

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Moyglare Nursing Home
Centre ID:	OSV-0000072
Centre address:	Moyglare Road, Maynooth, Kildare.
Telephone number:	01 628 9022
Email address:	info@moyglarenursinghome.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Moyglare Nursing Home Limited
Provider Nominee:	Damian Doyle
Lead inspector:	Sheila McKeivitt
Support inspector(s):	Leone Ewings
Type of inspection	Unannounced Dementia Care Thematic Inspections
Number of residents on the date of inspection:	47
Number of vacancies on the date of inspection:	7

About Dementia Care Thematic Inspections

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

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

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

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

The inspection took place over the following dates and times

From: 18 April 2016 10:00 To: 18 April 2016 19:30

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

Summary of findings from this inspection

The purpose of this inspection was to determine what life was like for residents with dementia living in the centre. In order to determine this inspectors focused on six outcomes and followed up on two outcome from the last monitoring inspection which took place in August 2014. There were 47 residents in the centre, 44 of the 47 residents in the centre had a diagnosis of cognitive impairment, alzheimers disease or dementia. The centre did not have a dementia specific unit.

Prior to this inspection the provider had been requested to complete and submit a self- assessment document and relevant polices. The inspectors reviewed these documents prior to this inspection. The judgments in the self assessment stated two were in compliance and three in substantial compliance with five outcomes. Inspectors inspected under six outcomes found the provider was in major non compliance with one outcome, moderate non compliance with three outcomes, substantial compliance with one outcome and compliant with one outcome.

Inspectors found the centre met the basic care needs of residents with dementia. However, there needs were not always met in accordance to the residents choice, in line with evidence based practice or in a timely manner. Residents with dementia were given restricted choices in relation to care provided to them. The management of residents with significant weight loss was not in line with the centres own assessment tools or their nutritional policy. Some nursing practices were not reflective of evidence based practice. There was a relatively high use of restraint. Inspectors saw that the provider had invested in equipment used as alternatives to restraint. However, records did not reflect their use prior to the use of restraint. Behaviours that challenged were managed by diversional therapies with the use of psychotropic medications as a last resort. However, residents care plans did not always reflect triggers or diversional therapies to use. The staffing levels and skill mix were found to meet the needs of residents. There was documented evidence that staff had received training to care for residents who had dementia. However, further training was required around evidence based nursing practices, management and grading of pressure ulcers, dementia specific activities, meeting the communication needs of non verbal residents, respecting residents right to choice and respecting residents dignity. The premises was kept well, however, the use of colour and additional signage may enable residents with dementia to maintain their independence for a longer period of time. The management of complaints was robust.

The action plans at the end of this report reflect where mandatory improvements need to be made.

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

Outcome 01: Health and Social Care Needs

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

There was a detailed admissions policy which was reflected in practice. In general nursing, medical and social care needs of these residents were being met. However, referrals were not been made in a timely manner to members of the allied health care team members when risks were identified. Also, all aspects of nursing care provided was not evidence based.

Residents had access to medical and allied health care professionals of their choice. All residents had chosen a general practitioner and pharmacist from practices close by to care for them. Residents' had access to a geriatrician and a consultant psychiatrist in the local acute hospital. Inspectors saw evidence of some referrals made, assessments completed and recommendations made in resident files. The provider sought external companies to come in and routinely assess residents eyesight and dental hygiene/needs. The general practitioner chosen by most of the residents routinely visited the centre twice each week. There was evidence that all residents had their medical needs including their medications reviewed on a four monthly basis by the pharmacist, general practitioner and person in charge. The pharmacist delivered medications when required and conducted an audit of medication management practices every three months.

Residents who had been transferred into and out of hospital had copies of their transfer letter from the centre to the acute hospital on file together with nursing and medical transfer letters from the acute hospital back to the centre.

Residents had comprehensive assessments completed pre-admission and on admission. These were reviewed on a four monthly basis and those reviewed reflected the residents' needs. However, it was not clear if the resident or their next of kin were involved in these reviews. Most identified needs had a corresponding care plan in place reflecting the care required to meet that need. However, residents' identified as being at high risk of malnutrition did not always have a nutritional care plan in place.

Residents nutritional needs were not being met and all high/maximum dependent residents' were not supported to enjoy the social aspects of dining as discussed further

under outcome 16. Residents had a malnutritional risk screening tool (MUST) completed on admission, this was reviewed on an ad-hoc basis even when residents were identified as at risk of malnutrition. Residents were routinely weighted on a monthly basis and their likes, dislikes and special diets were all recorded in their nursing assessment. However, this information was not reflected in documentation pertaining to each resident's diet held in the kitchen. For example, one resident identified as at high risk of malnutrition was seen by the dietician in September 2015 who advised a number of actions including fortifying the residents' food with cream, milk and/or butter and provide the resident with a soft modified diet. The list held by the kitchen staff did not reflect the need to fortify this residents' food. The resident had lost 4kg within one month this year and there was no documented evidence that any action had been taken to address this weight loss. There was no evidence that the residents general practitioner had been informed or that a referral had not been sent to the dietician for re-assessment.

The menu provided a varied choice of meals to residents. However, there was no evidence that the menu had been reviewed by a dietician to ensure its nutritional content was meeting the needs of all residents'. There was no evidence that any of the residents' identified as at risk of malnutrition were having their meals fortified in line with their dieticians recommendations. Residents who required support at mealtimes were provided with timely assistance from staff. However, this assistance was not given in line with best practice. For example, inspectors observed one staff assisting two residents at lunch time, both at the same time, one to the right and one to the left, another staff member was observed standing in front of the seated resident when providing assistance with their lunch. Inspectors also noted that meal portions appeared to be small and these did not differ according to the weight of the resident.

Inspectors reviewed documents pertaining to three of residents who had significant weight loss since their last review by their dietician. There was no evidence that any of the three had been re-assessed by their dietician and no evidence that two of the three residents' general practitioner had been informed of their most recent weight loss. The person in charge was asked to do a review of all residents identified as being at risk of malnutrition and submit a detailed plan of care for all these residents' to the Authority by close of business on Friday 21 April 2016.

Inspectors found that a resident who had a choking incident in the dining room had not been assessed by a speech and language therapist post the incident.

There was no resident receiving end of life care at the time of the inspection. Staff provided end of life care to residents with the support of the general practitioner and the palliative care team if required. Residents did not have their end of life preferences recorded or have an end of life care plan in place. The person in charge informed inspectors that they were now involved in the piloting of end of life assessment and care plan documents with the Irish Hospice Foundation and were in the process of commencing completion of these documents with residents.

Inspectors observed that an additional bed sheet was being used on top of residents bottom bed sheet. Staff informed inspectors that the purpose of there use was to protect the bottom sheet from getting wet. In addition, double sheets of plastic were

used on top of beds. This practice had the potential to increase the risk of the resident developing pressure ulcers. The practice observed was not evidence based.

This outcome was judged to be substantial compliant in the self-assessment, the inspector judged it as major non compliant.

Judgment:

Non Compliant - Major

Outcome 02: Safeguarding and Safety

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

The centre was safe and secure, some residents spoken with confirmed this.

Records reviewed showed staff had completed training in the protection, detection and prevention of elder abuse and those spoken with had a good clear and concise understanding of this policy.

There was a detailed evidence based restraint policy in place. There was a high number of residents with bed rails in use as a form of restraint. Some residents had an additional extension applied to the bed rail to make it higher, inspectors observed that this extension was not secure on a number of beds and posed a potential risk to residents. There were some forms of alternative equipment available such as a low low bed, floor, bed and chair sensor mats. However, a sample of restraint assessment forms reviewed did not outline what if any of these had been tried, tested and failed prior to bed rails being used as a form of restraint. Residents' with bed rails in use as a restraint did have care plans but these did not reflect when the bed rail extension was in use. The practice observed did not reflect evidence based practice, the centres own policy or the National Policy 2011 "Towards a Restraint Free Environment". This was discussed with the person in charge during the inspection.

Residents' displaying behaviours that challenged at times had care plans in place to reflect the care required to manage such behaviours. However, the content of these care plans did not always outline triggers or diversional therapies to use. Records reviewed showed that staff had received training in this area. Inspectors saw that psychotropic medications were used as a last resort to manage behaviours that challenge. As mentioned under outcome 11 the residents' medications were reviewed on a regular basis.

The policy available excluded a section on how to manage a residents' finances. Inspectors saw that the provider had detailed, clear and concise records of personal

finances he managed on behalf of one resident. These records included receipts for expenditures. However, the resident's money was not being lodged into a bank account in the resident's name.

This outcome was judged to be compliant in the self-assessment, inspectors judged it as being moderately compliant.

Judgment:

Non Compliant - Moderate

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

Residents' with dementia were consulted with and actively participated in the organisation of the centre. Residents' privacy was respected, including receiving visitors in private. However, their rights and dignity were not respected at all times. They had access to activities. Their choice was restricted and communication practices between staff and residents' with dementia required improvement.

Inspectors were informed that resident meetings occurred in the centre and minutes of these meetings were available for review. There was evidence that issues brought up by residents had been addressed and evidence of feedback to residents'. Residents had access to advocacy services. Contact details for the national advocacy service were available throughout the centre.

Residents privacy was respected by staff. However, the curtains in twin bedrooms required review as they currently did not ensure the privacy of the resident residing in the inner bed in these rooms. There were no restrictions on visitors and residents could receive visitors in private in different areas of the centre. All residents had been offered the choice to register to vote and a number of residents had chosen to do so within the centre others told inspectors they went out to the local polling station to vote. Residents had the choice whether to attend Mass in the oratory or not. Inspectors saw residents' had access to the local and daily newspapers.

Activities provided were displayed on an notice board and in each bedroom. They included some activities which were directly focused on meeting the needs of dementia residents'. These included 1:1 activities such as hand massage and group activities such as sonas and art.. However, the delivery of some group activities required review as the numbers in attendance were not in line with best practice guidelines. Records of residents' who participated in activities were good.

There was a policy providing staff with information on how to communicate with residents with dementia. Residents' with communication difficulties had a care plan in place reflecting their needs. However, the residents communication care plan and the centres communication policy was not reflected in practice. Staff were observed coming into and out of a communal area with a number of high dependency residents in the room, some communicated with residents others did not, overall the level of communication and interaction with residents was not satisfactory. For example, a staff member came into the room and turned off the television without speaking to any of the residents' in the room, another was observed moving a chair in which a resident was asleep without advising the resident before the move. The resident woke with a jump from the sudden unexpected movement of the chair.

There was a lack meaningful engagement with highly dependent residents' who were non verbal. Inspectors noted care staff had some pictorial charts available to them to facilitate them to engage with these residents'. However, inspectors did not see these being used by any member of staff during the course of this inspection. For example, inspectors were told that residents' were asked their choice for lunch at the morning tea time, however, inspectors did not see evidence of highly dependent residents' who were non verbal being given a choice for lunch at the morning tea time, although photos of meals on the menu were available to enable them make a choice.

There was a lack of choice given to residents'. Some residents who were assessed as high-maximum dependent were not given the choice of where they would like to eat. Staff informed inspectors that some residents' were not offered the choice to eat with other residents in the dining room because their chairs were too big to fit in the dining room at lunchtime and that they required assistance at mealtime. Inspectors observed some staff providing care to residents' prior to communicating with them or gaining their consent. For example, inspectors observed some staff place clothing protectors on residents without gaining their consent. The routine use of clothing protectors required review to ensure the dignity and choice of residents was respected at all times.

Overall, inspectors found a complete review of some staffs communication practices and routines required a complete review to ensure residents' choices were respected at all times.

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

Judgment:

Non Compliant - Moderate

Outcome 04: Complaints procedures

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

There was a complaints policy in place which met the regulatory requirements. A copy was on display in the centre.

Residents with dementia told inspectors that they would complain to the person in charge or any of the staff. A review of the complaints recorded over a two year period showed that they were all dealt with promptly by the designated complaints officer. The outcome of the complaint and the level of satisfaction where this could be determined was recorded. There was an appeals process, none on file had been appealed.

Judgment:

Compliant

Outcome 05: Suitable Staffing

Theme:

Workforce

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

No actions were required from the previous inspection.

Findings:

There was appropriate staff numbers and skill mix to meet the assessed needs of residents and for the size and layout of the centre.

Records reflecting registration details of staff nurses for 2016 were available for review. A sample of staff training files showed staff had up-to-date mandatory training in place. They also had obtained training in 2015 on how to meet the needs of residents with dementia. This included training on nutrition in dementia, dementia care and how to manage behaviours that challenged. However, as evidenced under outcome 11 and 16 this training was not always reflected in practice. Inspectors found staff nurses required refresher training in relation to best practice in the prevention and grading of pressure ulcers. All staff required further education on respecting residents rights and on communication with residents with dementia. In addition, inspectors observed further training was required on the delivery of activities to meet the needs of residents with dementia.

There was an actual and planned staff roster which reflected the staff on duty. Communication between the management team and staff was limited to verbal communication at handover. This limited time for discussion and feedback. Staff meetings did not occur in the centre. Appraisals were completed on an annual basis with staff.

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

Judgment:

Non Compliant - Moderate

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

Effective care and support

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

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

Findings:

The location, design and layout of the centre is suitable for its stated purpose and met residents' individual and collective needs in a comfortable and homely way. The premises took account of the residents' needs and was in line with Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

The centre was clean tidy, well light and well heated. Residents' bedrooms contained all the furniture they required including adequate storage facilities. They were encouraged to personalise their bedrooms and inspectors saw that most residents did so. Two newly developed bathrooms were viewed both containing showers and one containing an assisted bath. The communal areas included a large dining room divided into two sections and four sitting/living rooms. These communal rooms were adequate in size to meet the needs of residents'. However, they could be improved to enhance the life for residents with dementia. For example, inspectors observed the position of residents seats did not facilitate residents to engage with each other without some difficulty. Inspectors observed seating in these rooms was either positioned around the parameter of the room or in front of the television. The main sitting room and a smaller room positioned by the oratory lacked soft furnishings, areas of interest which may enhance residents with dementia to engage. There appeared to be a number of excess chairs in these rooms taking up space and restricting floor space available to residents. Inspectors observed an area outside the main dining room, a lovely quite area overlooking the garden which was currently being used to store equipment such as zimmer frames and weighing scales.

The corridors were wide and had handrails in place, however, inspectors observed a hoist charging on one corridor. Non slip floor covering was used throughout the centre. Residents had access to equipment required to meet their needs and the inspector saw that equipment such as pressure relieving mattresses, high-low beds, a low low bed and hoists had been serviced within the past year. Inspectors noted that although there was some signage throughout the centre this could be improvement by the use of colour to enable residents with dementia to maintain their independence for a longer period of time. Colour was not used to enhance the environment for residents. Its use may assist residents with dementia to maintain their independence for longer as the disease

progresses.

Residents could access the enclosed garden independently from the dining room and one of the sitting rooms. They were seen enjoying this area on the evening of this inspection.

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

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:

Sheila McKeivitt
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:	Moyglare Nursing Home
Centre ID:	OSV-0000072
Date of inspection:	18/04/2016
Date of response:	10/05/2016

Requirements

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

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

Outcome 01: Health and Social Care Needs

Theme:

Safe care and support

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

There was no evidence that residents' or their family were involved in their four monthly care plan review.

1. 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

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

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:

Residents care plans are updated and reviewed by nursing staff and the resident and/or family member every 4 months or if there is a change in the resident's care plan. They are signed by the resident and/or family member yearly. Going forward we will ask the resident or family member to sign the care plans every 4 months.

Proposed Timescale: 10/05/2016

Theme:

Safe care and support

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

Residents did not have their end of life preferences assessed/recorded.

2. Action Required:

Under Regulation 05(1) you are required to: Arrange to meet the needs of each resident when these have been assessed in accordance with Regulation 5(2).

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

As stated in your report we are taking part in a pilot programme. Following reviews and consultations with residents and MDT G.P will sign off on End of Life preferences. The residents End of Life preferences are recorded and available for staff if needed.

Proposed Timescale: 04/07/2016

Theme:

Safe care and support

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

Residents' did not have a care plan in place to reflect their end of life plan.

All residents' with nutritional needs did not have a care plan in place to reflect the care they required to meet their nutritional needs.

3. 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:

Re. End of Life care plans; As stated in your report we are taking part in a pilot programme. Following reviews and consultations with residents and MDT G.P will sign

off on End of Life preferences. The residents End of Life preferences are recorded and available for staff if needed.

Re. All residents' with nutritional needs have a care plan in place to reflect the care they require to meet their nutritional needs.

Proposed Timescale: 04/07/2016

Theme:

Safe care and support

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

Residents' had not been referred to allied health care team members such as a dietician and speech and language therapist as and when their expertise was required.

4. Action Required:

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

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

Resident's where appropriate will be assessed/reassessed by dietician and SALT.

Proposed Timescale: 23/05/2016

Theme:

Safe care and support

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

Staff assistance provided at mealtime was not reflective of a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais.

The management of residents' identified with significant weight loss was not reflective of a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais.

The use of additional bed linen was not reflective of a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais.

5. 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 staff will receive further training in providing assistance to resident's at mealtimes. Senior staff will continue to monitor same.
- Residents with nutritional needs have a care plan in place to reflect the care they require to meet their nutritional needs. The kitchen documentation pertaining to each resident has been updated to include resident's whose diets need fortification.
- Additional bed linen has been removed from all beds.

Proposed Timescale: 07/06/2016

Outcome 02: Safeguarding and Safety

Theme:

Safe care and support

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

The policies in place did not outline procedures to follow when managing a resident's accounts.

6. 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:

A Procedure has been written and adopted to follow when managing a resident's account.

Proposed Timescale: 10/05/2016

Theme:

Safe care and support

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

The use of restraint was not reflective of the centres or National Policy.

7. 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:

All resident's using restraints are being reassessed and if suitable a trial of having no restraints will be undertaken. This outcome will be documented to reflect best practice.

Proposed Timescale: 06/06/2016

Theme:

Safe care and support

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

The care plans for resident who at times displayed behaviours that challenged did not clearly outline how staff should respond to such behaviours.

8. Action Required:

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

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

Care plans for residents who at times display behaviours that challenge have been reviewed to ensure they include any identified triggers or diversional therapies to use.

Proposed Timescale: 10/05/2016

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

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

The delivery of dementia specific activities required review.

9. Action Required:

Under Regulation 09(2)(b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests and capacities.

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

The activities coordinator is to receive further training on delivery of dementia specific activities.

Proposed Timescale: 31/07/2016

Theme:

Person-centred care and support

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

Residents right to choice was not respected at all times by all staff.

10. Action Required:

Under Regulation 09(3)(a) you are required to: Ensure that each resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.

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

Training to be provided for all staff in Communication. Senior staff to monitor to ensure staff compliance.

Proposed Timescale: 07/06/2016

Theme:

Person-centred care and support

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

Residents' with communication difficulties were not facilitated to communicate in line with their care plan or the centres communication policy.

11. Action Required:

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

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

Training for all staff in Communication will be provided. Senior staff will monitor to ensure staff compliance.

Proposed Timescale: 07/06/2016

Outcome 05: Suitable Staffing

Theme:

Workforce

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

Some staff required further training on providing dementia specific activities to residents with dementia.

Staff nurses required refresher training in relation to best practice in the prevention and grading of pressure ulcers.

All staff required further education on respecting residents rights and communication with residents with dementia.

12. Action Required:

Under Regulation 16(1)(a) you are required to: Ensure that staff have access to appropriate training.

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

1. The activities coordinator is to receive further training on delivery of dementia specific activities.
2. Staff nurses will receive refresher training in relation to best practice in the prevention and grading of pressure ulcers.
3. All staff will receive further training on respecting residents rights and communication.

Proposed Timescale:

1. Completed by July 31st 2016
2. Completed by June 21st 2016
3. Completed by June 7th 2016

Proposed Timescale: 31/07/2016

Outcome 06: Safe and Suitable Premises

Theme:

Effective care and support

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

Storage facilities for equipment was not large enough to store all equipment safely.

The use of additional signage, points of interest and colour required review to ensure the premises continually met the needs of the 44 residents living in the centre with dementia.

Screening in twin bedrooms did not ensure the privacy of the resident residing in the inner bed.

13. 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:

1. Storage of equipment will be reviewed and reassessed on an ongoing basis.
2. Company contacted for advice and information regarding dementia specific signage.
3. Screening will be altered to ensure privacy.

Proposed Timescale: 29/06/2016