

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Heather House Community Nursing Unit
<b>Centre ID:</b>	OSV-0000714
<b>Centre address:</b>	St Mary's Health Campus, Bakers Road, Gurrabraher, Cork.
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<b>Type of centre:</b>	The Health Service Executive
<b>Registered provider:</b>	Health Service Executive
<b>Lead inspector:</b>	Breeda Desmond
<b>Support inspector(s):</b>	None
<b>Type of inspection</b>	Unannounced Dementia Care Thematic Inspections
<b>Number of residents on the date of inspection:</b>	49
<b>Number of vacancies on the date of inspection:</b>	1

## **About Dementia Care Thematic Inspections**

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was following receipt of unsolicited information. This monitoring inspection was un-announced and took place over 2 day(s).

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

From:	To:
10 June 2019 08:30	10 June 2019 17:00
11 June 2019 08:30	11 June 2019 15:00

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		Non-Compliant - Moderate
Outcome 05: Suitable Staffing		Non-Compliant - Moderate
Outcome 06: Safe and Suitable Premises		Substantially Compliant

**Summary of findings from this inspection**

This report sets out the findings of an unannounced thematic inspection that focused on six specific outcomes of dementia care. At the time of inspection there were 20 of 49 residents living in the centre with a formal diagnosis of dementia. Residents' dependencies ranged from low to maximum dependency, with many residents requiring a high level of support due to their communication, dependency, and enduring mental health needs.

The registered provider representative and person in charge were recently appointed to the governance structure of the centre. The inspector found that in general, this was a good service, where the registered provider representative, person in charge and care team were committed to delivering a person-centred approach to care and support, including a focus on promoting a restraint-free environment. Residents' autonomy and independence was promoted and people gave positive feedback about

their life in the centre. The inspector met with many residents and relatives during the two-day inspection and observed practices that suggested that care was delivered in a relaxed atmosphere. Care practices and interactions between staff and residents were observed using a validated observational tool. All care staff had responsibility supporting residents exhibiting aspects of responsive behaviours, and observations demonstrated that most engagement with residents was done in a positive connective way to enhance peoples' quality of life, however, on occasion, some observations showed little or no engagement with residents.

There were two staff on the activities team; activities were varied and activities staff showed good insight regarding individualised activities to enhance peoples' quality of life. The inspector reviewed care documentation which was evidenced-based for both clinical and social perspective. The centre was in the process of transitioning to a new documentation system, however, information was clinically focused with little person-centred information to inform a holistic approach to care. In addition, assessments and care plans were not comprehensive, or updated in accordance with regulatory requirements. While behavioural support plans were in place, they did not provide insight into the possible cause of behaviours to enable learning and perhaps mitigate recurrences of complex behaviours. Residents had timely access to medical services including out-of-hours services and allied health professionals.

Staffing levels were adequate to meet the assessed needs of residents. Staff had access to on-line, in-house training and external training. There was good oversight of staff training needs, and gaps identified in staff training had training scheduled within a few weeks of the inspection date.

Unsolicited information was received by the Office of the Chief Inspector highlighted poor oversight of student placement in the centre. These were followed up on this inspection and were found to be partially substantiated whereby better supervision of all staff was highlighted to ensure all care delivered was in compliance with best practice to ensure the safeguarding of residents.

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

*Outcome 01: Health and Social Care Needs*

**Theme:**

Safe care and support

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

**Findings:**

In general, the inspector observed good, kind care and interactions with residents and visitors. The inspector tracked the journey of residents with dementia and also reviewed specific documentation of care including medication management, restrictive practice and management of responsive behaviours. There were systems in place to optimise communication between residents and families, and next of kin advised the inspector that staff ring them to update them on their relatives condition. There were processes in place to ensure that when residents were admitted, transferred or discharged to and from the centre, that relevant and appropriate information was readily available and shared between services. Documentary evidence showed that residents and their families were involved in planning care and assessing care needs. Assessments were carried out on admission of all residents, including those people with a diagnosis of dementia. While validated assessment tools were used to support assessments and care, these were not updated in accordance with the regulations. Care plans were clinically orientated and contained little person-centred information to inform individualised care. Nonetheless, staff spoken with and observations demonstrated that staff knew people's preferences and in general, facilitated these in a kind manner. The evidence-based direct observation behavioural tool 'Antecedent-Behaviour-Consequence' (ABC) comprised part of residents' care plans. Antecedents to behaviours were not recorded appropriately to assist care staff in identifying a possible cause of such behaviours; while behaviours were recorded, responses to interventions were not comprehensively recorded to alleviate situations and possibly mitigate recurrences. Observation demonstrated that most staff understood the importance and significance of positive connective care and socialisation, however, some staff did not engage with residents or ignored them when they were seeking attention; a positive connective approach to someone calling may have de-escalated behaviours and prevented residents from becoming agitated. Other observation showed a task-oriented approach to care giving.

The general practitioner (GP) attended the centre on a daily basis; and residents had good access to psychiatry of old age, dietician, speech and language, dental, ophthalmology, chiropody and tissue viability. Residents with specialist chairs had been assessed by the occupational therapist. Review of medication management charts

showed that they were reviewed by the GP on a regular basis and documentation was in line with professional best practice guidelines. All medications to be crushed were individually prescribed. However, there were gaps in the drug administration records. The annual weighing chart was set out per month; however, several monthly weights were not completed in the sample of care plans reviewed.

Residents gave positive feedback about the quality of their meals, the menu choice and choice in where to dine. The inspector observed breakfast, snack, lunch and supper times on inspection. Tables were very pleasantly set and new menu cards were available on each table. Overall, observation demonstrated that the dining experience was a positive experience. The presentation and delivery of food was person-centred and staff were very familiar with people's preferences. While there were systems in place to ensure the fluid and nutrition intake of residents in accordance with their assessed needs, residents' intake or output were not recorded on night duty in the sample of fluid balance charts examined. Consequently, it could not be assured that residents were offered fluids or had a urinary output over a 12-hour period.

**Judgment:**

Non Compliant - Moderate

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

**Theme:**

Safe care and support

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

**Findings:**

CNMs were well known to residents and reported that they could raise any concerns or issues with them. Policies were in place for safeguarding vulnerable adults including information relating to restrictive practice. Training records indicated that all staff had up-to-date training related to protection and managing behaviour that was challenging. The restraint register showed a responsive approach to review and assessment of bedrails and the ongoing discussion promoting a restraint-free environment. Residents had individual access to secure doors where appropriate. While there was a positive culture regarding use of restraint and alternatives to promote better outcomes for residents, bedrail assessments were not completed appropriately to give an accurate assessment or decisions regarding risk associated with implementing bedrails to ensure best outcomes for residents. ABC charts were not completed correctly, that is, the narrative of the antecedent described what staff were attempting to do, for example, provide personal care, rather than describe the behaviour of the resident. Consequently, identifying issues to mitigate recurrences of certain behaviours could not occur. Residents' petty cash records were examined and these showed that two signatures were not routinely in place in line with best practice, to ensure both residents and staff were protected.

**Judgment:**

Non Compliant - Moderate

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

Person-centred care and support

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

The residents' guide and the statement of purpose were updated on inspection to ensure compliance with the regulations and ensure residents and their families had access to information about the service. There were no restrictive visiting arrangements. The inspector spoke with several family members that visited the centre; some came early in the morning to sit with their relative while having breakfast; others came at lunch time and throughout the day, and all were made welcome. The inspector observed guests visiting in the lounges, residents' bedroom, in the dining room and activities room.

Residents advised that they had access to community services including day services, such as Share and Headway; the inspector spoke with residents using these services and they gave positive feedback regarding how they were supported to use these services. There were two staff members rostered to activities. There was a daily programme of activities as well as special events, outings and celebrations. Residents reported that activities were based on their request and choice, and the activities sessions were a hive of chat, craft work and socialisation. Residents and relatives highlighted the recent garden day that was held in the centre the previous week where families and friends came into the centre and painted and decorated the garden raised flower beds, planters and set flowers; and reported what a wonderful day they had. People said that they participated if they wished and their right to not participate was respected and this was observed. There were three volunteers and they had been appropriately vetted; they had completed training in protection and documentation in accordance with the regulations was in place for them.

Residents had access to advocacy services and information relating to advocacy was displayed in the centre. The independent advocate facilitated residents' meetings. While it was reported that one meeting in 2019 had occurred in May, minutes from this meeting had not yet been furnished, nonetheless, verbal feedback was given to the person in charge regarding issues raised. Better oversight of the residents' meetings would ensure a more effective process for residents to participate in the organisation of the centre. Residents' were given satisfaction surveys at this meeting and they were being returned bit-by-bit; the person in charge advised that there was really good insightful information included in the feedback and issues were being addressed as they

arose. This feedback informed staff and management meetings.

Breakfast, lunch, tea time and snack times were observed. Residents came to the dining room for their breakfast, when they chose; and service was relaxed and individualised. Staff knew residents' preferences and routines and accommodated this in a cheery manner. People had choice in where to dine for their meals. Morning and afternoon snack time was observed in the activities room; the dessert trolley was wheeled around to each resident who was asked their preference. The desserts on the trolley were such that one family member reported that it was like 'afternoon tea in a posh restaurant', the choice was so appealing. The inspector observed that the activities person asked residents if they would like a tissue to protect their clothes and individualised care was delivered in a kind and gentle manner. The person in charge was in the process of getting residents' feedback relating to the possibility of having their lunch in the activities room if they wished, to facilitate continuity of their activity.

The inspector used the validated observational tool (Quality of Interaction Schedule – QUIS) to rate and record at five minute intervals the quality of interactions between staff and residents in the centre. These observations took place in day rooms, the dining rooms, nurses' station and activities room. Each observation lasted 30 minutes. Most staff demonstrated good practice, positive engagement and distraction technique interactions with all residents including people with communication needs, and adapted their approach to reflect the individuality of each resident, however, some observations showed no engagement with residents. While most staff sat and positively engaged with residents while assisting with meals, some staff members stood over residents and did not engage. The inspector observed that there was no interaction between a staff member and residents in the day room. Occasionally, practices observed were task-oriented with no flexibility in care delivery.

Staff and documentation referred to people as patients rather than residents, cognisant that this was their home and where they live, this was not respectful.

**Judgment:**

Non Compliant - Moderate

***Outcome 04: Complaints procedures***

**Theme:**

Person-centred care and support

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

**Findings:**

Residents and relatives spoken with were aware of their right to raise concerns. The person in charge outlined that work had commenced on policies, procedures and guidelines to ensure they were up to date, centre specific, referenced current legislation

and best practice guidance. While there were policies and procedures relating to the management of complaints, they were not centre specific. The complaints logs were examined and complaints were not recorded in line with the requirements set out in the regulations. Consequently, it was not assured that staff knew their responsibilities regarding the complaints procedure or that issues raised were dealt with appropriately.

A nominated person other than the person nominated in regulation 34 (1) (c) was not identified.

**Judgment:**

Non Compliant - Moderate

***Outcome 05: Suitable Staffing***

**Theme:**

Workforce

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

**Findings:**

Resources were in place with the appropriate number and skill mix to meet the assessed needs of residents. Care staff had completed or were in the process of completing FETAC level 5 training. Those who had not completed this training were encouraged to undertake it. Four members of staff were scheduled to undertake the dementia championing course. The person in charge had reviewed training records and had identified gaps in staff training and had scheduled training over the coming weeks. Overall, there was good oversight of training needs to ensure staff had up-to-date training appropriate to their role and responsibility.

The person in charge worked full time and three clinical nurse managers (CNMs) provided further support to the governance structure. The inspector met with the recently appointed person in charge. She was knowledgeable regarding the legislation and outlined that she and the CNMs' responsibilities included audits and staff supervision, in line with the regulations, to support the quality improvement strategy. The inspector concurred with the necessity to supervise staff appropriate to their roles and responsibility as observations detailed in outcome 3; other observation showed inappropriate handling techniques when assisting residents moving from sitting to standing position; and inconsistent supervision of residents when smoking.

A sample of staff files were reviewed and documentation was in line with the requirements set out in Schedule 2 of the Regulations. Vetting disclosures in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 were in place for staff and volunteers.

The general manager facilitated compliance meetings with the person in charge and

CNMs met every fortnight at a minimum to support the service; the person in charge met with the CNMs fortnightly to provide guidance as part of their quality improvement strategy. Staff meetings with other care staff had commenced following the appointment of the person in charge. Ward meetings were held on a daily basis on each unit to provide updates on clinical and social care. Minutes of meetings showed a variety of issues were discussed, but the main objective was to encourage quality improvement and staff were asked for their suggestions to support this premise.

**Judgment:**

Non Compliant - Moderate

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

**Theme:**

Effective care and support

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

**Findings:**

The design and layout of the centre was suitable for its stated purpose and appeared to meet the needs of residents. There was lift and stairs access to the upstairs unit. Overall, the premises was homely, warm, bright with natural light and pleasantly decorated. Sights from the centre, especially upstairs, were panoramic views of Cork city and several residents commented on how lovely it was to look out at. Suitable storage for assistive equipment was available to adequately store equipment discretely. While there was some signage to orientate people, improvement was necessary to minimise the risk of confusion and disorientation.

The provider discussed the premises and outlined the on-going updating and refurbishment works in the centre. Coffee docs on both floors for families to make hot beverages when visiting their relatives and friends were almost completed. Refurbishment of the seating area by the lifts and the additional activities room was in progress to provide further communal areas for residents to enjoy.

Residents' accommodation comprised single, twin and multi-occupancy four-bedded rooms with full en suite facilities. Assisted toilets, showers and bathrooms were available throughout and conveniently located adjacent to dining rooms, day rooms and the activities room. Residents had access to private storage space including secure storage. Bedrooms were personalised in accordance with individual preferences. Hand rails and grab-rails were available throughout. Assistive equipment such as specialist beds, mattresses and chairs were available. While there was sufficient supply of hot water, the water coming into the activities room was scalding. This was highlighted during the inspection and remedied before the inspection was completed.

The activities room on the ground floor was quite a large room with tables and seating for group and individual activities, a kitchenette, and a comfortable seating area around

a fire place with a large screen television. Residents had access to a large secure garden that could be accessed from many aspects of the building; it had well maintained shrubberies and walkways, seating, water feature and raised flower beds. There were two smoking shelters for residents; one outside the activities room and the second outside the dining room on the ground floor.

Sluicing facilities were available on both floors. Cleaning regimes were in place for routine cleaning as well as deep cleaning and curtain changing. There was a deep cleaning programme in place at the time of inspection in conjunction with routine cleaning; while there were records signed to indicate that deep cleaning was done, they did not indicate what was actually cleaned. Observation of cleaning practices showed that advisory signage was not consistently used to alert people that floors were wet; instead, the cleaning mop was placed diagonally across doorways to inhibit residents from entering their bedrooms, which posed a falls risk.

**Judgment:**

Substantially Compliant

## Closing the Visit

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

### Acknowledgements

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

### *Report Compiled by:*

Breeda Desmond  
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>	Heather House Community Nursing Unit
<b>Centre ID:</b>	OSV-0000714
<b>Date of inspection:</b>	10/06/2019
<b>Date of response:</b>	

### Requirements

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

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

### Outcome 01: Health and Social Care Needs

#### Theme:

Safe care and support

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

All policies, procedures and guidelines were not up to date, centre specific, or referenced current legislation and best practice guidance.

#### **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

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

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 schedule 5 policies will be updated by 30th August 2019.
- All other policies will be reviewed over the next 4 months and will be updated as required in consultation with Clinical Development Coordinator.
- All policies will be reviewed as required thereafter and policy review will be included in the centre's audit schedule.

**Proposed Timescale:** 30/11/2019

**Theme:**

Safe care and support

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

While validated assessment tools were used to support assessments and care, these were not updated in accordance with the regulations.

Care plans were clinically orientated and contained little person-centred information to inform individualised care.

The evidence-based direct observation behavioural tool 'Antecedent-Behaviour-Consequence' (ABC) comprised part of residents' care plans. Antecedents to behaviours were not recorded appropriately to assist care staff in identifying a possible cause of such behaviours; while behaviours were recorded, responses to interventions were not comprehensively recorded to alleviate situations and possibly mitigate recurrences.

**2. 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:**

- Comprehensive education on person centred care planning has been provided to nurses. On-going further education on will be provided by the Clinical Development Coordinator.
- Care plans will be updated to include more person centred information.
- Care plans will be audited monthly until to ensure an acceptable standard is reached. This will be overseen by the Clinical Development Coordinator.
- Audits will continue as per annual audit schedule from this point.
- Careplans and re-assessments will be completed every 4 months, or if the condition of the resident changes.
- Further education will be provided to staff on restrictive practices and completion of the ABC charts by the CDC, cognisant of the 2019 Hiqa Guidance on Restrictive practices.

- The ABC charts will be revised, and antecedents and responses to interventions will be recorded in an effort to identify triggers to responsive behaviours.

**Proposed Timescale:** 30/11/2019

**Theme:**

Safe care and support

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

There were gaps in the drug administration records.

The annual weighing chart was set out per month; however, several monthly weights were not completed in the sample of care plans reviewed.

While there were systems in place to ensure the fluid and nutrition intake of residents in accordance with their assessed needs, residents' intake or output were not recorded on night duty in the sample of fluid balance charts examined.

**3. 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:**

- All nurses will complete the Hse medication management course online annually.
- Medication administration audit will be introduced in conjunction with a more in-depth medication audit
- Audit of drug administration charts will be completed monthly using metrics and results and action plans discussed with nurses. The safety pause meeting will be used to facilitate this.
- Nurses now wear red tabards to indicate that they should not be disturbed while administering medication.
- The HCA linked with the resident will take responsibility for weighing the resident monthly, and reporting this to the nurse.
- Any resident who requires monitoring of fluid/and nutritional intake will be mentioned at handover, and records will be maintained for the full 24 hour period. This will be overseen by the CNM11 as part of their daily supervision.

**Proposed Timescale:** 31/10/2019

**Outcome 02: Safeguarding and Safety**

**Theme:**

Safe care and support

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

Bedrail assessments were not completed appropriately to give an accurate assessment or decisions regarding risk associated with implementing bedrails to ensure best outcomes for residents.

ABC charts were not completed correctly, that is, the narrative of the antecedent described what staff were attempting to do, for example, provide personal care, rather than describe the behaviour of the resident. Consequently, identifying issues to mitigate recurrences of certain behaviours could not occur.

Residents' petty cash records were examined and these showed that two signatures were not routinely in place in line with best practice, to ensure both residents and staff were protected.

**4. Action Required:**

Under Regulation 08(1) you are required to: Take all reasonable measures to protect residents from abuse.

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

- Multi-disciplinary input has significantly increased on site.
- All bedrail assessments are being re-assessed and guidance followed in relation to trialling alternatives with the input of the MDT, thus reducing use of restraint.
- Elderwell have been engaged for 18+ hours per week to provide positive engagement with residents to assist in reducing episodes of responsive behaviour. This intervention will be reviewed and increased as required.
- Residents cash has been removed from the unit, and is now kept in the admin office. Residents have been informed that they may request cash which will be facilitated by the administrative staff. Staff have been informed of this change via staff meeting and the pause meeting.
- Residents have a locked facility in their bedroom if they wish to keep money or personal belongings here.
- Governance of monies belonging to residents is now governed in accordance with the Patient property guidelines. The CNM11 will oversee this at unit level.

**Proposed Timescale:** 30/11/2019

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

**Theme:**

Person-centred care and support

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

Some observations showed no engagement with residents. While most staff sat and positively engaged with residents while assisting with meals, some staff members stood over residents and did not engage. The inspector observed that there was no interaction between a staff member and residents in one day room. Occasionally,

practices observed were task-oriented with no flexibility in care delivery.

Staff and documentation referred to people as patients rather than residents, cognisant that this was their home and where they live, this was not respectful.

**5. 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 Safety Pause meeting will be used to promote person centred care interactions.
- The CNM will lead this initiative.
- The QUIS observation tool will be used twice weekly on both units to assist staff in identifying positive and negative interactions with residents.
- Residents will be referred to as residents by all staff.
- All staff will be provided with training on person centred care.
- Staff will be facilitated in training on Dementia care.
- Additional Elderwell hours will be used to promote positive engagement with residents.
- CNM11 will lead the development of a more person centred culture, and poor practice will be identified and discussed at the daily pause meetings to ensure learning across the centre.

**Proposed Timescale:** 30/11/2019

**Theme:**

Person-centred care and support

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

While it was reported that one residents' meeting in 2019 had occurred in May, minutes from this meeting had not yet been furnished. Better oversight of the residents' meetings would ensure a more effective process for residents to participate in the organisation of the centre.

**6. Action Required:**

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

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

- Residents meeting will be held quarterly May, August, November and February.
- These will be facilitated by Elderwell and minutes of the meeting will be submitted to the PIC.
- Items will be addressed with the individual residents by the PIC, and a formal response will be included in the subsequent meeting.
- Any further works or renovations will be discussed with the residents in advance to allow them every opportunity to be involved in the organisation of the centre.

- Residents are presently being consulted about colour of bedrooms and décor of communal areas via the Activities team.

**Proposed Timescale:** 30/11/2019

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

**Theme:**

Person-centred care and support

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

The complaints logs were examined and complaints were not recorded in line with the requirements set out in the regulations. Consequently, it was not assured that staff knew their responsibilities regarding the complaints procedure or that issues raised were dealt with appropriately.

A nominated person, other than the person nominated in regulation 34 (1) (c), was not in place.

**7. Action Required:**

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

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

- The Complaints policy and complaints log book have been updated to ensure compliance with the regulations.
- Staff have been informed of the new policy and procedure via staff meeting and they are requested to sign when they have read and understood the policy.
- If a complainant is unhappy with the response to a complaint they are informed of the appeals process.
- The General Manager is named in the Complaints policy as the person other than the Person in charge to ensure that all complaints are appropriately responded to.
- Residents satisfaction surveys have been distributed to residents and family members, and they are being supported in completing these to promote engagement between the residents families and staff.

**Proposed Timescale:** 30/11/2019

#### **Outcome 05: Suitable Staffing**

**Theme:**

Workforce

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

Staff were not supervised appropriate to their roles and responsibility as observations

detailed in outcome 3; other observation showed inappropriate handling techniques when assisting residents moving from sitting to standing position; and inconsistent supervision of residents when smoking.

#### **8. 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:**

- Staff will be supervised appropriate to their role and responsibility.
- This is discussed at daily pause meeting.
- Moving and Handling training will be kept up to date. Moving and Handling training will take place 31st July.
- The Physiotherapist and Occupational Therapist have been asked to advise on moving and handling techniques where there is an identified issue.
- Moving and Handling technique will be monitored by the Physiotherapist and the CNM11.
- The QUIS observation tool will be used twice weekly on both units to assist staff in identifying positive and negative interactions with residents in an effort to raise awareness of the importance of positive connective care.
- All residents who smoke have a risk assessment completed. This indicates whether they require supervision or not. This will be updated as required as per policy.
- Supervision is provided by staff at designated times throughout the day.
- Staff will be reminded of their responsibility regarding this role at the pause meetings and via staff meetings.

**Proposed Timescale:** 25/07/2019

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

#### **Theme:**

Effective care and support

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

While there was some signage to orientate people, improvement was necessary to minimise the risk of confusion and disorientation.

There was a deep cleaning programme in place at the time of inspection in conjunction with routine cleaning; while there were records signed to indicate that deep cleaning was done, they did not indicate what was actually cleaned.

Observation of cleaning practices showed that advisory signage was not consistently used to alert people that floors were wet; instead, the cleaning mop was placed diagonally across doorways to inhibit residents from entering their bedrooms, which posed a falls risk.

#### **9. Action Required:**

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

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

- Signage is being reviewed on 25th July and updated to ensure that residents will be assisted in as far as possible in finding their way around the unit.
- Cleaning records will be updated to include an itemised log of all cleaning performed on a daily basis.
- Staff have been informed that 'wet floor' signs are to be used and the practice of placing a mop across the door to indicate a wet floor is absolutely not acceptable and poses a Health and Safety risk.
- CDC is currently sourcing education in relation to best practice on cleaning in residential units.

**Proposed Timescale:** 30/11/2019