

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Carysfort Nursing Home
Centre ID:	OSV-0000022
Centre address:	7 Arkendale Road, Glenageary, Co. Dublin.
Telephone number:	01 285 0780
Email address:	edward@carysfortnh.com
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Breda Pakenham & Edward Pakenham Partnership, trading as Carysfort Nursing Home
Lead inspector:	Sonia McCague
Support inspector(s):	Siobhan Kennedy; Niall Whelton
Type of inspection	Announced
Number of residents on the date of inspection:	51
Number of vacancies on the date of inspection:	1

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:
13 December 2017 07:30	13 December 2017 20:00
10 January 2018 11:55	10 January 2018 19:20

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

Outcome	Our Judgment
Outcome 01: Statement of Purpose	Substantially Compliant
Outcome 02: Governance and Management	Non Compliant - Moderate
Outcome 05: Documentation to be kept at a designated centre	Substantially Compliant
Outcome 07: Safeguarding and Safety	Compliant
Outcome 08: Health and Safety and Risk Management	Non Compliant - Major
Outcome 09: Medication Management	Compliant
Outcome 11: Health and Social Care Needs	Compliant
Outcome 12: Safe and Suitable Premises	Non Compliant - Major
Outcome 16: Residents' Rights, Dignity and Consultation	Substantially Compliant
Outcome 18: Suitable Staffing	Compliant

Summary of findings from this inspection

This purpose of this inspection was to inform a decision in relation to the application to renew the registration of this designated centre.

The provider submitted an application for the renewal of registration six months in advance of the registration expiry date of 13 February 2018. Inspectors found discrepancies between the information received and the information provided in the application to renew documentation. A key issue was the omission of a building, which was part of the designated centre, from the plans of the centre and application form. The building was included in the Statement of Purpose. This was communicated to the provider during and following this inspection. An amended statement of purpose and floor plan of the main building was received on 28 December 2017. However, the revised documents still did not include the separate building located on the grounds that was used as an office by the person in charge and those participating in management for the storage of residents' and general

records, and safekeeping of some resident's personal property.

Overall during the course of this inspection inspectors found that this centre is a good centre demonstrating compliance or substantial compliance in seven out of 10 outcomes measured. The centre was clean and well maintained and residents were well cared for. However this inspection also identified areas that required improvement including the management and review of risks including fire safety risks system; the system of governance and management in place and matters related to the premises.

Feedback provided from residents and relatives in questionnaires to the Health Information and Quality Authority (HIQA) and to inspectors during the inspection were positive. Staff were aware of the organisational and reporting structure within the centre and were aware of the ethos and principles underpinning the provision of nursing and social care. Residents had good access to nursing, medical and allied health care and the administration of medicines was satisfactory.

There were measures in place to protect residents from being harmed or suffering abuse and information received confirmed that residents felt safe in the centre.

Residents' assessed needs and arrangements to meet these assessed needs were set out in individual plans. Inspectors saw that there were good opportunities for residents to participate in activities, appropriate to their interests and capacities.

The inspectors found from an examination of the staff rosters, communication with staff on duty, residents and relatives that the levels and skill mix of staff at the time of inspection were sufficient to meet the health and social care needs of residents. There was evidence that staff had access to education and training, appropriate to their role and responsibilities.

Governance and management systems were in place. However, these arrangements required review and improvement to ensure the effective delivery of care and to ensure that the service provided was safe. The management and review of risks, emergency policies and procedures, fire safety, the statement of purpose and records relating to staff numbers and training required improvement.

Inspectors were not assured that the fire safety arrangements in place were adequate to ensure prompt, safe and efficient evacuation of residents from the designated centre. A lack of compartmentation of the building to contain the spread of fire and smoke in the event of a fire was found.

The premises furnishings and decor throughout was of a good standard. However, as previously reported, a part of the premise was not appropriate to the number and needs of the residents in accordance with the statement of purpose. Parts of the premises did not conform to the matters set out in Schedule 6 to meet residents' individual and collective needs. The suitability of some shared and multi-occupancy bedrooms that included residents at end of life also required review.

The findings from this inspection are identified in the body of this report and areas of

non-compliance requiring improvement are outlined within the action plans at the end of this report for response.

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):

No actions were required from the previous inspection.

Findings:

There was a written statement of purpose (SOP), and there was evidence that it had been kept under review, however, it did not fully contain or detail all of the information set out in Schedule 1.

While the most recent SOP version received 28 December 2017 had improved following feedback given to the provider and person in charge on 13 December 2017, the following matters were not sufficiently set out:

- The total staffing complement, in numbers and whole time equivalents (57 staff) was not compatible with the total number of staff identified in documents held by the person in charge such as staff training records (47) and roster (44).
- All rooms in the designated centre, their size and primary function, was not included in the statement of purpose. For example, the bathroom and toilet facilities available were not listed and the floor plans submitted did not reflect the facilities observed. For example, an additional bathroom and separate shower outlined in the ground floor plan was not available. In addition, the narrative under environment set out in the SOP included a separate building 'bungalow' which was not outlined in the floor plans submitted.
- The information in relation to admission of residents to the designated centre was incomplete as it stated 'etc, etc' which required clarification.

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):

No actions were required from the previous inspection.

Findings:

During the course of this inspection, inspectors found that there was a clearly defined management structure with explicit lines of authority and accountability. However the governance and management arrangements in place required review and improvement to ensure that the service provided was safe and effectively monitored.

While an auditing and management system was in place to capture statistical information in relation to monitoring resident outcomes, the management systems were ineffective as it failed to identify and assess the significant fire safety risks identified by inspectors that impacted on residents' welfare.

The governance and management arrangements failed to ensure the accuracy and reliability of records maintained. The auditing and monitoring systems had not identified a range of inadequate fire precautions and insufficient arrangements for the safe evacuation of dependent residents.

The governance and management arrangements failed to ensure information was reliable in the floor plans and statement of purpose to accurately reflect the facilities and layout of the centre.

There were sufficient resources available to meet the health and social care needs of residents. Staff and residents were familiar with the management team's roles and responsibilities for the provision of care and told inspectors that that they were friendly, approachable and readily available. A low level of incidents, accidents and complaints was reported with evidence of learning from audits implemented. An annual review of the quality and safety of care delivered to residents was completed.

Discussions with residents and relatives during the inspection and satisfaction surveys completed by or on behalf of residents were positive in respect to the provision of the care, the facilities and the services provided.

Management, staff, resident and relative meetings were held to aid and facilitate communication. Minutes of meetings were maintained. There was evidence of consultation with residents and their representatives in a range of areas from admission and on a daily basis including a monthly resident forum.

Recruitment procedures that involved the person in charge, training analysis and staff appraisal systems were in place to monitor and manage performance. A low turnover of staff was reported by the person in charge.

Despite the range of governance and management systems in place, a review and improvement was required to ensure that the service provided was safe, appropriate and effectively monitored.

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):

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

Findings:

During this inspection the registered provider was substantially compliant with this outcome.

Three issues were identified that required action

- The management of emergencies policy requires review as it referenced fire evacuation procedures that included the use a 'blanket drag' or 'two person carry' which the person in charge confirmed was not for use.
- A detailed record of fire practices and drills with any action taken to inform learning or remedy defects found was not maintained
- Inconsistencies were found in staffing numbers across a range of records that included the roster, statement of purpose whole time equivalents and staff training matrix.

Judgment:

Substantially Compliant

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

Theme:

Safe care and support

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

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

Findings:

During the course of this inspection inspectors determined that there were effective safeguarding systems in place.

Inspectors found improvements since the August 2016 inspection in relation to the management of residents presenting with behaviours that challenge. The provider also evidenced that there were measures in place to protect residents from being harmed or suffering abuse. Residents who spoke to inspectors confirmed that they felt safe in the centre and this was reiterated by relatives.

Staff had opportunities to participate in training in the protection of residents from abuse. Staff were knowledgeable about the different types of abuse, what to do in the event of a disclosure about actual, alleged, or suspected abuse and how to investigate an incident of abuse.

Good emphasis was placed on residents' safety with the exception of fire safety detailed in Outcome 8. Inspectors saw that a number of measures had been taken to ensure that residents felt safe. For example there was a keypad lock on the main entrance of the centre. Inspectors saw that there were aids and facilities in place to support mobile residents for example hand and grab rails in corridors which was a matter highlighted during the inspection on the 8 August 2016.

While there was a policy and procedure in place for the use of restraint it was evident in discussions with the inspectors that restraint was not fully understood by staff, for example whether the use of bedrails was a restraint while being an enabler to some. As a result of this confusion appropriate procedures were not always adhered to including notifying HIQA of the use of all restraints. By the second day of inspection this has been addressed.

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):

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

Findings:

During the course of this inspection the provider failed to assure the inspectors that there were sufficient measures in place to manage the risk of fire and ensure the safety of residents if a fire was to occur. For this reason a judgment of major non-compliance has been made.

The main issues of concerns where assurances were sought but not given by the provider are detailed below.

This designated centre is laid out over three floors. The internal escape stairway, which extends from second floor to ground floor, was not separated from the first floor bedroom corridor with fire rated construction. The full height of the internal escape stairway and the entire first floor bedroom corridors formed one enclosure. Inspectors were concerned that in the event of a fire in the building that this enclosure could rapidly fill with smoke. There is a risk that this would impede the evacuation of residents and staff at first and second floor level, who were required to enter this space as part of their means of escape. On the first day on this inspection the provider was informed of the inspectors concerns in relation to the lack of compartmentation in the designated centre. Inspectors were informed that some measures to contain fire and smoke at first floor level had previously been explored, but a plan was not in place at this stage.

In addition inspectors were not satisfied that adequate means of escape was provided for all residents. The configuration of the first floor meant that progressive horizontal evacuation would not be feasible as there was no subdivision of the bedroom corridor to provide a relative place of safety in an adjoining compartment.

Inspectors were concerned that in the event of a fire, adequate containment of fire and smoke could not be achieved throughout the building as not all areas that required containment, including some fire hazard rooms, were appropriately enclosed in fire rated construction. For example, inspectors were not assured that;

- the laundry room on the ground floor was adequately separated from the bedroom corridor with fire rated construction. Laundry rooms are considered as presenting a high fire risk, and this laundry room opened directly onto a bedroom corridor.
- the panel above a fire door at second floor level was fire rated.
- the store room beneath the main stairs was fitted with a fire rated door or smoke detector. This room contained the gas mains pipe.
- most fire doors provided throughout the building were fitted with smoke seals. The provider relied on doors fitting tightly to the door frame to contain smoke. However, inspectors observed some fire doors with gaps when closed and were concerned that fire doors would not be capable of adequately preventing the spread of smoke in the building.

In addition to the above inspectors also observed other practices that compromised fire safety, such as a fire door held open with a wedge, a fire door to a linen store left in the open position and some exits partially obstructed by furniture.

Records for the fire safety systems showed they were being serviced at the appropriate intervals. However, a certificate for annual inspection of the emergency lighting system, of a type detailed in the Irish Standard (I.S. 3217: 2013 Emergency Lighting) was not available. Inspection reports for the routine tests carried out on a quarterly basis were available, but included details of units which failed the test. The provider told inspectors that the matter would be addressed and the appropriate certificate would be forwarded to the Office of the Chief Inspector.

The provider also failed to assure the inspectors that adequate measures were in place to ensure the safe evacuation of residents in the event of a fire. For example:

- Taking into account the dependency of the residents in this centre, the inspectors were not satisfied that the external escape routes were suitable due to the grassy slope, uneven surfaces, stepped areas and partial obstruction of pathways. Inspector observed that the provider had constructed a partial new concrete pathway between the first and the second day of the inspection, however, external escape routes still did not provide adequate means of escape from the building.
- Inspectors were not assured that fire drill practices and documentation were sufficient to demonstrate that the arrangements for evacuation in the event of fire were fit for purpose. Inspectors were told by staff that fire drills take place as part of the structured fire safety training with an external instructor. Neither the provider or the records were able to illustrate how long it would take to evacuate residents from a specific compartment nor were records were available to identify issues that may have arisen during those drills.
- The inspectors reviewed the current layout, design, lack of compartmentation at first floor, staffing and residents' dependency levels. Following discussion with the provider, he failed to provide assurance that staffing arrangements were adequate to carry out an evacuation of residents from some parts of the building in the event of fire.

Although the registered provider had put in place health and safety and risk management policies and procedures, the risk register did not identify the fire safety risks identified by inspectors and therefore appropriate controls were not in place either to minimise or fully control these risks. For example, risk assessments were not available for two oxygen cylinders stored within the main escape stairway, nor was there a risk assessment for the use of free-standing hair drying equipment within the first floor bedroom escape corridor.

Judgment:

Non Compliant - Major

Outcome 09: Medication Management

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

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

Residents had access to a pharmacist and to a general practitioner (GP) of their choice. The majority of residents opted for the services of their previous GP. The processes in place for the management of medicines were safe.

The inspectors were informed by a staff nurse administering medicines to residents that the medication policy and procedures were useful guides in the management of residents' medication. They included information on the prescribing, administering, recording, safekeeping and disposal of unused or out of date medicines.

Staff nurses had participated in medication management training during July 2017.

Prior to administering medicines to residents the inspectors observed the staff nurse consulting with residents while administering medicines and performing good hand hygiene.

Medicines were contained in a blister pack prepared by the pharmacist. Prescription and administration sheets were available. Inspectors saw that the administration sheet contained the necessary information for example the medication identified on the prescription sheet, a space to record comments and the signature of the staff nurse corresponded to the signature sheet.

There was evidence of general practitioners (GPs) reviewing residents' medicines on a regular basis. On the day of inspection a GP was reviewing residents' care and medications. In the communications with the inspectors it was confirmed that staff implemented recommendations made following a review.

The inspectors were informed and saw that audits of medication management had been carried out by management and the pharmacist.

The system for storing controlled drugs was seen to be secure. They were stored safely in a locked safe/container in an area which was locked, however, it was noted that storage space was limited, as referenced in Outcome 12. Stock levels of controlled drugs were recorded at the beginning/end of each shift in a register in keeping with best practice. An inspector examined a random selection of medicines available and this corresponded to the register.

Judgment:

Compliant

Outcome 11: Health and Social Care Needs

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

needs and circumstances.

Theme:

Effective care and support

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

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

Findings:

Inspectors saw that the criteria for admission in the statement of purpose referred to carrying out a pre-assessment of residents' needs prior to admission. This was actioned by the person in charge and a comprehensive assessment is completed by the admitting nurse in collaboration with the residents and their families. Thereafter staff nurses are responsible for a number of residents' care plans. A review and audit of the comprehensive assessments was carried out on 8 November 2017 and the assistant director of nursing has overall responsibility for auditing care plans.

The inspectors saw that an audit of the documentation was carried out following the admission of a resident. Staff had been provided with guidance regarding writing care plans which directed care and had participated in training in July 2016. Some relatives who communicated with the inspectors confirmed that they are involved in the care planning process and are informed of their relatives' healthcare needs and any changes in their conditions.

Inspectors examined a sample of care plans. Information contained in the care plans was recorded in a computerised system with accessible panels located throughout the centre so that staff can read the care plan and easily input information. A staff member described how to access the plan of care.

Inspectors saw that the menus for the lunchtime meal were displayed on the tables in the dining rooms. There were two choices on the lunch menu at the time. Residents and relatives who communicated with the inspectors confirmed that meals were nutritional and a variety of choices were available.

There are two sittings arranged for residents in the dining rooms. Inspectors saw that the dining rooms were supervised and that staff assisted residents with their meals in a discreet and sensitive manner.

The centre provides care primarily for residents with long-term nursing needs and supervision. Resident dependency assessment rating provided by the person in charge showed 15 residents assessed as maximum dependency, six high, 14 medium and 16 low. The person in charge informed inspectors that 22 residents had a diagnosis of dementia and eight had a cognitive impairment.

From an examination of a sample of residents' care plans, discussions with residents, relatives and staff, inspectors were satisfied that the nursing and medical care needs of residents were assessed and appropriate interventions/treatment plans implemented. For example, there was information which detailed residents' choices with regard to

daily routines, risk assessments such as dependency, moving and handling, falls, use of bed rails, nutrition and continence.

There were arrangements in place to manage and monitor wounds. The inspectors, in particular, examined the care plans of two residents with wounds. The inspectors saw specific care plans and regular reviews. Wound assessment charts were in place. A noted improvement was evident for both residents. There was documentary evidence that residents were reviewed by tissue viability specialist services. Repositioning charts and monitoring charts for fluid and nutritional intake were available. Aids such as pressure relieving mattresses and specialist cushions were in place for those residents at risk of developing pressure ulcers, however if they chose not to have these items their wishes were respected.

There was evidence of appropriate medical and allied health care for example, referrals to the dietician, occupational and physio therapists, psychiatry of old age and speech and language therapists.

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:

The provider had not ensured that a part of the premises was appropriate to the number and needs of the residents in accordance with the statement of purpose prepared under Regulation 3. Parts of the premises did not conform to the matters set out in Schedule 6 to meet residents' individual and collective needs. For these reasons a judgment of major non-compliance was made.

The centre was operated by the current registered provider (partnership) since 1989. The designated centre consisted of the main building and a bungalow used by the person in charge and persons participating in management for administration purposes.

The premise was homely, clean, warm and well maintained. It was suitably decorated

throughout and communal rooms occupied by residents were colourfully co-ordinated with appropriate furnishings and fittings. The flooring, furnishings and decor throughout was of a good standard. CCTV was in place on corridors and communal areas.

There were emergency call facilities accessible from each resident's bed and in rooms used by residents. Inspectors observed safe floor covering, grab-rails in bathrooms, showers and toilet areas, and handrails along corridors and stair cases.

Inspectors read and confirmed with staff that residents were appropriately transferred to lower floor levels when their mobility and condition deteriorated. All residents accommodated on the first and second floors need to be able to mobilise independently and or be able to weight bear and use the stairs or chairlift with staff assistance. Inspectors were informed that residents on the first or second floor did not require a full body hoist, some were independently mobile and some required a sit-to-stand hoist or assistance of one or two staff for transfers or mobilising.

Inspectors found that the size, layout and available floor space for residents in some shared bedrooms (4, 5, 6 and 7) required particular attention, review and improvement. For each of the 36 residents (69%) accommodated in shared and or multiple occupancy bedrooms, their personal space was defined by a screen curtain for the purpose of providing them privacy. Some of these personal space areas had limited available or usable floor space for the individual residents. For example, the size of the personal usable floor space for a resident of the multi-occupancy bedrooms 5 and 7 was less than 5.5m² (metres squared). The size of the personal usable floor space for two residents in bedroom (4) when the screen curtain was pulled around their bed was less than 5m². In some shared bedrooms the beds were less than 1m apart with little or no space to access both sides of the bed.

A full review of the layout, occupancy levels and space provision in the multi-occupancy and shared bedrooms was required to ensure bedrooms are of a suitable and acceptable size and layout to meet the privacy, dignity and needs of all residents including those approaching the end of life. Other improvements were required to ensure the privacy and dignity of residents as outlined in Outcome 16. To date the registered provider has not submitted a written costed time bound plan to meet the requirements of the regulations and Schedule 6. The number of available bathrooms and toilet facilities also requires clarification, as outlined in outcome 1.

The suitability of storage was highlighted on previous inspections as needing improvement. However, this requirement was not fully addressed. During the inspection hoists and other equipment such as a dinamap machine used by staff for monitoring blood pressure was seen stored in residents' bedrooms, and wheelchairs, commode and laundry skips obstructed access to toilets and wash hand basins on the ground floor. A resident's modified chair was stored in their bedroom when not in use and was seen obstructing the emergency exit path from the bedroom. Residents' mobility aids were stored outside the conservatory when not in use by the residents who were seated in the dayroom.

Equipment for use by residents was available and found to be in good working order. However, handrails along circulating areas and bathrooms were found to be obstructed

by equipment such as linen skips, baskets and trolleys used by staff.

Chair/stair-lifts were in place on internal stairwells between each of the three floors and on the split level on the ground floor outside the main kitchen. However, those using wheelchairs were unable to circulate independently to the main entrance due to split level flooring.

Judgment:

Non Compliant - Major

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:

There was evidence that residents were consulted with and had opportunities to participate in their daily routine and in the organisation of the centre.

An active residents' committee was operational monthly, residents had opportunity to meet on a daily and regular basis with staff and management. Family members' involvement in residents' care and welfare was promoted. Feedback received from relatives and records of communication with family members confirmed this.

Access to and information in relation to the complaints process and independent advocacy services was available to residents. Residents' choice and autonomy were promoted. Practices observed demonstrated residents were offered choices. Residents who spoke with the inspectors said they were able to make choices about how they spent their day, where they ate meals, bed times or partake in activities. Residents knew who to complain to and had options to meet visitors in a private or in communal areas based on their assessed needs.

A comprehensive communication policy was in place. Communication and notice boards, daily newspapers, telephone and video call facilities were available. Some residents had personal electronic devices to enable them to engage in communication with the wider community. Management confirmed the availability of Wi-Fi to residents.

The inspectors established from speaking with residents and staff that opportunities to

maintain personal relationships with family and friends in the wider community was very much encouraged. Arrangements were provided for residents to attend family occasions and opportunities to socialise and link with the wider community by arranged outings with family or friends. Visits by members from the local community were also facilitated.

A register of visitors was maintained in the main entrance hall. Residents were seen receiving visitors in private or in communal rooms throughout the inspection.

The inspectors saw that residents' privacy and dignity was respected. Residents were seen to be well groomed and dressed in an appropriate manner, with clothes and personal effects of their choosing.

Many residents' bedrooms were personalised with items and memorabilia. An enclosed rear garden and patio area with garden furniture and flower beds was available from the ground floor conservatory of the main day/dining room.

Residents who spoke with the inspectors said they were well cared for by kind and helpful staff. Family also shared this view of the care and service provided. Contracts of care had been revised since previous inspections, issued to all residents and completed by or on behalf of residents.

Fifteen residents occupied six bedrooms that were identified as fire exits. As a result, their bedroom was to be accessible at all times and in the event of an emergency, therefore the choice or opportunity to lock the main bedroom door was restricted. In addition, inspectors confirmed with staff that the fire exit from bedroom 5, where four residents were accommodated, was used to access the centre on occasions to facilitate other resident admissions and transfer or discharge when the use of a wheelchair or stretcher was required. This bedroom had a ramp to gain access into the centre as there were a number of steps at the main entrance to the centre. This finding is included in the action plan of Outcome 12.

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:

Individual staff members highlighted that they had participated in training in relation to fire safety, infection-control, safeguarding the residents and moving and handling. Staff training and development was promoted. A staff training programme was in place, and a record of training for rostered staff was available.

Staff who communicated with the inspectors demonstrated that they had a good knowledge of the residents in the centre.

Residents and representatives were full of praise for the staff team and spoke highly of their competency, friendliness and delivery of care.

Inspectors observed staff on duty being patient and friendly towards residents, and respectful of their privacy and dignity for example knocking on residents' bedroom doors and supporting them appropriately.

Staffing levels and the staff skill mix were sufficient to meet the health and social care needs of residents. However, due to the findings outlined in Outcome 8, a review of staffing is required to mitigate the risks identified. Staff confirmed that they had sufficient supervision and direction and had time to carry out their duties and responsibilities. The inspectors reviewed the roster for staff and found that management, nursing, care and support staff were adequate. Requests and residents' alarm bells were promptly responded to by staff during the inspection. Residents chose the time that they wished to get up, eat and seek assistance with personal care and dressing, and this was seen to be facilitated by the staff team. Most residents remained in communal rooms and out of their bedrooms for the duration of this inspection.

A low turnover of staff was reported. Recruitment procedures were in place and ongoing when a vacancy arose, three care attendants were in the process of being recruited. A sample of staff files were reviewed against the requirements of Schedule 2 records and found to be compliant. The management team explained the systems in place to recruit, induct, supervise and appraise staff. Staff were seen to be sufficiently supervised and were supportive of residents and responsive to their needs in a timely manner. Residents were complimentary regarding the staff team and the numbers of staff available to them.

Staff handovers, allocation and meetings formed part of the operational management and communication systems that afforded staff to report and raise issues with management and discuss areas to be developed or improved.

Evidence of professional registration for all rostered nurses was available and current.

Inspectors were told that no volunteers were involved in the centre.

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:

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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 report¹

Centre name:	Carysfort Nursing Home
Centre ID:	OSV-0000022
Date of inspection:	13/12/2017
Date of response:	13/03/2018

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 (Stakeholder) is failing to comply with a regulatory requirement in the following respect:

The following matters were not sufficiently set out in the statement of purpose as required in Schedule 1:

- The total staffing complement, in numbers and whole time equivalents (57 staff) was not compatible with the total number of staff identified in documents held by the person in charge such as staff training records (47) and roster (44).

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

- All rooms in the designated centre, their size and primary function, were not included in the statement of purpose. For example, the bathroom and toilet facilities available were not listed and the floor plans submitted did not reflect the facilities observed. For example, an additional bathroom and separate shower outlined in the ground floor plan was not available. In addition, the narrative under environment set out in the SOP included a separate building 'bungalow' which was not outlined in the floor plans submitted.
- The information in relation to admission of residents to the designated centre was incomplete as it stated 'etc, etc' which required clarification.

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.

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

- (i) The Statement of Purpose (SOP) was updated to reflect accurately the Centre's whole time equivalent (WTE) staffing. Moving forward the Person in Charge will ensure that where there are any changes to staffing levels. The SOP is amended to reflect same.
- (ii) The RP is currently updating and amending the SOP to reflect the size and primary function of all rooms in the centre.
- (iii) The RP will have the floor plans updated to ensure that they coincide with the SOP.
- (iv) Following a review of the centre's facilities, the RP will continue to include the "bungalow" and its facilities within the designated centre. The floor plans and SOP will reflect same.
- (v) The information in relation to the admission of residents, contained in the SOP, has been updated and clarified.

Proposed Timescale:

- (i) Complete and ongoing
- (ii) 30/04/2018
- (iii) 30/04/2018
- (iv) 30/04/2018
- (v) Completed

Proposed Timescale: 30/04/2018

Outcome 02: Governance and Management

Theme:

Governance, Leadership and Management

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

The governance and management arrangements in place required review and improvement to ensure that the service provided was safe, appropriate and effectively managed.

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:

(i) The RP has undertaken a detailed review by reference to Regulation 23(c), with its legal advisers and the PIC to satisfy itself that the management systems are in place within the centre to ensure that the care service provided in the centre is safe, appropriate, consistent and effectively monitored.

(ii) With focus on the RP's obligations under Regulation 23(c) and to assuage concerns voiced by HIQA inspectors by reference to fire safety, the RP has engaged external Fire Safety Engineers inter alia:

(a) to undertake to review all fire safety concerns communicated to the Provider in HIQA's draft inspection reports issued on 30 January 2018 and 28 February 2018 so that they are reviewed/actioned in a belt-and-braces manner by the time scale below; and

(b) to advise the RP so that a belt-and-braces Fire Safety Monitoring Programme included as part of the regular health and safety audits in the Centre is put in place.

Proposed Timescale:

(i) Legal Advice & Review Completed.

(ii) (a) Review of Fire Safety Engineer to be completed before 16/4/2018 by reference to outcomes elsewhere in this Action Plan.

(b) Completed.

Proposed Timescale: 16/04/2018

Outcome 05: Documentation to be kept at a designated centre

Theme:

Governance, Leadership and Management

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

The management of emergencies policy requires review as it referenced fire evacuation procedures that included the use a 'blanket drag' or 'two person carry' which the person in charge confirmed was not for use.

3. 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 RP has reviewed its Management of Emergency Policy (March 2016) in conjunction with its legal advisers and the PIC by reference to Regulation 4(3) of the Care & Welfare Regulations and has been updated to reflect that the references to "blanket drag" and "two person carry" are removed from the policy.

Proposed Timescale: Completed

Proposed Timescale: 13/03/2018

Theme:

Governance, Leadership and Management

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

A detailed record of fire practices and drills with any action taken to inform learning or remedy defects found was not maintained

Inconsistencies were found in staffing numbers across a range of records that included the roster, statement of purpose whole time equivalents and staff training matrix.

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:

(i) The RP will ensure that there is a documented record of fire practices and drills and is implementing a Fire Drill Evaluation Form which allows the RP to assess staff response times, evacuation times, staff knowledge, equipment using a scoring system from which he can identify areas of good practice and any potential areas of concern.

The RP and PIC will ensure that a fire drill/evacuation practice is carried out monthly and will ensure that both day and night time drills are conducted.

To ensure that all staff are fully conversant with all fire safety and evacuation procedures (given the new compartmentations) the RP has arranged for additional training which does include fire safety, timed evacuation, identifying and responding to fire.

(ii) Staffing numbers across the range of records identified above have been reviewed and are now consistent across all records.

Proposed Timescale:

(i) Fire drill evaluation form is completed and to be used at the next fire drill. Monthly fire drills to commence on 20/03/2018. Fire Marshall training for senior staff completed on 15/02/2018. Further training arranged for 20/3/2018, 22/3/2018 and 26/3/2018.
(ii) Completed.

Proposed Timescale: 26/03/2018

Outcome 08: Health and Safety and Risk Management

Theme:

Safe care and support

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

In accordance with the risk management policy hazards particularly in relation to fire safety had not been identified and risk assessed.

5. Action Required:

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

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

(a) The Provider's Safety Statement is being updated to include hazard identification and assessment of risk particularly in relation to fire safety. The Risk Register already includes same;

(b) In advance of the finalisation of the updating of the Provider's Written Risk Management Policy, the Provider has undertaken fire safety risk assessments. These include the safe storage of oxygen and the use of a free-standing hairdryer.

(c) A three-monthly health and safety risk assessment will be undertaken, this will include fire safety. Where concerns are identified, risk assessments will be undertaken and actioned accordingly.

Proposed Timescale:

(a) Update of Policy to be completed by 16/4/2018.

(b) Fire safety risk audit completed.

(c) Health and safety risk assessments - Completed and repeating on a three monthly basis.

Proposed Timescale: 16/04/2018

Theme:

Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory

requirement in the following respect:

In accordance with the risk management policy measures and actions were not in place to control hazards and risks as they had not been identified and assessed.

6. Action Required:

Under Regulation 26(1)(b) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the risks identified.

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

Fire safety risk assessments have been undertaken. These include the safe storage of oxygen and the use of a free-standing hairdryer. A three-monthly health and safety risk assessment will be undertaken, this will include fire safety. Where concerns are identified, risk assessments will be undertaken and actioned accordingly.

Proposed Timescale:

- (i) Health & safety audit completed and repeating on a three monthly basis.
- (ii) Fire safety risk assessments complete.

Proposed Timescale: 13/03/2018

Theme:

Safe care and support

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

Inspectors observed practices that compromised fire safety, such as a fire door held open with a wedge, a fire door to a linen store left in the open position and some exits partially obstructed by furniture.

A certificate for annual inspection of the emergency lighting system, of a type detailed in the Irish Standard (I.S. 3217: 2013 Emergency Lighting) was not available.

7. Action Required:

Under Regulation 28(1)(c)(i) you are required to: Make adequate arrangements for maintaining all fire equipment, means of escape, building fabric and building services.

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

- (i) The RP does carry out daily fire checks and is including observing for the use of wedges and ensuring that fire doors are kept closed. All staff have been told that it is not acceptable that doors be wedged open and have been spoken to individually and asked that they be vigilant in terms of fire safety, have been told to remove any items, equipment etc. that may be obstructing fire exits and they have been asked to document and report this to the RP and/or the PIC. The RP and PIC will monitor for any non-compliances and address these as they occur.
- (ii) As part of its Action Plan to assuage concerns voiced by the HIQA inspectors, the RP has commissioned a new emergency lighting system to bring it in line with the Irish

Standard (I.S. 3217: 2013 Emergency Lighting). Once completed, the certificate will be made available to the Authority.

Proposed Timescale:

(i) Daily Fire Checks are Completed and Ongoing on a Daily Basis

(ii) Emergency lighting upgrade to be completed by 30/06/2018 and certificate to be forwarded once issued.

Proposed Timescale: 30/06/2018

Theme:

Safe care and support

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

Inspectors were concerned that in the event of a fire, adequate containment of fire and smoke could not be achieved throughout the building as not all areas that required containment, including some fire hazard rooms, were appropriately enclosed in fire rated construction.

The internal escape stairway, which extends from second floor to ground floor, was not separated from the first floor bedroom corridor with fire rated construction. The full height of the internal escape stairway and the entire first floor bedroom corridors formed one enclosure. Inspectors were concerned that in the event of a fire in the building that this enclosure could rapidly fill with smoke.

8. Action Required:

Under Regulation 28(2)(i) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

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

To assuage concerns voiced by the HIQA inspectors, the RP:

(i) Has upgraded the fire alarm system in the centre. A category L1 system has been installed which is designed for the protection of life, which has automatic detectors installed throughout the building with the aim of providing the earliest possible warning. The "bungalow" has also been connected to the new system.

(ii) The RP has engaged a Fire Safety Engineer and will ensure that belt-and-braces

arrangements are in put in place across the centre for detecting, containing and extinguishing fires including on the ground floor, the first floor and the second floor of the centre and same will be effected within the prescribed timeline below. The planned measures will permit that RP to affirm that the RP has taken a belt-and braces approach to address all concern voiced by the HIQA inspectors following the inspection on 10 January 2018, including with regard to the Centre's overall compartmentation, layout, containment and means of escape.

Proposed Timescale:

(i) Complete

(ii) All measures to be completed by 16/04/2018 with the Stairlift to be replaced by 16/04/2018.

Proposed Timescale: 16/04/2018

Theme:

Safe care and support

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

Inspectors were not assured that fire drill practices and documentation were sufficient to demonstrate that the arrangements for evacuation in the event of fire were fit for purpose.

Neither the provider or the records were able to illustrate how long it would take to evacuate residents from a specific compartment nor were records were available to identify issues that may have arisen during those drills.

9. 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:

The RP will ensure that there is a documented record of fire practices and drills and is implementing a Fire Drill Evaluation Form which allows him to assess staff response times, evacuation times, staff knowledge, equipment using a scoring system from which he can identify areas of good practice and any potential areas of concern.

The RP and PIC will ensure that a fire drill/evacuation practice is carried out monthly and will ensure that both day and night time drills are conducted.

The PIC will increase the frequency by which the Residents' Personal Evacuation Plans are reviewed and will include these in the quarterly care plan reviews.

Proposed Timescale:

- (i) Fire drill evaluation form is complete and to be used at the next fire drill.
- (ii) Monthly fire drills to commence on 20/03/2018.
- (iii) PEEPS to be reviewed every four months.

Proposed Timescale: 20/03/2018

Theme:

Safe care and support

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

Inspectors were not satisfied that adequate means of escape was provided for all residents. The configuration of the first floor meant that progressive horizontal evacuation would not be feasible as there was no subdivision of the bedroom corridor to provide a relative place of safety in an adjoining compartment.

Taking into account the dependency of the residents in this centre, the inspectors were not satisfied that the external escape routes were suitable due to the grassy slope, uneven surfaces, stepped areas and partial obstruction of pathways.

10. Action Required:

Under Regulation 28(1)(b) you are required to: Provide adequate means of escape, including emergency lighting.

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

The RP has engaged a Fire Safety Engineer and is undertaking works to ensure that belt-and-braces arrangements are in place across the centre for detecting, containing and extinguishing fires including on the ground floor, the first floor and the second floor of the centre and same will be effected within the prescribed timeline below. The planned measures will permit that RP to affirm that the RP has taken a belt-and braces approach to address all concern voiced by the HIQA inspectors following the inspection on 10 January 2018, including with regard to the Centre's overall compartmentation, layout, containment and means of escape.

Proposed Timescale:

All measures to be completed by 16/04/2018 with the Emergency lighting upgrade to be completed by 30/06/2018 and certificate to be forwarded once issued.

Proposed Timescale: 30/06/2018

Theme:

Safe care and support

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

The inspectors reviewed the current layout, design, lack of compartmentation at first floor, staffing and residents' dependency levels. Following discussion with the provider representative, he failed to provide assurance that staffing arrangements were adequate to carry out an evacuation of residents from some parts of the building in the event of fire.

11. Action Required:

Under Regulation 28(2)(iv) you are required to: Make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and safe placement of residents.

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

The RP has engaged a Fire Safety Engineer and is undertaking works to ensure that belt-and-braces arrangements are in place across the centre for detecting, containing and extinguishing fires including on the ground floor, the first floor and the second floor of the centre and same will be effected within the prescribed timeline below. The planned measures will permit that RP to affirm that the RP has taken a belt-and braces approach to address all concern voiced by the HIQA inspectors following the inspection on 10 January 2018, including with regard to the Centre's overall compartmentation, layout, containment and means of escape, which will include belt and braces arrangements, to support, in the event of fire, the evacuation of all persons in the centre and safe placement of residents.

Proposed Timescale: 16/04/2018

Outcome 12: Safe and Suitable Premises

Theme:

Effective care and support

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

Parts of the premises did not conform to the matters set out in Schedule 6 to meet residents' individual and collective needs in a suitable manner.

To date the registered provider has not submitted a written costed time bound plan to meet the requirements of the Regulations and Schedule 6.

The following matters required improvement as required under Schedule 6 Part 1 and 3:

- A full review of the layout, occupancy levels and space provision in some multi-occupancy and shared bedrooms was required to ensure bedrooms are of a suitable and acceptable layout to meet the privacy, dignity and needs of all residents including those approaching the end of life.
- A review of the privacy and dignity arrangements for all residents (15) occupying six bedrooms that were identified fire exits was required

The use of four residents bedroom (5) to facilitate other residents admission to the centre and or for transfer or discharge of other residents when the use of a wheelchair or stretcher required review and improvement

- Some residents had insufficient space for a bed, a chair and personal storage facility within the privacy screens pulled around their bed area. Bedrooms requiring particular attention and review included bedrooms 4 and 5 on the ground floor and 6 and 7 on the first floor
- There was less than 1m between beds and little or no space to access both sides of a bed as required

- The number of available and accessible bathrooms and toilet facilities require clarification to demonstrate compliance as required under Schedule 6 Part 1 and 3
- Handrails along circulating areas and bathrooms were found to be obstructed by equipment such as linen skips, baskets and trolleys for use by staff
- A lack of suitable storage provision was found. Hoists and other equipment was seen stored inappropriately in residents' rooms, and bathrooms with wheelchairs, commode and skips obstructing access to toilets and wash hand basins. Resident mobility aids were stored outside the conservatory when not in use by the residents who were seated in this dayroom
- Split levels on the ground floor existed which posed restrictions for those accommodated requiring the use of wheelchairs and chairs with wheels to circulate independently to other parts of the centre.

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:

(i) The RP has arranged for a full review of the layout and space provision in the multi-occupancy and shared bedrooms. The review will include consideration of privacy and dignity arrangements for those residents occupying rooms that have fire exits, the use of bedroom 5 as a route of access and multi-occupancy rooms. The review will include the number of available and accessible bathroom facilities. This review will also include storage. The review will also take into consideration residents ability to self-propel in wheelchairs and chairs with wheels.

An external independent healthcare company have been commissioned to undertake the review and provide recommendations to the RP.

(ii) Staff have been advised to ensure that corridors are not obstructed by equipment trolleys etc. and to ensure that a resident can at any time access a handrail at least on one side of the corridor. When not in use, all equipment is to be removed from the corridor immediately.

Proposed Timescale:

(i) Independent review to be complete by 31/4/2018. A costed plan will be developed and submitted to the Authority by 30/6/2018.

(ii) This practice will be monitored by the RP and PIC on an ongoing basis.

Proposed Timescale: 30/06/2018

Theme:

Effective care and support

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

The provider had not ensured that a part of the premises was appropriate to the number and needs of the residents in accordance with the statement of purpose prepared under Regulation 3.

13. 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:

The RP has arranged for a full review of the layout and space provision in the multi-occupancy and shared bedrooms. The review will include consideration of privacy and dignity arrangements for those residents occupying rooms that have fire exits, the use of bedroom 5 as a route of access and multi-occupancy rooms. The review will include the number of available and accessible bathroom facilities. This review will also include storage. The review will also take into consideration residents ability to self-propel in wheelchairs and chairs with wheels.

An external independent healthcare company have been commissioned to undertake the review and provide recommendations to the RP.

Proposed Timescale:

Independent review to be complete by 31/4/2018. A costed plan will be developed and submitted to the Authority by 30/6/2018.

Proposed Timescale: 30/06/2018

Outcome 16: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

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

Fifteen residents accommodated in six bedrooms that had an identified fire exit from the room were restricted in their choice to lock the main bedroom door.

14. Action Required:

Under Regulation 09(3)(a) you are required to: Ensure that each resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.

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

As discussed above, the issue of residents accommodated in bedrooms with an

identified fire exit, will be taken into consideration as part of the independent review. In the interim period, the RP and PIC have spoken with each of these residents. No resident has expressed concerns and have not indicated that they have any concerns with regards to their privacy and dignity. This has been documented in the form of a consent letter. These residents have also been advised that should they wish to move alternative accommodation within the centre will be provided.

Proposed Timescale:

- (i) Independent review to be complete by 31/4/2018.
- (ii) Consent letters complete.

Proposed Timescale: 30/04/2018