**Centre name:** Nazareth House Nursing Home Sligo  
**Centre ID:** OSV-0000369  
**Centre address:** Church Hill, Sligo Town, Sligo.  
**Telephone number:** 071 918 0900  
**Email address:** bredanaz@eircom.net  
**Type of centre:** A Nursing Home as per Health (Nursing Homes) Act 1990  
**Registered provider:** Nazareth House Management Limited  
**Lead inspector:** Marie Matthews  
**Support inspector(s):** Leanne Crowe  
**Type of inspection**  
Unannounced Dementia Care Thematic Inspections  
**Number of residents on the date of inspection:** 69  
**Number of vacancies on the date of inspection:** 1
About Dementia Care Thematic Inspections

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

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

Please note the definition of the following term used in reports: responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).
Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

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

The inspection took place over the following dates and times
From: 28 March 2018 09:00
To: 28 March 2018 22:00

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

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Summary of findings from this inspection
This inspection report sets out the findings of a thematic inspection which focused on six specific outcomes relevant to dementia care. The purpose of this inspection was to determine what life was like for residents with dementia living in the centre. Inspectors followed up on the four action plans following the previous inspection on 24 Feb 2017. Two of the four actions were completed and two had been progressed but had not achieved the desired outcome for residents. Non compliances relating to residents having restricted access to the external environment and nursing assessments and care planning are repeated on this inspection.

As part of the thematic inspection process, the providers had submitted a self-assessment tool on dementia care to the Authority comparing the services provided with the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013 and the National Quality Standards.
Standards for Residential Care Settings for Older People in Ireland. The provider had assessed the centre as substantially compliant in all areas. Inspectors found three outcomes were non compliant and three were substantially compliant.

The centre is registered to accommodate 70 residents. There were 69 residents on the day of the inspection. Thirty one residents had a formal diagnosis of dementia and a further 10 had some level of cognitive impairment. The Director of Nursing who is the person in charge was responsible for the day-to-day management of the centre, facilitated the inspection process. She was supported by an Assistant Director of Nursing and two Clinical Nurse Managers.

The inspectors met with residents and some relatives and spoke with staff members during the inspection. The journey of four residents with dementia was tracked. Care practices and the interactions between staff and residents with dementia were observed using a validated observation tool. Inspectors also reviewed documents such as admission assessments, discharge documentation, care plans, medical records, discharge records, training records and staff files. There was evidence of good practice in some areas. The paper-based care planning system was replaced with a new electronic system and most care plans were more person-centred. A training programme on core values had been rolled out to all staff.

The inspectors found a good standard of evidence-based care and appropriate medical and allied health care access for residents receiving long-term care. However, there were marked discrepancies in the standard of assessment and care planning for residents admitted for respite care which created risks for residents.

The system for management of complaints required improvement to ensure that verbal complaints were documented. Residents and relatives were very complementary regarding the staff and described them as kind and helpful. The staff interacted in a respectful manner with residents and demonstrated patience and knowledge of the residents’ needs and preferred daily routine.

The person in charge investigated any allegations of abuse and implemented appropriate safeguarding arrangements. The supervision of staff training required review, as several staff were overdue mandatory training in safeguarding, manual handling and fire safety. Enhanced storage facilities had been installed following an allegation of theft from a resident.

The centre is a two storey building and is configured in two distinct units with a central foyer between them. Lifts are provided between floors. The building is a modern design with large areas of glass which ensure good natural light. The foyer has a pleasant coffee shop that acts as a central hub which is well used by residents and visitors and helped to maintain links between the residents and the local community. Some signage was provided but this area required improvement to provide more picture references and better use colour to help orientate residents with dementia. Access to the garden was restricted as doors were not easily operated.
The action plan at the end of this report identifies these and other areas where improvements must be made to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and the National Standards for Residential Care Settings for Older People in Ireland.
Outcome 01: Health and Social Care Needs

Theme:
Safe care and support

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

Findings:
There were 69 residents accommodated at the time of the inspection including 13 who were admitted for respite care. Residents had a range of healthcare problems associated with old age and many had more than one medical condition. 31 residents had a formal diagnosis of dementia and a further 10 had some element of cognitive impairment.

Residents could retain their own GP or choose from one of the GPs who attended the centre. Inspectors saw that residents were reviewed regularly and there was good evidence of input by a consultant geriatrician. Some were under the care of mental health services and psychiatry of later life.

A key nurse was assigned to each resident who took responsibility for supervising clinical care and ensuring care plans were updated. Each resident was also assigned two care assistants who were responsible for daily care.

Good assessment and care planning was evident for residents admitted for long term care. The person in charge visited these residents prior to admission to determine any areas of risk such as their susceptibility to weight loss, skin damage or of sustaining a fall. There had been an increase in the number of residents admitted for respite care and these residents were not visited prior to admission to assess their care needs. Inspectors found that poor evidence of effective assessment and care planning for these residents and consequently there was increased risks for these residents. For example, inspectors reviewed the care of a respite resident who had sustained a fracture. There was no evidence that a falls risk assessment had been completed to determine the residents falls history or vulnerability to falls or to determine the level of assistance or equipment they resident might need.

An new electronic care planning system was in place since the last inspection and inspectors found that care plans were developed within 48 hours of admission. Care plans reviewed were more comprehensive and person centred.
There was a system in place to ensure each residents’ medication was regularly reviewed to ensure appropriate therapeutic levels were maintained. Residents had good input evident from support health professionals including speech and language therapists, dieticians and chiropodists. A physiotherapist was employed and inspectors observed this staff member interacting with residents and working to promote their mobility.

There were appropriate interventions in place to promote skin integrity. None of the residents had a pressure wound. On the last inspection Inspectors had identified that wound care practice required improvement. Inspectors reviewed the care plan of a resident with a leg ulcer. Wound assessment were completed and an evidence based treatment plan was available. Pain assessments were completed and analgesic medication was used during wound dressing. One of the nurses had completed training in wound care and supervised care.

The inspectors reviewed records of residents who were transferred to hospital from the centre. Comprehensive information about their health, medications and their specific communication needs were shared with the admitting hospital and this information was generated from the electronic care planning system. A record of this correspondence was not kept on the residents file.

Each unit had a sitting/dining room and meals were transported from the main kitchen in a heated trolley. The inspectors observed that the food served looked appetising and residents spoken with were complementary regarding the quality and variety of food available. Each table had a menu which was in picture format. The menu was also displayed in each dining room. Inspectors saw from the menu and from speaking with residents that a choice was offered at each mealtime and drinks and snacks were provided between meals.

Where residents required support to eat and drink this was seen to be offered discreetly and in a sensitive manner. Each resident was assessed on admission for their needs in relation to nutrition and hydration. A food diary was commenced if weight loss was detected to monitor dietary intake. There were no residents been monitored for weight loss at the time of the inspection. Where unintentional weight loss was identified inspectors saw that the resident was referred to a dietician.

Residents with communication difficulties or with an impaired swallow were referred to a speech and language therapist. Inspectors saw that their advice was included in a nutritional care plan and implemented in practice. Food supplements and fortified drinks prescribed were administered and a list of residents who required altered consistency meals or thickened fluids was communicated to catering staff and to care assistants.

There was inconsistencies identified in the communication care plans reviewed. Some contained useful information and evidenced referrals to the specialist bodies such as the National Council for the Blind (NCBI) One communication care plan reviewed where the resident had impaired sight did not reference any of the assistive equipment used by the resident.
There was a system in place to ensure medication was regularly reviewed. A sample of medication sheets reviewed was clear and distinguished between PRN, short-term and regular medication. The signature of the GP was present for each drug prescribed. Medication was being crushed for some residents prior to administration due to swallowing difficulty and this was identified on their medication charts.

End of life care was provided to residents with the support of their general practitioner and the local palliative care team. An end-of-life care plan was developed only when a resident health deteriorated and inspectors saw that end-of-life preferences were not routinely recorded. 30 residents had their own bedroom and 20 residents shared a bedroom. There was no palliative care room available. The person in charge confirmed that a single bedroom is offered to residents in receipt of palliative care where possible.

Inspectors saw that there were proactive measures in place to reduce hospital admissions including staff trained on the use of a syringe driver for end-of-life care and on sub-cutaneous fluid replacement to treat dehydration.

**Judgment:**
Non Compliant - Moderate

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### Outcome 02: Safeguarding and Safety

**Theme:**
Safe care and support

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

**Findings:**
Staff members had completed safeguarding training to help them to recognise and respond to abuse. Some staff were overdue this training and were scheduled to complete it in the coming wks. There was a safeguarding policy and procedures to provide guidance to the staff. Those spoken with could describe the indicators of abuse and were clear that they would report any suspicion or allegation of abuse and ensure it was investigated.

The inspectors reviewed the investigations completed into three allegations of abuse which had been notified to HIQA. There was evidence of a robust investigation by the person in charge and the relatives of the residents involved had been notified. Appropriate action had been taken to safeguard residents and the person in charge had liaised with the safeguarding team from the Health Services Executive (HSE). A recent complaint of damage to a residents’ clothing was also being investigated at the time of the inspection and was been treated as a safeguarding issue. In one of the safeguarding issues identified there was evidence of close supervision of the resident.
Inspectors reviewed the systems in place to safeguard residents' finances and the systems was found to be sufficiently robust to safeguard residents. Secure facilities had been provided in bedrooms to keep residents monies safe. The provider was a pension agent for one resident. The appropriate social welfare forms were completed and transparent accounts were available showing all transactions.

Arrangements were in place for staff to attend training on responding to responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). Training dates were scheduled for any staff member who had not had completed this training.

There was a policy available on restraint management (the use of bedrails and lap belts) Sixteen residents had bed-rails in use. The use of restraint had reduced since the last inspection. Risk assessments were completed and less restrictive options were considered prior to the use of the restraint. Where bedrails were used as an enabler, the enabling function was documented.

**Judgment:**
Substantially Compliant

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

**Theme:**
Person-centred care and support

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

**Findings:**
Substantial effort was made by management and staff to ensure that residents' privacy and dignity was respected at all times. Staff sought consent from residents for all care activities. Residents were supported to receive visitors in private if they wished in a number of quiet areas available throughout the centre. However, inspectors found that the size and layout of one twin room did not ensure that these residents' privacy and dignity was being respected at times, particularly during personal care. This was discussed with the centre's management at the end of the inspection, who committed to addressing this issue.

Staff were seen to be friendly and respectful towards residents. Residents were facilitated to exercise choice in their daily routine. Inspectors observed residents being offered choice in relation to their daily routine and activities. Staff knocked on residents' bedroom doors and waited for permission to enter.

There were adequate facilities for recreation for residents. A large coffee dock was
situated at the entrance to the nursing home, which provided a social area for residents, visitors and members of the community to gather. On the day of the inspection, a resident’s birthday party was held in this area and included music, cake and other treats. A small shop had also been established beside the coffee area, and was operated by a volunteer. Toiletries, food and drinks and other items were available. An activities programme had been developed and this was carried out across both units by a full-time activities co-ordinator. Records indicated that a combination of group activities and one-to-one activities were carried out across the week of the inspection, as well as sessions provided by external people such as musicians. These activities included pet therapy, Easter card-making, reminiscence therapy, board games, painting and karaoke. The activities co-ordinator outlined to inspectors how they ensured that residents were supported to participate in meaningful activities in line with their preferences and interests, and this was evidenced by comprehensive records. In addition to this, several initiatives were being developed to specifically support residents with dementia or other cognitive impairments. Outings were being planned for the summertime, which was facilitated by the hiring of a large bus.

Inspectors observed the quality of interactions between staff and residents using a validated observational tool to rate and record these interactions at five minute intervals in both dining-rooms and two sitting-rooms. Scores for the quality of interactions are +2 (positive connective care), +1 (task orientated care), 0 (neutral care), -1 (protective and controlling), -2 (institutional, controlling care). The scores reflect the quality of the interactions with the majority of residents. Inspectors’ observations concluded that on this inspection, the majority of interactions on a one-to-one basis were graded as positive connective care.

A communication policy was in place for residents. Communication aids and devices were used by residents. Dedicated care plans were in place to support residents with their communication needs, but a small number of those reviewed, required more detailed information to effectively guide staff. Staff were knowledgeable of residents' individual communication needs, and were observed interacting with residents in manners that met these needs.

Residents were consulted with and participated in the organisation of the centre. A residents' forum and a separate relatives' group met on a regular basis, and minutes of these meetings were available for review by inspectors. The minutes indicated that residents and relatives' opinions were sought on a variety of topics. While inspectors were informed that work was on-going since the most recent meeting to address residents' feedback, action plans had not devised to ensure these were completed.

Residents with dementia were supported to observe or abstain from religious practice in accordance with their wishes. Residents were visited by clergy from their respective faiths regularly. An oratory was located in the centre to facilitate religious services six days per week which people from the community also attended.

Advocacy services were available to residents and contact details posted in the centre. However a vulnerable resident who required advocacy services had not been supported to access the service. Inspectors were informed that an additional independent advocate was being sought to visit residents on a more informal basis, and to attend residents'
meetings.

Wireless internet and telephone services were available for use by residents. Voting was held in the centre.

**Judgment:**
Substantially Compliant

### Outcome 04: Complaints procedures

**Theme:**
Person-centred care and support

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

**Findings:**
There was a policy and procedure in place for the management of complaints, and a person responsible for dealing with complaints. For the most part, complaints of all residents, relatives, advocates and visitors were listened to and acted upon. However, there was evidence that informal or verbal complaints were not being appropriately managed or addressed. Inspectors found that an incident had been documented in a resident's nursing notes, however, there was no evidence that action had been taken to locally resolve the issue or had been escalated to the complaints' officer.

The complaints log was maintained in the centre and was reviewed by inspectors. It contained evidence that complaints received by the complaints officer were fully investigated, and action taken where required. Residents were promptly informed of the outcome of their complaint.

There was an appeals process that residents and their relatives were aware of.

**Judgment:**
Non Compliant - Moderate

### Outcome 05: Suitable Staffing

**Theme:**
Workforce

**Outstanding requirement(s) from previous inspection(s):**
The action(s) required from the previous inspection were satisfactorily implemented.
Findings:
Staff were seen to be friendly and respectful towards residents. They knocked on residents’ bedroom doors and waited for permission to enter and were heard offering residents the choice to attend organised activities or meals. There were sufficient staff levels and skill mix on duty during the inspection to meet the needs of the 69 residents. This was confirmed by residents and relatives spoken with and by staff working in the centre. Residents were very complimentary regarding the staff team, responses and numbers available. All staff members had completed training in dementia Care since the last inspection.

A planned and actual staff roster was available in each unit which identified the working times of each staff member and their grade. A key worker system was in place which helped ensure that staff were aware of residents’ preferences and care needs and that they were familiar to residents. Daily allocation sheets were used which helped ensure accountability.

Agency staff provided cover for staff vacancies. An agency staff member who commenced night duty on the day of inspection had not worked in the centre previously. Combined with the absence of proper risk assessments and care planning for respite residents, this increased the risks to vulnerable residents.

Recruitment procedures included the requirements of schedule 2 records in place in the samples of staff files reviewed. All staff had evidence of Garda vetting completed. Agency staff were vetted by the employment agency and copies of their vetting were forwarded to the centre. Supervision of staff was evident on staff files through induction, probation and appraisal arrangements. Inspectors saw that disciplinary procedures were followed where failures in care were identified.

There was evidence that staff meetings were held every 6 weeks which were attended by all grades of staff. Evidence of registration with an Bord Altranais agus Cnáimhseachais na hÉireann was available and up to date.

A training matrix was used by the person in charge to track training attended by staff. Inspectors saw that some staff members were overdue training in mandatory areas such as manual handling, fire safety and safeguarding. Further training dates were scheduled in the coming weeks. The management and supervision required tighter supervision to ensure all staff members completed mandatory training.

A range of other relevant training was provided to staff to help ensure practice was evidence based. One nurse had completed wound care training and a programme on core values had been rolled out by the assistant director of nursing which also covered training on dementia. The matrix also listed training in cardio pulmonary resuscitation (CPR), medicine management and infection control.

Judgment:
Non Compliant - Moderate

Outcome 06: Safe and Suitable Premises
Theme:
Effective care and support

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

Findings:
For the most part, the location, design and layout of the centre are suitable for its stated purpose and to meet residents’ needs in a homely and comfortable manner. However, inspectors found that the layout of one twin room within the centre did not meet the occupants’ privacy and dignity needs. This is discussed in further detail under Outcome 3, Residents’ Rights, Dignity and Consultation. Residents’ photographs had been displayed on their bedrooms doors to assist them in identifying their rooms. Inspectors noted that the design for residents with dementia could be further enhanced by painting key areas such as residents bedroom doors, toilet doors and toilet seats in contrasting different colours to help aid residents recognition of these areas.

The building was designed to meet the needs of dependent older people. It consisted of two distinct units over two floors. Lifts provided easy access between floors. Glass was incorporated into the design which provided good natural light.

The centre was warm, comfortable, well decorated and visually clean. The maintenance both internally and in the surrounding gardens was of a very good overall standard. There was some use of colour in the building for example there was brightly coloured picture signage provided identifying the oratory and dining rooms. Contrasting colours were used for handrails and between walls and floor coverings to provide contrast. Staff and members of the relatives and friends’ forum had identified replacing some of the art displayed throughout the building with more dementia-friendly pieces.

The centre has 30 single bedrooms and 20 double bedrooms. All had accessible en-suite toilet and shower facilities which could be seen from the residents bed. Screens were provided between beds in the shared rooms. A call bell system was available which was linked to hand held monitors carried by staff and an emergency call bell had been provided in the communal areas.

Two enclosed gardens had been developed off the ground floor units since the previous inspection and contained shaded seating, plants and other objects to engage residents. Large sliding doors provided access to these area but inspectors found the door handles were difficult to operate. The doors were heavy and hard to open so residents could not access the gardens without assistance. This did not promote their independence.

Judgment:
Substantially Compliant
Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Marie Matthews
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Health Information and Quality Authority
Regulation Directorate

Provider’s response to inspection report

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<td>OSV-0000369</td>
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<tr>
<td>Date of inspection:</td>
<td>28/03/2018</td>
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<td>Date of response:</td>
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Requirements

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

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

Outcome 01: Health and Social Care Needs

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The assessment and care plans for residents receiving respite was not robust and consequently it was not possible to ensure their care needs were met.

1. Action Required:
Under Regulation 05(2) you are required to: Arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
a resident or a person who intends to be a resident immediately before or on the person’s admission to the designated centre.

**Please state the actions you have taken or are planning to take:**
One to one supervision is being completed with all Nurses to ensure that they adhere to this requirement and ensure that there is a comprehensive assessment in place for all respite residents. Records will be retained of this supervision.

All residents now have an assessment and care plan in place within 48 hours.

A new handover report has also been developed and is being implemented into practice. This handover report will include details of the care plan and risks for each resident that has to be managed. This will improve the communication systems within the Nursing Home.

**Proposed Timescale:** 31/05/2018

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<td><strong>Theme:</strong></td>
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<td>Safe care and support</td>
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**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
Some staff were overdue training on safeguarding.

**2. Action Required:**
Under Regulation 08(2) you are required to: Ensure staff are trained in the detection and prevention of and responses to abuse.

**Please state the actions you have taken or are planning to take:**
A review has been completed of staff training needs;
All staff who require updating in safeguarding vulnerable adults have been scheduled to complete this training.
Two training sessions have been scheduled for the following dates – 12th and 28th of June 2018. It is compulsory for staff to attend this training.

**Proposed Timescale:** 30/06/2018

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<td><strong>Theme:</strong></td>
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<td>Person-centred care and support</td>
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**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
Some residents right to freedom of movement was restricted as they did not have free access to the outdoor environment. The external doors were too difficult to open.
3. Action Required:
Under Regulation 09(3)(a) you are required to: Ensure that each resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.

Please state the actions you have taken or are planning to take:
The door detailed in the inspection report is being assessed by a building company to determine if the opening mechanism can be adjusted or altered to allow ease of access to this particular section of the garden. Following the assessment, a review will be conducted of the options available and a decision that is achievable will be made to rectify the issue. During this assessment period, staff have been advised to assist any resident who cannot open the door on their own.

Proposed Timescale: 31/07/2018
Theme: Person-centred care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Inspectors found that the size and layout of one twin room did not ensure that these residents' privacy and dignity was being respected at times, particularly during personal care.

4. Action Required:
Under Regulation 09(3)(b) you are required to: Ensure that each resident may undertake personal activities in private.

Please state the actions you have taken or are planning to take:
The needs of each resident in a shared room will continually be reviewed so that they can undertake personal activities in private and ensure that these residents' privacy and dignity is being respected at times.

Proposed Timescale: 18/05/2018
Theme: Person-centred care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Independent advocacy services were not made available to a resident who required the service.

5. Action Required:
Under Regulation 09(3)(f) you are required to: Ensure that each resident has access to independent advocacy services.

Please state the actions you have taken or are planning to take:
The resident identified during this inspection has been referred to an independent
advocacy service. All residents will be referred to an independent advocacy service when this is required.

**Proposed Timescale:** 18/05/2018

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<tr>
<td><strong>Theme:</strong> Person-centred care and support</td>
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<tr>
<td><strong>The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:</strong> There was evidence that informal or verbal complaints were not being appropriately managed or addressed.</td>
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<td><strong>6. Action Required:</strong> Under Regulation 34(1) you are required to: Provide an accessible and effective complaints procedure which includes an appeals procedure.</td>
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<td><strong>Please state the actions you have taken or are planning to take:</strong> A comprehensive complaints procedure is in place that meets best practice. Supervision has been provided to all the Nurses to ensure that they inform senior management of any dissatisfaction/complaint with the service from any source. The aspirations of the complaints policy will be included at the next and future staff meetings.</td>
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<td><strong>Proposed Timescale:</strong> 31/07/2018</td>
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<td><strong>Theme:</strong> Workforce</td>
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<tr>
<td><strong>The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:</strong> The system to ensure all staff members were provided with mandatory training required review as some staff members were overdue training in manual handling, fire safety and safeguarding.</td>
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<td><strong>7. Action Required:</strong> Under Regulation 16(1)(a) you are required to: Ensure that staff have access to appropriate training.</td>
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<td><strong>Please state the actions you have taken or are planning to take:</strong> In order to manage staff training, a computerised system matrix is now in place that can produce the following information under each training heading: The date the staff member was trained; and the date that refresher training is due. The Manager will issue a print-off of the training matrix for staff three months in advance where training is due to be updated, on the first day of each month. This</td>
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matrix will be on the staff notice board.

The matrix will also help highlight those staff who are overdue training and provide the manager with the ability to plan and organise this training.

**Proposed Timescale: 31/07/2018**

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<td><strong>Theme:</strong></td>
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<tr>
<td>Effective care and support</td>
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**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
The design for residents with dementia could be further enhanced by painting key areas such as residents bedroom doors, toilet doors and toilet seats in contrasting different colours to help aid residents recognition of these areas.

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

**Please state the actions you have taken or are planning to take:**
An environmental Nursing Home Audit for Dementia, Disability and Sensory Impairment based on best practice and evidenced based research is being completed and a Service Improvement plan is to be developed where this is required.

**Proposed Timescale:** 31/07/2018