

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Glendale Nursing Home
<b>Centre ID:</b>	OSV-0000228
<b>Centre address:</b>	Shillelagh Road, Tullow, Carlow.
<b>Telephone number:</b>	059 918 1555 or 059 918 1500
<b>Email address:</b>	nursinghome@glendale.ie
<b>Type of centre:</b>	A Nursing Home as per Health (Nursing Homes) Act 1990
<b>Registered provider:</b>	Glendale Care Limited
<b>Provider Nominee:</b>	John Mangan
<b>Lead inspector:</b>	Caroline Connelly
<b>Support inspector(s):</b>	Ide Batan
<b>Type of inspection</b>	Announced
<b>Number of residents on the date of inspection:</b>	60
<b>Number of vacancies on the date of inspection:</b>	0

## 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.

**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.**

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was announced and took place over 2 day(s).

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

From:	To:
15 July 2014 10:30	15 July 2014 19:00
16 July 2014 09:10	16 July 2014 16:45

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

Outcome 01: Statement of Purpose
Outcome 02: Governance and Management
Outcome 03: Information for residents
Outcome 04: Suitable Person in Charge
Outcome 05: Documentation to be kept at a designated centre
Outcome 06: Absence of the Person in charge
Outcome 07: Safeguarding and Safety
Outcome 08: Health and Safety and Risk Management
Outcome 09: Medication Management
Outcome 10: Notification of Incidents
Outcome 11: Health and Social Care Needs
Outcome 12: Safe and Suitable Premises
Outcome 13: Complaints procedures
Outcome 14: End of Life Care
Outcome 15: Food and Nutrition
Outcome 16: Residents' Rights, Dignity and Consultation
Outcome 17: Residents' clothing and personal property and possessions
Outcome 18: Suitable Staffing

**Summary of findings from this inspection**

This monitoring inspection was announced and took place over two days. This was Glendale Nursing Home's fifth inspection by the Authority and as part of the monitoring inspection, the inspectors met with one of the company directors, the new nominated provider, new person in charge, residents, relatives, and staff members. The inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files. The findings of the inspection are set out under 18 outcome statements. These outcomes set out what is expected in designated centres and are based on the requirements of 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. Residents' comments are found throughout the report.

There had been a number of changes to the management structure since the last inspection. The previous nominated provider and person in charge had resigned their posts and a new person in charge and nominated provider had been appointed in the last number of weeks. The new nominated provider is a nominated provider for a number of other designated centres throughout the country. Interviews were conducted with the provider nominee and person in charge during the inspection and they both displayed a good knowledge of the Standards and regulatory requirements in relation to their relevant roles.

The new person in charge had only taken up post just a week before the inspection but had worked in the centre for five years. She had worked in the centre as a Clinical Nurse Manager 2 (CNM2) prior to taking the role of person in charge. She was found to be an experienced nurse and manager who was involved in the day-to-day running of the centre and was found to be easily accessible to residents, relatives and staff. There was evidence of individual residents' needs being met and the staff supported residents to maintain their independence where possible.

The inspectors found the premises, fittings and equipment were clean and there was appropriate use of colour and soft furnishings to create a homely environment. The collective feedback from residents and relatives was one of satisfaction with the service and care provided. Community and family involvement is encouraged with residents saying their relatives/visitors felt welcome at any time and there were a large number of visitors in the centre during the inspection

The person in charge, providers and staff demonstrated a commitment to good quality care delivery and continuous improvement with comprehensive auditing of the service and care resulting in improvements for residents.

During the inspection inspectors identified that some improvements were required in health and safety, infection control, restraint practice and in policies and procedures to enhance the findings of good practice on this inspection. These are discussed under the relevant outcome statements. The related actions are set out in the Action Plan under the relevant outcome. These improvements are required to comply 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.

**Section 41(1)(c) of the Health Act 2007. 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.**

***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 and function had recently been updated to reflect the changes in the management of the centre and this was viewed by the inspector, it clearly described the service and facilities provided. It identified the staffing structures and numbers of staff in whole time equivalents. It also described the aims, objectives and ethos of the centre. The facilities, management structure and services provided were set out and other relevant information provided.

A synopsis of the philosophy of care of the centre as outlined in the statement of purpose and function is to "provide care which is tailored to individual needs of the residents" and that "each resident should be treated with respect, in warm, friendly and homely surroundings". This ethos was reflected in day-to-day life, through the manner in which staff interacted, communicated and provided care. The statement of purpose was found to meet the legislative requirements.

**Judgment:**

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 was a comprehensive quality improvement programme in place. The inspector viewed the yearly continuous improvements projects programme to facilitate quality improvements throughout the centre. The person in charge, the providers and staff displayed a strong and clear commitment to continuous improvement in quality person-centred care through regular audits of all aspects of resident care and the facilities, staff appraisals and provision of staff training.

The person in charge, although new to her role had an audit schedule in place for 2014 which was ongoing from the previous management team and showed the inspectors regular ongoing audits that were completed in 2014. There were a number of areas audited on a weekly basis, others on a monthly basis and others identified on an ongoing periodic basis.

The inspectors viewed a very comprehensive governance report completed for the year 2013. This governance report identified the aims and objectives set for 2014 in all areas of care, health and safety, facilities, training and staffing. The inspectors saw that the objectives for 2014 included ensuring there was learning and development when need was identified and to further develop senior staffs' auditing skills. The inspectors saw that different audits were delegated to senior staff members to complete. The audits were seen to be very comprehensive. Feedback and actions from all audits were given to staff and they were discussed at staff meetings and were used for the purposes of ongoing quality monitoring and continuous improvement. Results of the audits were also made available to residents and relatives and fed back through the residents' association.

The inspectors were satisfied that the quality of care is monitored and developed on an ongoing basis.

As discussed at the commencement of the report there had been a number of changes to the management structure since the last inspection. The previous nominated provider and person in charge had resigned their posts and a new person in charge and nominated provider had been appointed in the last number of weeks. The new nominated provider is a nominated provider for a number of other designated centres throughout the country. Interviews were conducted with the provider nominee and person in charge during the inspection and they both displayed a good knowledge of the Standards and regulatory requirements in relation to their relevant roles. The new provider informed the inspector that he plans to be in the centre one to two days per week and has held meetings with staff, and plans to hold further meetings with staff, residents, and relatives to outline the new governance and management arrangements. Due to the numerous changes a clearly defined management structure needs to be fully implemented with further definition of roles and the lines of authority and accountability particularly in relation to the clinical management team. The clinical management team currently consisted of a person in charge an Assistant Director of Nursing (ADON) a CNM3 and two CNM2.

There was evidence of regular management meetings in the past and the person in charge told the inspectors it is her plan for these to continue with these to ensure compliance with regulatory requirements and good governance of the centre.

The centre is purpose-built and provides a good standard of resident accommodation. The inspectors found that the premises, fittings and equipment were very clean, however, there were areas that required redecoration and flooring that required replacement and this will be discussed further under outcome 12. Landscaped gardens, sensory and courtyards with seating were available for residents' and relatives' use.

There was appropriate assistive equipment available to meet residents' needs such as electric beds, wheelchairs, hoists, pressure-relieving mattresses and Zimmer frames. The person in charge informed the inspector that if further equipment was required for residents, funding would be made available, and they were currently investigating the purchase a further hoist for residents use. The inspectors formed the opinion that currently there were sufficient resources to ensure the effective delivery of care to the residents.

**Judgment:**  
Non Compliant - Minor

***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):**  
No actions were required from the previous inspection.

**Findings:**  
A sample number of contracts of care were viewed by the inspectors. The contracts were seen to be comprehensive, were agreed within a month of new admissions and they stipulated details of the service provided and the fee to be paid. They detailed what was included and what was excluded from the fee as is required by regulation.

The residents guide was viewed by the inspectors to be easily available to residents. It was found to be comprehensive and met all the criteria required in the legislation.

**Judgment:**  
Compliant

***Outcome 04: Suitable Person in Charge***

*The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.*

**Theme:**  
Governance, Leadership and Management

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

No actions were required from the previous inspection.

**Findings:**

The new person in charge had only taken up post just a week before the inspection but had worked in the centre for five years and had worked in the centre as a Clinical Nurse Manager 2 (CNM2) prior to taking the role of person in charge. She was found to be an experienced nurse and manager who was involved in the day-to-day running of the centre and was found to be easily accessible and well know to residents, relatives and staff.

The person in charge was becoming familiar with her roles and levels of responsibility and was receiving a comprehensive induction and support programme from the previous director of nursing. There was evidence of a continued commitment to creating an environment that supported quality improvement. She had been involved as a CNM2 in auditing, training and development which she told the inspectors she planned to continue and further develop.

Staff and residents were aware of the change to the person in charge and many identified the person in charge as the one with overall authority and responsibility for the service. A fit person interview was conducted with her during the inspection and she displayed a good understanding of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). She has kept her knowledge base current by attending numerous education and training courses, however she did not have a managerial qualification but informed the inspectors she was investigating the availability of managerial training.

**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):**

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



**Findings:**

The inspectors were satisfied that the records listed in Schedules 2, 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 were maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. Overall records were seen to be maintained and stored in line with best practice and legislative requirements.

The inspectors viewed the insurance policy and saw that the centre is adequately insured against accidents or injury to residents, staff and visitors.

The inspectors viewed policies, procedures and guidelines which were centre specific and were reviewed on a regular basis. However, there was not a policy on staff training and development available in the centre, which is a requirement of Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. Although the person in charge told inspectors that they had provided staff training in relation to some of the policies there was not evidence of staff having read and signed off on all policies.

**Judgment:**

Non Compliant - Moderate

***Outcome 06: Absence of the Person in charge***

*The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.*

**Theme:**

Governance, Leadership and Management

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

No actions were required from the previous inspection.

**Findings:**

The provider had informed the Authority in accordance with legislation of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during her absence. The provider had also informed the Authority of the appointment of the new person in charge.

There was no change to the ADON who had been appointed to her current role in 2010. The ADON was interviewed by the inspectors and was found to be an experienced nurse with managerial experience. The ADON will act up in the absence of the person in charge as she has done in the past. The inspectors were satisfied that she demonstrated an awareness of her responsibilities under the relevant legislation in being in charge of the centre.

**Judgment:**

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):**

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

**Findings:**

The training records viewed by the inspectors showed that staff received ongoing elder abuse prevention and safeguarding training. This training was provided on an annual basis by the CMN3 to all staff and staff that spoke to inspectors confirmed that they had received this training.

Staff interviewed by inspectors were aware of what to do if an allegation of abuse was made to them and the provider and person in charge told the inspectors there was a policy of no tolerance to any form of abuse in the centre. There were notices to that effect seen in the reception area and throughout the centre. Any allegations of abuse had been acted on immediately, investigated fully and appropriate action taken. Notification was sent to the chief inspector as required by legislation.

Residents' finances were safeguarded by the policy on the management of residents' accounts and personal property. The inspectors met with the accounts manager who confirmed that the centre is not a pension agent for any resident and since the last inspection the centre has adopted the policy of not accepting any money and valuables for safekeeping for residents. Locked storage is provided to residents to store and safeguard their own money and valuables.

The inspectors saw that bedrails were currently being used for 26 residents, some who have requested them for their comfort. The inspector saw that assessments for the use of bedrails were being completed on residents and some alternatives had been tried. These assessments were reviewed on a regular basis and there was evidence that residents were being checked and these checks were documented. The person in charge told the inspector she was very aware that there were a high number of residents using bedrails and was endeavouring to reduce that number with further low low beds, other equipment and further education for staff. Many families had requested bed rails and further education was also required for residents and relatives. The policy on restraint viewed by the inspectors was dated 2011 and required review and updating to ensure that when restraint is used in the centre it is only used in accordance with national policy on restraint as published on the website of the department of health. The inspector viewed a comprehensive policy on managing behaviour that is challenging reviewed in 2013. The CMN3 provided training to staff on behaviour that challenges and on management and prevention of this behaviour. Staff and training records confirmed this took place. The CNM3 was instrumental in developing behavioural plans for

residents. There was evidence in care plans of evidenced based assessments and treatment plans for residents who exhibited any challenging behaviour. The staff and records confirmed they had reduced episodes of challenging behaviour through person centre care and education of staff.

**Judgment:**  
Compliant

***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 fire policies and procedure were viewed by the inspectors and were found to be centre-specific. There were notices for staff on "what to do in the case of a fire" appropriately placed throughout the centre. The centre was compartmentalised for fire purposes and compartments were clearly identified. Examination of the fire register indicated that the fire alarms and fire extinguishers, hoses, blankets and emergency lighting were all checked and serviced by external companies and records reviewed showed that they had all been checked and serviced on a number of dates in 2013 and in 2014. There was a daily check of the escape routes undertaken. However, the inspectors saw that a number of fire resistant doors throughout the centre were held open by door wedges which prevented closure in the event of fire. The person in charge told the inspectors that the providers were looking into the provision of magnetic hold backs which automatically released when there was a fire for all doors but these were not available or fitted at the time of the inspection.

Training records confirmed that fire training was provided to staff on various dates in August and December 2013 and in June 2014. Regular fire evacuation drills were undertaken which demonstrated effective evacuation and improvements for the future. Staff indicated that they were aware of what to do in the event of fire.

The emergency evacuation plan was viewed by the inspector and showed arrangements in place to evacuate residents in the event of an emergency and where temporary accommodation would be provided in the event of being unable to return to the centre. It also included action to be taken if water was not available and where to acquire a rented generator. There was evidence that this generator was now available out-of-hours as required from the last inspection. The emergency plan, although very comprehensive, required updating to include action to be taken in the event of other emergencies such as the kitchen or laundry not being in operation.

The centre-specific health and safety statement, reviewed January 2014, was found by the inspector to be very comprehensive. The risk management policy and risk registrar was also viewed by the inspectors which contained numerous safe working practice sheets and hazard identification sheets with control measures. The inspectors noted that this contained risk assessments and measures actions in place to control the following specified risks for abuse, violence and aggression, self harm, unexplained absence of a resident, accidental injury to residents, visitors or staff as identified in the regulations.

The inspectors saw that numerous clinical risk assessments were undertaken, including falls risk assessment, assessments for dependency and pressure sore development, continence, moving and handling and individual assessments for residents who smoked. On the day of the inspection there was not a risk assessment for the pond in the enclosed sensory garden but this was forwarded to the inspector the day after the inspection. The provider utilised sensor alarms for residents identified at risk of wandering and placing themselves at risk and alerting alarms to support residents at risk of falls. Accidents were found to be responded to appropriately on an individual basis in order to prevent re-occurrences and care plans outlined strategies to prevent further risks while also supporting residents' independence. Residents were referred to appropriate external clinicians such as fall clinics, if deemed necessary. A falls audit was undertaken and this identified residents at particular risk. Low-beds and crash mats were used to prevent injury when this was deemed appropriate.

Training on moving and handling was provided by the CMN3 who had completed the train the trainer course in moving and handling. Training records seen by inspectors showed that this training to be up to date for staff and safe practice was observed when staff were assisting residents using the hoist and other equipment. The CNM3 observed staffs practice on a daily basis and corrected staff if they were not abiding by best practice guidelines.

The premises were seen to be very clean and the members of household staff and laundry staff interviewed were able to clearly demonstrate to the inspectors, best practice in the prevention of the spread of infection. Personal protective equipment such as gloves and aprons were readily available and hand sanitisers were located at the entrance and throughout resident and staff areas. However, the inspectors formed the opinion that the practice of good hand hygiene was not embedded in the culture of the centre as inspectors observed throughout the two day inspection that staff did not always take opportunities to cleanse their hands using the alcohol gels provided. The system currently in operation in the laundry was not consistent with the standards published by the Authority for the prevention and control of healthcare associated infections in that soiled linen was brought to the laundry past the clean linen which could cause cross infection. The laundry has two entrances/exits but these were not used appropriately. Considerations need to be given to the layout of the laundry and to work practices to ensure the staff abide by best practice in infection control in the management of laundry to ensure procedures are consistent with the standards for the prevention and control of healthcare associated infections published by the authority.

**Judgment:**  
Non Compliant - Major

**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:**

The inspectors observed that medications were stored, and disposed of appropriately in line with An Bord Altranais Guidance to Nurses and Midwives on Medication Management (2007). Residents who spoke with the inspector were knowledgeable about their medications. Resident medications were being reviewed at least on a three-monthly basis and many more frequently, and this was seen by the inspectors to be documented in the resident's notes.

The centre had recently changed pharmacy provider so the pharmacist has not yet become fully involved in reviewing medications on a regular basis but the person in charge said there are plans to have further involvement of the pharmacists in the provision of information to residents and to staff and the regular review of residents' medications as is required by legislation.

Inspectors accompanied nurses on medication rounds and safe practice in medication administration, and in the recording of the drugs administered was observed, and this was carried out in line with An Bord Altranais Guidelines 2007. The medication prescription sheet generally contained all the required information and included the resident's photo. However, inspectors saw that a number of charts for residents that required their medications to be crushed did not meet the requirements of legislation. Although there was a space at the top of the chart to say yes or no if the resident required medications crushed this was not signed by the GP to say residents' medications could be crushed. Individual medications were not individually prescribed as suitable for crushing and signed by the GP. Therefore some crushed medications were not administered in accordance with the directions of the prescriber. The supply, distribution and control of scheduled controlled drugs was checked and deemed correct against the register. Nurses were checking the quantity of medications at the start of each shift. The nurses displayed a good knowledge of medications, effects and side effects.

The medication policy had recently been updated to include medication reconciliation. The policy was seen by the inspectors to include required policies and procedures on all aspects of medication administration, storage and safe keeping as required by legislation.

The medication trolleys were secured and the medication keys were held by the nurse in charge. Medication management was the subject of audit by the management team and inspectors saw the results of these audits which are fed back and actioned by the staff.

**Judgment:**  
Non Compliant - Moderate

***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):**

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

**Findings:**

The inspectors saw that there was a comprehensive log of all accidents and incidents that took place in the centre which was the subject of audit, and increased supervision was in place for residents who were at high risk of falling.

Incidents as described in the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 have been reported in accordance with the requirements of the legislation. There were timely quarterly returns and written notifications were received within three days of accidents as required.

Notifications that were sent in were reviewed prior to and throughout the inspection and the inspectors were satisfied with the outcomes and measures that were put in place.

**Judgment:**  
Compliant

***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):**

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

**Findings:**

There were two different GPs that provided medical services to the residents. There was a responsive out-of-hours service available seven days per week. Inspectors saw that GPs visited routinely and undertook rounds on a weekly basis. Residents' care was seen to be reviewed at a minimum three monthly but usually more frequently. Residents' medical records were inspected and these were current with entries including referrals, reviews, blood and swab results. The medical records confirmed very regular reviews by the GPs.

The inspectors found that residents' general healthcare needs were adequately met and monitored. Vital signs and weights were recorded monthly; blood sugar levels were recorded daily or weekly as required.

Residents' additional healthcare needs were met. A chiropody service is provided to the residents on a regular basis. Dietician and speech and language services were provided by professionals from a nutritional company which was also contactable by telephone for advice as required. All supplements were appropriately prescribed by a doctor. Residents have regular nutritional screening and regular weight monitoring. Physiotherapy services were available as required and funded privately by residents. The inspector saw evidence of a physiotherapy review in one of the residents' notes. Access to occupational therapy services were provided via referral to community HSE services. The inspectors were satisfied that facilities were in place so that each resident's well-being and welfare was maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. Residents, where possible, were encouraged to keep as independent as possible and inspectors observed residents moving freely around the corridors. Residents and relatives said they were satisfied with the healthcare services provided.

Inspectors saw that residents had assessments completed on admission which included; dependency level, moving and handling, falls risk, pressure sore risk assessment, nutrition, mental test score examination, and assessment for the onset of depression was also screened for on a regular basis. These assessments were generally repeated on a three monthly basis or sooner if the residents' condition had required it. The person in charge and staff demonstrated an in-depth knowledge of the residents and their physical, social and psychological needs and this was reflected in the person-centred care plans available for each resident and named nurses were responsible for the planning of that care. The care plans were used to prescribe and direct personalised care for the residents and a copy of the care plan was available to all staff and the care staff completed their daily checks in conjunction with the care plans. The care plans were reviewed and updated at least three monthly and more frequently as required. There was evidence of residents and their representative's involvement in the discussion, understanding and agreement to their plan of care as is required by legislation.

The inspector viewed the wound care provided in the centre. Wounds were assessed using an appropriate measurement system with assessed size, type, exudate and wound bed which enabled staff to see easy progress or deterioration. Photographic evidence was also used and the inspector was able to see improvements made in wound healing. There was evidence that consent for photographs and treatment was documented in the

residents care plans but further development was required to ensure there was a comprehensive consent policy in the centre.

The inspector observed that residents appeared to be well cared for, which was further reflected in residents' comments that their daily personal care needs were well met.

There were very good links with psychiatric services and community services for residents who required these services and assessments and treatment reviews were seen in residents notes

**Judgment:**

Compliant

***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):**

No actions were required from the previous inspection.

**Findings:**

Glendale Nursing Home is a purpose-built single-storey building which caters for 60 residents in 60 single en-suite bedrooms. Communal accommodation includes a reception area, and a spacious lounge with comfortable seating and décor, television and piano. The reception desk and office of the person in charge is located in the lobby.

Two further sitting rooms and three dining rooms are available for residents' use. A library, oratory, hairdressers' room and visitors' toilets are provided. General practitioners have an office to meet with residents in private. The centre was observed to be bright, furnished to a good standard and clean throughout. There were appropriate pictures, furnishings and colour schemes. The communal space was adequate and the design of the building allows freedom of movement for residents to walk around and choice as to where they spend their time. There is a smoking shelter erected in one of the inner gardens which is also connected to the call-bell system. The furnishings are comfortable and suitable for residents use and the bedrooms were found to be personalised with photos, flowers, furnishings and rugs. All rooms have telephone access points and televisions. However the inspectors noted that in some bedrooms there was paint chipped off the walls and the paint on one bed rail was peeled and in poor repair. The corridors and main entrance was carpeted but the inspectors noted this was worn, torn, patched in areas and required replacement.



There are two small inner courtyards which are wheelchair accessible and which residents have easy access to. The large sensory garden was seen by the inspectors and was well laid out and maintained. This was also wheelchair accessible.

Residents reported that the centre offered a comfortable environment. They enjoyed the spacious well maintained gardens with plenty of seating available for residents and visitors.

The kitchen was very clean and well organised and kitchen staff have their own toilet, washing and changing facilities separate to those provides for all other staff. The corridors were wide allowing easy access for residents in wheelchairs and those people using walking frames or other mobility appliances.

Appropriate assistive equipment, such as electric beds, hoists, pressure relieving mattresses, wheelchairs and walking frames, were generally available to meet the needs of residents. Hoists and other equipment were all maintained however on the day of the inspection there was some issues in finding the location of service records and the up-to-date contract for the removal of waste which were forwarded to the inspector following the inspection.

The provider employs a maintenance person who responds to all the day-to-day maintenance of the building, grounds and equipment. Grab rails and non-slip flooring are provided in appropriate areas. A call bell system is in place.

Closed circuit television (CCTV) was positioned at the entrance to the building in corridors, and outside in the grounds. The person in charge said this was to maintain the safety of the residents and this is what is outlined in the centre's policy on the use of CCTV in accordance with the data protection acts 1998 and 2008.

**Judgment:**  
Non Compliant - Minor

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

**Findings:**  
There was a written operational policy and procedure for making, handling and investigating complaints from any person about any aspect of the care or service provided. The complaints procedure contained an independent appeals policy. The complaints procedure was on display in the main foyer and at other locations in the

centre. The complaints log viewed by inspectors detailed complaints made, investigation, action taken and outcomes of these complaints as required by legislation.

**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:**

The provider had completed, and the inspectors reviewed, the self-assessment questionnaire and the overall self-assessment of compliance with Regulation 14, and Standard 16: End of Life Care. The person in charge had assessed the centre as being compliant but had also identified actions to further enhance end of life care which included further discussion with residents and relatives and the provision of training for all staff.

The inspectors viewed the end of life policy which had been reviewed and amended in January 2014 and was found to be comprehensive. The inspector observed that the policy guided staff in assessing a resident's needs should their health deteriorate rapidly, including regular review by the general practitioner. The Health Service Executive (HSE) palliative care team offers guidance as required in respect of appropriate management of illness. There was evidence in residents' notes of involvement of the palliative care team with referral and reviews seen by the inspector in residents' files. A member of the senior staff and the pastoral care staff had completed further education in palliative care and end of life care and they have provided training for all grades of staff. Training records showed that the majority of staff had undertaken end of life training in February and March 2014 with further training planned. Staff who spoke to the inspector demonstrated knowledge of how to provide good end of life care. The centre used discrete signage to alert people that there was someone at end of life.

Care practices and facilities in place were seen by the inspectors to ensure residents received end-of-life care in a way that met their individual needs and wishes and respected their dignity and autonomy. Individual religious and cultural practices were facilitated there is a small oratory available for prayer and quiet reflection. Ministers from a range of religious denominations are available to hold services on a regular basis. All resident rooms are large single en-suite rooms. Family and friends were facilitated to be with the resident when they were dying. Overnight facilities were available for relatives' use both in the residents' room, or in a separate area if required. Staff offer support and comfort to families and tea/coffee and dining facilities are made available as

required.

The inspectors reviewed a sample of five care plans and found that there was evidence of engagement and consultation regarding spirituality and dying. Each resident had an end of life assessment completed. Some were quite detailed specifying their wish to remain in the centre and not be transferred to the acute hospital if their condition deteriorated, funeral and burial arrangements: others had limited detail. The nursing staff said it was a new process and they were only getting familiar with talking to the residents about end of life in detail. The inspectors saw a detailed end of life care plan that had been implemented for a resident who had passed away in the centre and it was seen to be comprehensive and covered all aspects of emotional, psychological and physical needs.

Documentation confirmed that in the last two years approximately 60% of residents had their end of life care needs provided in the centre without the need for transfer to the acute hospital. The staff informed the inspector that they hope to increase this percentage of residents having end of life provided in the centre with more open discussion with residents and families around end of life care and further involvement of the GPs.

There was evidence in residents' medical notes of regular medical and medication reviews by the GPs with visits increasing towards end of life as 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 reviewed the self assessment completed by the person in charge and the overall assessment of compliance with Regulation 20, and Standard 19: Food and Nutrition. The person in charge assessed the centre as compliant and the inspector concurred with this assessment. There was an up to date policy on food and nutrition which was found to be comprehensive. The inspector observed that food and hydration needs were assessed on admission using the malnutrition universal screening tool (MUST) and this was repeated on a monthly basis or more frequently if required. The inspectors observed mealtimes including breakfast, mid morning refreshments and lunch. Residents had their breakfast served in bed at a time of their choosing.

There were three dining rooms available for residents' use for lunch and tea. Inspectors observed lunch time where tables were appropriately and attractively set and residents enjoying a leisurely lunch. Assistance was offered in a discreet and respectful manner and specialist cutlery was available for residents who required same. The centre had recently introduced a red tray monitoring system in which residents who were nutritionally compromised received a red tray with colour coded plates. Staff informed the inspector that red trays could not be removed until the nurse had assessed the quantity of food the resident had eaten and this was then documented in their food plan. The staff reported good improvements in nutritional intake since the introduction of the system which has heightened awareness for all staff. There were plenty of staff available in the various dining rooms and a senior staff member informed the inspector that they supervised the dining room constantly during mealtimes.

Snacks and hot and cold drinks including juices and fresh drinking water were readily available throughout the day. The days of the inspection were particularly warm days and the inspectors observed staff giving residents extra drinks and encouraging them to drink plenty.

Residents were offered a varied nutritious diet. The menu cycle made allowances for the preferences of individual residents, including those on special diets and provided for those who required a modified consistency diet. The variety, quality and presentation of meals were of a high standard. Residents expressed satisfaction with the food and the dining experience.

Nutritional support and dysphasia training had also been provided to staff in 2014. Dietetic support was available, and residents were weighed monthly and weekly if there were changes to their weight. There was evidence that the documentation of a weight loss/gain prompted an intervention once a concern was identified, including the commencement of food and fluid charts, and the inspectors saw detailed food and fluid charts maintained for specific residents. Dietary assessments and nutritional care plans were seen in residents' notes. There was evidence in a number of residents' notes of referral and review by the speech and language therapist and swallow plans were seen. A number of residents required thicken fluids which was in their plans and staff confirmed this was communicated to them.

The inspectors saw that the special dietary needs of residents were communicated in writing to the catering staff with each residents' care plan for nutrition available in the kitchen. The inspector met with the chef who confirmed that she received an update of the current status of the residents pertinent to their nutrition. Catering staff had in-depth knowledge of residents' likes and dislikes. The chef stated that if a resident did not like what was on the menu, an alternative was available. The head chef had undertaken a train the trainer course in food safety and provided this training to staff.

The inspectors observed that there were a number of the residents taking nutritional supplements. These were appropriately prescribed by the general practitioner. The inspector saw in residents' care plans that residents were seen by their GP on a regular basis and there was evidence that residents saw the dentist as required. Oral assessments were completed by staff.

Menus were displayed outside the dining rooms and were viewed by the inspectors. The menus indicated that choice was available to residents for breakfast, lunch and tea. Residents confirmed that they were always asked what they wished to have for main meals.

**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):**

No actions were required from the previous inspection.

**Findings:**

The inspector heard residents being addressed in an appropriate and respectful manner and residents said staff always treated them with kindness and respect. Inspectors observed residents' privacy and dignity being respected and promoted by staff.

Residents told inspectors that they were encouraged to exercise choice in areas such as meals and mealtimes, times for getting up and going to bed, and social and recreational fulfilment. There was also ample private space available for residents to meet with their visitors. Residents and relatives commended staff on how welcoming they were to all visitors. Residents could receive visitors in private if they wished and many were seen to visit in the reception area in the centre as well as in the lounges and residents bedrooms.

There was a residents' committee in place which met on a monthly basis, all residents were invited to attend but generally the same four or five residents were in attendance. The minutes of the last three residents meetings were viewed by the inspectors and issues discussed included activities, food and nutrition and staffing levels. There was evidence that residents were consulted in the running of the centre. There was evidence in the minutes of response by staff to some of the issues raised, however the minutes did not fully identify responses to other issues raised or actions taken in response. There was a suggestion box available in the reception area but residents' satisfaction surveys were not completed as another was of eliciting the views of the residents. Residents' right to continue to participate fully as citizens was supported by the arrangements made for voting in elections.

There was evidence that the centre had employed different communication strategies for residents who had difficulty with communication. Pictorial menus were seen and plans were outlined in residents care plans on how to ensure effective communication.

The centre employs a dedicated activities / recreation coordinator and team who provide an interesting and varied choice of activities seven days of the week. The inspectors saw that there was a comprehensive programme of activities available and the inspectors met the activity staff throughout the inspection. The activity staff told the inspectors that they try to take personal interests and hobbies of the residents into consideration when developing the activity programme so that it suits all tastes and abilities. Residents' right to choice in participation was respected by staff and while many residents participated in organised activities, inspectors observed that others chose to spend time in their room or in another room while activities were going on.

The centre had a minibus which is used to provide day trips for residents to places of their choice. Links had been developed with the local community and many volunteers provide entertainment for the residents.

**Judgment:**

Compliant

***Outcome 17: Residents' clothing and personal property and possessions***  
*Adequate space is provided for residents' personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.*

**Theme:**

Person-centred care and support

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

No actions were required from the previous inspection.

**Findings:**

The resident's bedrooms were bright, clean and cheerful. Residents interviewed said that they were happy with the accommodation provided and they were encouraged to personalise their rooms with pictures of family and friends and individual items and possessions. Plenty of storage space was provided with wardrobes chest of drawers and lockers available. Locked storage space was made available to residents who wished to store or lock away private items, money or valuables.

The laundry system was discussed under Outcome 7. Residents clothing was washed daily and residents told inspectors they were happy with the laundry facilities. Clothes were discreetly marked and residents reported that their clothing was generally returned laundered, and in a timely fashion.

**Judgment:**

Compliant

**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):**

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

**Findings:**

Residents spoke positively about staff and indicated that staff were caring, responsive to their needs, and treated them with respect and dignity.

Staff demonstrated an understanding of their role and responsibilities to ensure appropriate delegation, competence and supervision in the delivery of person-centred care to the residents.

There was evidence of good communication amongst staff with all staff attending handover meetings. The inspector viewed minutes of regular staff meetings between the nursing staff, care staff, catering staff and housekeeping staff and noted that numerous relevant issues were discussed.

The human resource policy was centre-specific and included details for the recruitment, selection and Garda Síochána vetting of staff. There is a comprehensive induction for new staff. Nursing staff said that, because they were always on with another one or two nurses, they always felt they had somebody to consult with and the senior staff were available daily for supervision.

The inspector reviewed the planned and actual rotas. The inspectors noted that there were adequate staff numbers on the day of the inspection to meet the needs of the residents. Residents and staff agreed that there were staff available in sufficient numbers and with the appropriate skills and competencies to meet the personal and health needs of residents.

An appraisal system was in place to allow each staff member to be informed of their progress and strengths, and have an opportunity to develop their capabilities. The inspector viewed a number of staff files which contained full and satisfactory information and documents specified in Schedule 2 of the Regulations including all records of nurses' registration with An Bord Altranais.

An extensive variety of professional development training was provided to staff. There was a yearly training matrix which identifying mandatory training for staff as well as

other pertinent training including end of life, nutrition and MUST training, dementia care and challenging behaviour, infection control, food hygiene, recreational training, epilepsy and restraint. The records showed that care assistants had received Further Education Training Awards Council (FETAC) Level 5 training. Training records viewed by the inspector confirmed the provision of an appropriate level of training to all staff.

**Judgment:**  
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:***

Caroline Connelly  
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>

Centre name:	Glendale Nursing Home
Centre ID:	OSV-0000228
Date of inspection:	15/07/2014
Date of response:	14/08/2014

### 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.

### 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:**

Due to the numerous changes in the management team a clearly defined management structure needs to be fully implemented with further definition of roles and the lines of authority and accountability particularly in relation to the clinical management team.

#### **Action Required:**

Under Regulation 23(b) you are required to: Put in place a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

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

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

We will put in place a clearly defined management structure that identifies the lines of authority and accountability, specifying roles, and details of responsibilities for all areas of service provision.

**Proposed Timescale:** 05/09/2014

**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:**

There was not a policy on staff training and development available in the centre, which is a requirement of schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

**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 policy will be created, adopted and implemented on staff training and development. The policy will be agreed/signed off by the DON and RP. Complete

**Proposed Timescale:** 14/08/2014

**Theme:**

Governance, Leadership and Management

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

There was not evidence of staff having read and signed off on all policies.

**Action Required:**

Under Regulation 04(2) you are required to: Make the written policies and procedures referred to in regulation 4(1) available to staff.

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

Each department does have a full copy of all policies and procedures. There is documentary evidence to support that staff have read and signed policies. On the day of inspection the person in charge omitted to show the inspectors the paperwork. We will review the current system of policy sign off signatures.

**Proposed Timescale:** 20/10/2014

## 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:

The practice of good hand hygiene was not embedded in the culture of the centre as inspectors observed throughout the two day inspection that staff did not always take opportunities to cleanse their hands using the alcohol gels provided.

The system currently in operation in the laundry was not consistent with the standards published by the authority for the prevention and control of healthcare associated infections in that soiled linen was brought to the laundry past the clean linen which could cause cross infection.

### Action Required:

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

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

Hand Hygiene: Audit on-going to establish the extent of the issue. 2 staff members to attend training course in RCS in Sept.

Laundry: We have identified an egress and exit for the laundry. The policy has been reviewed and amended and will be implemented on W/C 18/8/14. Person in charge will review in one month.

### Proposed Timescale: 19/09/2014

### Theme:

Safe care and support

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

Inspectors saw that a number of fire resistant doors throughout the centre were held open by door wedges which prevented closure in the event of fire.

### Action Required:

Under Regulation 28(1)(a) you are required to: Take adequate precautions against the risk of fire, and provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.

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

The RP is currently working with fire services and engineers to implement a programme to ensure the building complies with fire regulations. The plan includes magnetic hold backs for bedroom doors. The plan includes magnetic hold backs for bedroom doors. Wedges are no longer in use. Residents, relatives and staff have been advised

accordingly.

**Proposed Timescale:** 01/12/2014

### **Outcome 09: Medication Management**

**Theme:**

Safe care and support

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

Individual medications were not individually prescribed as could be crushed and signed by the GP.

**Action Required:**

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

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

All medication charts to be reviewed. Moving forward we plan to have a 'no crush' standard where possible. Where a need to crush medication is identified, we will ensure that each individual medication will be clearly identified.

**Proposed Timescale:** Ongoing

### **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:**

In some bedrooms there was paint chipped off the walls and the paint on one bed rail was peeled and in poor repair. The corridors and main entrance was carpeted but the inspectors noted this was worn, torn, patched in areas and required replacement.

**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. Bedrail has been replaced.
2. A planned walkthrough of the building will be undertaken by PIC and RP to identify which areas need painting, following which a programme of redecorating will be put in

place.

3. Plan to identify areas where carpet needs to be replaced. All carpet replacement to be completed by 1st. Jan. 2015.

**Proposed Timescale: 31/12/2014**