

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Donore Nursing Home
Centre ID:	OSV-0000032
Centre address:	13 Sidmonton Road, Bray, Wicklow.
Telephone number:	01 286 7348
Email address:	donore_91@yahoo.com
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Brecon (Care) Limited
Provider Nominee:	John Percival Griffin
Lead inspector:	Ann Wallace
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	21
Number of vacancies on the date of inspection:	5

About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

- Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- to carry out thematic inspections in respect of specific outcomes
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or wellbeing of residents.

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.

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 inform a registration renewal decision. This monitoring inspection was announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
18 August 2017 09:00	18 August 2017 19:00
21 August 2017 11:00	21 August 2017 18:00

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

Outcome	Our Judgment
Outcome 01: Statement of Purpose	Substantially Compliant
Outcome 02: Governance and Management	Non Compliant - Moderate
Outcome 03: Information for residents	Compliant
Outcome 05: Documentation to be kept at a designated centre	Substantially Compliant
Outcome 07: Safeguarding and Safety	Non Compliant - Moderate
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 09: Medication Management	Compliant
Outcome 10: Notification of Incidents	Non Compliant - Major
Outcome 11: Health and Social Care Needs	Non Compliant - Moderate
Outcome 12: Safe and Suitable Premises	Non Compliant - Major
Outcome 13: Complaints procedures	Compliant
Outcome 14: End of Life Care	Compliant
Outcome 15: Food and Nutrition	Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Non Compliant - Moderate
Outcome 18: Suitable Staffing	Non Compliant - Moderate

Summary of findings from this inspection

This was an announced inspection by the Health Information and Quality Authority (HIQA). The purpose of the inspection was to inform an application to renew registration of the centre. The inspector also considered information received by the Authority and notifications submitted relating to safeguarding and safety and suitable staffing. During the inspection, the inspector reviewed the information and noted that the centre had completed an investigation into the concerns in line with relevant safeguarding guidelines.

As part of the inspection, the inspector met with residents, relatives, the provider

nominee, the person in charge (PIC), the Assistant Director of Nursing (ADON) and members of staff who were present in the centre during the inspection. The inspector also observed practices and reviewed documentation such as policies and procedures, staff files, clinical governance and audit documents, care plans, medical records and the records from allied healthcare professionals.

The inspector reviewed the pre-inspection questionnaires which had been issued to residents and relatives by HIQA prior to the inspection. A number of these had been completed and returned to the centre. The feedback from the residents' and the relatives' questionnaires was positive and there were high levels of satisfaction reported for the care and services provided by the centre. Respondents praised the staff, the medical attention and the food.

Residents were seen to be afforded choice in how they spent their day moving around the centre spending time in different areas including the lounges and the garden. The inspector found that at most times there were adequate staffing levels and skill mix to meet the resident's assessed needs. However the reduced staffing levels between 6pm and 8pm were not sufficient to meet the assessed needs of the residents taking into account the layout of the centre.

In most cases residents' health needs were seen to be met with good access to a range of medical and allied health care professionals when required however one resident with high level needs did not have a comprehensive multidisciplinary review of their changing needs. This was an outstanding action from the previous inspection.

The inspector found that there were governance and management arrangements in place to review the quality and safety of care and services provided in the centre but they were not consistently applied in line with the centre's own policies and procedures. There was an established staff team with low turnover of staff. Staff had good access to training and all staff had attended mandatory training on fire safety, moving and handling and the detection and prevention of elder abuse. Staff had also attended training on managing responsive behaviours.

A number of areas where improvement was required were noted in relation to safeguarding and safety, health and safety, privacy and dignity, notification of incidents and health and social care needs. These are detailed in the report and set out in the action plan at the end.

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

Outcome 01: Statement of Purpose

There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The Statement of Purpose was reviewed in December 2016 and included most of the requirements of Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

However the Statement of Purpose did not accurately describe the facilities and services provided for the residents in relation to access to the first floor bedrooms and bathrooms.

Judgment:

Substantially Compliant

Outcome 02: Governance and Management

The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

There were clear management arrangements in the centre and systems in place to

monitor the quality and safety of the service, however these were not consistently implemented in line with the centre's own policies and procedures.

The inspector found that there was a clear management structure with defined lines of authority and accountability. Staff were clear about their roles within the centre and demonstrated accountability in their work.

Residents who spoke with the inspectors said that they saw the person in charge or her deputy on a daily basis and were able to raise any issues or concerns with them. The provider nominee was in the centre most days and was well known to staff and residents. Staff reported that they were clear about whom to raise issues with and that they found the management in the centre were focused on the residents' needs and were approachable.

The inspector found that there were systems in place to monitor the quality of care and the experience of the residents on an ongoing basis, for example care planning, dependency levels, restrictive practices, incidents, complaints and responsive (challenging) behaviours. Monthly audits of medication records were also carried out. Although information relating to these key areas was collated each month, this information was not analysed and as a result there was no evidence of learning or improvements made following the monitoring/reviews. For example, detailed information was collected relating to incidents which had occurred in the centre but this had not been used to identify trends such as the times of falls or where they occurred in the centre.

Documents showed that the centre held a programme of meetings including hand over meetings at the beginning of each shift, resident meetings, staff meetings and quality management meetings. Minutes were recorded for all staff and resident meetings. The inspector noted that decisions from the staff and quality management meetings were communicated to the relevant staff. It was not clear how the minutes of the resident's meetings were communicated to those residents who did not attend the meetings.

The annual review of care and services in the centre for 2016 was made available to the inspector. The report included feedback from residents and their families and was made available to residents.

Judgment:

Non Compliant - Moderate

Outcome 03: Information for residents

A guide in respect of the centre is available to residents. Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

Theme:

Governance, Leadership and Management

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

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

Findings:

The issues arising from the previous inspection related to resident contracts which did not clearly identify all of the additional fees charged by the centre for services. The inspector reviewed a selection of residents' contracts and found that since the last inspection the centre had included a list which clearly stated the additional fees for specific services into the contracts. This was verified by the residents and families with whom the inspector spoke during the inspection.

The provider had reviewed the Resident's guide in December 2016. The document was available for residents and their families on admission to the centre. It provided information on the facilities and services available for residents, the terms and conditions of residency, the complaints procedure and the arrangements for visiting. The guide was well laid out and provided information in an easy to read format.

Judgment:

Compliant

Outcome 05: Documentation to be kept at a designated centre
The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

Although this outcome was not investigated during this inspection the inspector found that;

- 1] The centre's policies and procedures relating to monitoring the safety and efficacy of services are not consistently implemented.
- 2] One staff file did not contain a full employment history.

Judgment:

Substantially Compliant

Outcome 07: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place

and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

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:

One action from the previous report had not been satisfactorily implemented relating to a resident who occupied a twin room and was unable to personalize the space due to the responsive behaviours of another resident.

The inspector found that policies and procedures were in place to safeguard and protect residents from abuse. Incidents, allegations and concerns relating to the abuse of residents had been recorded. Training records showed that staff attended safeguarding training. Staff who spoke with the inspector were able to articulate the policies and procedures relating to the detection of and protection of residents from abuse. Residents told the inspector said that they felt safe at the centre and that they could approach the staff and managers in the centre if they had any concerns.

" I feel very safe here"

" Yes I feel safe. I have the staff"

" The centre is very safe and there are always plenty of staff ".

However the inspector noted that following a recent incident the centre's own safeguarding policy had not been effectively implemented.

The inspector found that in line with the ethos of the centre, managers and staff were working towards a restraint free environment in line with best practice guidance. Records showed that the use of bed rails was minimal in the centre. The use of bedrails was monitored and recorded in the centre's restraint log. The inspector reviewed a sample of assessments for bed rails and found that individual resident risk assessments documented that alternatives to bed rails had been considered. Risk assessments and care plans showed evidence of resident and family involvement in decisions regarding risk management and restraint.

The majority of residents living at the centre displayed responsive behaviours. Staff were knowledgeable about individual residents and what might trigger responsive behaviours in individuals. Staff were aware of the appropriate techniques to be used with individuals when responsive behaviours were exhibited. However the inspector noted that one resident who occupied a twin room was unable to display their personal items in their bed space and locker due to the responsive behaviours of the resident with whom they shared the room.

The inspector observed staff using a variety of techniques to support and manage residents who presented with responsive behaviours. Individual resident care plans and risk assessments documented the triggers for responsive behaviours and the interactions to be implemented if they occurred. Resident records documented multidisciplinary assessments and reviews had been completed for residents with escalating responsive behaviours. This included regular reviews by the general practitioner (GP), consultant psychiatrist and the community mental health team.

There were clear systems in place to safeguard resident's monies. These included invoices for all goods and services and a monthly balance for each resident. The finances of those residents for whom the centre was an agent were managed by a suitably qualified person from outside the centre's staff who informed the inspector that the systems were in line with the best practice guidance from the Department of Social Protection.

Judgment:

Non Compliant - Moderate

Outcome 08: Health and Safety and Risk Management

The health and safety of residents, visitors and staff is promoted and protected.

Theme:

Safe care and support

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

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

Findings:

The inspector found that the health and safety of residents, staff and visitors was actively promoted.

There were comprehensive policies in place relating to health and safety and risk management. These had been recently reviewed and met the requirements of the regulations. There was an up-to-date Health and Safety Statement. A comprehensive emergency plan was in place.

The inspector found that there was a log of all incidents occurring in the designated centre but not all incidents and accidents were reviewed in line with the centre's policies and procedures. As a result there was no evidence of learning and improvements being made to prevent a recurrence of the incident.

The risk management policy was reviewed and was seen to comply with Regulation 26 (1). The centre's risk register had been updated to include current clinical risks such as responsive behaviours displayed by some residents in the centre. This was a requirement from the previous inspection. The inspectors spoke with staff and found them to be aware of relevant risks in their areas of work. Staff were observed to follow

correct risk management procedures in their day-to-day practices for example correct moving and handling techniques and infection control procedures.

The fire safety policy was detailed and centre specific and included a clear evacuation procedure to be followed in the event of a fire. Fire exits were found to be unobstructed. Staff allocation records showed that a member of staff was allocated on each shift to check that the fire escapes were kept clear and that there were no trip hazards to obstruct evacuation in the event of a fire.

Records reviewed by the inspector showed that fire safety equipment including fire detection equipment and alarm systems were checked and serviced at regular intervals.

Staff had attended fire safety training and fire evacuation drills were carried out at regular intervals. Staff who spoke with the inspector were clear about the procedure to follow in the event of a fire. Residents told the inspector that they were involved in the fire drills and were clear about what to do in the event of a fire. The PIC ensured that residents admitted to rooms on the first floor were independently mobile with supervision and would be able to escape down the stairs in the event of a fire.

Up to date records were available for the servicing of nursing and moving and handling equipment such as hoists and specialist beds and mattresses. All equipment had been serviced within the last twelve months, this was a requirement from the last inspection.

Clinical risk assessments were undertaken for residents, including falls risk assessment, assessments for skin integrity, resident dependency, continence, moving and handling, residents who smoked and responsive behaviours. Clinical risk assessments were recorded in resident's care plans and were reviewed four monthly or more often if a resident's condition changed. Staff who spoke with the inspector were able to articulate the risks relating to individual residents and the management plans that were in place to manage identified risks.

The inspector observed staff washing their hands regularly and staff were seen to wear personal protective clothing such as gloves and aprons. The inspector noted that soap and hand sanitizer were available throughout the premises. Hand soap and paper towels were available at hand wash basins. The centre was clean and the housekeeping team maintained records of cleaning schedules completed on each day.

Judgment:

Non Compliant - Moderate

Outcome 09: Medication Management

Each resident is protected by the designated centre's policies and procedures for medication management.

Theme:

Safe care and support

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

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

Findings:

There were appropriate management systems in place to ensure safe medication practices.

There was a comprehensive medication policy in place which gave clear guidance to nursing staff on the procedures to follow for ordering, monitoring, documenting, administering and the disposing of un-used and out-of-date medications. The policy included the procedure to follow in the event of medication errors. Medication audits were completed monthly.

A sample of medication records was reviewed. The inspector found that the records recorded the name of the drug and the time of the administration and that the nurse signed the medication record after each administration. The drugs were administered within the prescribed timeframes. If a resident refused medication this was recorded correctly. Drugs being crushed were signed by the general practitioner (GP) as suitable for crushing and liquid alternatives had been sourced where possible. This was a requirement from the last inspection. Staff administering medication were seen to follow appropriate medication management practices in line with relevant professional best practice guidance. Residents' medication was reviewed regularly by their GP.

Medications were stored securely. Controlled drugs were stored in a locked cupboard within a locked cupboard in the medications room. Nurses kept a register of controlled drugs. They were checked by two nurses at the change of each shift. There were no controlled drugs in the centre at the time of the inspection.

There was an effective system in place to manage the return of out-of-date and un-used medications with records providing a clear audit trail.

Judgment:

Compliant

Outcome 10: Notification of Incidents

A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

While the designated centre maintained a log of all accidents and incidents the inspector found that two notifiable incidents had not been notified to the Authority. Another incident had not been reported to the Authority within the specified time frame.

Judgment:

Outcome 11: Health and Social Care Needs

Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

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:

The inspector found that most residents had an assessment of their needs, care plans that described how their needs were to be met and that their needs had been reviewed on a regular basis. However the inspector found that four residents did not have care plans in place for an identified need for example psycho-social needs or communications and one resident did not have a record of multidisciplinary review even though their physical and psychosocial needs had significantly changed. This was a requirement from the previous inspection.

The inspector reviewed a selection of resident's records and spoke with staff who developed and used them. Documentation showed that prior to admission an assessment was carried out by the PIC and the provider nominee to ensure that the potential resident's needs could be met in the centre. When residents were admitted, a more detailed assessment was completed by nursing staff within 48 hours and a care plan was developed with the resident and their family. Risk assessments were completed in key areas such as falls risk, nutritional risks, pressure sore risk, responsive behaviours and moving and handling risks. Clear risk management plans were in place which supported resident autonomy and promoted self care abilities and independence. Care plans and risk assessments were agreed with the resident and their family, for example one relative stated:

"The staff always encourage him to be as independent as is possible for him to be"

In most cases care plans were seen to provide clear information to staff providing care and support to residents. However the centre had recently changed its care planning documentation and the inspector found that three residents did not have communication care plans in place and two residents did not have a care plan in relation to their psychosocial needs. Skin integrity risk assessments had not been reviewed within the four month period for two residents. This was a breach of the centre's own policies and procedures relating to care planning and had not been identified in the monthly care

plan audits.

Medical and care records showed that residents had good access to relevant medical and allied health and social care professionals. General Practitioners (GP) visited the centre weekly and residents could keep their own GP if they wished to do so. Out of hours GP services were available for residents. A range of allied health care services attended the centre when required. These included; physiotherapy, dietician, speech and language therapy, consultant psychiatrist and community mental health services. Specialist nursing services such as palliative care and tissue viability nurses provided specialist input on referral from the centre. The inspector noted that appropriate referrals had been made to specialist nursing services and that the palliative care team were involved with one resident at the time of the inspection. The inspector saw examples where recommendations had been implemented for example with seating arrangements, special diets and mobility aids.

The inspector found that for most residents there were clear records of staff reviewing and updating resident's records as their needs changed. This was done at least four monthly or more frequently if a resident's condition changed. Residents and their families were involved in the reviews if they chose to attend. However four residents had gaps in their care planning and care review documentation as described above.

There were clear records of residents being supported to attend medical and other health care appointments. Arrangements were made with families or staff in the centre to ensure that residents were able to attend appointments. Transport was available to take residents to appointments when required. If a family member was not available to take a resident to an appointment a member of staff went with the resident to support them and ensure that the resident's current needs were communicated to the relevant health professional.

The inspector found that where residents were temporarily absent from the centre relevant information was sent with them in relation to their medication and assessments of their needs. On the residents return to the centre from hospital there was a clear summary of their needs and any changes to medication.

Judgment:

Non Compliant - Moderate

Outcome 12: Safe and Suitable Premises

The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

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:

The layout and design of the centre did not meet the needs of all of the residents who lived at the centre. Two of the actions from the previous inspection were not resolved. These related to one twin bedroom not affording resident's privacy and dignity, and toilet and bathroom facilities on the ground floor not situated close to residents' bedrooms.

The designated centre is a two storey house which has been extended and adapted to provide accommodation for 26 residents. There are five single bedrooms, four twin bedrooms and four multi-occupancy rooms with three or four residents. The bedrooms do not have en-suite facilities but each bedroom has a wash basin and storage for individual resident's toiletries and wash bowls. The provider had completed an extensive internal refurbishment within the existing building in December 2016.

The refurbishment made a number of improvements to the layout of the centre including the creation of a spacious well lit communal lounge at the rear of the building and improvements to the size and layout of the wheelchair accessible facilities on the ground floor. The provider had also made improvements to access on the first floor by raising the level of the first floor landing and reducing the height differential between the levels so that only one step is now required at the top of the stairs. However the inspector found that bedrooms and bathrooms on the first floor were not wheelchair accessible and were not suitable for residents with mobility needs.

The layout of one three bed room on the first floor was not suitable for three residents. This was due to the very limited space around one bed, its proximity to the shared wash hand basin, the lack of appropriate screening, the lack of space to undertake personal activities in private and the lack of space for a bedside chair. At the time of the inspection there was only one resident occupying this room.

The inspector noted that all residents occupying the bedrooms on the first floor were mobile and residents told the inspector that they were satisfied with their bedroom and bathroom facilities. Residents were observed using the toilet facilities independently.

The centre does not have a lift between floors. A stair lift is provided for residents. The inspector observed that the residents who occupied the first floor were able to use the stairs independently or with the supervision of one member of staff. The stair lift had been serviced within the last twelve months however the inspector did not observe any residents using the stair lift during the inspection.

One twin room on the ground floor was not of a suitable size and layout for twin occupancy. This was due to the very limited space around each bed, the lack of appropriate screening, the lack of space to undertake personal activities in private and the lack of space for a bedside chair.

The two residents who occupied this room were high dependency and were not suitable for accommodation on the first floor and as the centre did not have an alternative room available on the ground floor the needs of these two residents could not be adequately

met within the current layout of the premises.

There was one toilet on the ground floor which was not wheelchair accessible. Two wheelchair accessible toilet/shower rooms are available on the ground floor however one of these is situated off the communal lounge at the rear of the building and is not close to the residents' bedrooms. The accessibility and distance of toilet and bathroom facilities on the ground floor are an outstanding requirement from the previous inspection.

All bedrooms have accessible call bell systems for each bed. Residents have their own wardrobe and chest of drawers or shelving. Some residents had personalized their rooms with photographs and artefacts from home or their own art work that they had created in the centre. Two single rooms on the ground floor had access directly onto the pleasant courtyard areas leading to the main garden.

The communal areas are light and spacious and were well used by the residents during the inspection which gave the centre a real sense of community. There is a small dining room to the side of the building with patio doors which lead out to the courtyard area and the garden. In addition to the recently developed communal lounge there is a smaller quiet lounge area next to the nurse's station which provides quiet comfortable seating for those residents who prefer a calm space and who need a higher level of nursing supervision. The inspector observed residents chatting together and playing card games in this area. Some residents took their meals in this area.

Visitors were made welcome in the communal areas except at meal times.

The outside space is nicely laid out for residents and is a particular strength of the centre. The courtyard garden surrounds the premises and provides several small outside seating areas. The areas are nicely laid out with raised beds and flower pots, garden chairs and tables and seating. The courtyard provides access to the main garden which is laid mostly to lawn and is used for barbecues and crazy golf during the fine weather. Residents were using the garden and courtyard areas throughout the inspection for socializing, relaxing and gentle exercise activities.

There is a small area in the courtyard designated as a smoking area which was available for residents who wished to smoke under the supervision of care staff.

The centre provides a range of assistive equipment including wheelchairs, specialist mattresses and hoists. The inspector reviewed the service records for the equipment and found that they had been serviced within the last year. Management were reviewing the equipment storage facilities available in the centre to ensure that these were adequate to meet the ongoing needs of residents.

There is a small laundry room just off the main building. There is a separate domestic room with sluice facilities and storage for cleaning equipment. Both rooms were clean and tidy on the days of the inspection. Appropriate fire detection and fire safety equipment was available in the laundry room.

Judgment:

Non Compliant - Major

Outcome 13: Complaints procedures

The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

All complaints were being recorded in the centre. Complaints were being listened to and acted upon.

The centre had a comprehensive complaints policy in place. The policy clearly outlined the processes in place to make a complaint, who to go to and what could be expected from the centre to manage the complaint. The complaint policy was displayed in the entrance hall. The procedure was included in the resident's guide and the statement of purpose.

The inspector reviewed the complaints log and found that written and verbal complaints had been recorded. The document included the actions taken by the centre to resolve the complaint, the outcome of the complaint and the complainant's satisfaction with the outcome. The complaints log was reviewed monthly as part of the centre's monthly management audit. The PIC informed the inspector that the centre used the learning from complaints to make relevant changes and improvements such as staff training or changes in policy or procedures. There was no evidence to suggest that anyone had been adversely affected from making a complaint.

Judgment:

Compliant

Outcome 14: End of Life Care

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

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

There were systems in place to make sure that when residents were approaching end of life that appropriate care and support was available to meet their needs and preferences for end of life care.

The inspector found that where residents had expressed their views about end of life care these had been recorded and included in their end of life care plan and in case of emergency care plans. There was clear evidence of resident and family involvement in end of life care decisions. Where appropriate GP and members of the multidisciplinary team had been involved in the decisions around end of life care.

The centre had clear policies and procedures in relation to end of life care. Staff who spoke with the inspectors were aware of the policies and procedures and their role in supporting residents and their families at end of life. Staff stated that families and friends were encouraged to be involved in supporting the resident at end of life.

The centre worked with the community palliative care nursing team to provide end of life care for residents when required.

Judgment:

Compliant

Outcome 15: Food and Nutrition

Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

The inspector found that residents were provided with food and drinks in quantities to meet their needs. There were processes in place to ensure that individual resident's nutritional needs were met. This was a particular strength of the designated centre.

The inspector met with residents during the lunchtime meal and observed the evening meal being served. Residents stated that they were mostly happy with the food provided in the centre. This was verified in the questionnaires that were returned to the inspector which documented high levels of satisfaction with the meals provided in the centre. For example resident's reported

"The food's great"

"Lovely cakes and biscuits"

The inspector observed that the meals were nicely presented. The main meal was two courses with a choice of main course and dessert. Hot and cold drinks were served with

the meals. The meal experience was unhurried and residents were chatting around the table throughout. Staff were seen offering discreet support and encouragement to those residents who needed help at meal times.

The centre had clear processes in place to ensure that resident's nutritional risk and needs were identified and monitored. Residents' records showed that referrals were made to the resident's general practitioner and to the dietician when required. Food and fluid intake records were maintained for those residents identified as being at risk. The inspector noted that improvements were needed in monitoring residents weights and body mass indices (BMI) in line with the recommendations by the dietician. This had been identified by staff and an improvement had been implemented.

The inspector spoke with the chef who was knowledgeable about individual resident's nutritional needs and their plan of care regarding nutrition. The kitchen had up to date information about residents who required special diets including fortified diets, textured diets and thickened fluids.

Menus were prepared monthly, adjusted seasonally and accommodated resident's food choices and feedback. The provider nominee took responsibility for purchasing fresh meat, fish, fruit and vegetables from local markets and suppliers. All food was prepared in the centre's kitchen. Home-baked cakes and desserts were available each day. The chef confirmed that alternative meal choices were available for all residents and that snacks were available at all times. The inspector observed residents being offered a variety of snacks and drinks throughout the day.

Judgment:
Compliant

Outcome 16: Residents' Rights, Dignity and Consultation
Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

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:
The inspector found that there was a person centred approach to the residents in the centre that respected their privacy and dignity. However the inspector observed that the configuration of one of the twin bedrooms on the ground floor and one three bed room on the first floor did not ensure that the privacy and dignity of the residents who occupied these rooms could be maintained at all times due to the lack of appropriate

screening and the lack of space to undertake personal activities in private.

The inspector also noted that on some days residents spent long periods of time without access to meaningful activity and one resident who had responsive behaviours spent long periods of the day in their bedroom with limited access to activities or social interaction. Two of these issues were requirements from the previous inspection.

There was a dedicated activities coordinator who provided a programme of activities over three days each week. At other times the care staff provided activities and entertainments if they had the time. As a result the inspector found that residents spent long periods of time without access to meaningful activity.

Feedback from families and residents was very positive about the activities that were on offer and about the staff who delivered activities but complained that there were long periods without anything for residents to do especially at weekends.

During the inspection activities staff were available in the centre. The inspector observed that staff offered support and gentle encouragement to residents throughout the activity sessions. Residents were encouraged to meet in the communal areas for most activities but residents were offered 1:1 activities in their rooms if they preferred or if their dependency meant that they were not able to join in the group activity on offer. There were also groups of residents choosing to spend time together and chatting and socializing. Some residents did not want to participate but enjoyed observing the activities taking place. Staff knew which activities individual residents preferred.

The activities taking place during the inspection included music sessions, board and card games, relaxation sessions, craft activities and gentle exercises. Activities staff accompanied residents who wanted to walk into the local town or walk along the seafront. Records showed that this happened one day most weeks in the fine weather. Some residents went out with their families and visitors at other times during the week.

Throughout the inspection residents were seen to be making choices about how and where to spend their day. For example when to get up, what to eat and drink at meal times and whether to take part in the activities on offer. There were several visitors in the centre during the inspection and residents could meet with their visitors in private in their rooms or in the communal areas.

There were televisions and newspapers available for residents. There was a telephone that residents could use in private. Residents had access to wifi and one resident used this to keep in touch with family who lived at a distance.

Where residents had communication needs these were identified during their assessment and most were documented in the residents' care plans. However the inspector found that not all residents had a communications care plan. Staff knew the residents and were aware of individual resident's communication needs and what support was needed to engage with them effectively.

There were three monthly residents meetings and meeting records showed that topics such as food, the laundry service and activities were discussed regularly. The meetings

were facilitated by an external facilitator. Minutes were documented but it was not clear how the minutes of the meetings were disseminated to those residents who did not attend the meetings. Where issues were raised the centre provided feedback to individual residents on what had been done to resolve issues.

Residents had access to advocacy through an independent advocate who was known to the centre. Details were provided in the resident's guide and on the notice boards. However the inspector found that this information could be improved to include information about access to national advocacy services and the local community advocacy services both of which were available in the area.

Judgment:

Non Compliant - Moderate

Outcome 18: Suitable Staffing

There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

Theme:

Workforce

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

No actions were required from the previous inspection.

Findings:

The inspector reviewed the staffing levels at the centre and found that at most times there were sufficient staff with the required skills to meet the needs of the residents in the centre. However between 6pm and 8 pm in the evening the staffing was reduced to one carer and one nurse. These levels did not support adequate care and supervision for the residents taking into account their identified needs and the layout of the centre. This was addressed by the provider following feedback and a second carer was rostered onto the rota between 6pm and 8pm going forward.

The assistant director of nursing (ADON) worked opposite the person in charge. The ADON provided supervision of care and services that were provided on each shift and support to staff and residents as required. The inspector found that there was an open door approach from managers that supported effective communications and created an open culture in the centre. Staff who spoke with the inspector told them that managers were approachable and that their decisions were resident focused.

Staff knew the residents and their families and were able to tell the inspector about individual resident's needs and preferences for care. The inspector found that this

information was reflected in individual residents' care plans. Staff demonstrated genuine respect and empathy in their interactions with residents and their families. This was reflected in the feedback that the inspector received in the questionnaires and during the inspection.

"I find the staff very welcoming and communicative and I have observed how patient and kind they are to my relative and to all of the residents"

" I am well cared for. All staff are courteous"

" Care staff are excellent"

There was sufficient housekeeping and catering staff available in the centre to ensure that the needs of residents were being met.

The inspector observed good communications and team work between the staff working in the centre. Staff demonstrated respect and cooperation in their dealings with each other which helped to create a positive atmosphere. This was verified in feedback from relatives who visit the centre.

"The staff are friendly and caring and there is always a good atmosphere in Donore"

The centre had a system in place for monitoring that staff training was in date. Training records for fire safety, moving and handling and recognizing elder abuse were available for staff and records showed that all staff working in the centre had received up to date training or were listed to attend update training in the near future. There were other training opportunities available for staff for example in relation to responsive behaviours and understanding dementia. The centre used a variety of training methods including in-house training following incidents, resident profiling, e-learning, specialist practitioners such as mental health professionals and outside trainers.

There were effective recruitment procedures in place in the centre. A total of four randomly selected staff files were reviewed and most contained the required document as per Schedule 2 of the regulations. One staff file did not include a complete employment history for the member of staff.

The provider nominee informed the inspector that all staff received Garda vetting before starting employment at the centre. This was verified in the staff files that were reviewed during the inspection. All nurses in the centre were registered with the Nursing and Midwifery Board of Ireland. There were no volunteers working in the centre at the time of the inspection.

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:

Ann Wallace
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	Donore Nursing Home
Centre ID:	OSV-0000032
Date of inspection:	18/08/2017 & 21/08/2017
Date of response:	06/10/2017

Requirements

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

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

Outcome 01: Statement of Purpose

Theme:

Governance, Leadership and Management

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

The Statement of Purpose did not accurately describe the facilities and services provided for the residents in relation to access to the first floor bedrooms and bathrooms

1. Action Required:

Under Regulation 03(1) you are required to: Prepare a statement of purpose containing

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

the information set out in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

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

The Statement of Purpose has been amended to describe the facilities and services provided for the residents in relation to access to the first floor bedrooms and bathrooms. Only mobile residents will reside on the first floor.

Proposed Timescale: 07/09/2017

Outcome 02: Governance and Management

Theme:

Governance, Leadership and Management

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

Although information relating to key areas was collated each month this information was not analysed and as a result there was no evidence of learning or improvements made following the monitoring/reviews.

2. Action Required:

Under Regulation 23(c) you are required to: Put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

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

Since the inspection Information relating to key areas collated weekly will be analysed monthly for learning or improvements, this is done through our Quality Management System with regular meetings. Where any adverse trends are identified from the data, Corrective and Preventative Action will be taken.

Data collected on a weekly basis will be analysed on a monthly basis by the PIC /Nurses.

This analysis will seek to identify adverse trends

Corrective Action already taken will be recorded and the date for completion noted. If the CAR is first raised at the Quality Meeting the proposed Corrective Action along with the completion date will be noted.

Proposed Timescale: 30/09/2017

Outcome 05: Documentation to be kept at a designated centre

Theme:

Governance, Leadership and Management

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

The centre's policies and procedures relating to monitoring the safety and efficacy of services are not consistently implemented.

3. Action Required:

Under Regulation 04(1) you are required to: Prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.

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

The HSE is meeting us on 28th September 2017 to select training days.

Proposed Timescale: 21/09/2017

Theme:

Governance, Leadership and Management

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

One staff file did not contain a full employment history.

4. 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 staff files audited to ensure that the records set out in Schedules 2, 3 and 4 are kept and are available for inspection by the Chief Inspector. The one staff member in question now has a full employment history in their file.

Proposed Timescale: 30/09/2017

Outcome 07: Safeguarding and Safety**Theme:**

Safe care and support

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

One resident who occupied a twin room was unable to display their personal items in their bed space and locker due to the responsive behaviours of the resident with whom they shared the room.

5. Action Required:

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

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

The resident with responsive behaviours has now been moved to a room of her own and the other resident is now sharing with another resident and both are very happy with the outcome and they can now display their personal items in their bed space and

locker.

Proposed Timescale: 30/09/2017

Theme:

Safe care and support

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

Following a recent incident the centre's own safeguarding policy had not been effectively implemented.

6. Action Required:

Under Regulation 08(3) you are required to: Investigate any incident or allegation of abuse.

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

Where a complaint has been fully investigated and evidence exists that professional misconduct may have taken place, the employee or other persons will be reported to the body or bodies responsible for professional regulation, e.g. and An Bord Altranais (in the case of nurses) and other registration bodies when established.

All staff have been made aware that an incident report is to be completed by the Deputy PIC in the absence of the PIC to investigate any incident of allegation of abuse within 3 working days to be submitted to HIQA and the governing bodies in the case of nurse under allegation with the An Bord Altranais.

Proposed Timescale: 04/08/2017

Outcome 08: 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:

Not all incidents and accidents were reviewed in line with the centre's policies and procedures. As a result there was no evidence of learning and improvements being made to prevent a recurrence of the incident.

7. Action Required:

Under Regulation 26(1)(d) you are required to: Ensure that the risk management policy set out in Schedule 5 includes arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents.

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

The charge nurse on duty prior to end of the shift must on the day of the incident will record in the incident /accident report book and the ADON will conduct an investigation and submit to the PIC so as to provide evidence of learning and improvements made to prevent a recurrence of the incident.

All adverse events and incidents will be investigated within 12 hours, and no later than 24 hours after the event.

Learning from incidents and implementing improvements is an essential element in Risk Management. This is the function of our Quality Management System (QMS).

Proposed Timescale: 04/08/2017

Outcome 10: Notification of Incidents

Theme:

Safe care and support

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

Two notifiable incidents had not been notified to the Authority within the specified time frame and one incident had not been notified to the Authority within the specified time frame.

8. Action Required:

Under Regulation 31(1) you are required to: Give notice to the chief inspector in writing of the occurrence of any incident set out in paragraphs 7(1)(a) to (j) of Schedule 4 within 3 working days of its occurrence.

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

We will ensure The Chief Inspector shall be notified of of any incident set out in paragraphs 7(1)(a) to (j) of Schedule 4 within 3 working days of its occurrence.

Proposed Timescale: 02/08/2017

Outcome 11: Health and Social Care Needs

Theme:

Effective care and support

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

Skin integrity risk assessments had not been reviewed within the four month period for two residents. This was a breach of the centre's own policies and procedures relating to care planning and had not been identified in the monthly care plan audits carried out by senior staff

9. 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:

All Skin integrity risk assessments will be formally reviewed, at intervals not exceeding 4 months; the care plan has now been revised.

Proposed Timescale: 12/09/2017

Theme:

Effective care and support

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

Three residents did not have communication care plans in place and two residents did not have a care plan in relation to their psychosocial needs.

10. 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:

The three residents now have communication care plans in place and the two residents have care plans in place in relation to their psychosocial needs.

Proposed Timescale: 07/09/2017

Theme:

Effective care and support

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

One resident did not have a record of multidisciplinary review even though their physical and psychosocial needs had significantly changed. This was a requirement from the previous inspection.

11. Action Required:

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

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

The resident whose physical and psychological needs had significantly changed now has a care plan in place.

We will ensure each resident is consulted with, and participates in, the development of their individual care plan with the multidisciplinary team.

We will ensure the residents care plan is formally reviewed every four months or more frequently if there is a change in needs or circumstances.

The Residents and or their families will be encouraged to partake in the care planning and when they raise an issue during the process the matter will be noted by the named nurse who will respond to the resident within one week.

The named nurse shall review the resident's care on an ongoing basis.

Reassessment of the care plan is managed by the named nurse. Reviews will take into account changes in circumstances, new developments and outcomes already achieved during the past four months.

Proposed Timescale: 12/09/2017

Outcome 12: Safe and Suitable Premises

Theme:

Effective care and support

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

Bedrooms and bathrooms on the first floor were not wheelchair accessible and were not suitable for residents with mobility needs.

12. 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:

Only mobile residents with low dependency will be accommodated on the first floor, As stated in Statement of purpose.

Proposed Timescale: 17/08/2017

Theme:

Effective care and support

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

A twin room on the ground floor was not of a suitable size and layout for twin occupancy. This was due to the very limited space around each bed, the lack of appropriate screening, the lack of space to undertake personal activities in private and the lack of space for a bedside chair.

The layout of one three bed room was not suitable for three residents. This was due to the very limited space around one bed, its proximity to the shared wash hand basin, the lack of appropriate screening, the lack of space to undertake personal activities in private and the lack of space for a bedside chair.

13. 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:

The twin room on the ground floor is now converted into single room occupancy .
The three bed room are now two bedrooms on the first floor.

Proposed Timescale: 24/08/2017

Theme:

Effective care and support

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

One of the wheelchair accessible toilet/shower rooms is situated off the communal lounge at the rear of the building and is not close to the residents' bedrooms. The accessibility and distance of toilet and bathroom facilities are an outstanding requirement from the previous inspection.

14. 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:

The clinical team is satisfied that there are adequate toilets on the ground floor

Proposed Timescale: 11/09/2017

Outcome 16: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

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

The inspector observed that the configuration of one of the twin bedrooms on the ground floor and one three bed room on the first floor did not ensure that the privacy and dignity of the residents who occupied the rooms could be maintained at all times because of the lack of appropriate screening and the lack of space to undertake personal activities in private.

15. 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:

One resident now occupies room 4 the third bed has been taken out.

Proposed Timescale: 04/09/2017

Theme:

Person-centred care and support

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

The inspector found that residents spent long periods of time without access to meaningful activity. The inspector also noted that one resident who had responsive behaviours spent long periods of the day in their bedroom and that they had limited access to meaningful activities or social interaction.

16. Action Required:

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

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

In consultation with GP after the registration inspection, GP has written in medical notes in last paragraph some of these are due to dementia and she has recorded that no need for psychiatric opinion at this point.

We have also consulted resident's family regarding present condition.

Meeting with G.P was on 27/08/2017. Care plan revised in conjunction with residents family and MDT on 27TH August 2017. Activities will be provided to avoid this resident spending long periods alone in her room.

Proposed Timescale: 27/08/2017

Theme:

Person-centred care and support

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

Some residents did not have a communications care plan in place.

17. 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:

All residents who have specialist communication requirements have communication care plans in place.

Proposed Timescale: 30/09/2017

Outcome 18: Suitable Staffing

Theme:

Workforce

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

Between 6pm and 8 pm in the evening the staffing was reduced to one carer and one nurse which did not support adequate care and supervision for the residents considering their needs and the layout of the centre.

18. 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:

We have recruited a new health care assistant. Induction taking place on 8th September 2017.

A new HCA commencing work on 4th oct 2017. Meanwhile two staff members are on the floor everyday 6pm- 8 pm.

Proposed Timescale: 08/09/2017