### Centre name:
Merlin Park Community Nursing Unit

### Centre ID:
OSV-0000635

### Centre address:
Merlin Park, Galway.

### Telephone number:
091 775 566 / 091 775 568

### Email address:
unit5mph@hse.ie

### Type of centre:
The Health Service Executive

### Registered provider:
Health Service Executive

### Provider Nominee:
JJ O'Kane

### Lead inspector:
Marie Matthews

### Support inspector(s):
None

### Type of inspection:
Unannounced

### Number of residents on the date of inspection:
45

### Number of vacancies on the date of inspection:
7
About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

▪ Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
▪ Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider’s compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

▪ to monitor compliance with regulations and standards
▪ to carry out thematic inspections in respect of specific outcomes
▪ following a change in circumstances; for example, following a notification to the Health Information and Quality Authority’s Regulation Directorate that a provider has appointed a new person in charge
▪ arising from a number of events including information affecting the safety or wellbeing of residents.

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.

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 ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times
From: 21 April 2017 09:30
To: 21 April 2017 18:30

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

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Our Judgment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome 01: Statement of Purpose</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 02: Governance and Management</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 05: Documentation to be kept at a designated centre</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 07: Safeguarding and Safety</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 08: Health and Safety and Risk Management</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 11: Health and Social Care Needs</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 12: Safe and Suitable Premises</td>
<td>Non Compliant - Major</td>
</tr>
<tr>
<td>Outcome 13: Complaints procedures</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 16: Residents’ Rights, Dignity and Consultation</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 18: Suitable Staffing</td>
<td>Compliant</td>
</tr>
</tbody>
</table>

Summary of findings from this inspection
This inspection was the ninth inspection of Merlin Park Community Nursing Unit by the Health Information and Quality Authority (HIQA). This inspection was undertaken to follow up on actions required, following findings of non compliance from the last inspection in October 2016. The centre is registered to accommodate 52 residents however there were 45 residents on the day of inspection. The majority of residents in the centre were assessed as having either maximum or high dependency needs.

The inspector observed care practices and reviewed records including nursing and medical records, accident and incidents, complaints and staff related records. The inspector also reviewed the premises, met with staff members and spoke with residents and relatives. The health care needs of residents were met and improvements were evident in the management of behaviours associated with dementia.

Some governance issues were identified during the inspection. There was poor compliance with required actions from the last inspection. Practice in relation to
record keeping was inconsistent between the two units which make up this centre. Fire drills had not been completed by all staff and daily and weekly fire safety checks were not recorded. This was also an action from the last report. Service records for fire equipment were available in one unit but not in the other. The person in charge was not present on the day of inspection and some documentation required to evidence compliance with the action plan from the last inspection was not accessible as a result. A copy of the complaints log for one unit was also not available as well as a copy of the annual review of the safety and quality of the service. This was subsequently submitted post the inspection by the person in charge.

The actions in relation to restraint practice and the deployment of staff to ensure residents were provided with meaningful activities were addressed. Staffing levels were found to be appropriate to residents needs however a copy of the vetting disclosure from An Garda Síochána was not maintained on site on individual staff files. Similar to findings on previous inspections, the premises was found to be non-compliant with regulatory requirements due to the configuration of bedrooms in multi-occupancy rooms. The toilet facilities also compromised the privacy of residents. The fact that many residents had high dependency needs and spent most of the day by their bedrooms meant the centre was hospital like in appearance. Plans to provide a new centre were not yet available.

In total, 11 of the actions from the last inspection were addressed. A further 3 were partially addressed. It was not possible to review two actions as documentation was not available and three actions were not addressed. These are repeated in the action plan at the end of this report along with the 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 and the National Quality Standards for Residential Care Settings for Older People in Ireland.
Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

Outcome 01: Statement of Purpose
There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:
Governance, Leadership and Management

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

Findings:
On the previous inspection the governance arrangements identified in the statement of purpose did not reflect the current governance arrangements. The document on display in the centre had not been revised however the person in charge subsequently emailed an amended copy. It included the information required under regulation 3 and Schedule 1 of the regulations.

Judgment:
Substantially Compliant

Outcome 02: Governance and Management
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.

Theme:
Governance, Leadership and Management

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

Findings:
Governance issues were identified during the inspection. There was poor compliance with some actions from the last inspection and management practices were inconsistent in the centre. The person in charge was not present on the day of inspection. The inspector was told she was on duty in another centre. A clinical nurse managers was
providing cover for the person in charge and facilitated the inspection but some 
documentation required to evidence compliance with the action plan from the last 
inspection was not available. An action has been included under outcome 5 requiring the 
person in charge to address this. Other governance issues were identified during the 
inspection. For example, the fire register in one area of the centre was not being used 
to record maintenance of fire detection systems and in-house daily and weekly checks 
on fire escape routes and fire equipment. Staff working in one unit had not taken part in 
a fire drill in the last year.

There was a monitoring systems to review the quality and safety of the service and the 
inspector saw that the clinical nurse managers had completed a range of clinical audits. 
An annual report on the overall review of the safety and quality of care of residents was 
not available on the last inspection. This document was not available in the centre on 
the day of inspection but a copy was subsequently emailed to the Authority.

Judgment: 
Non Compliant - Moderate

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

Theme: 
Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s): 
No actions were required from the previous inspection.

Findings: 
The person in charge stated that all staff had been appropriately vetted by An Garda 
Síochána but a copy of the vetting disclosure was not maintained on site on individual 
staff files. Some documents required to evidence compliance with the regulations and 
with the action plan from the last inspection were not available in the centre. A copy of 
the complaints records for one unit was missing. The annual review of the safety and 
quality of the service was not in the centre at the time of inspection but was submitted 
pot the inspection. The staff rota did not contain the person in charge of the centre on 
it.

Judgment: 
Non Compliant - Moderate

Outcome 07: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place
and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

**Theme:**
Safe care and support

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

**Findings:**
On the previous inspection the inspector identified issues with the management of behaviours associated with the behaviour and psychological symptoms of dementia (BPSD).

This action was addressed. The inspector reviewed a sample of care plans for residents with BPSD. Individual behaviours were well described in the care plans and the triggers that caused the behaviours were monitored and described. The care plans reviewed contained appropriate guidance to help the staff to respond in a consistent manner to alleviate the residents’ anxiety.

On the last inspection practice in relation to restraint management was not in line with evidence based practice. At the time of this inspection there were fourteen residents with bedrails in use. Thirteen of these were described as enablers to assist residents. A restraint register was maintained. In the sample of care plans reviewed there was evidence of a multidisciplinary input into the decision to put in place the restraint. The inspector saw that the enabling function was recorded. Risk assessments had been undertaken for these.

**Judgment:**
Compliant

**Outcome 08: Health and Safety and Risk Management**
The health and safety of residents, visitors and staff is promoted and protected.

**Theme:**
Safe care and support

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

**Findings:**
On the last inspection, the records maintained did not indicate how many staff were
involved in fire drills or the duration or content of the drills that took place and there were no records available of daily checks on fire escape routes. Records to evidence that the centres’ fire alarm, fire detection system and emergency lighting were serviced were also not available. The provider stated in his response to the action plan from the last inspection that these records and daily checks were been completed.

The inspector found poor compliance with this outcome again on this inspection and practice was inconsistent between the two units. There were no records that any fire drills had taken place in the last year in unit five and in unit six only one fire drill was recorded. The record of this drill did not evidence the duration or content of the drill or indicate if they fire evacuation procedures were appropriate. The person in Charge told the inspector previously that as the centre is part of a larger HSE campus, service records were held centrally. Since the last inspection a separate fire register was maintained in each unit but the inspector found that it was only been completed in unit six.

Suitable fire fighting equipment including extinguishers, fire doors, emergency lighting and alarm equipment was available in both units. However, records to show that the fire detection system and emergency lighting system were inspected and tested quarterly and that fire extinguishers were serviced were only available for unit six in the designated centre. All fire exits were observed to be unobstructed and the staff on duty were able to describe what happened when the fire alarm was activated and were clear on their role on the safe evacuation of residents in the event of a fire.

On the previous inspection the inspector found that some accident forms were incomplete and that neurological observations were not always recorded when a resident had sustained an unwitnessed fall or had a suspected head injury. The inspector reviewed a sample of accident and incident forms during this inspection and found that they were appropriately completed. Neurological observations were recorded when a resident had sustained an unwitnessed fall or had a suspected head injury. All accidents and incidents were inputted into an electronic risk management system. The inspector saw that each incident was audited by the clinical nurse manager and that appropriate action was taken to try to prevent further incidents. There was appropriate risk assessment and controls evident in the care plans reviewed to help minimise the risk of the resident sustaining an injury.

**Judgment:**
Non Compliant - Moderate

---

**Outcome 11: Health and Social Care Needs**

Each resident’s wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident’s assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

**Theme:**
Effective care and support
Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
The inspector reviewed a sample of residents care records in each unit. Staff demonstrated a good knowledge and understanding of each resident’s needs. A General Practitioner service was contracted by the provide to look after the resident medical needs and the medical records reviewed evidenced that residents were seen regularly. Residents were also supported by access to a dietician, speech and language therapist, occupational therapist and a physiotherapist.

On the last inspection the inspector identified that the social and emotional needs of residents confined to bed were poorly met. This action had been addressed. A daily allocation of staff was completed and staff were appropriately deployed to help ensure that there was meaningful activities for residents who spent long periods in bed. A record of the activity provided was recorded in the care records.

Care plans reviewed were more comprehensive and contained a better level of detail to guide care. The inspector saw that these were updated as necessary to reflect a change in the residents condition or the advice of a specialists. There was improved linkage noted between the assessments completed and the care plans in place.

Judgment:
Compliant

Outcome 12: Safe and Suitable Premises
The location, design and layout of the centre is suitable for its stated purpose and meets residents’ individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:
Effective care and support

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

Findings:
Similar to findings on previous inspections, the design and layout of the premises did not conform to the matters listed in Schedule 6 of the Health Act 2007(Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. The current design and layout is institutional and impacts negatively on the residents’ privacy and dignity.
On the previous inspection the premises was found to resemble a clinical/hospital setting rather than that of a long term residential centre. 10 bedrooms were multi-occupancy rooms accommodating four residents which impacted on the residents privacy and affected the time they got to sleep and were awoken at as any noise from other residents affected all residents in the multi-occupancy rooms. Residents had privacy screens around their beds during person care but the inspector observed that residents resting in their beds could be viewed from the hallway by other residents or visitors to the centre.

Separate bathroom facilities were provided on each unit. Some toilet facilities provided were in shared cubicles which were partitioned by a light wooden structure which did not afford privacy. The inspector was informed that these were for use by visitors however this was not clearly indicated on the signage.

The provider stated that continued efforts would be made to make the units more homely for residents. Bedrooms had been repainted and new curtains provided between beds since the last inspection. Two bedrooms which were not open at the time of the last inspection due to a water leak had been brought back into service. The walls and skirting board on the corridors in both units were however were still chipped and damaged and required repainting. The inspector found that other than painting a hall table at the entrance to unit 5, there was little evidence of that any work to make the reception area more homely.

In response to the action plan from the last inspection the provider stated that the centre had been identified to be allocated a new building. The inspector was informed that a brief for the new building was been worked on by the HSE estates department but no plans were available at the time of this inspection.

During the last inspection it was identified that there was no mechanically operated extract ventilation to remove smoke from the room designated for smoking. This action was not addressed. The provider was still within the agreed time frame for this action. The staff on duty said that residents who smoked were supervised and the exterior door and a window were opened when the room was in use to remove smoke.

Judgment:
Non Compliant - Major

Outcome 13: Complaints procedures
The complaints of each resident, his/ her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:
Person-centred care and support

Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily implemented.
Findings:
On the last inspection, the inspector identified that complaint forms were poorly completed and did not always show evidence that the complaint was investigated or that the complainant was satisfied with the outcome of the investigation.

The findings on this inspection regarding complaints management were inconsistent. A complaints log was available in unit 6 and in the sample of complaints reviewed by the inspector there was evidence that they were appropriately investigated. The outcome of the complaint was recorded and relayed to the complainant and their satisfaction with the actions taken was recorded. The inspector found however that the complaints log for unit 5 was not available. The provider was requested to ensure a full investigation into a complaint made by a resident in unit 5 was completed. It was therefore not possible to review the providers’ compliance with this action. This action is therefore repeated in this report.

Judgment:
Non Compliant - Moderate

Outcome 16: Residents' Rights, Dignity and Consultation
Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

Theme:
Person-centred care and support

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

Findings:
69% of the residents accommodated were assessed as having either maximum or high dependency needs and the inspector observed that several spent time in bed or sitting by their bedside. Staff allocation sheets had been introduced since the last inspection and the inspector saw that there were designated staff members allocated to each resident who spend time in their bedrooms to ensure that they had opportunities to participate in activities in accordance with their interests and capacities. Staff were observed interacting with residents and speaking about residents in a courteous and respectful manner. Residents stated that they were happy with the care provided.

Individual and group activities were organised and these were coordinated by an activities co-ordinator who split her time between the two units. Another staff member assisted the activities coordinator. An activity schedule was displayed in the communal areas in both units and the inspector saw that social activities were been recorded in the resident’s care notes.
On the last inspection the inspector found that the approach to mealtimes was institutional and did not facilitate residents to choose the time they had their meals. The food is supplied to the centre from the main hospital which restricts the mealtimes to the times set in this hospital and removes an input from residents into the choices available. The inspector was told that the person in charge had met with the catering department and as a result hot snacks were now available to residents in the evening.

An arrangement had been made for one resident to order specific foods directly from the kitchen in accordance with her preference. However, staff did not have the autonomy to order specific items of food to meet the preference of individual residents. A satisfaction survey had also been completed and the inspector saw that residents stated that they are happy with meal times.

**Judgment:**
Substantially Compliant

---

**Outcome 18: Suitable Staffing**
There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

**Theme:**
Workforce

---

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

**Findings:**
Residents spoken with told the inspector that they the staffing levels were adequate to meet the needs of residents. The inspector reviewed the planned and actual staffing rota found that the centre had a good staff to resident ratio. 69% of the 45 residents accommodated were assessed as having either maximum or high dependency needs. Six nurses and eleven care assistants were on duty in the morning. This reduced to five nurses and nine care assistants in the afternoon. In the evening there were four nurses and four care assistants on duty and this reduced to four nurses and two care assistants at night. In addition there was an activities coordinator employed for 30 hours each week, 2 catering staff in each unit and two laundry staff. Care/multi task attendants also ensure the centre was appropriately cleaned and all had completed FETAC level 5 training. 11 of the nursing staff had completed a diploma in gerontology. The person in charge was not included in the staff rota as required in the regulations.

The person in charge confirmed that all staff had been appropriately vetted by An Garda Síochána however a copy of the vetting disclosure from An Garda Síochána was not
maintained on site on individual staff files. An action has been included under outcome 5 requiring the provider to address this action.

**Judgment:**
Compliant

## Closing the Visit

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

**Acknowledgements**

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

**Report Compiled by:**

Marie Matthews  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority
Provider’s response to inspection report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Merlin Park Community Nursing Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000635</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>21/04/2017</td>
</tr>
<tr>
<td>Date of response:</td>
<td>11/05/2017</td>
</tr>
</tbody>
</table>

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: Statement of Purpose

**Theme:**
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The statement of purpose on display in the centre had not been revised to reflect the accurate governance arrangements.

1. **Action Required:**
Under Regulation 03(1) you are required to: Prepare a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

---

1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Residents in Designated Centres for Older People) Regulations 2013.

Please state the actions you have taken or are planning to take:
The new updated statement of purpose is now available in both units.

Proposed Timescale: 11/05/2017

Outcome 02: Governance and Management
Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The governance systems in place were not ensuring that the fire safety procedures in place in the centre were effective.

2. Action Required:
Under Regulation 23(c) you are required to: Put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

Please state the actions you have taken or are planning to take:
We have received a copy of the certificate of service and testing of fire alarm system in our unit fire register signed and dated from maintenance company of when they have been on site. The company will record in our fire register in the future. We have identified a holding area in both units for the fire register to ensure compliance.

Proposed Timescale: 11/05/2017

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A copy of the annual review of the quality and safety of care was not made available in the centre.

3. Action Required:
Under Regulation 23(f) you are required to: Make available a copy of the review referred to in regulation 23(d) to residents and, if requested, to the chief inspector.

Please state the actions you have taken or are planning to take:
A copy of the annual review is now available in the unit.

Proposed Timescale: 11/05/2017
### Outcome 05: Documentation to be kept at a designated centre

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The staff rota did not contain the person in charge of the centre on it.

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

Please state the actions you have taken or are planning to take:
The staff rota now contains the person in charge we have updated our rota template.

**Proposed Timescale:** 11/05/2017

### Proposed Timescale: 11/05/2017

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
A copy of the vetting disclosure from An Garda Síochána was not maintained on site on individual staff files.

A copy of the complaints log for one unit was also not available.

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

Please state the actions you have taken or are planning to take:
(1) We have as per HSE policy, the available certification of Garda vetting in our centre we are awaiting direction from a national perspective, with regards to additional information regarding Garda vetting. We don’t have any disclosure issues with Garda Vetting with any of the staff employed in the unit.
(2) The complaints folder containing the complaints log is now in both units.

Proposed Timescale: (1) Awaiting national direction (2) Completed

**Proposed Timescale:** 11/05/2017
the following respect:
A record of each fire drill and a record for the maintenance of fire fighting equipment were not available for one area of the centre.

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

Please state the actions you have taken or are planning to take:
The record of fire drill and maintenance of fire equipment is available in both units we have received the certificates from the maintenance companies who carried out the work.

Proposed Timescale: 11/05/2017

Outcome 07: Safeguarding and Safety

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The forms used for risk assessments for restraints were not evidence based.

7. Action Required:
Under Regulation 07(3) you are required to: Ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.

Please state the actions you have taken or are planning to take:
The restraint risk assessment has been reviewed and we have new risk assessments form’s that are evidence based practice in place.

Proposed Timescale: 11/05/2017

Outcome 08: Health and Safety and Risk Management

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were no records that any fire drills had taken place in the last year in unit five and in unit 6 only one fire drill was recorded.
The record of the drill in unit 6 did not evidence the duration or content of the drill or indicate if they fire evacuation procedures were appropriate.

8. Action Required:
Under Regulation 28(1)(e) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and residents are aware of the procedure to be followed in the case of fire.

**Please state the actions you have taken or are planning to take:**
We have carried out a simulated fire drill for both units and recorded the details in our unit’s fire register since inspection. We have the fire drill documentation for last year in Unit 5 fire register.

**Proposed Timescale:** 11/05/2017

<table>
<thead>
<tr>
<th>Outcome 12: Safe and Suitable Premises</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theme:</strong>  Effective care and support</td>
</tr>
</tbody>
</table>

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The design and layout of the premises did not conform to the matters listed in Schedule 6 of the Health Act 2007(Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. The current design and layout is institutional and impacts negatively on the residents privacy and dignity.

The toilet facilities provided for residents were in shared cubicles which were partitioned by a light wooden structure which did not afford the resident’s privacy.

There was no mechanically operated extract ventilation to remove smoke from the room designated for smoking.

**9. Action Required:**
Under Regulation 17(1) you are required to: Ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.

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

1) The new build brief is available in draft form a copy sent to the inspector.

(2) The toilet facilities for residents are single structures each ward has an ensuite facility and the residents toilets on the corridor are single structures.

(3) A new smoking room has been identified that meets the regulation require for a designated smoking room.

**Proposed Timescale:** 31/12/2020

<table>
<thead>
<tr>
<th>Outcome 13: Complaints procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theme:</strong></td>
</tr>
</tbody>
</table>
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Evidence that a complaint made by one of the residents was properly investigated to the satisfaction of the resident were not available

10. **Action Required:**
Under Regulation 34(2) you are required to: Fully and properly record all complaints and the results of any investigations into the matters complained of and any actions taken on foot of a complaint are and ensure such records are in addition to and distinct from a resident’s individual care plan.

**Please state the actions you have taken or are planning to take:**
The complaints folder is available in both units and all complaint

**Proposed Timescale:** 11/05/2017