

Health Information and Quality Authority  
Social Services Inspectorate

Inspection report  
Designated centres for older people



Health  
Information  
and Quality  
Authority

An tÚdarás Um Fhaisnéis  
agus Cáilíocht Sláinte

<b>Centre name:</b>	Ramelton Community Hospital
<b>Centre ID:</b>	615
<b>Centre Address:</b>	Ramelton Community Hospital
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	Letterkenny,
	Co. Donegal
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<b>Type of centre:</b>	<input type="checkbox"/> Private <input type="checkbox"/> Voluntary <input checked="" type="checkbox"/> Public
<b>Registered provider:</b>	Health Service Executive (Kieran Doherty)
<b>Person in charge:</b>	Philomena Gallagher
<b>Date of inspection:</b>	15 and 16 March 2011
<b>Time inspection took place:</b>	<b>Day 1 Start:</b> 08:50 hrs <b>Completion:</b> 19:45 hrs <b>Day 2 Start:</b> 08:50 hrs <b>Completion:</b> 18:30 hrs
<b>Lead inspector:</b>	Sonia McCague
<b>Support inspector(s):</b>	Siobhan Kennedy
<b>Type of inspection:</b>	<input checked="" type="checkbox"/> Registration <input checked="" type="checkbox"/> Scheduled <input checked="" type="checkbox"/> Announced <input type="checkbox"/> Unannounced

## About inspection

The purpose of inspection is to gather evidence on which to make judgments about the fitness of the registered provider and to report on the quality of the service. This is to ensure that providers are complying with the requirements and conditions of their registration and meet the standards; that they have systems in place to both safeguard the welfare of service users and to provide information and evidence of good and poor practice.

In assessing the overall quality of the service provided, inspectors examine how well the provider has met the 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* under the following topics:

1. Governance and leadership: how well the centre is organised.
2. The quality of the service.
3. How well the healthcare needs of residents are met.
4. Premises and equipment: appropriateness and adequacy.
5. Communication: information provided to residents, relatives and staff.
6. Staffing: the recruitment, supervision and competence of staff.

This report summarises the findings of the inspection under some or all of these topics, highlighting areas of good practice as well as areas where improvements were required as follows:

**Evidence of good practice** – this means that an acceptable standard was reached and the provider demonstrated a culture of review and improvement and aimed to drive forward best practice.

**Some improvements required** – this means that practice was generally satisfactory but there were areas that need attention.

**Significant improvements required** – this means that unacceptable practice was found.

The report also identifies minor issues, where applicable, to which the provider should give consideration to enhance the quality of the service.

**Registration inspections** are one element of a process to assess whether providers are fit and legally permitted to provide a service. The registration of a designated centre is for three years. After that, the provider must make an application for registration renewal at least six months before the expiration date of the current registration. New providers must make an application for first time registration 6 months prior to the time the provider wishes to commence.

In controlling entry to service provision, the Chief Inspector of Social Services is fulfilling an important regulatory duty under section 40 of the Health Act 2007. Part of this duty is

a statutory discretion to refuse registration if the Chief Inspector is not satisfied about a provider's fitness to provide services, or the fitness of any other person involved in the management of a centre.

The registration inspection is one element for the Chief Inspector to consider in making a proposal to the provider in respect of registration. Other elements of the process designed to assess the provider's fitness include the information provided in the application to register, the Fit Person self-assessment and the Fit Person interviews. Together these elements are used to assess the provider's understanding of, and capacity to, comply with the requirements of the regulations and the Standards. Following assessment of these elements, a recommendation will be made to the Chief Inspector and the formal legal process for registration will proceed. As a result, this report does not outline a final decision in respect of registration.

The report is available to residents, relatives, providers of services and members of the public, and is published on our website [www.hiqa.ie](http://www.hiqa.ie).

## About the centre

### Description of services and premises

Ramelton Community hospital is operated by the Health Service Executive (HSE). The hospital was opened in 1981. The centre provides a broad spectrum of care to people primarily over 65 years of age. This includes long term continuing care, short term assessment, respite, convalescent, rehabilitation, palliative care, and dementia care.

A day hospital and physiotherapy department is operational within the premises of the designated centre. The day hospital is managed by the person in charge and provider. The provider is also responsible for a health centre located on this site and next to the centre.

Services within the centre comprise of the ward where residents reside, an inpatient and outpatient physiotherapy department and a day hospital where up to 18 community clients attend daily, Monday to Friday.

Accommodation confirmed to inspectors and to be used by residents consisted of the following:

- 17 single bedrooms (rooms 18-21,28,32,37,47-54,56 and 58)
- five twin bedrooms (rooms 26,29,41,44 and 45)
- one three-bedded room (room 25 that had a tracking hoist for highly dependent persons)
- all rooms had a wash-hand basin facility
- two assistive shower rooms with assistive toilets, one was identified as female and was shared with day hospital clients
- one bath/bathroom (no toilet facility within and shared with day hospital clients)
- one male assistive toilet (shower to be reinstated according to person in charge)
- one independent toilet
- rooms 25 and 26 have a shared en suite toilet facility between rooms
- rooms 45 have an en suite shower facility (no toilet)
- room 29 has an en suite toilet
- room 37 has a toilet within the room screened by a curtain
- room 41 has an en suite toilet
- rooms 18 and 21, 49 and 51, 50 and 52 had adjoining doors that had been secured/locked
- two sitting rooms, the courtyard and Lennon rooms (shared with day hospital clients during music/activity sessions)
- one dining room (shared with day hospital clients)
- one treatment room
- a hairdressers room (shared with day hospital clients)
- a prayer room

Other rooms within the centre included:

- a laundry room
- staff rooms, toilets and changing facilities

- two administration offices
- a clinical room
- a sluice room
- a utility room
- tea room
- a cleaners' store
- a family room
- a main kitchen, pantry and dry goods store

An enclosed courtyard and sheltered seating area for smoking was available to residents and shared with day hospital clients.

## Location

The centre is located on an elevated site on the outskirts of Ramelton village, off the Letterkenny road in County Donegal. It is located on the same site as a Health Centre, is next to a church and opposite a primary school.

<b>Date centre was first established:</b>	22 June 1981
<b>Number of residents on the date of inspection</b>	27 (plus one resident in hospital)
<b>Number of vacancies on the date of inspection</b>	2

<b>Dependency level of current residents</b>	<b>Max</b>	<b>High</b>	<b>Medium</b>	<b>Low</b>
<b>Number of residents</b>	19	4	3	1

## Management structure

Ramelton Community Hospital is operated by the HSE and the nominated person on behalf of the provider is Kieran Doherty, General Manager. The Person in Charge is Philomena Gallagher, Director of Nursing who manages the centre on a day-to-day basis. She is supported by clinical nurse managers, staff nurses, care assistants, ancillary staff (referred to as multi-task attendants) and a range of administrative and clerical staff.

<b>Staff designation</b>	<b>Person in Charge</b>	<b>Nurses</b>	<b>Care staff</b>	<b>Catering staff</b>	<b>Cleaning and laundry staff</b>	<b>Admin staff</b>	<b>Other staff</b>
<b>Number of staff on duty on day of inspection</b>	1	4	3	2	3	2	*3

\* day hospital

## Summary of findings from this inspection

This was an announced registration inspection which took place over two days and was the second inspection of the centre by the Authority.

As part of the registration process the provider has to satisfy the Chief Inspector of Social Services that he/she is fit to provide the service and that the service will comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended). As part of the application for registration, the provider was requested to submit relevant documentation to the Authority including completion of the Fit Person Self Assessment document. The documentation was reviewed by inspectors to inform the inspection process. In order to assess the fitness of the provider and the person in charge, "fit person" interviews were held.

Since completing the fit person self assessment, a number of initiatives had been taken to improve services. These included greater involvement by the provider in the day-to-day operation of the centre. The provider also said he was undertaking a review of all community hospitals in Donegal in line with the required standards and that a submission to the estates department capital development programme had been made in this regard. Other improvements included a policy implementation group that had been set up to develop and implement relevant policies and procedures, the development and provision of an information booklet, furniture and allocation of family room for residents. A painter had also been engaged to attend to the décor along corridors.

The inspection methodology also included discussions with residents, relatives, the provider, the person in charge, nursing, caring and catering staff, observation of care practices and examination of records and the premises. The provider had applied for registration for 30 residents and at the time of inspection, there were 27 residents being accommodated in the centre, of whom, 26 were over 65 years of age.

The overall view of inspectors was that the provider and person in charge had good knowledge of the relevant legislation and Standards. Despite evidence of good practice and a commitment by the centre's management and staff team to continually work to improve the quality of the service that residents received, much work was needed in order to achieve full compliance. Inspectors assessed the progress made in respect of the nine requirements highlighted in the Action Plan of the previous inspection report of the centre. Although some action had been taken, many issues remained outstanding. Actions not fully addressed related to risk management, staff training, the premises and the statement of purpose. These issues are discussed within this report and are restated within the Action Plan at the end of this report.

In the main, residents and relatives were complimentary of the care provided and of the facilities available within the hospital. Inspectors observed staff interacting with residents and relatives in a caring and enabling manner. Residents spoke highly of staff and referred to them as being 'approachable' and 'kind'.

The Action Plan at the end of this report identifies areas where improvements are needed to meet the requirements of 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*.

### **Comments by residents and relatives**

Inspection questionnaires were completed by eight residents and seven relatives and had been forwarded to the Authority prior to the inspection. In addition, inspectors ascertained the views of a number of residents and relatives during the inspection.

In general, the views were positive. Residents expressed satisfaction with the quality, quantity and choice of food provided. They told inspectors that they felt safe and well cared for and gave a positive account of life in the centre.

Residents and relatives confirmed that they knew how to raise any issue or concern and said they would have no hesitation in talking to the nurses or the person in charge in that regard.

## Overall findings

### 1. Governance: how well the centre is organised

**Outcome:** The centre is well organised and managed and complies with the requirements of the Health Act 2007, the regulations and standards.

**Good governance involves the effective and efficient deployment of resources in accordance with the stated purpose and function of the centre. Governance includes setting clear direction for the service, a commitment to continual improvement and having a system in place to effectively assess and manage risk.**

#### Evidence of good practice

During the fit person interviews, the provider, the person in charge and key senior manager demonstrated that they had good knowledge of 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*. The provider has a background in general and psychiatric nursing and has worked at a senior management level for approximately 10 years. He told inspectors that he was involved in compiling the fit person self assessment form and demonstrated knowledge of the content of the document during the fit person interview. He described the philosophy of care underpinning the centre and understood the roles of the provider and the person in charge. He communicated that there were sufficient arrangements in place to respond to requirements that required significant expenditure.

The person in charge, Philomena Gallagher is a registered nurse who works full time in the centre. She has worked in this centre since 1985, initially as a staff nurse and clinical manager prior to taking up the post of director of nursing. She has attended relevant training including a postgraduate diploma in front line management, a postgraduate diploma in community health, an honours degree in Nursing and plans to commence a postgraduate course in gerontology. She stated that she was involved in the completion of the fit person self assessment programme in consultation with the provider and staff. She and the staff facilitated the inspection process by having documentation available for examination.

Inspectors interviewed a key senior manager, Marion Howe who is a registered nurse who works full time in the centre and manages the centre in the absence of the person in charge. She has a postgraduate qualification in management and in gerontology. Through interview and general observation during the inspection, she demonstrated that she had the necessary knowledge and competencies to carry out the duties and responsibilities of this role.

Correspondence was received by the Authority dated 24 February 2010 from the HSE State Claims Agency confirming that the centre had been indemnified by the State.

An up-to-date directory of residents in relation to each resident in the designated centre in an electronic and manual format was maintained and available to inspectors when requested.

A comprehensive emergency plan dated February 2011 was available specific to this centre and the staff members.

Residents' finances were found to be managed in accordance with regulations and best practice.

A written operational policy and procedure relating to the making, handling and investigation of complaints from any person about any aspects of service, care and treatment provided in, or on behalf of a designated centre was available and well advertised. The record/template detailing information required in line with the operational policy and procedure has since been improved to include timeframes, acknowledgements, and the outcome of the complaint as to whether or not the complainant was satisfied.

### **Some improvements required**

An allegation of abuse had been investigated and managed in accordance with the centre's policy. However, the Chief Inspector of Social Services had not been informed of this incident and of a pressure sore within the prescribed timeframe.

The statement of purpose required amendment in relation to matters listed in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended). The statement of purpose was discussed with the provider and person in charge, as it needed to include the services of the designated centre as a separate entity from the day hospital and to include facilities, rooms, and whole time equivalent staffing levels for residents in the designated centre.

The provider and person in charge told inspectors that a contract of care was with solicitors for review and a contract with each resident had not been agreed within one month of or since admission to the designated centre.

A resident's guide which included a summary of the statement of purpose; the provision of services and facilities to residents; the most recent inspection report; a summary of the complaints procedure (provided for in Regulation 39); and the address and telephone number of the Chief Inspector was available. However, because the statement of purpose required amendment, the terms and conditions in respect of accommodation to be provided for residents and a standard form of contract for the provision of services and facilities to residents was not available or agreed. The resident's guide was therefore incomplete.

Some of the written and operational policies listed in Schedule 5 such as the management of risk, the creation of, access to, retention of and destruction of records, behaviour management and the prevention, detection and response to abuse had not been implemented in practice and were in a draft format.

Policies were mainly generic and were not tailored to reflect specific practices described in this centre to guide staff.

## Significant improvements required

While there was a corporate risk management policy and procedure this was not specific to the centre and had not been implemented throughout the centre. A health and safety statement was available but had not been updated or implemented in practice.

A record of identified risks was available. However this file was incomplete and there was little evidence found that recorded measures had been implemented or applied to reduce or address identified risks. For example, a lack of mandatory training and appliances cluttering floor areas was identified in February and June 2010. Adequate measures to address these risks had not been implemented. The provider and person in charge were made aware of this during the inspection.

Risks identified by inspectors included the following:

- all staff had not received mandatory training including fire safety and evacuation, manual handling and food hygiene in line with best practice and legislation
- risk assessment forms were incomplete and there was no evidence that identified risks had been managed appropriately
- a record of monthly falls was recorded however it was not evident if measures were in place and were reviewed or if measures were put in place to address findings
- a resident in a wheelchair found it difficult to negotiate a safe path from the bedroom to the dining room as the route contained hoists, a hot food trolley and a number of staff who were serving the lunch time meal
- the room storing unlocked refrigerated medicines had a key pad lock and the code to this room was known to unauthorised staff who had access to prescription drugs/medication
- the external fire assembly point was located opposite the entrance to the centre. This area was small and if occupied by dependent residents and staff it may obstruct access by emergency services
- double doors from the kitchen onto the corridor were ill-fitting and would not contain the spread of fire in the event of incidents in this area, compartmentalisation in this corridor was minimal
- inspectors were informed by the person in charge that instructions from the fire officer was that an emergency button/control was to be fitted in the kitchen to knock off gas in the event of an emergency and smaller fire extinguishers were to be available for safe staff handling
- hand rails were limited and provided along one side of main corridors
- floor covering was in poor condition and floor tiles were missing in areas
- some radiators along corridors were very hot to touch despite thermostats in place
- the fixed bath height at 33.5 inches above floor level is not ergonomically suitable, it could not be used by independent residents and could only be accessed by using a hoist and staff assistance. This bath facility was inadequate and posed a risk to residents and staff manoeuvring the hoist in a restricted environment
- the day hospital and physiotherapy department are located within the centre, and people using and transporting people to these services from the community had open access into the residents' home when attending these services on daily basis, Monday to Friday. Inspectors noted that visitors had not entered or recorded visits and residents' facilities such as the internal courtyard, dining room, bathrooms and toilets were used by day hospital clients.

Other environmental hazards were found that posed risks to residents circulating internally and externally. Internal risks included a build up of equipment obstructing corridors and circulating areas used by residents. Work practices included staff leaving bed-round trolleys and linen equipment outside resident rooms resulting in handrails not being accessible and residents having difficulty getting around mobile trolleys safely. One resident was observed trying to negotiate past three bed-round trolleys and two linen skips which had been stored along a main corridor.

A lack of appropriate safe storage areas for hoists was found. Equipment including hoists were stored on a corridor obstructing safe access to one resident's room, the tearoom and the newly designated family room. Unattended laundry trolley's obstructing the limited space was also found in this area during busy times, as the linen rooms were also located in this area.

External risks included narrow and uneven paving in the internal courtyard, covers of service points were damaged, potholes in the driveway and a low-level perimeter fence that was in a poor state of repair and broken in parts.

Inspectors found that evacuation procedures, records regarding testing of the fire alarm detection system, extinguishers and equipment and training were in place. However, adequate precautions had not been taken for containing fire as many bedroom doors and the main kitchen doors were warped and unable to close properly. The provider told inspectors that all doors were due to be replaced. The person in charge informed inspectors that the fire officer had identified this requirement previously.

The Authority had received correspondence dated 31 August 2010 in relation to the planning and development regulations. However, this did not meet the requirements of the Health Act 2007, (Registration of Designated Centres for Older People) Regulations 2009 (as amended). A declaration from a competent person confirming that the premises are in substantial compliance with building controls and fire safety legislation had not been submitted.

## 2. Quality of the service

**Outcome: Residents receive a good standard of service, appropriate treatment and are treated with courtesy and respect.**

**A quality service is one where residents are protected from harm or abuse, where practice is person-centred, where rights are protected, where residents are enabled to play an active part in the centre and where management, staff and residents work together towards continuous improvement.**

### Evidence of good practice

Information concerning current affairs, local matters, voluntary groups, community resources and events was provided. Daily and weekly newspapers were available to residents and arrangements were in place to receive visitors, go on outings with friends and family, and home visits. A karaoke singer entertained a group of residents and day hospital clients on one afternoon and mass was celebrated during the inspection. Both events were held in the courtyard sitting room. Musicians had been arranged to come to the centre during March and a storyteller was planned to visit during the Bealtaine Festival in May.

Inspectors found that staff had a detailed knowledge of residents' care needs and observed a friendly and supportive relationship between staff, residents and relatives.

Written operational policy and procedures relating to residents' fees and personal property and possessions were available and staff demonstrated they were competent in this regard. Residents' possessions and personal clothing were maintained in a respectful manner.

Inspectors saw that residents were provided with choices in relation to the main meal, deserts and refreshments. The food was prepared and cooked from fresh, was well presented and in portions suitable to residents' appetite. The quality of food was described as "good" and there was extra food and/or supplements available daily. Fresh drinking water, milk and juices were provided to residents throughout the day and hot drinks were available between meals and on request. An inspector spoke with the cook on duty who was knowledgeable about her role and of residents' dietary needs and wishes.

There was a detailed policy and procedure on elder abuse. The staff training records showed that the training on elder abuse was provided. Feedback from the staff on the training and response to abuse was positive and during discussion with the inspector, staff were knowledgeable about reporting mechanisms and what to do in the event of a disclosure about actual, alleged, or suspected abuse.

A local hairdresser attended the centre regularly and residents were complimentary of this service. A laundry service was available within the centre and arrangements were in place for residents to have their personal clothes laundered within the fee.

## Some improvements required

A private area (previously a single bedroom) had recently been made available for residents to receive visitors separately. This room required further modification to enable residents to meet relatives in private. Inspectors noted that the door did not close fully and bedroom furniture and fittings were still in place.

An environmental health inspection took place on the 14 September 2010 and non-compliant areas were reported. The person in charge told inspectors that most of these matters had been addressed. Inspectors noted that while some staff involved in catering had received training pertinent to this role, relief staff such as multi-task attendants did not and had recently been working in the kitchen to cover sick leave.

## Significant improvements required

Residents' rights, to privacy, dignity and choice were not protected in all circumstances and opportunities for residents to be fully consulted were not provided. A day hospital is located within the centre. Entrance to the day hospital is via the same entrance to the centre. The person in charge said that she has responsibility for this service and that up to 18 clients attended the day hospital daily. Inspectors found that day hospital clients had a significant impact on the lives of residents in this centre and examples of this included the following:

- day hospital clients used residents bathroom and toilet facilities, as indicated in the last inspection report
- day hospital clients shared the designated dining room and mealtimes were at set times for residents and day hospital clients to facilitate services, limiting resident choice and person-centred care. During this inspection the dining room was seen to be able to accommodate a maximum of 17 residents at lunch time during one sitting. The remaining residents (10 on the day) had their lunch in the sitting rooms or bedrooms. Difficulties may arise in the event that 30 residents (application for 30 people) choose/wished to dine in the dining room
- day hospital clients walked through the courtyard sitting room occupied by residents to access the internal courtyard and smoking area
- day hospital clients, people attending physiotherapy, taxi-drivers and escorts all entered the centre (and the resident's home) freely and without challenge by staff.

Other examples whereby the quality of the service negatively impacted on residents' were as follows:

- some multiple occupancy bedrooms had reduced in occupancy. However, screening curtains had not been altered to increase residents individual space, instead vacant spaces was used for equipment storage
- locks between an adjoined multiple-occupancy bedroom via en suite were not functioning many bedroom doors and wardrobe doors were warped and unable to close properly
- lockable facilities were not available in all bedrooms
- communal sitting rooms lacked practical assistive furniture such as coffee/drinks tables and immobile residents were dependent on staff to assist them in accessing drinks

- the Lennon sitting room was congested with little space to move due to the placement by staff of residents who primarily used large modified/specialised chairs
- the overall state of repair and décor of the centre was poor and hospital like rather than home-like. There was little identifiable or orientation features along corridors and on individual doors
- care was primarily task orientated and institutional despite efforts made by staff with residents to personalise some bedrooms with pictures and personal items
- household staff were seen working and hovering in sitting rooms while residents were being assisted into these rooms and while they were in the room

A designated activity staff member was included on the staff rota. However, this person had responsibility for assisting clients in the day hospital daily resulting in an activities programme being offered to residents from 14:00 hrs to 15:30 hrs Monday to Friday. Inspectors saw that activities at this time were not exclusive to residents as day hospital clients were also involved. While other staff were involved in assisting residents with their general care needs, they did not engage residents in person-centred and stimulating activities. Inspectors noted that the dedicated activity staff member had been involved in holding a residents' focus group and in the assessment of residents' social history. However, a lack of opportunities to implement specific and individual activities was found. Inspectors were told by residents and staff that there were limited activities available particularly at weekends. This is a recurrent issue which was identified as requiring improvement in the last inspection and is again restated in this report.

### 3. Healthcare needs

**Outcome: Residents' healthcare needs are met.**

**Healthcare is integral to meeting individual's needs. It requires that residents' health, personal and social care needs are assessed and reviewed on an ongoing basis, within a care planning process, that is person centred. Emphasis is firmly placed on health promotion, independence and meaningful activity.**

#### Evidence of good practice

Records of admissions, doctors' visits, health care referrals and follow-up appointments were maintained in a safe and accessible place.

Inspectors found that there was a pre-admission procedure in place to assess residents prior to admission. The person in charge or deputy spoke with each resident and where appropriate his/her representative, the referral source/hospital and obtained as much documentation as possible to ensure that they had good knowledge of each resident's needs prior to admission.

Resident files showed that their health, personal and social care needs were assessed and reviewed on an ongoing basis. A proactive approach to health promotion had been adopted that included monitoring of blood pressure, temperature, pulse and weight. Flu vaccines were offered and screening of blood and urine was evident in the medical notes reviewed.

Entries in care records indicated that residents had access to a general practitioner (GP) as required and an on call emergency service was available. Allied health professional services including physiotherapy and chiropody, occupational therapy, dietetics, speech and language therapy, optician and dental treatment were available to residents within the centre. When residents had to access such services externally, transport to out-patient appointments or clinics was arranged and facilitated by the care team.

A medication management policy was in place. It suitably addressed the procedure for prescribing, administration, crushing, storing and disposal of medication. If crushed medications were required by a resident, this was prescribed by the doctor. Errors were recorded and reported. Nursing staff demonstrated a good knowledge of medication management and told inspectors that they had received education on medication management. Inspectors reviewed the procedures in place for the management of controlled drugs and found they were well managed, with records to indicate that regular checks were carried out by staff members at the changeover of each shift. The person in charge carried out weekly audits to review areas such as medication administration and drug stock levels.

There was a detailed policy and procedure on elder abuse. Good links with the psychiatry of old age and community psychiatry team was in place. The senior social worker/elder abuse case worker was actively involved in recently reported incidents. Feedback from

staff during discussion with inspectors, demonstrated that they were knowledgeable about reporting mechanisms and what to do in the event of a disclosure about actual, alleged, or suspected abuse.

There was a policy for end of life care and the person in charge said they had good links with the palliative care team. There were no residents requiring end of life care at the time of this inspection.

Evidence-based assessment tools were used to inform practice and improvements in recording practice had been made since the last inspection in order to capture ongoing assessments in the care planning process. Resident's care plans were updated regularly to include their changing needs described by staff. Resident records were held electronically and in hardcopy. Inspectors noted that specific documentation held electronically took a long time to retrieve. The staff agreed and were to follow up on this finding.

### **Some improvements required**

A comprehensive draft health promotion policy was in place and inspectors saw examples of staff supporting residents to be independent whilst maintaining their safety. However, while there was evidence of some proactive measures to protect residents from harm, six highly dependent residents that used restrictive equipment including alarm mats, lap belts and reclining chairs, were left unsupervised in the Lennon sitting room for lengthy periods after personal care had been provided. These residents were observed by inspectors to have had little staff interaction except when staff escorted another resident in/out of the room. There was little evidence of meaningful activities and the room was congested as a result of specialised equipment used by these residents. Two policies were found in relation to the use of restraint. Inspectors noted these to be generic policies that included language such as "cot sides" and harness" and found they were not tailored and specific to practice described by staff in this centre.

Documentation in relation to accidents and falls audits was not clear to inform quality improvements. For example, restraint measures in place and any alternative less restrictive interventions considered were not recorded to identify the risks of having or not having restraint measures in place or any alternative less restrictive interventions considered but not adopted to achieve the necessary protection for residents.

## 4. Premises and equipment: appropriateness and adequacy

**Outcome:** The residential care setting provides premises and equipment that are safe, secure and suitable.

A good physical environment is one that enhances the quality of life for residents and is a pleasant place to live. It meets residents' individual and collective needs in a comfortable and homely way, and is accessible, safe, clean and well maintained. Equipment is provided in response to the assessed needs of each of the residents and maintained appropriately.

### Evidence of good practice

The centre was clean and warm and directional signage to emergency exits was prominently displayed in corridors. Closed Circuit Television cameras (CCTV) were used to monitor the points of entry and exit from the centre which did not intrude on residents' privacy.

Room temperatures throughout the centre were satisfactory and water temperatures were below 43<sup>0</sup> C. The person in charge told inspectors that a generator was available in the event of a power failure.

The main kitchen was spacious and well equipped. It had adequate storage facilities for dried foods and there was a plentiful supply of fresh fruit, vegetables and meat. The dining room adjoins the main kitchen. This room was brightly painted and had six large windows with views onto the front of the centre. Catering staff had decorated the dining room for St Patrick's Day with various symbolic and picturesque items including shamrocks and leprechauns. Residents were very complimentary of the efforts made by staff to celebrate festive occasions and meals provided. Tables were attractively set and staff were available to assist as required.

Assistive devices including tracking and mobile hoists, assistive shower chairs, modified wheel chairs, electrically operated beds and pressure relieving equipment was available to residents and had been well maintained.

### Some improvements required

The provider and person in charge were aware that the care environment and premises presents considerable challenges to comply with 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*.

A number of requirements were highlighted to the provider, the person in charge and clinical nurse manager. These included but are not limited to the following:

- internal signage throughout the centre required attention, for example, one resident's room had a fixed sign on the door stating isolation ward, however this resident was not being isolated and did not have an obvious infection
- room numbering throughout the centre was unclear and identification of rooms was not obvious
- the centre's facilities were shared with day hospital clients
- paintwork was chipped and worn on walls, ceilings and skirting boards in many areas, tiles were missing around toilets in a number of en suites and bathroom facilities
- ventilation was poor in the cleaners' room despite the provision of mechanical ventilation; this room did not have a wash hand basin
- ventilation was poor in the assisted shower room (room 30)
- the space generated from the reduction in multiple occupancy rooms had assistive equipment and chairs stored in them which left little room for residents' use
- a lack of storage was evident throughout the centre resulting in equipment and trolleys stored in residents' individual and communal spaces
- maintenance work was not carried out within a reasonable timeframe, the outside store room was inaccessible once inside due to poor housekeeping and lack of disposal of unused items
- waste drain/sockets were missing from an ensuite shower and the door was unable to close
- some bedroom furniture including lockers, wooden shelving and wardrobes were worn and in poor condition
- soap and hand towel dispensers were not in all en suite toilet facilities
- one resident's room had a toilet facility separated/screened from the room by a curtain; the inspector noted that this facility lacked privacy and did not have a window or ventilation separate from the room
- the ladies toilet (green door) had two locks, one of which could not be undone in an emergency. The floor covering was worn and in need of replacement
- inspectors were told that the shower in the male toilet was to be reinstated, this male toilet had a toilet and wash hand basin. The light shade over the wash-hand basin was removed and the light was not working
- residents' bathroom, shower room and toilets were used by day hospital clients and as a result these facilities were limited Monday to Friday and may not always be available at a time preferred by residents
- the enamel on the bath was chipped which may pose a potential risk of cross infection
- the bath was unsuitable for independent, it did not have a lock and a wall was damp with paint flaking off around pipes
- room 17 was used for storage of chairs, the door did not close fully and ventilation was poor on entry
- some taps had no distinctive indicator to distinguish hot tap from cold tap, and some tap fittings were loose
- light covers/shades were missing from lights along corridors
- single rooms were small in size and less than 9.3m<sup>2</sup> which is restrictive when using or providing assistive equipment for dependent residents. Secured connecting doors were in place between some sets of single rooms

- wall mounted units were seen in some residents rooms which were not fitted with locks/latches and could not be closed securely. Some of these units were at bedsides and were at head height when in bed
- locks were not working within some en suites shared between multiple occupancy rooms
- bedroom and wardrobe doors were unable to close in some rooms which detracted from efforts to create a home-like atmosphere
- the sluice room was poorly ventilated despite an open window and the sanitary wear, paintwork and floor tiles were in disrepair
- the laundry room was unlocked while unsupervised, it was small, did not have a wash-hand basin, was poorly ventilated and there was inadequate space available to separate clean and soiled laundry, or to iron and sort laundry. Personal laundry was provided for residents within the fee and general laundry was sent out of the centre for laundering. The person in charge told inspectors that consideration to provide an external facility had been proposed
- a windowpane in the oratory was cracked
- the Lennon sitting room had double doors out into an internal courtyard. This exit was unfinished as the architrave was not painted and the ramp proposed on the last inspection had not been completed. This exit to the courtyard involved a step down from room occupied primarily by immobile residents in modified chairs with wheels
- the courtyard sitting room floor was worn on exit to the courtyard
- the hairdresser's room did not have a separate wash-hand basin
- a call bell system was provided in each bedroom and bathroom and toilet to support residents' safety. Residents said they were satisfied that staff responded when they rang the call bell and inspectors noted the call bells were answered promptly. However, inspectors noted that call bell facilities were not available in all en suite facilities
- the main light in some bedrooms had been repositioned from the centre of ceilings to over-bed heads
- external guttering was in need of cleaning and parts of footpaths were covered in moss

### **Significant improvements required**

A programme of routine maintenance and renewal of the fabric and decoration of the premises had not been completed since the last inspection or within the timeframes set by the provider.

## **5. Communication: information provided to residents, relatives and staff**

**Outcome: Information is relevant, clear and up to date for residents.**

**Information is accessible, accurate, and appropriate to residents' and staff needs. Feedback is actively sought from residents and relatives and this informs future planning and service provision. Information is recorded and maintained in accordance with legal requirements and best practice and is communicated to staff on a need to know basis to ensure residents' privacy is respected.**

### **Evidence of good practice**

The involvement of the person in charge in the day-to-day running of the centre facilitated good communication between residents and staff. Individual roles and responsibilities were clearly defined and staff were able to describe to inspectors the reporting arrangements and levels of accountability within the organisation. Residents, relatives and staff spoke positively about the open approach to communication and told inspectors that they felt able to approach staff or any member of the management team if they had a concern.

Good communication arrangements were in place with regard to ensuring the up to date healthcare needs of residents. This was conducted at "handover meetings" which took place when there was a shift change in the staff group and case conferences between multidisciplinary team members was noted. Records showed daily communications between staff and regular staff meetings where practice-related issues were discussed such as the need to involve all staffing in resident activities and a review of restraint and fall risk.

Feedback was actively sought from residents and relatives informally on a daily basis and in residents' committee meetings. Minutes were available and shared with relevant people.

A policy on the provision of information was available and described the different methods to be adopted in the centre. Residents communicated that they felt staff were available to talk to them when needed and that information on events such as appointments were conveyed to them in a timely way.

A management group consisting of managers from all HSE designated centres had been set up to develop, review and implement policy documents in line with best practice, shared experiences and regulatory requirements. Learning opportunities between centres were shared and communicated in this forum. Management staff had been proactive at revising and developing key policies and procedures to comply with the regulations, many had been implemented into practice and staff meetings held enabled staff to discuss practice issues and policies.

Local and national newspapers were provided and a mobile telephone was available for residents' use.

Confidential records had been maintained in a safe and secure manner.

Inspectors were told by the person in charge that the local fire brigade had visited, received a plan of the centre and were familiar with its layout in the event of emergencies.

### **Some improvements required**

All staff employed and working in the designated centre and the day hospital were included on the roster available and some staff worked in both areas on a regular basis and to cover leave such as sick leave. Therefore it was unclear as to exact staffing levels and skill mix provided to residents in the designated centre and inspectors were told that planned rosters changed frequently.

## 6. Staff: the recruitment, supervision and competence of staff

**Outcome: Staff are competent and recruited in sufficient numbers to meet residents' needs.**

**Staff numbers and skill-mix are determined by the size and complexity of the service and there should be sufficient competent staff on duty, both day and night, to meet the needs of residents. Robust recruitment and selection procedures ensure the appointment of suitably qualified and experienced staff. Staff are supported in their work by ongoing training and supervision.**

### Evidence of good practice

The person in charge and deputy were on duty during this registration inspection. They were knowledgeable of residents' needs and abilities, and were aware of residents' previous lifestyles and leisure pursuits. Both the person in charge and deputy were actively engaged in the day to day management of residents' healthcare and staff supervision. A management structure and team was in place to support their roles. Different grades of staff were aware of their reporting relationships and told inspectors that they felt well supported by the person in charge, clinical managers whom they could approach when they needed advice or assistance.

The person in charge had worked in the centre for 20 years and deputy had worked in the centre for 17 years. They had attended relevant training and education courses to enhance her roles and professional development.

Staff interviewed demonstrated a clear understanding of their roles and responsibilities, while acknowledging the lack of mandatory training available due to management difficulties in releasing staff and providing cover. Inspectors observed staff speaking to residents in a gentle, professional and friendly manner. Staff described reporting mechanisms in place to ensure appropriate delegation, supervision and competence in providing care to residents. Nurses and carers were identified and allocated to a number of individual residents to enhance consistency in care. Discussion with staff and observation throughout the inspection confirmed that there was good interaction and direction provided by the person in charge and deputy in overseeing the delivery of person-centred care. Staff demonstrated good knowledge of residents' individual preferences and needs. Inspectors noted that staff were caring to residents and treated them with great respect and affection.

Inspectors interviewed the household staff and found them to be knowledgeable in the principles and practice of infection control and the safe use of cleaning products. Cleaning materials were stored safely in a lockable store room when not in use. Inspectors observed that equipment such as commodes and wheelchairs were clean. The household staff took pride in their work and knew residents well. Inspectors spoke with the laundry staff member who was knowledgeable about the various processes for different categories of laundry.

Sheets, towels and blankets were sent to a contracted laundry. Residents' clothing was laundered on site, or by family members.

During discussion with inspectors, care staff were found to be familiar with the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

### **Some improvements required**

The majority of nurses (15) on the rota had current recorded evidence indicating they were registered with An Bord Altranais with the exception of three nurses. The current professional registration of the three nurses was subsequently submitted to the Authority.

The recruitment, selection and vetting of staff had been carried out centrally and a sample containing the range of documents to be held in respect of persons managing or working at a designated centre were available for inspection. Three staff files were reviewed by inspectors who found one file incomplete and not containing a third reference.

### **Significant improvements required**

Following the last inspection, staff appraisal was to be introduced to monitor staff performance and training needs. While this process had been developed it had not yet been implemented with all staff.

Inspectors were informed that agency staff were not contracted to work in this centre. While adequate staffing levels and skill mix were present on the days of the inspection and residents confirmed that their needs were met promptly, arrangements to cover annual leave, sickness and other unplanned absences were limited due to the HSE recruitment moratorium. Examples of this included the laundry person who was deployed to the main kitchen, the grounds person and activity person who were deployed as care attendants to cover sick leave, therefore impacting on other services. The activity person works week days and mainly in the day hospital and has approximately one and a half hours in the designated centre before helping with tea-time. Residents were seen to have limited access to meaningful activities and one to one contact. Care staff were otherwise occupied each morning to engage with residents once personal care had been attended to and residents assisted to the sitting rooms. Background music and DVD's were playing in communal rooms. While residents seemed disinterested in both and were keen to talk with inspectors.

Inspectors were told by the provider and person in charge that staff within the other community hospitals had been redeployed to the centre to address staff shortages when needed. They anticipated that meeting the Authority's standards would be challenging but said they wanted to provide quality services to residents.

## Closing the visit

Feedback was given to the provider on the second afternoon of this inspection. At the close of the inspection visit, a feedback meeting was held with the person in charge and key senior manager to report on the inspectors' findings, which highlighted both good practice and where improvements were needed.

### Acknowledgements

The inspectors wish to acknowledge the cooperation and assistance of the residents, relatives, provider and staff during the inspection.

#### *Report compiled by:*

Sonia McCague

Inspector of Social Services  
Social Services Inspectorate  
Health Information and Quality Authority

25 May 2011

Chronology of previous HIQA inspections	
Date of previous inspection	Type of inspection:
<b>9 September 2010</b> <b>Regulatory Monitoring Visit</b>	<input type="checkbox"/> Registration <input checked="" type="checkbox"/> Scheduled <input type="checkbox"/> Follow up inspection  <input type="checkbox"/> Announced <input checked="" type="checkbox"/> Unannounced

### Provider's response to inspection report \*

<b>Centre:</b>	Ramelton Community Hospital
<b>Centre ID:</b>	615
<b>Date of inspection:</b>	15 and 16 March 2011
<b>Date of response:</b>	27 June 2011 and 22 August 2011

### Requirements

These requirements set out what the registered provider must do to meet 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*.

#### 1. The provider has failed to comply with a regulatory requirement in the following respect:

The identification and assessment of risks throughout the designated centre and the precautions in place to control risks had not been completed. Refer to in the body of this report.

Not all reasonable measures to prevent accidents to any person in the designated centre and in the grounds of the designated centre had been completed in line with the health and safety policy.

Risks identified by inspectors included the following:

- all staff had not received mandatory training including fire safety and evacuation, manual handling and food hygiene in line with best practice and legislation
- risk assessment forms were incomplete and there was no evidence that identified risks had been managed appropriately
- a record of monthly falls was recorded. However, it was not evident if measures

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

were in place were reviewed or if measures were put in place to address findings

- a resident in a wheelchair found it difficult to negotiate a safe path from the bedroom to the dining room as the route contained hoists, a hot food ban brie and a number of staff who were assisting with the serving of the lunch time meal
- the room storing unlocked refrigerated medicines had a key pad lock. However, the code to this room was known to unauthorised staff who had access to prescription drugs/medication
- the external fire assembly point was located opposite the entrance to the centre. This area is small and if occupied by dependent residents and staff it may obstruct emergency services access and entry
- double doors from the kitchen onto the corridor were ill fitting and would not contain the spread of fire in the event of incidents in this area, compartmentalisation in this corridor was minimal
- inspectors were informed that an emergency button/control was to be fitted in the kitchen to knock off gas in the event of an emergency and smaller fire extinguishers were to be available for safe staff handling
- hand rails were limited and provided along one side of main corridors
- floor covering was in poor condition and floor tiles were missing in areas
- some radiators were very hot to the touch despite thermostats in place
- the fixed bath height at 33.5 inches above floor level is not ergonomically suitable, it could not be used by independent residents and could only be accessed by using a hoist and staff assistance. This bath facility is inadequate and poses a risk to residents and staff manoeuvring the hoist in a restricted environment
- the day hospital and physiotherapy department are located within the centre, and people from the community had open access into residents home when attending these services on daily basis, Monday to Friday. Inspectors noted that visitors had not entered or recorded visits and residents' facilities such as the internal courtyard, dining room, bathrooms and toilets were used by day hospital clients
- a build up of equipment obstructing corridors and circulating areas used by residents was found due to work practices
- handrails not being accessible and residents having difficulty getting around due to work practices
- a lack of appropriate safe storage resulted in bulky equipment being stored along corridors obstructing safe access to resident's room
- narrow and uneven paving in the internal courtyard, covers damaged of service points and potholes in the driveway
- a low-level perimeter fence was in a poor state of repair and broken in parts.

**Action required:**

Put in place a comprehensive written risk management policy and implement this throughout the designated centre.

**Action required:**

Ensure that the risk management policy covers, but is not limited to, the identification and assessment of risks throughout the designated centre and the precautions in place to control the risks identified including those outlined above.

<b>Action required:</b> Ensure that the risk management policy covers the arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents.	
<b>Action required:</b> Take all reasonable measures to prevent accidents to any person in the designated centre and in the grounds of the designated centre.	
<b>Action required:</b> Provide handrails in circulation areas and grab-rails in bath, shower and toilet areas.	
<b>Action required:</b> Provide safe floor covering.	
<b>Action required:</b> Provide training for staff in the moving and handling of residents.	
<b>Reference:</b> Health Act, 2007 Regulation 31: Risk Management Procedures Standard 26: Health and Safety Standard 29: Management Systems	
<b>Please state the actions you have taken or are planning to take with timescales:</b>	<b>Timescale:</b>

<p>Provider's response</p> <p>The hospital operates a risk register where all risks are identified/assessed and reviewed.</p> <p>1.1</p> <ul style="list-style-type: none"> <li>▪ the two remaining staff will receive fire training before</li> <li>▪ in-house evacuation procedures are on-going each month</li> <li>▪ manual Handling – Training ongoing and in-house training in the process of being arranged, all staff will be trained by</li> <li>▪ food hygiene – refresher hygiene course has taken place in April 2011 for seven staff which was given by catering manager. further food hygiene course will be held. Ongoing in-house refresher courses will continue.</li> </ul> <p>1.2</p> <ul style="list-style-type: none"> <li>▪ action plan now in place for all risk assessments</li> <li>▪ the DON carries-out a monthly audit of falls and follow-up discussion with staff. recorded on computer system</li> <li>▪ hot food trolley now goes in opposite direction to relieve congestion on corridors</li> <li>▪ locked medication refrigerator now in treatment room</li> <li>▪ Fire officer has advised that this is the correct area for fire assembly point.</li> <li>▪ all bedroom doors and the double kitchen doors will be replaced with fire doors</li> <li>▪ emergency button/control to knock of gas in kitchen will be installed. Appropriate fire extinguishers purchased</li> <li>▪ hand rails will be provided</li> <li>▪ Floor covering to be costed and to be added into Minor Capital Works for 2012/2013</li> <li>▪ contractor has completed the work and checked all thermostats</li> <li>▪ new locations for day hospital clients have been sourced and other alternatives discussed and a report will be compiled for the general manager</li> <li>▪ visitors encouraged to sign the visitors book</li> <li>▪ all staff have been made aware of keeping corridors and residents areas free from obstruction, back trolleys are always stored in clean utility room when not in use</li> <li>▪ sourcing extra storage for equipment being stored along corridors</li> <li>▪ Uneven paving in courtyard, damaged service covers and potholes in the driveway have been fixed</li> <li>▪ new perimeter fencing erected</li> </ul> <p>1.3</p> <p>A draft risk management policy exists which will be signed- off by the P.P.G Group prior to implementation.</p>	<p>December 2011</p> <p>Ongoing</p> <p>April 2012</p> <p>November 2012</p> <p>Complete</p> <p>Ongoing</p> <p>Complete</p> <p>Complete</p> <p>December 2011</p> <p>December 2011</p> <p>December 2011</p> <p>January 2012</p> <p>Complete</p> <p>January 2012</p> <p>Ongoing</p> <p>Complete</p> <p>August 2011</p> <p>Complete</p> <p>Complete</p> <p>September 2011</p>
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1.4	Draft risk management policy includes all of the above in risk register	December 2011
1.5	The arrangement for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents is included in the draft risk management policy and the risk and incident escalation guideline.	December 2011
1.6	All reasonable measures to prevent accidents to any person in the designated centre and in the grounds as indicated in the report will be addressed.	December 2011
1.7	Handrails will be addressed. A new shower with grab rails in the process of being installed. We have had two occupational therapists doing an assessment on the bathroom and shower room and we are awaiting their report and recommendations on same.	December 2011 December 2011  December 2012
1.8	Safe floor covering will be addressed through Minor Capital. A training plan for the moving and handling of residents is in place and five staff have been recently trained.	April 2012

**2. The provider has failed to comply with a regulatory requirement in the following respect:**

A number of requirements and deficiencies in the premises were highlighted to the provider, the person in charge and clinical nurse manager. These included but are not limited to the following:

- internal signage throughout the centre required attention
- room numbering throughout the centre was unclear and identity of rooms was not obvious
- the centres facilities were shared with day hospital clients
- paintwork was chipped and worn on walls, ceilings and skirting boards in many areas and tiles were missing around toilets in a number of en suites and bathroom facilities
- Ventilation was poor in the cleaners' room despite the provision of mechanical ventilation. This room did not have a wash-hand basin

- ventilation was poor in the assisted shower room (room 30)
- the space generated from the reduction in multi-occupancy rooms had assistive equipment and chairs stored in them which left little room for residents use
- a lack of storage was evident throughout the centre resulting in equipment and trolleys stored in residents individual and communal spaces
- the outside store room was inaccessible once inside due to poor housekeeping and lack of disposal of unused items
- waste drain/sockets were missing from an en suite shower and the door was unable to close
- some bedroom furniture including lockers wooden shelving and wardrobes were worn and in poor condition
- soap and hand towel dispensers were not in all en suite toilet facilities and floor tiles were missing around toilets
- one residents room had a toilet facility separated/screened from the room by a curtain, this facility lacked privacy and did not have a window or ventilation separate from the room
- the ladies toilet (green door) had two locks, one of which could not be undone in an emergency situation. The floor covering was worn and in need of replacement
- inspectors were told that the shower in the male toilet was to be reinstated, this male toilet had a toilet and wash-hand basin. The light shade over the wash hand basin was removed and the light was not working
- residents' bathroom, shower room and toilets were used by day hospital clients and as a result these facilities were limited Monday to Friday and may not always be available at a time preferred by residents
- the enamel on the bath was chipped which may pose a potential risk of cross infection
- the bath was unsuitable for independent use, the bathroom did not have a lock and one wall was damp with paint flaking off around pipes
- room 17 door did not close fully and ventilation was poor on entry
- some taps had no distinctive indicator to distinguish hot tap from cold tap, and some tap fittings were loose
- light covers/shades were missing from lights along corridors
- single rooms were small in size and less than 9.3m<sup>2</sup>
- wall mounted units were seen in some residents rooms which were not fitted with locks/latches and could not be closed securely
- locks were not working within some en suite shared between multi-occupancy rooms
- bedroom and wardrobe doors were unable to close in some rooms which detracted from efforts to create a homelike atmosphere
- the sluice room was poorly ventilated despite an open window. The sanitary wear, paintwork and floor tiles were in disrepair
- the laundry room was unlocked while unsupervised, it was small, did not have a wash hand basin, was poorly ventilated and there was inadequate space available to separate clean and soiled laundry
- a windowpane in the oratory was cracked
- the Lennon sitting room had double doors out into an internal courtyard. This exit was unfinished as the architrave was not painted and the ramp proposed on the last inspection had not been completed. This exit to the courtyard involved a step down from a room occupied primarily by residents in modified chairs with wheels
- the courtyard sitting room floor was worn on exit to the courtyard

- the hairdressers room did not have a separate wash-hand basin
- a call bell system was provided in each bedroom and bathroom and toilet to support residents' safety. Residents said they were satisfied that staff responded when they rang the call bell and inspectors noted the call bells were answered promptly. However, inspectors noted that call bell facilities were not available in all en suite facilities
- the main light in some bedrooms had been repositioned from the centre of ceilings to over bed heads
- external guttering was in need of cleaning and parts of footpaths were covered in moss

**Action required:**

Provide suitable premises for the purpose of achieving the aims and objectives set out in the statement of purpose, and ensure the location of the premises is appropriate to the needs of residents.

**Action required:**

Comply with the Planning and Development Acts 2000-2006 and any building byelaws that are in force.

**Action required:**

Ensure the physical design and layout of the premises meets the needs of each resident, having regard to the number and needs of the residents.

**Action required:**

Ensure that the maximum number of residents and the maximum number of residents accommodated in shared rooms in the designated centre does not exceed the number for which the designated centre is registered by the Chief Inspector of Social Services.

**Action required:**

Ensure the premises are of sound construction and kept in a good state of repair externally and internally.

**Action required:**

All parts of the designated centre should be kept clean and suitably decorated.

**Action required:**

Provide adequate private and communal accommodation for residents.

**Action required:**

Provide suitable communal space for residents for the provision of social, cultural and religious activities appropriate to the circumstances of the residents.

**Action required:**

Provide suitable facilities for residents to meet visitors in communal accommodation and a suitable private area, which is separate from the residents' own private rooms.

<b>Action required:</b> Ensure the size and layout of rooms occupied or used by residents are suitable for their needs and provide adequate sitting, recreational and dining space separate to the residents' private accommodation.	
<b>Action required:</b> Provide sufficient numbers of toilets, and wash-hand basins, baths and showers fitted with a hot and cold water supply, which incorporates thermostatic control valves or other suitable anti-scalding protection, at appropriate places in the premises.	
<b>Action required:</b> Make suitable adaptations, and provide such support, equipment and facilities, as may be required.	
<b>Action required:</b> Provide and maintain external grounds, which are suitable for, and safe for use by residents.	
<b>Action required:</b> Provide ventilation, heating and lighting suitable for residents in all parts of the designated centre.	
<b>Reference:</b> Health Act, 2007 Regulation 19: Premises Standard 25: Physical Environment Standard 28: Purpose and Function	
<b>Please state the actions you have taken or are planning to take with timescales:</b>	<b>Timescale:</b>
Provider's response: 2.1  The isolation sign that was on an individual resident's room has been removed as it is no longer required.  2.2  Discussion will be held with residents as to their views on how rooms are best identified. Some completed and the majority of residents stated they did have difficulty locating their rooms – we will now look at ways to identify all bedrooms. 2.3  New location for day hospital has been assessed and other options investigated. A report will be compiled for the General Manager.	Complete   Sept 2011 November 2011  January 2012

2.4	Painting on corridor complete. Further painting will be included in Minor Capital Works 2012/2013.	December 2012
	Replacement of tiles ongoing.	Ongoing March 2012
	Ventilation and wash-hand basin in cleaning room and ventilation in room 30 will be addressed.	Complete
	Wash-hand basin has been installed in cleaning room	Complete
2.5		
	In all cases, only residents own chair is stored beside bed in the space generated from the reduction in multi occupancy rooms.	December 2011
2.6		
	Trolleys stored in clean utility except when ward round is being done. Extra storage being sourced.	Complete
2.7		
	Outside store room now accessible.	June 2012
2.8		
	Waste drains have now been replaced and doors to be replaced as per recommendation of fire office	Complete Dec 2011
2.9		
	All lockers have now been replaced and are lockable. Wooden shelving and Wardrobes to be replaced.	Complete December 2012
2.10		
	Soap and hand towel dispensers installed in all en suites Missing floor tiles to be included in Minor Capital 2012/2013	February 2012
2.11		
	Ventilation has been installed Toilet facility in one room will be renovated	Complete December 2012
2.12		
	The ladies toilet has had the extra lock removed. Floor covering will be added to Minor Capital 2012/2013	Complete December 2011

<p>2.13</p> <p>Light shade over the wash hand basin has been removed. Shower in the male toilet is in the process of being re-instated. We have had this room assessed by occupational therapists and are awaiting their report</p>	<p>January 2012</p>
<p>2.14</p> <p>Refer to Point 2.3</p>	<p>Complete</p>
<p>2.15</p> <p>Enamel chipped on bath is caused by the use of the hoist and it is felt that the same would occur with a new bath. Stringent infection control measures are adhered too.</p>	<p>August 2011 December 2011</p>
<p>2.16</p> <p>A new lock will be fitted on bathroom door. (ordered) Occupational health have been here and carried out an assessment on the bath height etc. now awaiting their report and recommendations. Bathroom will be painted</p>	<p>August 2011</p> <p>June 2012</p>
<p>2.17</p> <p>Refer to point 2.8</p>	<p>Complete</p>
<p>2.18</p> <p>Taps with no distinctive indicator of hot and cold and loose fitting taps will be fixed/replaced as required</p>	<p>Complete</p> <p>December 2012</p>
<p>2.19</p> <p>Light shade covers that were missing from lights along corridors have been replaced.</p>	<p>Complete</p>
<p>2.20</p> <p>Single rooms were small in size and less than 9.3 metre square – estates will review and plan agreed with registered provider.</p>	
<p>2.21</p> <p>Wall mounted units which were present in some residents rooms with no locks have since been removed with the exception of one where the resident has requested that it be left in place.</p>	<p>June 2012</p>

<p>2.22</p> <p>Doors will be replaced.</p>	<p>June 2012</p>
<p>2.23</p> <p>Refer to Point 2.8.</p>	<p>December 2012</p>
<p>2.24</p> <p>The sluice room was poorly ventilated and in general disrepair. This will be included in Minor Capital Works 2012. Infection control sister from Letterkenny General Hospital has been here and carried out an assessment of what is required from sluice room and she will then liaise with the maintenance department re same.</p>	<p>December 2012</p>
<p>2.25</p> <p>Keypad for laundry door is being sourced by maintenance Laundry is small and poorly ventilated etc will be included in Minor Capital 2012. New ventilation installed on the 9<sup>th</sup> August 2011</p>	<p>December 2012</p>
<p>2.26</p> <p>Cracked window pane in oratory will be replaced</p>	<p>Complete</p>
<p>2.27</p> <p>Architrave on door into the courtyard completed. The ramp from the Lennon Room to the courtyard is being completed.</p>	<p>December 2012</p>
<p>2.28</p> <p>The Courtyard sitting room floor will be included in Minor Capital 2012 and will be risk assessed on a regular basis prior to completion</p>	<p>Complete</p>
<p>2.29</p> <p>Wash hand-basin in hairdressers has been installed</p>	<p>December 2011</p>
<p>2.30</p> <p>Call bell system for en suites will be provided</p>	<p>Complete</p>
<p>2.31</p> <p>The main light in some bedrooms had been repositioned from the centre of ceilings to over bed-heads – this was approved by technical services during electrical upgrade.</p>	<p>Complete</p>

2.32	Gutters have been cleared and moss treated.	January 2011
2.33	Suitable premises for the purpose of achieving the aims and objectives set out in the statement of purpose will be achieved with the relocation of day hospital services.	June 2012
2.34	HSE Estates have been informed of the requirements in this report. Minor Capital works have been identified and a programme of repair/replacement to comply with the Planning and Development Act 2000-2006 will be prioritised and agreed with the HSE Estates and the Registered Provider.	December 2012
2.35	Registered Provider has reviewed the Donegal Community Hospital's and a submission for minor capital development has been made to HSE Estates.	Complete
2.36	The maximum number of residents accommodated will not exceed the agreed thirty.	Ongoing
2.37	A programme of improvements is ongoing to ensure that the premises are kept in a good state of repair externally and internally.	Complete
2.38	Cleanliness is always maintained within the centre as a cleaning schedule is in place for all parts within the building.  A painting/decorating schedule will be included in the Minor Capital for 2012.	December 2012
2.39	Residents have private accommodation within their own bedrooms and the family room and communal accommodation is provided within the Lennon and Courtyard sitting rooms.	Complete
2.40	Refer to point 2.35	June 2012
2.41		

Refer to point 2.35	June 2012
2.42	
Family room is available for residents to meet visitors, wardrobe left in situ for family members to hang up their coats etc.	Complete
2.43	
Refer to point 2.35	December 2012
2.44	
Refer to point 2.35	December 2012
2.45	
Work being undertaken to address uneven paving and service point covers completed.	Complete
Potholes have been filled.	Complete
2.46	Complete
Technical services has been contacted and have arranged for the contractor who completed the work to check all thermostats.	
See 2.31.	December 2012
Ventilation work will be included in Minor Capital.	

**3. The provider has failed to comply with a regulatory requirement in the following respect:**

A declaration from a competent person confirming that the premises are in substantial compliance with building controls and fire safety legislation has yet to be submitted.

Bedroom doors and the main kitchen doors were warped and unable to close properly and limited compartmentalisation was provided along the kitchen corridor.

All staff had not received relevant fire safety training.

**Action required:**

Provide to the Chief Inspector, together with the application for registration or renewal of registration, written confirmation from a competent person that all the requirements of the statutory fire authority have been complied with.

<b>Action required:</b> Make adequate arrangements for detecting, containing and extinguishing fires.	
<b>Action required:</b> Provide suitable training for staff in fire prevention.	
<b>Action required:</b> Ensure, by means of fire drills and fire practices at suitable intervals, that the staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire, including the procedure for saving life.	
<b>Reference:</b> Health Act 2007 Regulation 32: Fire precautions and records Standard 26: Health and Safety	
<b>Please state the actions you have taken or are planning to take with timescales:</b>	<b>Timescale:</b>
<p>Provider's response:</p> <p>A letter from Technical Services regarding the declaration confirming that the premises are in substantial compliance with building controls and Fire Safety Legislation was e-mailed to the Inspector in April 2011 and an independent review of Fire Safety is currently underway.</p> <p>New fire doors to be replaced in accordance with direction from Fire Officer.</p> <p>The two remaining staff will receive fire safety training. Further dates for fire training have been allocated. In-house fire evacuation drills ongoing monthly.</p>	<p>Ongoing</p> <p>June 2012</p> <p>December 2011 Dec 2011</p>

**4. The provider has failed to comply with a regulatory requirement in the following respect:**

Residents' rights, to privacy, dignity and choice were not protected in all circumstances and opportunities for residents to be fully consulted were not provided.

A lack of opportunities to implement specific and individual activities was found.

The clients attending day hospital located and operated within the centre shared residents' facilities, limiting freedom of choice, availability and provision of facilities and services.

Facilities, practices and systems that negatively impacting on residents' included:

- the screening curtains in shared rooms had not been altered to increase residents individual space and was used for equipment storage

- locks between adjoined multi-occupancy rooms via en suite were not functioning
- many bedroom doors and wardrobe doors were warped and unable to close properly
- lockable facilities were not available in all bedrooms
- communal sitting rooms lacked practical assistive furniture such as coffee/drinks tables and immobile residents were dependent on staff to assist them in accessing drinks
- the Lennon sitting room was congested with little space to move due to the placement by staff of residents who primarily used large modified/specialised chairs
- the overall state of repair and décor of the centre was poor and hospital like, with little identifiable or orientation features along corridors and on individual doors
- care was primarily task orientated and institutional despite efforts to personalise some bedrooms with pictures and personal items
- household staff were seen working and hovering in sitting rooms while residents were being assisted into these rooms and while in sitting rooms

**Action required:**

Provide facilities for the occupation and recreation of each resident.

**Action required:**

Provide each resident with the freedom to exercise choice to the extent that such freedom does not infringe on the rights of other residents.

**Action required:**

Provide residents with privacy to the extent that each resident is able to undertake personal activities in private.

**Action required:**

Put in place adequate arrangements to ensure the operations of the designated centre are conducted with due regard to the sex, religious persuasion, racial origin, cultural and linguistic background, and any disability of residents.

**Action required:**

Put in place arrangements to facilitate residents' consultation and participation in the organisation of the designated centre.

**Reference:**

Health Act 2007  
 Regulation 10: Residents' Rights, Dignity and Consultation  
 Standard 2: Consultation and Participation  
 Standard 4: Privacy and Dignity  
 Standard 17: Autonomy and Independence  
 Standard 18: Routines and Expectations

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

**Timescale:**

<p>Provider's response:</p> <p>4.1 Facilities for the occupation and recreation of each resident includes entertainment, plans in place for June and July and ongoing. All staff will be more proactive with their involvement and activities with residents. Activities Person is now on the ward on an ongoing basis and doing activities all day Monday – Friday.</p> <p>4.2 Residents are free to exercise choice and staff are committed to providing person centred care to all residents.</p> <p>4.3 Family room is available for residents who wish to have privacy with their family and friends.</p> <p>4.4 Adequate arrangements are in place to ensure the operations of the designated centre are conducted with due regard to the sex, religious persuasion, racial origin, cultural and linguistic background of all residents. All staff are very aware on how to treat each resident with regard to the afore mentioned.</p> <p>4.5 Focus groups and satisfaction surveys are carried out monthly. This provides residents with an opportunity to express any concerns that they have and these are then addressed by management and staff.</p>	<p>Complete</p> <p>Ongoing</p> <p>Ongoing</p> <p>Ongoing</p> <p>Complete</p>
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<p><b>5. The person in charge has failed to comply with a regulatory requirement in the following respect:</b></p> <p>Rostered staff providing care and employed to work in the designated centre also worked in others areas including the day hospital but were included in the designated centre roster.</p> <p>Suitable arrangements were not available or in place to cover emergency leave such as sick leave.</p>
<p><b>Action required:</b></p> <p>Maintain a planned and actual staff rota, showing staff on duty at any time during the day and night.</p>

<b>Action required:</b>	
Ensure that the numbers and skill mix of staff are appropriate to the assessed needs of residents, and the size and layout of the designated centre.	
<b>Reference:</b>	
Health Act, 2007 Regulation 16: Staffing Standard 23: Staffing Levels and Qualifications	
<b>Please state the actions you have taken or are planning to take with timescales:</b>	<b>Timescale:</b>
Person in Charge's response:	
5.1	
There has always been a planned staff rota showing staff on duty any time of day and night. On recommendations from the inspector day hospital staff are now on a separate rota.	Complete
5.2	
Every attempt is made to ensure adequate numbers and skill mix of staff are appropriate to the assessed needs of the residents. There is work in progress to establish adequate skill-mix to dependency levels of residents.	December 2011

<b>6. The person in charge has failed to comply with a regulatory requirement in the following respect:</b>
Mandatory staff training and training pertinent roles undertaken by staff had not been provided to all staff.
<b>Action required:</b>
Provide staff members with access to education and training to enable them to provide care in accordance with contemporary evidence-based practice.
<b>Action required:</b>
Supervise all staff members on an appropriate basis pertinent to their role.
<b>Reference:</b>
Health Act 2007 Regulation 17: Training and Staff Development Standard 24: Training and Supervision

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Person in charge's response:  6.1  Refer to Point 1.1  6.2  All Nursing staff have access to centre for Nursing and Midwifery Education and Letterkenny Institute of Technology programmes of education and personal development plans are in the process of identifying training requirements. All mandatory training is ongoing.	          Ongoing          Ongoing

<p><b>7. The person in charge has failed to comply with a regulatory requirement in the following respect:</b></p> <p>The Chief Inspector had not been notified of incidents within the prescribed timeframes.</p>
<p><b>Action required:</b></p> <p>Give notice to the Chief Inspector without delay of the occurrence in the designated centre of any serious injury to a resident within the prescribed timeframes.</p>
<p><b>Action required:</b></p> <p>Give notice to the Chief Inspector without delay of the occurrence in the designated centre of any allegation, suspected or confirmed abuse of any resident.</p>
<p><b>Reference:</b></p> <p>Health Act, 2007        Regulation 36: Notification of incidents        Standard 8: Protection        Standard 29: Management Systems</p>

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Person in charge's response:  7.1 <ul style="list-style-type: none"> <li>• All relevant staff are aware of their obligation to report any serious injury to a Resident to the Health Information and Quality Authority.</li> </ul> 7.2 <ul style="list-style-type: none"> <li>• All relevant staff are aware of their obligation to report any</li> </ul>	          Complete          Complete

incident of abuse to the Chief Inspector. Staff training up to date and ongoing for all Staff within the hospital on elder abuse.	
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<p><b>8. The provider has failed to comply with a regulatory requirement in the following respect:</b></p> <p>The statement of purpose did not include all matters listed in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and it needed to include the services of the designated centre separate from that of the day hospital.</p>	
<p><b>Action required:</b></p> <p>Compile a Statement of purpose that describes the facilities and services, which are provided for residents.</p>	
<p><b>Action required:</b></p> <p>Compile a Statement of purpose that consists of all matters listed in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).</p>	
<p><b>Reference:</b></p> <p>Health Act, 2007  Regulation 5: Statement of Purpose  Standard 28: Purpose and Function</p>	
<p><b>Please state the actions you have taken or are planning to take with timescales:</b></p>	<p><b>Timescale:</b></p>
<p>Provider's response:</p> <p>8.1</p> <p>Size of rooms was included in statement of purpose at the time of inspection. The inspector requested that the day hospital whole time equivalent be removed. Same completed. Physiotherapy also removed from statement of purpose, as per the requirement of the inspector, and facilities and services are now included.</p> <p>8.2</p> <p>Statement of purpose now includes all matters listed in Schedule 1 of the Health Act 2007 (Care ad Welfare of Residents of Designated Centres for Older People) Regulation 2009 (as amended).</p>	<p>Complete</p> <p>Complete</p>

<p><b>9. The provider has failed to comply with a regulatory requirement in the following respect:</b></p> <p>Contracts of care had not been agreed with each resident.</p>	
<p><b>Action required:</b></p> <p>Agree a contract with each resident within one month of admission to the designated centre.</p>	
<p><b>Action required:</b></p> <p>Ensure each resident's contract deals with the care and welfare of the resident in the designated centre and includes details of the services to be provided for that resident and the fees to be charged.</p>	
<p><b>Reference:</b></p> <p>Health Act, 2007  Regulation 28: Contract for the Provision of Services  Standard 7: Contract/Statement of Terms and Conditions</p>	
<p><b>Please state the actions you have taken or are planning to take with timescales:</b></p>	<p><b>Timescale:</b></p>
<p>Provider's response:</p> <p>9.1</p> <p>A Contract of care is now available and residents/family will be able to sign.</p> <p>9.2</p> <p>Included in contract of care.</p>	<p>August 2011</p> <p>August 2011</p>

<p><b>10. The provider has failed to comply with a regulatory requirement in the following respect:</b></p> <p>The resident's guide was incomplete as the statement of purpose required amendment and the terms and conditions in respect of accommodation to be provided for residents and standard form of contract for the provision of services and facilities to residents was not available.</p>
<p><b>Action required:</b></p> <p>Produce a resident's guide which includes a summary of the statement of purpose; the terms and conditions in respect of accommodation to be provided for residents; a standard form of contract for the provision of services and facilities to residents; the most recent inspection report; a summary of the complaints procedure provided for in</p>

Regulation 39; and the address and telephone number of the Chief Inspector.	
<b>Reference:</b> Health Act 2007 Regulation 21: Provision of Information to Residents Standard 1: Information	
<b>Please state the actions you have taken or are planning to take with timescales:</b>	<b>Timescale:</b>
Provider's response:  10.1  Residents guide now includes a summary of the statement of purpose.	Complete

<b>11. The provider has failed to comply with a regulatory requirement in the following respect:</b>  Policies were mainly generic and not tailored to reflect specific practice described in this centre. Operational policies listed in Schedule 5 such as the management of risk, the creation of, access to, retention of and destruction of records, behaviour management and the prevention, detection and response to abuse were in a draft format.	
<b>Action required:</b>  Put in place all of the written and operational policies listed in Schedule five to reflect agreed practice in this centre.	
<b>Reference:</b> Health Act, 2007 Regulation 27: Operating Policies and Procedures Standard 29: Management Systems	
<b>Please state the actions you have taken or are planning to take with timescales:</b>	<b>Timescale:</b>
Provider's response:  11.1 <ul style="list-style-type: none"> <li>• Policies will all be made site specific. Draft policies will be signed off by PPG Group.</li> </ul>	December 2011

**12. The provider has failed to comply with a regulatory requirement in the following respect:**

Residents were seen to be left unsupervised for lengthy periods after personal care had been provided. They had little staff interaction and there was little evidence of meaningful activities.

The sitting room nearest the nurse's office was congested and occupied by residents using specialised equipment and restraint measures.

Restraint policies were generic and included language such as "cotsides" and harness"

**Action required:**

Facilitate all appropriate health care and support each resident on an individual basis to achieve and enjoy the best possible health.

**Reference:**

Health Act, 2007  
 Regulation 9: Health Care  
 Standard 13: Healthcare

<b>Please state the actions you have taken or are planning to take with timescales:</b>	<b>Timescale:</b>
<p>Provider's response:</p> <p>12.1</p> <p>Activities for residents will be reviewed to provide meaningful activities. Activities Person now full time on ward since Monday, 15 August 2011.</p> <p>The specialised equipment are chairs which have been recommended by the Occupational Therapist for the resident following assessment by them and to ensure the safety and comfort of the resident.</p> <p>A new restraint policy is now available. Staff make every effort to ensure that residents are not left unsupervised for long periods during the day. Further staff awareness around same is ongoing.</p>	<p>Complete</p> <p>Ongoing</p>

**13. The provider has failed to comply with a regulatory requirement in the following respect:**

Documentation in relation to accidents and falls audit were not clear to inform quality improvements.

<b>Action required:</b>	
Establish and maintain a system for reviewing the quality and safety of care provided to, and the quality of life of, residents in the designated centre at appropriate intervals.	
<b>Action required:</b>	
Establish and maintain a system for improving the quality of care provided at, and the quality of life of residents in, the designated centre.	
<b>Reference:</b>	
Health Act, 2007 Regulation 35: Review of Quality and Safety of Care and Quality of Life Standard 30: Quality Assurance and Continuous Improvement	
<b>Please state the actions you have taken or are planning to take with timescales:</b>	<b>Timescale:</b>
<p>Provider's response:</p> <p>13.1</p> <p>The quality and safety of care provided to residents is monitored on a continuous basis and recorded on a computerised setting. The accidents/falls are audited monthly by the director of nursing who then discusses the outcome of same with clinical nurse managers. This in turn is discussed in hand-over, ward meetings and is now also sent via computer messaging to ensure the nurses are aware of all findings. Care assistants and multi-task attendants are informed of same at meetings.</p>	Ongoing

<b>14. The provider has failed to comply with a regulatory requirement in the following respect:</b>
<p>There was no recorded evidence available on the days of the inspection to confirm three rostered nurses were currently registered with An Bord Altranais.</p> <p>Three staff files were reviewed by inspectors who found one file incomplete and not containing a third reference.</p> <p>Visitor's records were not maintained.</p>
<b>Action required:</b>
Ensure that records listed under Schedule 3 (records in relation to residents) and Schedule 4 (general records) are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval, kept up-to-date and in good order, kept in a safe and secure place and made available at all times for inspection and monitoring purposes under the Act.

<b>Reference:</b> Health Act, 2007 Regulation 22: Maintenance of Records Standard 32: Register and Residents' Records	
<b>Please state the actions you have taken or are planning to take with timescales:</b>	<b>Timescale:</b>
Provider's response:  14.1  The PIN's of all nursing staff were sent to the Inspector in May when they were all obtained by the director of nursing.  The third reference from the incomplete file was posted to the inspector in March 2011.  Visitors are encouraged to sign visitors' book but not everyone is compliant.  Residents' records are held on a computerised system and medical notes are maintained in a locked facility.	    Complete  Complete  Complete  Complete

**Any comments the provider may wish to make:**

**Provider's response:**

None supplied

**Provider's name:** Kieran Doherty

**Date:** 27 June 2011 and 22 August 2011

