

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Carndonagh Community Hospital
<b>Centre ID:</b>	OSV-0000616
<b>Centre address:</b>	Convent Road, Carndonagh, Donegal.
<b>Telephone number:</b>	074 937 4164
<b>Email address:</b>	finola.mccolgan@hse.ie
<b>Type of centre:</b>	The Health Service Executive
<b>Registered provider:</b>	Health Service Executive
<b>Provider Nominee:</b>	Kieran Woods
<b>Lead inspector:</b>	Geraldine Jolley
<b>Support inspector(s):</b>	Damien Woods;
<b>Type of inspection</b>	Announced
<b>Number of residents on the date of inspection:</b>	40
<b>Number of vacancies on the date of inspection:</b>	6

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

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

From:	To:
30 March 2015 08:30	30 March 2015 19:00
31 March 2015 08:30	31 March 2015 16:00

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 was an announced inspection in response to an application by the provider to the Health Information and Quality Authority (the Authority) to renew registration of this centre. This was inspection twelve of this centre undertaken by the Authority. During the inspection the delivery of care and support to residents was observed. Documentation such as care plans, medical records, accident/incident reports, policies and procedures, staff files and the registration application was reviewed. The inspector talked with residents, relatives and varied members of the staff team during the inspection.

Residents and relatives returned questionnaires to the Authority and on review these

indicated a high level of satisfaction with the service particularly the dedication and commitment of staff to provide high standards of care. Eight residents and five relatives/carers completed the pre-inspection questionnaires. Residents and relatives were positive in their feedback about the information provided to them, the positive attitudes and dedication of the staff team and the efforts made to support residents to maintain their independence. There were two comments made about the availability of staff which relatives felt was not timely as staff were sometimes very busy and there was also a comment made about the lack of communal space in the general care units.

Residents that the inspector talked to during the inspection said that "the staff were very kind", "were helpful and encouraged us to do as much as we can for ourselves" and they described the food as "very good with plenty of variety". One resident said that he could always talk to the staff and said that they listened "to my worries and helped solve some problems". Residents also said they enjoyed a range of activities and valued the efforts of the activity coordinator to vary the programme regularly. Residents said they felt safe and attributed this to the competence of staff and their professional manner.

Carndonagh Community hospital is operated by the Health Service Executive (HSE). The main hospital was built in 1956 and provides a broad spectrum of care to people in the Inishowen area. This includes long term continuing care including dementia care, short term assessment, respite, convalescent, rehabilitation and palliative care. It comprises of three units, Oak and Elm provide general care and Ard Aoibhinn is dedicated to the care of people who have dementia.

Care, nursing staff and ancillary staff were well informed and conveyed a comprehensive understanding of individual residents' needs, wishes and preferences. They described how independence and well being was promoted by supporting residents to continue to do as much as possible for themselves and by encouraging residents to remain stimulated and engaged with their treatment programmes and activities. The inspector found that some residents had made significant improvements and could now communicate more effectively and were more independent however these changes were not described fully in care records to enable to learn from the interventions employed. Residents had access to doctors and to the services of allied health professionals. Care plans outlined health and social care needs and were based on arrange of evidence based assessments. The inspector found that while the standard of care planning was generally good, the needs of residents who had dementia in all units needed to be outlined more comprehensively to ensure that staff were familiar with their abilities as well as their needs for support and to reflect evidence based practice.

Systems were in place to ensure the environment was safe for residents, staff and visitors. There were policies, procedures, systems and practices in place to assess, monitor and analyse potential risks and control measures were in place to ensure risk was minimised. The centre was clean and well organised. The fire safety arrangements were satisfactory and staff were familiar with the fire safety routines, the location of firefighting equipment and the actions they were required to take should the fire alarm be activated. There was an ongoing programme of decoration

and maintenance. Storage space was identified for attention during this inspection as there were hazards caused by the storage of equipment such as hoists in hallways.

The person in charge and the clinical nurse managers demonstrated good knowledge of the legislation and standards throughout the inspection. They were aware of the legislative responsibilities of the person in charge and provider including the notifications that had to be made to the Authority. The provider attended the feedback meeting. The inspector found that there was a strong commitment to ensure compliance with legislation and to ensure residents had a good quality of life that met their needs.

The last inspections of the centre were conducted on 28 January and 30 June 2014. The latter was a themed inspection that reviewed the arrangements in place for end of life care and food and nutrition. The inspector found that while there was a good standard of compliance in many areas deficits were found in the provision of communal space, the use of communal bedroom areas, completion of end of life care plans and the identification of diabetes. These areas were reviewed during this inspection and the action plans had been addressed with the exception of the actions related to the premises that remain outstanding. This and other areas such as social care for residents with dementia care needs and care planning are outlined for attention in the action plan of this report.

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

***Outcome 01: 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 provider had submitted a revised statement of purpose as part of the application to register. This was found to contain all the required information described in schedule 2.

**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 is a clearly defined management structure that identifies the lines of authority and accountability. The person in charge is supported by clinical nurse managers on site and also has supervisory support from the director of nursing in a neighbouring community hospital.

Effective management systems and sufficient resources were in place to ensure the delivery of care that met appropriate standards of quality and safety. The quality of care

and experience of the residents was reviewed regularly through an audit system which was based on a formal review conducted each month on areas such as medication management, care plans, pressure area care and moving and handling. Areas where shortfalls were identified were identified for remedial work and the inspector saw that there was gradual improvement recorded over time. There were reports of all audit activity available and these were made available to residents.

The audit activity included consultation with residents and their families as required by regulation 23-Governance and Management. The inspector was told that formal meetings with residents and relatives took place twice a year. There is a plan under development to improve the facilities and eliminate the multiple occupancy bedrooms.

**Judgment:**

Compliant

***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 comprehensive resident's guide detailing a summary of the services provided was available.

The inspector viewed a sample of four contracts of care issued to residents and found that there was an agreed written contract in place which included details of the services to be provided, the fee payable by the resident and any charges made for additional services.

Some documents such as the complaints procedure were noted to be available in pictorial formats to enhance accessibility.

**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 person in charge is a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service and she works full time in the centre.

She demonstrated good clinical knowledge and understanding of her legal responsibilities as required by the regulations and standards. She had engaged in continuous professional development and had achieved a post graduate diploma in palliative care. She demonstrated good knowledge of areas such as nutrition, wound care and dementia care. She confirmed that she kept up to date by attending training in the nursing development unit on topics of interest.

She was aware of the challenge presented by the premises issues and was aware of the changes required to achieve compliance with the personal space standards for residents.

Her mandatory training in adult protection, manual handling and fire safety and her registration with an Bord Altranais agus Cnáimhseachais na hÉireann (Nursing and Midwifery Board of Ireland) (ABA) were all in date.

Appropriate arrangements were in place for the management of the centre in the absence of the person in charge. There were a number of experienced clinical nurse managers who worked full-time who deputised in the absence of the person in charge.

The inspector found that that they had a good knowledge of the management systems, had engaged in continuous professional development and were familiar with the legal responsibilities of the person in charge including requirements in relation to the submission of notifications to the Chief Inspector.

**Judgment:**

Compliant

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

**Theme:**

Governance, Leadership and Management



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

No actions were required from the previous inspection.

**Findings:**

The centre had a well established and generally well organised administration system. The inspector reviewed a range of documents, including residents' care records, staff records, the directory of residents, financial records, duty rotas and training records. The inspector found that overall records were maintained in a manner so as to ensure completeness and accuracy. Some improvements were required.

For example: The directory of residents was noted to lack some of the required information such as the address of next of kin and the telephone number and address for general practitioners. While there was a policy on staff recruitment there was no policy to guide the training and development needs of staff and the missing persons policy required review as the date set for this had expired.

**Judgment:**

Substantially Compliant

***Outcome 06: Absence of the Person in charge  
The Chief Inspector is notified of the proposed absence of the person in charge from the designed 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:**

Appropriate arrangements were in place for the management of the centre in the absence of the person in charge. An experienced clinical nurse manager, deputised in the absence of the person in charge.

There were also four other clinical nurse managers who had lead responsibility for varied functions in the centre that supported the role of person in charge. This included nurses who had responsibility for day care and the dementia care unit. All nurses interviewed had a good understanding of the legal responsibilities of the person in charge, the notifications that were required and the arrangements in place in the event of an emergency.

**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):**

No actions were required from the previous inspection.

**Findings:**

Measures to protect residents being harmed or suffering abuse were in place. The Health Service Executive policy and procedures for the prevention, detection and response to allegations of abuse- Safeguarding Vulnerable Persons at Risk of Abuse was in place. Staff had received training in adult protection to safeguard residents and to protect them from harm and abuse. Further training on the revised new procedures was scheduled.

Staff knew what constituted abuse and knew what to do in the event of an allegation, suspicion or disclosure of abuse, including how incidents were to be reported. They described being diligent about incidents such as unexplained bruising and investigating any such incidents. Relatives confirmed to the inspector that staff informed them promptly of any injuries or relevant matters that presented. A notification of abuse was under investigation. The inspector saw that the established procedures were being followed and that measures had been put in place to safeguard residents. The required notifications had been made.

There was a visitors' record that enabled staff to monitor the movement of persons in and out of the building to ensure the safety and security of residents. This was noted to be signed by visitors entering and leaving the building. Residents the inspector spoke to and those who had completed questionnaires reported that they felt safe in the centre. They indicated that the competence of staff and the call bell system contributed to their sense of security.

The centre had a policy on the use of restraint to ensure residents were protected from potential harm. As described earlier this required review as it had not been updated within the time frame indicated for review. The use of any measures that could be considered as restraints such as bed rails was underpinned by an assessment and was regularly reviewed. The inspector noted there was a low incidence of bed rail use with only four residents using this equipment at the time of the inspection.

There were no residents with fluctuating behaviour patterns or challenging behaviour. Staff could describe interventions such as one to one support, engaging residents in activity and in conversation as ways of effectively managing such behaviour to protect the dignity of the resident.

**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):**

No actions were required from the previous inspection.

**Findings:**

There were systems in place to promote and protect the safety of residents, staff and visitors to the centre. The centre had an up to date Health and Safety Statement dated January 2015. The risk management arrangements in place were overseen by the health and safety committee made up of representatives from the multidisciplinary staff group in the centre and included the pic, a health and safety representative from the maintenance team, a nurse, clerical staff and allied health professionals. There was good emphasis on general hazard identification and preventive actions were outlined. For example the prevention measures for slips, trips and falls included the use of hazard signs and the careful management of cables particularly cables under and around specialist beds.

There were systems in place to ensure good infection control management. There were hand sanitising solutions and hand gels available throughout the centre. These were noted to be used frequently by staff as they moved from area to area and from one activity to another. Hand washing and hand drying facilities were located in toilet and sluice areas. There were supplies of personal protective equipment readily available in all units. Precautions were also in place to reduce risk of legionella development. A risk assessment had been completed at the end of 2014 and there was a routine in place to activate water outlets not in regular use.

There was an emergency plan issued in December 2014 that described several hazard situations that could prompt evacuation of the centre. This included power failure, flooding and fire. There was a plan in place to guide staff in such a situation and a practice evacuation had been conducted last year. There had been areas of learning from this exercise such as ensuring that mobile residents moved to safety first needed to be located in an area away from the exits to avoid congestion and the location of wheelchairs to be used in such a situation was changed as it was not readily accessible.

Clinical risks such as skin fragility, tissue viability, compromised nutrition status and dementia were described in care records but overall protocols were not included as part of the risk management system to alert staff to the general hazards associated with these risks. There were good descriptions of the risks presented and the control measures in place described in the relevant areas of care records.

Measures were in place to prevent accidents in the centre and grounds. The building was generally clutter free and there were grab rails in hallways and in bathrooms and toilets. An evidenced based falls prevention programme had been introduced and there

was a system to identify residents most at risk of falls to alert staff to their degree of vulnerability. Manual handling assessments were available, were up to date and reflected resident's dependency and capacity to mobilise. While the assessments indicated where hoist transfers were required the information for staff did not outline the type of hoist or sling size to be used which could create a risk. Accidents and incidents were recorded and there were good descriptions of the events that happened and the measures taken to prevent recurrences. The falls analysis undertaken described the number and nature of events. There had been 16 incidents recorded, 12 in the dementia care unit Ard Aobhinn and 4 in the remaining units. The factors that could have contributed to each incident and prevention measures were identified for learning from incidents/adverse events involving residents. The remedial actions taken included the use of low low beds, reviews of medication and reassessment of specialist mattresses in use. Falls risk assessments were noted to be reviewed following incidents and neurological observations were recorded where falls were unwitnessed or where head injury was suspected.

There were moving and handling procedures in place and all staff were trained in moving and handling of residents. Equipment was noted to be in good condition and regularly serviced however some was stored in hallways due to limited storage space which could present a trip hazard.

The fire safety arrangements overall were satisfactory however some checks undertaken were not recorded. There was a fire safety procedure and clear floor plans of the building that identified the routes to the fire exits were on display. One of the health care staff had a lead role for fire management. He was very familiar with all areas of the service and the client group and described the fire arrangements to the inspector. A fire register was in place and this described the regular checks of fire fighting and fire alert equipment as well as fire drills and unplanned activations of the fire alarm. The scheduled monthly inspections of equipment were up to date and recorded. The emergency lighting was checked weekly and the system had been renewed fully and upgraded in February 2015. There had been 3 unplanned activations of the fire alarm, two were associated with toasters in kitchen areas and one with a broken activation point that occurred during cleaning. An action plan in a previous report required that the fire hose reels be relocated as their position and location in hallways presented a risk to persons walking past. This matter had been addressed.

Staff described their training to the inspector. They described how they were taught to use the ski sheets to move residents and to proceed with progressive horizontal evacuation through each set of fire doors. Regular fire drills were completed and there were two simulated evacuations conducted in June and July 2014 as part of the fire drill exercises.

The fire alarm was serviced quarterly, a list of fire fighting equipment was available and was serviced on an annual basis as required. There were adequate means of escape and fire exits were noted to be unobstructed. There was a daily check of the fire alarm and of the fire exits however these checks were not recorded to confirm that this was done and it is a requirement of this report that all fire safety checks are recorded.

The centre had a missing person procedure and there were personal profiles outlined that described safety measures in place to ensure that residents did not leave the building unnoticed. Exit doors were alarmed and the dementia unit was secure. The

inspector noted that these profiles also contained information on what to do in the event of fire however some comments did not specify the measures to be adopted to keep residents safe such as the use of wheelchairs or fire sheets for evacuation purposes.

**Judgment:**

Non Compliant - Moderate

***Outcome 09: Medication Management***

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

**Theme:**

Safe care and support

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

No actions were required from the previous inspection.

**Findings:**

The inspector found that there were safe systems in place for the management of medication. There was clinical space where medication trolleys and supplies of medication were securely stored. The fridges used to store medication were purpose designed, clean and functioning at an appropriate temperature which was checked and recorded daily by staff.

Staff were well informed about the medication in use and residents' medication regimes. The inspector was told that residents admitted for respite care take in their own supplies of medication for the duration of their stay. Residents have a choice of pharmacist and 3 pharmacies provide the medication supply. Resident's medication was noted to be reviewed every three months by the GP, nursing staff or by specialist services. Medications that required special control measures were carefully managed and kept in a secure cabinet in keeping with professional guidelines. Nurses maintained a register of controlled drugs. Two nurses signed and dated the register and the stock balance was checked and signed by two nurses at the change of each shift. One resident had a syringe driver in situ and pain relief medication was administered as prescribed.

In the dementia care unit residents were noted to be observed closely when taking medication and where required liquid preparations were used where available. The inspector observed that medication was administered in accordance with the centre's policy and An Bord Altranais agus Cnáimhseachais na hÉireann (Nursing and Midwifery Board of Ireland) guidelines. Staff had completed the on line medication management training to ensure their knowledge was up to date and that they adhered to good practice standards. There were written operation policies relating to the ordering, prescribing, storing and administration of medicines to residents. The person in charge demonstrated that there were ongoing audits of medication management in the centre. The prescription sheet included all the appropriate information such as the resident's name and address, any allergies, and a photo of the resident. The General Practitioner's signature was present for all medication prescribed and for discontinued medication. Maximum does of PRN (as required) medication was recorded in the majority of cases

but some prescription charts did not have this information to guide staff.

Residents who had conditions that could fluctuate such as epilepsy had supplies of emergency medication available. Non nursing staff did not have training to administer this medication which meant that nursing staff had to accompany residents to appointments or going out which in some cases restricted social opportunities. The inspector found that training to provide the required expertise should be provided for non nursing staff where appropriate to ensure that residents' choices and needs could be effectively addressed.

**Judgment:**

Substantially Compliant

***Outcome 10: Notification of Incidents***

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

**Theme:**

Safe care and support

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

No actions were required from the previous inspection.

**Findings:**

The inspector reviewed the notifications supplied to the Authority and the accidents and incidents that had occurred in the designated centre. On review of these incidents and cross referencing with notifications submitted the inspector found that the centre generally adheres to the legislative requirement to submit relevant notifications to the Chief Inspector.

**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 39 residents in the centre during the inspection and one resident was receiving care in hospital. There were 29 residents assessed as having maximum or high level care needs and the remaining 10 residents had medium level needs. The majority of residents were noted to have a range of complex healthcare issues and were being treated for more than one medical condition.

The arrangements to meet residents' assessed needs were set out in individual care plans which were maintained on a computer programme. Recognised assessment tools were used to evaluate residents' progress and to assess levels of risk for deterioration, for example vulnerability to falls, dependency levels, nutritional care, risk of developing pressure area problems and moving and handling requirements. Four resident's care plans and certain aspects of other care plans related to the management of nutrition, complex care and dementia were reviewed. Care plans for residents assessed as high falls risk and who used bedrails were also examined.

The inspector found that good standards of personal and nursing care were in place and this was supported by timely medical and allied health professional input when required. The risk assessments completed were suitably linked to care plans where a need/risk was identified. Staff conveyed good knowledge of the personal choices and wishes expressed by residents in relation to how they spent their time, the activities they attended and how they wished their personal care to be addressed. The inspector saw evidence that the ethos of person centred care was promoted each day. Residents could for example get up at times of their choice and could remain in bedroom areas or go to the communal areas to meet others or take part in activity. The sitting areas were supervised and staff welcomed each resident as they arrived, provided tea or coffee, biscuits or fruit and newspapers and engaged with them in a positive and friendly manner.

Care plans provided a good overview of residents' care and how care was delivered. On admission, a comprehensive nursing assessment and additional risk assessments were completed for all residents. This assessment was based on a range of evidence based practice tools. For example, a nutritional assessment tool was completed to identify risk of nutritional deficits, a falls risk assessment to determine vulnerability to falls and a tissue viability assessment to assess pressure area risk. The inspector noted that the assessments were used to inform care plans and that care was delivered in accordance with established criteria to ensure well being and prevent deterioration. They were updated at the required intervals or in a timely manner in response to a change in a resident's health condition. Residents had access to GP services and there was evidence of medical contact at least three monthly and more frequently when required. A review of residents' medical notes showed that GP's visited the centre to review medications and to respond to changes in health care. Access to allied health professionals such as speech and language therapists, dieticians, occupational therapists and community mental health nurses was available. There was evidence that residents and relatives were involved in care plans and their views were recorded and incorporated into daily care practice. The inspector noted that in the dementia care unit there was good detail on who residents still recognised and how they responded during visits from friends and relatives.

Care plans for residents with dementia required more development to ensure they are

person-centred and reflect individual needs and how these should be addressed to ensure good outcomes for residents. For example while communication capacity was described well there was variable information available on orientation to surroundings, the social care needs of residents and how these were being addressed or what interventions were put in place when residents had fluctuating behaviour patterns.

There was a record of residents' health condition and treatment given completed each day and night. Reviews and evaluations of care were evident at the required intervals however the inspector noted that in some cases the information in reviews did not convey the progress residents had made or the impact of the social and psychological support provided to ensure residents well-being. For example where staff had introduced a comprehensive programme for a resident and a significant improvement had taken place such as improved communication ability and capacity to enjoy an enhanced quality of life this change was not evident in the information recorded. There were processes in place to ensure that when residents were admitted, transferred or discharged to and from the centre, relevant and appropriate information about their care and treatment was available and shared between providers and services.

Residents had opportunities to participate in activities that were meaningful and purposeful to them, and which suited their needs, interests and capacities. A specific activity co-ordinator worked in the service and she was supported by staff on placement through a community employment scheme. However opportunities in the dementia care unit were noted to be more limited. There was evidence of one to one social interactions that were very positive taking place throughout the day and staff were noted to have very good relationships with residents however there was a lack of coordination and structure to the way social care was provided and there were long periods of the day when residents did not have any specific activity planned.

There were some residents with behaviours that challenged such as restlessness or resistance when personal care was in progress and who required high levels of observation. The inspector saw that staff engaged residents constructively and supervised them closely to ensure their safety and appropriate care was delivered to residents and their welfare was promoted.

**Judgment:**

Non Compliant - Moderate

***Outcome 12: Safe and Suitable Premises***

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

**Theme:**

Effective care and support



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

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

**Findings:**

The centre is comprised of two units Oak and Elm and a dementia care unit called Ard Aoibhinn, which was developed in 2007. The number of registered places is 46 - 16 residents in Ard Aoibhinn and 30 in Oak and Elm wards.

The inspector found that there were a number of aspects of Oak and Elm which were not in compliance with requirements of the Health Act 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland. These matters have been highlighted in previous inspection reports and the provider has informed the Authority on 16 December 2014 of the plans being developed in conjunction with the HSE estates office to have the centre redeveloped to the appropriate specifications. A final plan with associated costs has not yet been made available.

The areas that were noted to require attention were: The sitting room was confined for the number of residents who used the area and it was difficult to manoeuvre residents in wheelchairs and specialist chairs when the room was fully occupied. The dining space was also inadequate and could not accommodate all residents comfortably. Some residents remained in their bedrooms or in the sitting room for their meals which limited opportunities for social engagement at mealtimes. A number of bedroom areas are multiple occupancy and accommodate more than two residents. Elm unit had a bedroom that accommodated four residents and another that had three occupants. Oak had two bedrooms that accommodated four residents. This communal layout compromised privacy and the way staff could provide person centred care.

Ard Aoibhinn is purpose designed unit established to meet the needs of people with dementia. The unit has many features that reflect good dementia design and that promote independence. These include different colours on bedroom doors, good lighting and varied areas to sit or to take part in activities. It comprises eight single rooms and four twin bedrooms. All bed rooms have an en suite toilet, shower and wash-hand basin. There was appropriate equipment for use by residents and staff which was maintained in good working order. Equipment, aids and appliances such as hoists, call bells, hand rails were in place to support and promote the independence of residents. Service records indicated that equipment was maintained in good working order.

The centre was noted to be visibly clean and equipment such as commodes and hoists were clean and in good condition. There had been a replacement programme for some equipment and this was ongoing the inspector were told.

In addition to the space issues that require attention the following areas also require remedial action: All rooms provided storage space for residents' belongings. There was generous space in some bedrooms however in communal rooms this was more restricted. While this was not an issue for residents receiving convalescent, respite or rehabilitative care, it impacted on residents receiving long term care who could only have a limited number of possessions near their beds.

Storage capacity for equipment such as hoists was limited and some were stored in hallways which presented a trip hazard. There was chipped paintwork and damage to tiles in several areas in Oak and Elm units which presented an infection control risk as well as looking unsightly.

**Judgment:**

Non Compliant - Moderate

***Outcome 13: Complaints procedures***

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

**Theme:**

Person-centred care and support

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

No actions were required from the previous inspection.

**Findings:**

The inspector found that the requirements of regulation 34- Complaints Procedures were met. Relatives and residents were aware that there was a complaints procedure in place and told the inspector they would approach the person in charge or any member of staff should they have concerns.

The complaints procedure was available and there was a pictorial outline on one side of the document to assist with understanding of the complaint process. If not satisfied with the outcome of a complaints investigation an appeal could be made to the customer services officer for the HSE area and the contact details for this office were readily available.

The inspector saw from the records maintained that the outcome of investigations were recorded and that there was a conclusion indicating if the complainant was satisfied. There were no active complaints at the time of the inspection.

**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):**

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

**Findings:**

This outcome was the subject of a thematic inspection in June 2014 and aspects of end of life were examined in detail during that inspection. There was one action outlined for improvement. While some residents had comprehensive information described in end of life care plans this information was not available for all residents. The inspector found in the sample of records reviewed that residents end-of-life care preferences/wishes had been identified and documented particularly who they wished to be with them and if they wanted to remain in the centre.

The policy of the centre is all residents are for resuscitation unless documented otherwise. A multi disciplinary approach was undertaken to include the resident where possible, their representative, the GP and the nursing team. The inspector was satisfied that caring for a resident at end-of-life was regarded as an integral part of the care service provided in the centre and that the legislative requirements and good practice standards were met. There was one resident in receipt of end of life care during this inspection. The centre had dedicated rooms with ensuite facilities for end of life care. Overnight facilities and refreshments were offered to residents' family members and friends and there was space for a number of people to spend time with residents when end of life care was in progress.

Staff were familiar with and could describe when end of life care became care of the dying and the procedures in place to support a dignified and peaceful death. This included a procedure for the practical care of the body after death and the arrangements to support relatives with administration such as the registration of the death. Staff said that they supported each other during times when end of life care was in progress and discussed fully all aspects of care at hand overs to ensure all staff were aware of changes and the care 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):**

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

**Findings:**

The inspector found that the arrangements in place to provide residents with a varied and balanced diet that met their nutritional needs and preferences were satisfactory. There were systems in place for assessing, reviewing and monitoring residents' nutritional intake and residents that were at risk of nutrition shortfalls were identified

and monitored closely. There was a food and nutrition policy in place that provided detailed guidance to staff and is supported by a range of procedures that included health promotion, the management of fluids and hydration, percutaneous endoscopy nutrition systems, medication management and the care of residents with specific conditions such as diabetes. Staff were familiar and knowledgeable about the policies in place and knew where policy documents were located when they needed to refer to them. This outcome was comprehensively inspected at the last inspection in June 2014. One action in relation to diabetic care had been identified for action. The inspector found that there were systems in place to identify the possibility of diabetes and that proactive monitoring for diabetes was in place. In relation to the use of equipment one of the staff nurses had a lead role for monitoring the use of equipment and individual glucose monitoring devices had been ordered in accordance with recent good practice guidance.

Residents told the inspector that the food was "very good" and also said "we are always offered a choice". Residents' food likes and dislikes were recorded and staff could describe to the inspector the varied modifications that were made to ensure their choices were met.

As described earlier there was dining space in each unit although as described earlier this was limited in the Oak/Elm units. The inspector observed that meals were well presented, served in individual portions and residents who needed assistance were not left waiting for their meals. Staff were observed to assist residents in a manner that protected their dignity during meal times. There was an appropriate number of staff available to serve meals and staff sat beside residents who needed prompting or assistance to eat and ensured they knew what they were being offered and took time with meals. Staff interviewed could describe the different textures of food that was served and how they adhered to safe swallowing guidelines. Snacks, beverages and cold drinks were available throughout the day. There was an emphasis on including fresh fruit and the inspector saw that varied fruits were served at tea and coffee times. Staff prompted residents to have drinks where residents could not assist themselves.

Records reviewed showed that residents' nutritional status was assessed using a recognised evidence based tool and reviewed as necessary. Care plans to address specific nutritional needs were in place and where risk factors such as unintentional weight changes were evident that these were assessed and monitored. The monitoring arrangements including monthly weights and more frequent monitoring was put in place if fluctuations upwards or downwards were noted. All residents who were vulnerable to weight loss had been assessed and had a nutritional care plan in place. Residents have access to Health Service Executive community professionals such as occupational and speech and language therapists. The inspector saw that standards in this area of practice which commenced in 2013 had been sustained.

**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 found that residents had access to a range of social opportunities that were suitable to their needs, were age appropriate and reflected their interests. There was information in care records that described communication capacity and obstacles to communicating effectively such as difficulty hearing, vision problems or cognitive impairment. The inspector observed that staff engaged with residents throughout the day and ensured that residents who spent periods of time in bed were visited regularly and engaged in conversation. Contacts were noted to be cheerful, pleasant and respectful with plenty of general conversation in evidence.

Residents who had dementia were noted to be well supported and staff described how they helped residents orientate to their environment and participate in day to day life to their maximum capacity. They described spending time with residents, giving them choices, time to respond to questions, speaking slowly and also providing reminders so that they knew when meal times were example were to take place.

There were arrangements in place for consultation with residents through regular meetings and there was a well established network with residents' families. Feedback on the service was also requested during individual care plan reviews and as part of monitoring procedures for the service.

Residents confirmed that they could follow their religious beliefs and said that they could attend mass or have priests or ministers visit them in the centre. Care records contained information on religious practice. Residents were facilitated to exercise their political rights and could vote in local, European and national elections. Visitors were welcomed throughout the day and there were no restrictions on visits. The inspector saw that some family members visited at meal times and helped their relatives as part of the support they were able to provide. Residents had access to the television, radio and to daily and local newspapers. Staff said that residents really appreciated hearing local news and they kept them up to date with community events.

There was a range of social events organised by the activity coordinator and the inspector found that social care options were varied and available daily. Music sessions and singing were very popular and there was examples of residents' craft work on

display. A visit by a drama group had proved very popular and had been enjoyed so much that it was hoped that this would be a regular feature according to some residents. In the dementia unit social opportunities were noted to be less evident. There was social contact but an organised programme that was adhered to each day was not in place. Care staff were noted to engage in one to one activity with residents however there was an absence of structure to social care which meant that residents were unsure of what was happening from day to day.

**Judgment:**

Non Compliant - Moderate

***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:**

There were systems in place to safeguard residents' property and money. The Health Service Executive (HSE) procedures for personal property and money was adhered to and well established.

The inspector reviewed these procedures and found that there were up to date records of personal property and money held for safe keeping. The administrator could describe how finances were managed and had a clear system in place to account for any money held on behalf of residents. There was an individual record for each resident and all transactions were recorded and could be easily identified.

Residents' personal spaces were personalised with photographs, pictures and other possessions. The communal space arrangements severely limited what residents could have by their beds as described earlier however staff encouraged residents to personalise the space around them and to have some personal items on display.

There was a system in place to reduce the loss of clothing and residents said that clothing was well cared for and returned to them in good condition.

**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):**

No actions were required from the previous inspection.

**Findings:**

The inspector reviewed staffing levels on each unit and discussed the staff allocation with the person in charge and the staff team. They described how they allocated workloads and determined staffing requirements. The person in charge said that admissions were limited and the number of residents accommodated restricted if staff resources were not available. The inspector was found that the day and night staff allocation was appropriate to meet the needs of residents. There was no illness leave and one health care assistant post was filled by an agency staff who had worked in the centre long term.

The inspector carried out interviews with varied staff members and found that they were knowledgeable about residents' individual needs, fire procedures and the system for reporting suspicions or allegations of abuse. Staff told the inspector that they were well supported and that senior staff provided good leadership and guidance.

The inspector noted that staff meetings were used to reflect on practice and that deficits in procedures were discussed and remedial actions taken. For example an incorrect weight record was brought to the attention of staff as the incorrect weight recorded should have triggered a referral to specialist services and more intensive monitoring but this had not occurred.

The inspector was provided with details of the training that had been provided to staff during 2014. Training had been provided on a range of topics that included:

- Elder abuse, the protection of vulnerable people and Children First
- Fire safety
- Hand hygiene and infection control
- Cardipulmonary resuscitation
- End of life care
- Medication management
- Moving and handling

All staff had up to date training in moving and handling and the 3 staff who required updated fire training were scheduled to do this In April 2015.

All staff who worked in the dementia care unit had training in dementia care and this was due to be updated as part of the preparation for themed inspection programme on dementia care.

Evidence of professional registration for nurses was available.

Residents and staff were observed to have good relationships and residents said they valued the way staff remembered their preferences and the ways they liked their daily routines and personal care to be carried out. The inspector observed that call-bells were answered promptly, staff were available to assist residents and there was appropriate supervision in the dining rooms and sitting rooms throughout the inspection days.

**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:***

Geraldine Jolley  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority



## Health Information and Quality Authority Regulation Directorate

### Action Plan



### Provider's response to inspection report<sup>1</sup>

<b>Centre name:</b>	Carndonagh Community Hospital
<b>Centre ID:</b>	OSV-0000616
<b>Date of inspection:</b>	30/03/2015
<b>Date of response:</b>	30/06/2015

### 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 05: Documentation to be kept at a designated centre

#### Theme:

Governance, Leadership and Management

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

The policy to guide staff on missing persons and restraint had not been reviewed within the time frame that had been established. Both procedures were due for review in 2012.

#### Action Required:

Under Regulation 04(3) you are required to: Review the policies and procedures

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

referred to in regulation 4(1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.

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

While the National Policy on Restraint has not been updated a review and update of the local Policy on Restraint will be undertaken and implemented

**Proposed Timescale:** 31/10/2015

**Theme:**

Governance, Leadership and Management

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

A policy on staff training and development was not available as required by schedule 5- Regulation 4-Written Policies and Procedures

**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:**

Policy on Staff Training and Development is under review at present. First Draft for feedback due to be available mid July. Implementation date September

**Proposed Timescale:** 30/09/2015

**Theme:**

Governance, Leadership and Management

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

The directory of residents did not contain all the required information outlined in schedule 3.

**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:**

An Electronic Directory of Residents has been updated to include the addresses of the next of kin and telephone numbers and addresses of the GP's

**Proposed Timescale:** 30/06/2015

### **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 lack of storage arrangements for large equipment presented trip hazards as this equipment was sometimes stored in hallways.

**Action Required:**

Under Regulation 26(1)(a) you are required to: Ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.

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

Review of hazards re: storage arrangements undertaken and completed. Hazards identified have been included on the risk register.

**Proposed Timescale:** 30/06/2015

### **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:**

Medication prescribed on an "as required" PRN basis did not always have the maximum dose in 24 hours outlined.

**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:**

A review of medication kardex scheduled in conjunction with the 4 monthly reviews in July. This will include input from the pharmacists regarding all medications. PRN maximum daily doses will be included for the remaining kardex.

**Proposed Timescale:** 31/07/2015

## Outcome 11: Health and Social Care Needs

### Theme:

Effective care and support

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

Reviews and evaluations of care were evident at the required intervals but in some cases the information in reviews did not convey the progress residents had made or the impact of the social and psychological support provided to ensure residents well-being.

### **Action Required:**

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

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

Care plan reviews scheduled for July. These reviews will include the resident's progress and the impact of the psychosocial support provided. Reviews will include residents and their families, where appropriate .

**Proposed Timescale:** 31/07/2015

### Theme:

Effective care and support

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

Care plans for residents with dementia required more development to ensure they are person-centred and reflect individual needs and how these should be addressed to ensure good outcomes for residents. For example while communication capacity was described well there was variable information available on orientation to surroundings, the social care needs of residents and how these were being addressed or what interventions were put in place when residents had fluctuating behaviour patterns.

### **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:**

Care plan reviews to include and reflect the information required for individualised actions in orientation to surroundings, social care and managing fluctuating behaviours of residents with dementia.

**Proposed Timescale:** 31/08/2015

**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:**

The sitting room in Oak/Elm units was confined for the number of residents who used the area and it was difficult to manoeuvre residents in wheelchairs and specialist chairs when the room was fully occupied. The dining space was also inadequate and could not accommodate all residents comfortably. A number of bedroom areas are multiple occupancy and accommodate more than two residents. Elm unit had a bedroom that accommodated four residents and another that had three occupants. Oak had two bedrooms that accommodated four residents. This communal layout compromised privacy and the way staff could provide person centred care.

**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:**

Plans for refurbishment are in progress to include maximising single and double room occupancy. Also there are plans to extend the day and dining room for residents. These plans are dependent on securing the necessary funding and thus the timescale given is by necessity approximate

**Proposed Timescale:** 31/12/2016

**Theme:**

Effective care and support

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

Residents receiving long term care could only have a limited number of possessions near their beds due to restricted storage.

Storage capacity for equipment such as hoists was limited and some were stored in hallways which presented a trip hazard.

There was chipped paintwork and damage to tiles in several areas in Oak and Elm units which presented an infection control risk as well as looking unsightly.

**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:**

Plans are in progress to upgrade existing multiple occupancy bedrooms to maximise space for individual residents. Plans include storage for equipment and new interior decoration.

**Proposed Timescale:** 31/12/2016

**Outcome 16: Residents' Rights, Dignity and Consultation**

**Theme:**

Person-centred care and support

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

In the dementia unit social opportunities were not formally organised in a way that ensured social activity was available each day. Care staff were noted to engage in one to one activity with residents however there was an absence of structure to social care which meant that residents were unsure of what was happening from day to day.

**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:**

Reviews of all residents with dementia social care will be undertaken to ensure a structured programme is available to each individual resident.

**Proposed Timescale:** 31/08/2015