation drills from all parts of the building and compartments had not been maintained with the record to inform learning or improve safety arrangements.

Simulated fire evacuation drills had not been completed at varying times of the day or night to test the worst case scenario when the maximum number of four staff were available to residents at night.

**29. Action Required:**

Under Regulation 28(1)(e) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and residents are aware of the procedure to be followed in the case of fire.

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

Fire Safety Awareness training has been completed by all staff. Simulated fire evacuation drills are part of training although not all staff have participated in simulated drills. Simulated fire evacuation drill training will be carried out for both day time and night time.

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