<table>
<thead>
<tr>
<th><strong>Centre name:</strong></th>
<th>Dean Maxwell Community Nursing Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Centre ID:</strong></td>
<td>OSV-0000665</td>
</tr>
<tr>
<td><strong>Centre address:</strong></td>
<td>The Valley, Roscrea, Tipperary.</td>
</tr>
<tr>
<td><strong>Telephone number:</strong></td>
<td>050 521 389</td>
</tr>
<tr>
<td><strong>Email address:</strong></td>
<td><a href="mailto:catherine.lanphier@hse.ie">catherine.lanphier@hse.ie</a></td>
</tr>
<tr>
<td><strong>Type of centre:</strong></td>
<td>The Health Service Executive</td>
</tr>
<tr>
<td><strong>Registered provider:</strong></td>
<td>Health Service Executive</td>
</tr>
<tr>
<td><strong>Provider Nominee:</strong></td>
<td>Alice Clohessy-McGinley</td>
</tr>
<tr>
<td><strong>Lead inspector:</strong></td>
<td>Mary Costelloe</td>
</tr>
<tr>
<td><strong>Support inspector(s):</strong></td>
<td>None</td>
</tr>
<tr>
<td><strong>Type of inspection</strong></td>
<td>Announced</td>
</tr>
<tr>
<td><strong>Number of residents on the date of inspection:</strong></td>
<td>20</td>
</tr>
<tr>
<td><strong>Number of vacancies on the date of inspection:</strong></td>
<td>7</td>
</tr>
</tbody>
</table>
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 inform a registration renewal decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From: To:
04 January 2017 09:30 04 January 2017 17:00
05 January 2017 09:30 05 January 2017 15:00

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

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Our Judgment</th>
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</thead>
<tbody>
<tr>
<td>Outcome 01: Statement of Purpose</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 02: Governance and Management</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 03: Information for residents</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 04: Suitable Person in Charge</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 05: Documentation to be kept at a designated centre</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 06: Absence of the Person in charge</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 07: Safeguarding and Safety</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 08: Health and Safety and Risk Management</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 09: Medication Management</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 10: Notification of Incidents</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 11: Health and Social Care Needs</td>
<td>Non Compliant - Moderate</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 14: End of Life Care</td>
<td>Compliant</td>
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<tr>
<td>Outcome 15: Food and Nutrition</td>
<td>Compliant</td>
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<tr>
<td>Outcome 16: Residents’ Rights, Dignity and Consultation</td>
<td>Compliant</td>
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<tr>
<td>Outcome 17: Residents’ clothing and personal property and possessions</td>
<td>Compliant</td>
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<tr>
<td>Outcome 18: Suitable Staffing</td>
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</tbody>
</table>

Summary of findings from this inspection

This report sets out the findings of an inspection, which took place following an application to the Health Information and Quality Authority, to renew registration. This inspection was announced and took place over two days. As part of the inspection the inspector met with residents, relatives and staff members. The inspector observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files.
On the days of inspection, the inspector was satisfied that the residents were cared for in a safe environment and that their nursing and healthcare needs were being met. The inspectors observed sufficient staffing and skill mix on duty to meet the needs of residents.

The quality of residents’ lives was enhanced by the provision of a choice of interesting things for them to do during the day and an ethos of respect and dignity for both residents and staff was evident.

The person in charge and staff demonstrated a comprehensive knowledge of residents’ needs, their likes, dislikes and preferences. Staff and residents knew each other well, referring to each other by first names. Residents were observed to be relaxed and comfortable when conversing with staff.

The collective feedback from residents was one of satisfaction with the service and care provided.

The building was warm and comfortable but as outlined in previous inspection reports the design and layout of parts of the existing building still did not meet the needs of all residents or comply with the requirements of the Regulations. For example, there were inadequate showering facilities, storage for equipment and no private visitors’ space. This impacted on residents’ privacy, dignity, comfort and choice.

Other improvements were required in relation to restraint management documentation, updating of some policies, fire safety training and fire drills, storage of medicines and complaints management.
Outcome 01: Statement of Purpose
There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:
Governance, Leadership and Management

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

Findings:
The inspector reviewed the statement of purpose dated August 2016 submitted in advance of the inspection. It complied with the requirements of the regulations. The statement of purpose accurately reflected the services and facilities; along with the aims, objectives and ethos of the centre.

Judgment:
Compliant

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

Theme:
Governance, Leadership and Management

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

Findings:
The provider had established a clear management structure, and the roles of managers and staff were clearly set out and understood. A fulltime person in charge had been appointed to the post since the last inspection and the recruitment of a clinical nurse manager 2 (CNM2) was in progress. Supports were in place to assist the person in
charge deliver a good quality service. These supports included a risk advisor, infection prevention and control manager, business manager and senior operations manager. The management team were in regular contact. There were established regular meetings of persons in charge to discuss issues of concern and to share learning. Formal management meetings took place on a regular basis.

The inspector was satisfied that the person in charge had the appropriate experience and qualifications for the role. A senior nurse currently deputised in the absence of the person in charge. There was an on call out of hour’s system in place.

Systems were in place to review some aspects of the safety and quality of care. Regular audits and reviews were carried out in relation to incidents, medication management, hand hygiene and infection control. Staff confirmed that results of audits were discussed with them to ensure learning and improvement to practice. Additional training had been recently provided to staff and further training was scheduled following an audit of hand hygiene in November 2016. A report on the quality and safety of care of residents in the nursing home had been documented for 2016, the improvement plan outlined the need to recruit a CNM2.

Judgment:
Compliant

Outcome 03: Information for residents
A guide in respect of the centre is available to residents. Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

Theme:
Governance, Leadership and Management

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

Findings:
The centre had a resident's guide which was available to residents and visitors. It was also included in a residents information pack given to new and prospective residents and their families. The guide contained all information as required by the regulations.

Contracts of care were in place for all residents. The inspector reviewed a sample of contracts of care, they included details of the services to be provided and fees to be charged. However, the details regarding additional charges were not clearly set out. The person in charge informed the inspector that additional monthly charges were for prescription charges but this was not clear.

Judgment:
Substantially Compliant
### Outcome 04: Suitable Person in Charge

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

**Theme:**
Governance, Leadership and Management

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

**Findings:**
The person in charge was a registered nurse with the required experience in the area of nursing the older adult. She had been employed in the post since May 2016, she worked full time. She was on-call at weekends and out of hours.

The person in charge was knowledgeable regarding the regulations, HIQA's Standards and her statutory responsibilities. She demonstrated very good clinical knowledge. She was very knowledgeable regarding the individual needs of each resident.

The person in charge had engaged in continuous professional development. She had recently completed training on restraint management, open disclosure, designated officer in safeguarding and a first time manager's course.

The inspector observed that she was well known to staff, residents and relatives. Throughout the inspection process the person in charge demonstrated a commitment to delivering good quality care to residents and to improving the service delivered. All documentation requested by the inspector was readily available.

**Judgment:**
Compliant

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

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

**Theme:**
Governance, Leadership and Management
**Outstanding requirement(s) from previous inspection(s):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
The inspector was satisfied that records as required by the regulations were maintained in the centre, however, improvements were required to updating some polices and the directory of residents.

All records as requested during the inspection were made readily available to the inspector. Records were maintained in a neat and orderly manner and kept in a secure place.

All policies as required by Schedule 5 of the regulations were available; however, some policies such as the emergency plan, fire policy and complaints policies required updating to reflect current practices in the centre. Other policies such as the restraint policy were not fully reflected in practice.

The inspector reviewed a sample of staff files which contained all of the information as required by the regulations.

The directory of residents required updating in order to fully comply with all the requirements of the regulation. The address of the next of kin, the date, time and cause of death when established was not always included.

**Judgment:**
Substantially Compliant

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**Outcome 06: Absence of the Person in charge**
The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/ her absence.

**Theme:**
Governance, Leadership and Management

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

**Findings:**
The person in charge and management team were aware of the requirement to notify the Chief Inspector of the proposed absence of the person in charge. Notifications as required had been submitted in the past.

**Judgment:**
Compliant

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

Findings:
The inspector found that while measures were in place to protect residents from being harmed or abused, the documentation to support the management of restraint was still not in line with the centre's own policy or national policy on the use of restraint. This issue had been brought to the attention of the provider following the last inspection.

The inspector reviewed the updated policy on prevention, detection and response to elder abuse and new safeguarding policy. Staff spoken with confirmed that they had received training in relation to the prevention and detection of elder abuse and were knowledgeable regarding their responsibilities in this area. The person in charge had recently completed the designated safeguarding officer training course and seven staff had attended recent safeguarding training. Further training on the new safeguarding policy was scheduled for February and April 2017.

The inspector was satisfied that residents' finances were managed in a clear and transparent manner. There was a policy in place on the management of residents' personal property. Small amounts of money were kept for safekeeping on behalf of some residents. All money was securely stored. Individual balance sheets were maintained for each resident and all transactions were clearly recorded and signed by two staff members. Receipts were kept for all purchases and expenditure.

The inspector reviewed the policies on responding to behaviours that challenge and use of restraint. The policy on behaviours that challenged outlined guidance and directions to staff as to how they should respond and strategies for dealing with behaviours that challenged.

The policy on restraint was based on the national policy 'Towards a restraint free environment' and included clear directions on the use of restrictive procedures including risk assessment and ensuring that the least restrictive intervention was used for the shortest period possible. Staff continued to promote a restraint-free environment and the numbers of residents using bedrails had reduced since the previous inspection. There were five residents using bedrails at the time of inspection.

However, the documentation to support the management of restraint was not in line with the centre's own policy or national policy on the use of restraint. Risk assessments completed were not in line with policies. There was no evidence that alternatives had
been tried or considered or of the risks involved in using the restraint. There was no evidence of multidisciplinary input into the decision to use the restraint measure and consent for the use of restraint was not always documented. There were no care plans in place to guide staff on the use of bedrails, however, staff did carry out regular checks on residents using bedrails and these checks were recorded.

The inspector reviewed a sample of files of residents who presented with responsive behaviour and noted that while care plans were in place they did not clearly outline guidance for staff regarding known triggers and distraction techniques. While ABC charts were in use to log episodes of responsive behaviour, these were not consistently updated. Staff spoken with were clearly able to describe the care but this was not always reflected in the care plans. Some residents were prescribed psychotropic medicines on a 'PRN' as required basis. These medicines were administered occasionally for some residents. Staff spoken with informed the inspector that these were always administered as a last resort only when other strategies had been trialled and possible underlying causes had been eliminated. However, records were not always maintained to indicate the rationale for administration of these medications or what other interventions had been tried to manage the behaviour. This is discussed further under Outcome 11: Health and social care needs.

Staff spoken with and training records reviewed indicated that most staff members had received training on restraint management and managing actual and potential aggression (MAPA).

The inspector reviewed a sample of staff and volunteers files and noted that safeguarding measures such as Garda vetting were in place, however, the person in charge could not confirm if Garda vetting was in place for all staff. She undertook to carry out an audit of all staff files to provide assurance that all staff had Garda vetting in place.

The inspector observed staff interacting with residents in a respectful and friendly manner. Residents spoken with and those who completed questionnaires indicated that they felt safe in the centre.

**Judgment:**
Non Compliant - Moderate

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**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:
While the provider had systems in place to protect the health and safety of residents, staff and visitors, the emergency plan required updating, some staff had not completed all fire safety training modules and no recent fire drills had taken place.

There was a health and safety statement available. The inspector reviewed the risk register and found that it had been regularly reviewed and updated following the last inspection. All risks specifically mentioned in the Regulations such as assault, accidental injury, aggression and violence and self harm were included.

There was an emergency plan in place which outlined guidance for staff in the event of a range of emergencies however, there was no guidance for staff in the event of an evacuation of the centre.

Training records reviewed indicated that all staff members had received up-to-date training in moving and handling. Staff spoken with confirmed that they had received training. The inspector observed good practice in relation to moving and handling of residents during the inspection.

The inspectors reviewed the fire policies and procedures. Records indicated that all fire fighting equipment had been serviced in February 2016 and the fire alarm was serviced on a quarterly basis. The last fire alarm service took place on 10 October 2016. Systems were in place for regular testing of the fire alarm, daily and weekly fire safety checks and these checks were being recorded. All staff spoken with stated that they had received fire safety training. The person in charge confirmed that fire safety training for staff included three separate training modules including evacuation, person on fire and fire extinguisher training. These training modules took place on different days. Training records reviewed indicated that all staff had attended some of the modules but many staff had not attended all three. Records reviewed indicated that fire drills did not take place regularly; the last drill took place in September 2015.

The inspector noted that infection control practices were robust. There were comprehensive infection control policies in place relating to infection prevention and control. Hand sanitising dispensing units were located at the front entrance and throughout the building. Staff were observed to be vigilant in their use. The inspector reviewed the most recent hand hygiene audit which indicated 72% compliance. The person in charge told the inspector that following the disappointing audit results all staff had received teaching sessions in hand hygiene and a specialist infection control nurse had completed infection control training with staff. A further hand hygiene audit was scheduled for February 2017.

Judgment:
Non Compliant - Moderate

Outcome 09: Medication Management
Each resident is protected by the designated centre’s policies and procedures for medication management.
**Theme:**
Safe care and support

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

**Findings:**
The inspector generally found evidence of good medicines management practices. The medication management policy required updating to reflect recent changes to the storage and administration of medicines as the blister pack system was no longer in use.

The inspector spoke with nursing staff on duty regarding medicines management issues. They demonstrated competence and knowledge when outlining procedures and practices on medicines management. Nursing staff spoken with had concerns regarding the new medicines system; they demonstrated that there was insufficient storage space on the medicines trolley to securely store all medicines. Medicines were being stored in individual zip locked bags insecurely on top of the medicines trolley during the medicines round. This posed a risk to residents, staff and visitors. Nursing staff advised that they had requested a new medicines trolley to safely store all medicines.

Medicines requiring strict controls were appropriately stored and managed. Secure refrigerated storage was provided for medicines that required specific temperature control. The temperature of the refrigerator was monitored and recorded on a daily basis.

The inspector reviewed a sample of medicine prescribing and administration sheets. All medicines were regularly reviewed by the general practitioners (GP). Medicines that were required to be crushed were being administered as prescribed.

Systems were in place to record medicine errors which included the details, outcome and follow-up action taken. Staff were familiar with these systems.

Systems were in place for checking medicines on receipt from the pharmacy and the return of unused and out-of-date medicines to the pharmacy.

Regular medicine management audits were carried out by senior nursing staff. The inspector reviewed the most recent audit dated October 2016 which indicated generally good compliance and included areas for improvement. Most nursing staff had completed recent medicines management training updates.

**Judgment:**
Non Compliant - Moderate

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**Outcome 10: Notification of Incidents**
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.
**Theme:**
Safe care and support

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

**Findings:**
The inspector was satisfied that a record of all incidents occurring in the designated centre was maintained and, where required, notified to the Chief Inspector.

The person in charge was aware of the legal requirement to notify the Chief Inspector regarding incidents and accidents. To date all relevant incidents had been notified to the Chief Inspector by the person in charge.

**Judgment:**
Compliant

**Outcome 11: Health and Social Care Needs**
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/ her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/ her changing needs and circumstances.

**Theme:**
Effective care and support

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

**Findings:**
The inspector found that residents’ healthcare needs were met and they had access to appropriate medical and allied healthcare services, however, access to chiropody services was not timely. Each resident had opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

All residents had access to a choice of general practitioner (GP) services. There was an out-of-hours GP service available. The inspector reviewed a sample of files and found that GPs reviewed residents on a regular basis.

A range of other services were available including speech and language therapy (SALT), physiotherapy, occupational therapy (OT), dietetic services and psychiatry of later life. The person in charge told the inspector that chiropody services were difficult to access on a regular and consistent basis. The inspector reviewed residents’ records and found
that residents had been referred to these services and results of appointments and recommendations were written up in the residents’ notes.

The inspector reviewed a number of residents’ files including the files of residents with restraint measures in place, nutritionally at risk, with wounds, presenting with responsive behaviours and communication issues. See Outcome: 7 Safeguarding and Safety regarding restraint and responsive behaviours.

The inspector found that nursing documentation had improved since the previous inspection and was generally completed to a high standard. Comprehensive up-to-date nursing assessments were completed. A range of up-to-date risk assessments had been completed including in nutrition, falls, dependency, manual handling, bedrail use, oral care and skin integrity. Care plans were generally found to be person-centred, individualised and clearly described the care to be delivered. Care plans were in place for all identified issues with the exception of restraint measures. Care plans had been reviewed and updated on a regular basis. Recommendations from allied health services such as SALT, dietician and OT were reflected in and updated in residents care plans. Systems were in place to record evidence of residents' and relatives' involvement in the development and review of their care plans.

The inspector was satisfied that weight loss was closely monitored; residents were nutritionally assessed using a validated assessment tool. All residents were weighed monthly or more often if staff had concerns. Nursing staff told the inspector that if there was a change in a resident’s weight, nursing staff would reassess the resident, liaise with the GP and referrals maybe made to the dietician and SALT. Files reviewed by the inspector confirmed this to be the case. Some residents were prescribed nutritional supplements which were administered as prescribed.

The inspector was satisfied that wounds were being well managed. There were adequate up-to-date wound assessments and wound charts in place.

As discussed under Outcome 7: Safeguarding and safety, documentation to support the management of restraint was not in line with the centres own policy or national policy on the use of restraint. There were no care plans in place to guide staff on the use of bedrails, however, staff did carry out regular checks on residents using bedrails and these checks were recorded. The inspector reviewed a sample of files of residents who presented with responsive behaviour and noted that while care plans were in place they did not clearly outline guidance for staff regarding known triggers, distraction techniques and use of prescribed psychotropic medicines. While ABC charts were in use to log episodes of responsive behaviour, these were not consistently updated. Staff spoken with were clearly able to describe the care but this was not always reflected in the care plans.

Staff continued to provide meaningful and interesting activities for residents. Each resident had a meaningful activities assessment completed and each resident’s preferences were documented in their care plan. There were two activity coordinators employed, both had completed a range of training specific to their roles. The weekly and daily activities schedule was displayed. The inspectors observed residents enjoying a variety of activities during the inspection including light exercises, bingo, knitting and
discussing the daily newspaper headlines. Many of the residents actively partook and residents informed the inspector that they enjoyed the variety of activities taking place; particularly music sessions and the exercise programme. Other activities included imagination gym, cookery, gardening, art and Sonas programme (therapeutic programme specifically for residents with Alzheimer disease). Mass was celebrated weekly in the centre and the daily local church services were relayed by video link to the television in the ‘snug’ dayroom. Residents spoken with told inspectors how they enjoyed being able to join in the local church ceremonies. Day service users joined the residents for some activities during the week days, residents enjoyed the social interaction and getting local news.

**Judgment:**
Non Compliant - Moderate

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**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:**
As stated in previous inspection reports the design and layout of parts of the existing building did not meet with the needs of residents or comply with the requirements of Regulations.

While the inspector found the physical environment of the existing building to be clean, bright and warm it still did not comply with some of the regulations and National Standards for Residential Care Settings for Older People in Ireland. For example, there was inadequate showering facilities, storage for equipment and no private visitors space.

There was a variety of comfortable communal day spaces which had been recently painted available for residents use. Bedroom accommodation was provided in 15 single bedrooms and six twin bedrooms. The twin bedrooms had en suite toilet and shower facilities. The single bedrooms were small in size. The person in charge and nursing staff confirmed that the centre continued to operate within the procedures outlined in the statement of purpose for the management of the small sized single rooms as requested by the Authority and residents assessed as requiring the use of a hoist were not accommodated in these rooms.
There was still only one bathroom with specialised bath available for the use by all residents. There were no other separate shower facilities for residents occupying single bedrooms. Residents did not have a choice of bath or shower and lack of adequate showering facilities impacted on the privacy and dignity of all residents. Some of the single bedrooms were located a distance from the bathroom which also impacted on residents privacy, dignity and comfort. Staff confirmed that because there was only one bath available it was not always available to residents at the time of their choice. The inspector noted that while staff were sensitive to residents’ rights for privacy and dignity, the physical environment posed significant challenges when delivering personal care and attending to residents’ care needs.

There was still inadequate space for the storage of equipment. Staff spoken with confirmed that this was an ongoing issue as there was no separate storage available to store equipment such as specialised chairs, wheelchairs, walking frames and hoists when not in use.

There was a well equipped kitchen, sluice room, cleaner’s room and laundry.

There were two enclosed gardens with appropriate garden furniture and safe surfaces.

There was an appropriate level of assistive equipment, such as specialist chairs, wheelchairs, walking aids, hoists, specialist mattresses, pressure relieving cushions and beds to meet residents’ needs. However, up to date service records for equipment such as hoists were not available during the inspection, the person in charge forwarded recent service certificates for the ceiling hoists to the inspector following the inspection. Service contracts were in place with several different companies for the servicing of various items of equipment. There was no comprehensive list of equipment with service due dates or up to date service certificates available in the centre therefore the inspector could not determine if all equipment had been recently serviced.

**Judgment:**
Non Compliant - Major

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**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:**
The inspector found that improvements were required to complaints management.

The complaints policy required updating in order to reflect the changes to the nominated complaints officer.

The complaints procedure displayed was not user friendly in that it was not clear how to make a complaint, the print size was small and it did not include the name of the current nominated complaints officer.

The inspector reviewed the complaints log and noted that there were no open complaints. Details of complaints had been recorded including the details of the complaint, investigation carried out, action taken and details of the complainants satisfaction with the outcome.

The inspector was informed that there were no recent written complaints but that verbal complaints received had not been recorded. The person in charge told the inspector that there had been a number of recent complaints in relation to inadequate heating in the centre but these had not been recorded. She advised that there had been issues with the heating system and that repair works were on going at the time of inspection.

**Judgment:**
Non Compliant - Moderate

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**Outcome 14: End of Life Care**

*Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.*

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

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

**Findings:**
The inspector was satisfied that caring for a resident at end of life continued to be regarded as an integral part of the care service provided in centre.

Two palliative care suites were provided for end-of-life care. The wishes of the resident were documented and a record was maintained of the resident’s physical, spiritual and emotional needs and the needs of the relatives, before, during and after death. Facilities were provided for relatives who wished to stay overnight.

This practice was informed by the centre’s policy on end-of-life care. The policy included guidelines for involving the resident and their families in planning the end-of-life care. The inspector read where residents’ end-of-life preferences were discussed and documented in care plans. The local palliative care and home care teams also provided
support and advice when required. Training records confirmed that many staff had received end of life care training.

Judgment:
Compliant

Outcome 15: Food and Nutrition
Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.

Theme:
Person-centred care and support

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

Findings:
Residents were offered a varied nutritious diet. The quality and presentation of the meals were of a high standard and a number of the residents told inspectors that the food was always very good. Some residents required special diets or modified consistency diets and these needs were met. The inspector spoke with the chef who was knowledgeable regarding residents special diets, likes and dislikes. The chef confirmed that food issues were discussed at residents monthly meetings and suggestions from residents were always acted upon.

Residents stated that food, drinks and snacks were available to them at all times. A variety of hot and cold drinks and snacks were available throughout the day. Staff were observed offering and encouraging drinks throughout the days of inspection. The inspector saw a variety of home-cooked food being served throughout the days of inspection including apple tarts, brown bread and soups.

The menus were displayed and offered a choice at every meal.

The inspector observed the dining experience and noted it to be a pleasant one. Meals were served in a large bright dining room. A choice of drinks was offered. The atmosphere during dinner was relaxed and unhurried. It was seen as an opportunity for social interaction with good banter and plenty of chat between residents and staff. Staff were observed to sit beside residents who required assistance with their meals while encouraging other residents to eat independently. Nursing staff monitored the meal times closely.

Judgment:
Compliant

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

Theme:
Person-centred care and support

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

Findings:
Staff were observed to treat residents in a dignified manner and in a way that maximised their choice and independence. The inspector observed that residents were always referred to by their first name and politely asked if they needed anything, given choices around what they would like to do, where they would like to sit and what they would like to eat and drink.

The inspector noted that while staff were sensitive to residents’ rights for privacy and dignity, the physical environment posed significant challenges when delivering personal care and attending to residents’ care needs. There was still only one bathroom with specialised bath available for the use by all residents. There were no other separate shower facilities for residents occupying single bedrooms. Residents who wished to have a shower were facilitated in the showers located in the en suite bedrooms of other residents. Residents did not have a choice of bath or shower and lack of adequate showering facilities impacted on the privacy and dignity of all residents. Some of the single bedrooms were located a distance from the bathroom which also impacted on residents privacy, dignity and comfort. Staff confirmed that because there was only one bath available it was not always available to residents at the time of their choice. The action relating to this issue is included under Outcome 12: Safe and suitable premises.

Bedroom and bathroom doors were closed when personal care was being delivered. Staff were observed to knock and wait before entering bedrooms.

A number of the questionnaires completed by residents and family members by way of feedback to HIQA confirmed that the centre made every effort to maintain residents’ independence.

Residents’ religious and political rights were facilitated. Mass was celebrated weekly in the centre and the daily local church services were relayed by video link to the television in the 'snug' dayroom. Arrangements were in place for residents of different religious beliefs. Staff told the inspector that residents were facilitated to vote and explained that residents had been facilitated to vote in-house during recent elections.

There was an open visiting policy in place. The inspector observed some visitors coming and going throughout the inspection. Relatives indicated in completed questionnaires that they were always made to feel welcome by staff. Residents had access to the centre’s cordless phones and some residents had their own mobile handset device. Staff
were aware of the different communication needs of residents and care plans set out the ways in which those who had a communication impairment required intervention.

The centre was part of the local community and residents had access to radio, television, daily and regional newspapers. Day service users joined the residents for some activities during the week days, residents enjoyed the social interaction and getting local news.

Judgment:
Compliant

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

Theme:
Person-centred care and support

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

Findings:
There was a laundry room with ample space for washing and drying and sorting of residents' clothing. The inspector noted that good care was taken of residents' personal laundry. Residents and relatives were satisfied with the laundry arrangements and stated that mislaid clothing was not an issue.

Adequate personal storage space including a wardrobe and chest of drawers was provided in residents’ bedrooms.

Judgment:
Compliant

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

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

**Findings:**
On the days of inspection, there was an adequate ratio of staff to residents on duty throughout the day. On the day of inspection there were four nurses and four multi-task assistants providing direct resident care on duty during the daytime; two nurses and two multi-task attendants providing direct resident care on duty in the evening time from 17.00 to 22.30 and one nurse and two multi-task attendants on duty at night time 22.30 to 08.00. The person in charge was also on duty during the day time. Staff rotas reviewed by the inspectors indicated that these were the usual arrangements. The person in charge told the inspector that following the last inspection some work practices including the administration time of night time medicines had been reviewed to allow for better supervision of residents by the evening and night time staff.

The inspector was satisfied that safe recruitment processes were in place. There was a recruitment policy in place based on the requirements of the Regulations. A sample of staff files reviewed were found to contain all documentation as required by the regulations. Garda Síochána vetting was in place for all staff. Nursing registration numbers were available and up-to-date for all staff nurses.

The management team were committed to providing on-going training to staff. Staff had recently completed training in nutritional assessment, medication management, falls management, infection control, risk management, wound care, care planning and use of cleaning chemicals.

**Judgment:**
Compliant

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**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:**

Mary Costelloe  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority
Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider’s response to inspection report

| Centre name: | Dean Maxwell Community Nursing Unit |
| Centre ID:    | OSV-0000665                           |
| Date of inspection: | 04/01/2017                           |
| Date of response:   | 02/02/2017                           |

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 03: Information for residents

| Theme: | Governance, Leadership and Management |

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The details regarding additional charges were not clearly set out in the contract of care.

1. Action Required:
Under Regulation 24(2)(b) you are required to: Ensure the agreement referred to in regulation 24 (1) relates to the care and welfare of the resident in the designated centre and includes details of the fees, if any, to be charged for such services.

1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Residents contracts of care have being amended setting out details in relation to additional charges

Proposed Timescale: Complete

Proposed Timescale: 02/02/2017

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:
Policies such as the emergency plan, fire policy and complaints policies required updating to reflect current practices in the centre. The restraint policy was not fully reflected in practice.

2. Action Required:
Under Regulation 04(3) you are required to: Review the policies and procedures referred to in regulation 4(1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.

Please state the actions you have taken or are planning to take:
The Emergency Plan, Fire Policy and complaints policies are being reviewed and updated. Nursing documents have been updated to reflect the restraint policy in practice.

Proposed Timescale: 28/02/2017

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The directory of residents required updating in order to fully comply with all the requirements of the regulation. The address of the next of kin, the date, time and cause of death when established were not always included.

3. Action Required:
Under Regulation 19(3) you are required to: Ensure the directory includes the information specified in paragraph (3) of Schedule 3.

Please state the actions you have taken or are planning to take:
The directory of residents has been updated to fully comply with all the requirements of the regulation.

Proposed Timescale: Complete

**Proposed Timescale: 02/02/2017**

**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:**
Documentation to support the management and use of restraint was not in line with the centres own policy or national policy on the use of restraint. Risk assessments completed were not in line with policies. There was no evidence that alternatives had been tried or considered or of the risks involved in using the restraint. There was no evidence of multidisciplinary input into the decision to use the restraint measure and consent for the use of restraint was not always documented. There were no care plans in place to guide staff on the use of bedrails.

Some residents who presented with responsive behaviour were prescribed psychotropic medicines on a 'PRN' as required basis. These medicines were administered occasionally for some residents. However, records were not always maintained to indicate the rationale for administration of these medications or what other interventions had been tried to manage the behaviour.

4. **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:**
All staff will have training in behaviours that challenge (MAPA). Dates of training to be finalised
All care plans will be reviewed and Risk Assessments will be completed in line with restraint policy as necessary. ABC charts will be completed for all residents with challenging behaviour.
Multi disciplinary input will be sought when considering the use of restraint, to include GP, OT, and professionals as relevant. Records will be maintained indicating the rationale for administration of PRN medication or what other interventions had been tried to manage the behaviour. A care plan will be developed to guide staff on the use of bedrails when and if required. Audits will be carried out on a quarterly basis to monitor the use of all restraint. Consent for the use of restraint will be documented appropriately.

**Proposed Timescale: 28/02/2017**

**Theme:**
Safe care and support
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The inspector reviewed a sample of staff and volunteers files and noted that safeguarding measures such as Garda vetting were in place, however, the person in charge could not confirm if Garda vetting was in place for all staff. She undertook to carry out an audit of all staff files to provide assurance that all staff had Garda vetting in place.

5. Action Required:
Under Regulation 08(1) you are required to: Take all reasonable measures to protect residents from abuse.

Please state the actions you have taken or are planning to take:
An audit of all staff files has been undertaken; the person in charge can confirm that Garda vetting is in place for all staff.

Proposed Timescale: Complete

Outcome 08: Health and Safety and Risk Management
Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The emergency plan in place did not outline guidance for staff as to what their role might be in the event of evacuation of the centre.

6. Action Required:
Under Regulation 26(2) you are required to: Ensure that there is a plan in place for responding to major incidents likely to cause death or injury, serious disruption to essential services or damage to property.

Please state the actions you have taken or are planning to take:
The Emergency Plan has being updated detailing guidance for staff on their roles in the event of evacuation of the centre.

Proposed Timescale: Complete

Proposed Timescale: 02/02/2017
Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The person in charge confirmed that fire safety training for staff included three separate training modules including evacuation, person on fire and fire extinguisher training. These training modules took place on different dates. Training records reviewed indicated that all staff had attended some of the modules but many staff had not attended all three.

7. Action Required:
Under Regulation 28(1)(d) you are required to: Make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.

Please state the actions you have taken or are planning to take:
Fire training is ongoing; the next fire training session has been arranged for the 7th February, 2016. Further dates to be confirmed by the Fire officer. Staff in the unit will have received training all modules by the end of April.

Proposed Timescale: 30/04/2017
Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Records reviewed indicated that fire drills had not taken place regularly or recently, the last drill took place in September 2015.

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:
A fire drill took place on the 11th January, 2017 which was attended by 9 staff. The next fire drill is scheduled to take place on the 7th February to coincide with the fire training session.

Proposed Timescale: Complete

Proposed Timescale: 02/02/2017

Outcome 09: Medication Management

Theme:
Safe care and support
The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Nursing staff spoken with had concerns regarding the new medicines system. There was insufficient storage space on the medicines trolley to securely store medicines. Medicines were being stored in individual zip locked bags insecurely on top of the medicines trolley during the medicines round. This posed a risk to residents, staff and visitors.

9. Action Required:
Under Regulation 29(4) you are required to: Store all medicinal products dispensed or supplied to a resident securely at the centre.

Please state the actions you have taken or are planning to take:
Purchase of a new medication trolley has been approved which will provide sufficient storage space for individual medication thereby eliminating risk to residents, staff and visitors. Discussions are taking place with alternative pharmacies in the town that may be in a position to provide daily blister pack medications for residents as previously supplied.
All nursing staff in the unit to complete online medication management training, certificates for same to be submitted to the person in charge by the 28th February, 2017

Proposed Timescale: 31/03/2017

Outcome 11: Health and Social Care Needs

Theme:
Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There were no care plans in place to guide staff on the use of bedrails. Responsive behaviour care plans in place did not clearly outline guidance for staff regarding known triggers, distraction techniques and use of prescribed psychotropic medicines. While ABC charts were in use to log episodes of responsive behaviour, these were not consistently completed. Staff spoken with were clearly able to describe the care but this was not always reflected in the care plans.

10. Action Required:
Under Regulation 05(3) you are required to: Prepare a care plan, based on the assessment referred to in Regulation 5(2), for a resident no later than 48 hours after that resident’s admission to the designated centre.

Please state the actions you have taken or are planning to take:
All staff will have training in behaviours that challenge (MAPA). Dates of training to be finalised
ABC charts will be completed for all residents with challenging behaviour.
All care plans will be reviewed, where appropriate responsive behaviour care plans have been updated to clearly outline guidance for staff regarding known triggers, distraction techniques and use of prescribed psychotropic medicines. Risk Assessments will be completed in line with restraint policy as necessary. Multi disciplinary input will be sought when considering the use of restraint, to include GP, OT, and professionals as relevant. Consent for the use of restraint will be documented appropriately. Records will be maintained indicating the rationale for administration of PRN medication or what other interventions had been tried to manage the behaviour. A care plan will be developed to guide staff on the use of bedrails when and if required. Audits will be carried out on a quarterly basis to monitor the use of all restraints.

Proposed Timescale: Complete

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**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The person in charge told the inspector that chiropody services were difficult to access on a regular and consistent basis.

11. **Action Required:**
Under Regulation 06(2)(c) you are required to: Provide access to treatment for a resident where the care referred to in Regulation 6(1) or other health care service requires additional professional expertise.

Please state the actions you have taken or are planning to take:
All options to increase access will be explored.

Proposed Timescale: 28/04/2017

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**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was only one bathroom with specialised bath available for the use by all residents. There was no other separate shower facilities for residents occupying single bedrooms. Staff advised that these residents used the showers located in the en suite bedrooms of other residents. Residents did not have a choice of bath or shower and lack of adequate showering facilities impacted on the privacy and dignity of all residents. Some of the single bedrooms were located a distance from the bathroom
which also impacted on residents privacy, dignity and comfort. Staff confirmed that because there was only one bath available it was not always available to residents at the time of their choice. The inspector noted that while staff were sensitive to residents’ rights for privacy and dignity, the physical environment posed significant challenges when delivering personal care and attending to residents’ care needs.

There was still inadequate space for the storage of equipment. Staff spoken with confirmed that this was an on going issue as there was no separate storage available to store equipment such as specialised chairs, wheelchairs, walking frames and hoists when not in use.

There was no comprehensive list of equipment with service due dates or up to date service certificates available in the centre therefore the inspector could not determine if all equipment was recently serviced. The person in charge did not know when some equipment was serviced or due to be serviced, this posed a risk to residents and staff.

12. **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:
Through the Capital Plan 2016 – 2021 for Services for Older People funding has been allocated for a programme of refurbishment works within the unit. This is part of the overall control development plan for North Tipperary. A room has been identified within the unit that will be converted into a shower room which will be available to all residents. A storage area will be identified for equipment not in use.
A log of equipment will be developed to include service dates and other relevant information (repairs, purchase date etc.). These will be completed by the 30th June, 2017

Proposed Timescale: 30/06/2017 for development of shower room and other minor works and the 31/12/2021 for the completion of refurbishment works under the capital plan

**Proposed Timescale:** 31/12/2021

**Outcome 13: Complaints procedures**

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

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The complaints policy required updating in order to reflect the changes to the nominated complaints officer.
The complaints procedure displayed was not user friendly in that it was not clear how
to make a complaint, the print size was small and it did not include the name of the current nominated complaints officer.

13. **Action Required:**
Under Regulation 34(1) you are required to: Provide an accessible and effective complaints procedure which includes an appeals procedure.

**Please state the actions you have taken or are planning to take:**
The complaints policy has been updated to reflect the changes to the nominated complaints officer. The information displayed is now user friendly and clear on how to make a complaint.

Proposed Timescale: Complete

**Proposed Timescale:** 02/02/2017
**Theme:**
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Verbal complaints had not been recorded. The person in charge told the inspector that there had been a number of recent complaints in relation to inadequate heating in the centre but these had not been recorded.

14. **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 log has been reviewed and updated to include verbal complaints.

Proposed Timescale: Complete

**Proposed Timescale:** 02/02/2017