<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Merlin Park Community Nursing Unit 5&amp;6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000635</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Merlin Park, Galway.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>091 775 568</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:unit5mph@hse.ie">unit5mph@hse.ie</a></td>
</tr>
<tr>
<td>Type of centre:</td>
<td>The Health Service Executive</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>Health Service Executive</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Marie Matthews</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>Mary McCann</td>
</tr>
<tr>
<td>Type of inspection:</td>
<td>Announced</td>
</tr>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>44</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>8</td>
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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 1 day(s).

The inspection took place over the following dates and times

From: 24 January 2018 10:00
To: 24 January 2018 22:00

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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<tbody>
<tr>
<td>Outcome 01: Statement of Purpose</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 02: Governance and Management</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 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>Non Compliant - Moderate</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>Substantially Compliant</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>Compliant</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 - Major</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>Compliant</td>
</tr>
<tr>
<td>Outcome 14: End of Life Care</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 15: Food and Nutrition</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 16: Residents' Rights, Dignity and Consultation</td>
<td>Non Compliant - Moderate</td>
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<tr>
<td>Outcome 17: Residents' clothing and personal property and possessions</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 18: Suitable Staffing</td>
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Summary of findings from this inspection

This report set out the findings of a two day announced registration renewal inspection, which took place following an application to the Health Information and Quality Authority (HIQA), to renew registration of the designated centre. The provider’s responses to the action plans from the previous inspection in April 2017 were also reviewed.

Merlin Park Community Nursing unit is a 52 bedded residential care centre run by the
Health Services Executive (HSE) in the grounds of Merlin Park hospital on the outskirts of Galway. It comprises two single storey units and was originally designed as tuberculosis hospital. There were 44 residents accommodated on the day of the inspection. The layout of the centre is essentially unchanged and although the provider has made some changes to make it more homely, it continues to pose a challenge to providing a home like environment for residents and ensuring their privacy and dignity are protected due to the configuration of some bedrooms in ward-type units. Practices for showering residents did not ensure the dignity of residents as ensuite bathrooms were not of sufficient size to meet the residents’ needs. Though bed numbers have been reduced in recent years and some new furnishings and small modifications have been made the building, the centre is still clinical in its appearance. The provider has plans to build a new centre to bring the service into compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older Persons) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland, however these plans are at an early stage and planning permission has not yet been secured. The provider representative who was present for part of the inspection stated that the estimated completion date for this rebuild is the end of 2021.

Inspectors identified poor risk management during the inspection with regard to protecting residents’ risk of leaving the centre and the management response to previous incidents of absconsion inadequate. As a result of concerns raised, the person in charge took immediate steps to secure the centre. While a management team was in place with a person in charge and two clinical Nurse Managers based in the centre, the processes for auditing/reviewing the safety and quality of care were not robust as they had did not include respite and short stay residents.

During the course of this inspection, the inspectors spoke with a 7 resident’s and 6 staff members and two relatives. Quality questionnaires completed by residents and relatives in advance of the inspection were also reviewed. The inspectors interactions with residents and staff, observed practices and reviewed records such as the centres accidents and incident log, the risk register, nursing notes and care plans, medical records, policies and procedures and a sample of staff personnel files and staff training records. There was good evidence of regular review of residents by a General Practitioner and residents had regular input from all allied health professionals. Residents said they were happy and felt safe and there were arrangements in place to safeguard them from abuse.

Inconsistencies were identified in relation to the completion of care documentation and care documentation for short stay and respite residents was poor.

The inspectors found that of the 18 outcomes inspected, seven were compliant and five were substantially compliant. However 2 outcomes were judged to have major non compliances identified and 4 had moderate non compliances. At the feedback meeting at the end of the inspection, the findings were discussed with the person in charge. The actions required from this inspection are outlined in body of the report and the action plan at the end. HIQA did not agree that the providers response to the non compliance in relation to
Regulation 09(3)(b) would ensure that each resident may undertake personal activities in private.
Outcome 01: Statement of Purpose

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

Theme: Governance, Leadership and Management

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

Findings:
A copy of the centres' Statement of Purpose was available which described the aims, objectives and ethos of the service. It contained most of the information required by Schedule 1 of the Regulations however it omitted details of a registration condition applied by the Chief Inspector and did not include a clear description of the centre layout. It also omitted details of the centres emergency plan.

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

Findings:
While there was a clear management structure in place with clear lines of accountability, the management systems were not ensuring that the service provided was safe at all times. Inspectors found that the response by management to identified risks was not
robust and had not resulted in a safer environment for residents. This is discussed further under outcome 8.

Audits of accidents and incidents, medication, care documentation, meal times, activities, hygiene, nutrition and care plans were completed but where issues were identified a quality improvement plan was not developed to ensure that deficits were addressed. Inspectors also found that the care plan audits completed did not include the residents receiving respite care. An annual report on the quality and safety of care had been completed using a template provided by the authority. On review the inspectors found that this lacked detail and did not accurately summarise the findings from various audits. The report included a summary however it did not include a improvement plan to address areas of non compliance. For example the issues regarding the suitability of the building identified during the inspection were not referenced or the providers plans to build a new centre.

The person in charge was supported by two clinical nurse managers. She told inspectors that she was also well supported by the provider representative and described him as approachable and accessible. The person in charge met with the provider representative weekly and there was also evidence of formal management meetings which were held every two months. Issues discussed in the minutes included the findings of various audits completed, recent admissions, accidents and incidents, residents’ care, staffing levels, vetting arrangements for staff, recent HIQA inspections and complaints. The person in charge also met monthly meeting with the Directors of Nursing from the other community nursing units in the county.

Judgment:
Non Compliant - Moderate

**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:**
Each resident had an agreed contract of care which outlined the fee payable and the services covered by that fee. There were no additional fees incurred by residents with the exception of the services of a hairdresser. The cost of this service was not referenced in the contracts or included in an attached schedule. The inspectors also found that the contracts of care did not specify if the room to be occupied by the resident was a single or shared room.
An accessible residents guide was available in large font which described the services provided and included pictures to illustrate the services and facilities available.

**Judgment:**
Substantially Compliant

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**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 meets the criteria required by the regulations in terms of qualifications and experience. She is an experienced registered nurse and works full-time in the centre. She had good knowledge of residents care needs. She could describe in an informed way the residents care needs. Residents and relatives spoken with were positive in their feedback to inspectors. She had maintained her professional development through on-going education and had completed a diploma in gerontology and a post-graduate diploma in primary care. She had completed all mandatory training required by the regulations as well as recent training in clinical audit.

**Judgment:**  
Compliant

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**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):**  
Some action(s) required from the previous inspection were not satisfactorily
Findings:
All policies required by Schedule 5 of the regulations were in place and there was a system in place to ensure they were regularly reviewed. A directory of residents’ was maintained which contained the information required in the regulations.

Some care documentation particularly in respect of respite or short stay residents was poorly completed or contained generic information that did not give a good overall picture of the residents clinical status or care needs.

Some of the risk assessments completed prior to use of a restraint measure were poorly completed and the enabling function was not always clearly recorded.

Personal emergency evacuation plans (PEEPs) were available for each resident however these did not always indicate the level of assistance or assistive equipment the resident would require.

Judgment:
Non Compliant - Moderate

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 provider was aware of his responsibility to notify the Authority in the event that the person in charge would be absent for a period of 28 days or more. Appropriate deputising arrangements for the person in charge were in place.

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

**Findings:**
The HSE policy on safeguarding vulnerable adults was available and records reviewed confirmed that there was an on-going program of refresher training on protection of vulnerable adults. Inspectors reviewed the management of residents’ finances. Some residents were responsible for their own finances and some were supported by family. Where the provider representative acted as an agent for residents there were written statements provided two monthly to residents and the management of finances were in accordance with best practice.

Inspectors reviewed the provider’s response to an incident that occurred between two residents and saw that appropriate safeguarding measures were put in place to ensure the safety of all residents. Staff members who spoke with inspectors were aware of the various types of abuse and on the policy for reporting safeguarding allegations/ incidents.

There was a HSE policy to guide staff in the management of responsive behaviours associated with dementia. Inspectors saw that all staff members had completed training to assist them to respond appropriately to residents.

There was evidence of appropriate referral and review of residents with responsive behaviours by psychiatry of later life. However in the sample of behaviour support reviewed there was not always clear guidance to help staff to identify the triggers that might cause an escalation of the behaviours and or proactive and reactive strategies to help reduce the residents’ anxieties.

There was a HSE policy and procedure in place for the use of restraint which clearly outlined the various types of restraint. Inspectors saw that a restraint register was available which was kept up to date and the options such a low entry beds and sensory mats were used instead of restraints such as bedrails. Inspectors saw that risk assessments were completed prior to using any form of restraint however some of these were observed to be poorly completed and where a bedrail was in place to support the resident the enabling function was not always clearly recorded. Similar issues were identified on the last inspection. An action has been included under outcome 5 requiring the provider to address this issue.

**Judgment:**
Substantially Compliant

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

**Findings:**
The arrangements for identification, recording, investigation and learning from serious or adverse events involving residents were inadequate. Two notifications had been submitted by the person in charge since the last inspection where residents with dementia had left the centre without the knowledge of staff. Inspectors reviewed the provider’s response to these incidents and the arrangements for keeping residents at risk safe. The provider’s response to these incidents was poor and did not ensure the safety of residents.

A review by staff of one of the incidents identified an open window in the laundry or sluice as a possible means of exit. During the inspection inspectors found that an open window in the sluice room and the door to this room was ajar. The window in question had a defective catch and could not be secured. Though the fault had been recorded in the centre's risk register and forwarded to the estates department for repair, no action had been taken to fix the window. This issue was immediately brought to the attention of the person in charge by inspectors and the defective lock on the window was repaired. The person in charge also arranged to have a keypad lock fitted to the sluice door and the self closing device adjusted. Although missing person profiles were found on residents files, there was also no evidence that any missing person drills were completed to ensure that the staff could respond promptly to locate a resident who left the centre unknown to staff.

Other risks were identified during the inspection that required controls. For example protective gloves were kept in an open dispenser along the corridors which could be accessed by residents with dementia and pose a risk of choking.

An action from the last inspection related to fire drills had been addressed. Inspectors found that there was recorded evidence available of fire evacuation drills completed. The records indicated the duration of the drills, the staff that took part and identified impediments to a quick evacuation. Personal emergency evacuation plans (PEEPs) were available for each resident however these did not always indicate the level of assistance or assistive equipment the resident would require. Records were available in the centre to verify that fire extinguishers, fire alarms and emergency lighting were regularly.

All staff had received training in fire safety and the centres' evacuation procedures. Staff spoken with by the inspectors was clear on the fire safety procedures and knew what to do in the event of a fire. All fire exit doors were observed to be free from obstruction. Bedroom doors were wide enough to allow immobile residents to be evacuated in their beds. Fire evacuation plans showing the building layout and nearest evacuation route
were displayed in both units.

The centre had supportive handrails along corridors which had been a contrasting colour to the walls. The environment was free of obstructions. Good falls prevention measures were observed to be in place including low entry beds, hip protectors, crash mats, alarm sensors mats and crash mats. Overhead tracking hoists were also fitted in some bedrooms to assist residents. Those at risk of falling were identified by a symbol to make staff aware of the risk. The person in charge had also recently purchased motion sensor alarms to alert staff if a resident at risk of sustaining a fall was getting out of bed without assistance. This had reduced the number of falls occurring.

Appropriate infection control procedures were observed in each unit including hand sanitising gels and protective equipment. All staff members had received training in hand hygiene. An emergency plan which provided guidance in the event of fire, flood, power outage or structural damage to the centre was also available.

Judgment:
Non Compliant - Moderate

<table>
<thead>
<tr>
<th>Outcome 09: Medication Management</th>
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<tr>
<td>Each resident is protected by the designated centre’s policies and procedures for medication management.</td>
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<table>
<thead>
<tr>
<th>Theme:</th>
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</thead>
<tbody>
<tr>
<td>Safe care and support</td>
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<table>
<thead>
<tr>
<th>Outstanding requirement(s) from previous inspection(s):</th>
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<tbody>
<tr>
<td>No actions were required from the previous inspection.</td>
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</table>

Findings:
The inspectors reviewed a sample of prescription and administration records in unit six and saw that they were in line with best practice guidelines. Written evidence was available that three-monthly reviews were carried out. Where PRN or ‘as required’ medication was prescribed the maximum dosage to be administered in 24 hours was stated. Where residents were prescribed blood thinning medication their blood was checked regularly to ensure the correct therapeutic dose and the medication was checked by two nurses and administered according to the INR levels (International Normalized Ratio).

Medications that required strict control measures (MDAs) were carefully managed and kept in a secure cabinet in keeping with professional guidelines. Nurses kept a register of MDAs. The inspector checked a sample of balances and found them to be correct.

A secure fridge was provided for medications that required specific temperature control. The inspector noted that the temperatures were within acceptable limits at the time of inspection. There were appropriate procedures for the handling and disposal of unused
and out-of-date medicines.

Residents had a choice of pharmacies and the pharmacy staff assisted with medication audits. Staff attended regular training on medication management however some nursing staff had were overdue training. An action is included under outcome 18 requiring the person in charge to address this.

**Judgment:**
Compliant

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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 person in charge and the provider representative were aware of the legal requirement to notify the Chief Inspector regarding serious incidents and accidents. To date all relevant incidents had been appropriately notified to the Authority.

**Judgment:**
Compliant

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

**Theme:**
Effective care and support

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

**Findings:**
The centre had 30 long stay residents accommodated at the time of the inspection. A further 12 residents were receiving respite care and 6 were identified as short stay
typically (less than 3 months). The inspectors reviewed a sample of care plans in each unit. Care documentation completed for respite residents was of a different standard to that used for long stay residents and those reviewed were less comprehensive to that for long stay residents.

Assessments were completed on admission for all residents, however the inspectors found it difficult to see what if any care plans were enacted to guide care for residents receiving respite care. While audits of care plan were completed by the person in charge for both units, the care records for respite residents were not included in audits of care plans to evaluate their effectiveness. This practice created risk as there was only minimal guidance available to staff on the health, personal and social care needs of these residents. An example of the risk created by this practice was clearly demonstrated when a respite residents assessed as been at high risk had absconded shortly after admission as discussed under outcome 8. These matters were brought to the attention of the person in charge who assured the inspectors that appropriate action would be taken to ensure appropriate assessment and care planning for respite and short stay residents.

Residents could choose from one of five General Practitioners (GP) who provided care to residents in the centre and there was evidence in the medical files reviewed of regular review by GPs. Residents also had access to specialists consultants where required.

Inspectors saw that residents had good access to allied health professionals where required including dietetic service, chiropody and speech and language therapy (SALT) services, opticians, audiology physiotherapy and psychiatry of later life was available. None of the current residents had pressure wounds. Inspectors saw that care plans were developed and interventions were in place to ensure the skin integrity of residents at risk.

Pain assessments were completed by staff where pain was identified and inspectors saw that pain care plans were developed to guide care and assist staff to reduce pain. However some of the care plans reviewed were generic and some were not linked to the pain assessments completed.

Observations such as blood pressure, pulse and weight were assessed on admission and according to assessed need thereafter. There was evidence available of communication between the centre and acute care services when a resident was being transferred for care. Residents were accompanied by a relative to their out-patient clinic appointments and hospital admissions.

Judgment:
Non Compliant - Major

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
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:
Inspectors acknowledged that there had been improvements to the decoration of the premises since the last inspection. For example, the entrance hall in unit 5 had been wallpapered and a new hall table and lamp had been provided which helped to create a homelike welcoming entrance. The centre was clean, warm and the space around some residents' beds was personalised in so far as was possible.

On previous inspections, HIQA identified challenges posed by the design and layout of the building which does not conform to matters listed in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). Some of these issues continue to impact on the privacy and dignity of residents and these areas are discussed in more detail under Outcome 16 of this report. The centre comprised of two distinct units and was originally designed as a hospital. The general layout had not changed and the centre still resembles a clinical/hospital setting.

Ten bedrooms are in multi-occupancy and were still referred to as wards by the staff. While the number of beds in each room had been reduced since the centres initial registration to four beds in eight rooms and three beds in two rooms, the additional space had not been always been utilised to create a more personalised homelike area for residents to enhance their living space in a meaningful way. The curtain screens provided between beds in one four bedded room remained configured based on 6 beds and the space where the bed had been removed was not utilised for the benefit of the residents.

All multiple occupancy bedrooms had an ensuite bathroom with a level access toilet and shower however, the size of these facilities made it difficult for residents who required the assistance of two staff to maintain their privacy and dignity during personal hygiene care and particularly when showering. There were 7 single bedrooms in unit 6 and 8 in unit 5, one of which had an ensuite bathroom. One of largest single bedrooms in unit 5 was designated as a palliative care /special purpose room for use by residents who became unwell and who were normally accommodated in multiple occupancy rooms. This was not in use on the day of the inspection.

In addition to the ensuite facilities, a large accessible bathroom was provided on each unit. These were used by residents in single rooms which did not have ensuite facilities. There were also some shower rooms no longer in use in both units which were been used for storage. Additional toilets were also available in shared cubicles which did not
afford the resident privacy as they were partitioned by a light wooden structure which did not extend from floor to ceiling. There were also cubicle areas with wash hand basins which the staff said were no longer used but which could be better used as an accessible bathroom.

Communal space was available in each unit and efforts had been made to make these sitting rooms more homelike. Both rooms had had a fireplace, pictures and ornaments and a dresser. The dining room in unit 6 was spacious however the dining room in unit 5 was small and did not provide sufficient space for the 26 residents accommodated in this unit. Consequently some residents had their meals in the sitting room or by their beds. This is described in more detail under outcome 15.

Overhead tracking hoists were provided in bedrooms to assist residents and an emergency call bell system was provided in each bedroom and in most communal areas used by residents however there was no emergency call bell in the conservatory area in unit 5.

Laundry and cleaning facilities are provided in both units. An enclosed area was provided at the rear of the centre which was accessible to both units however this was observed to be overgrown and poorly maintained.

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

**Findings:**
The action from the last inspection in relation to the complaints investigations was addressed. A complaints log was maintained in each unit. Those complaints recorded were investigated and addressed appropriately and the inspectors saw that outcome was communicated to the complainant in a timely manner.

The residents spoken with said they had no concerns about speaking with staff if they had a concern. Relatives spoken with said the staff responded promptly to any concerns they had. The HSE policy 'your service, your say' was displayed in the centre which set out the timeframes to respond to and investigate to a complaint and to inform the complainant of the outcome. The policy included details of an independent appeals procedure and the ombudsman. The person in charge was nominated as the complaints
officer for the centre with overall responsibility to investigate complaints.

Judgment:
Compliant

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 person in charge confirmed that the centre was supported by the community palliative care team. A spacious single room was designated for use by residents receiving end of life care which had a sofa that could be used by relatives. Deceased residents were remembered at an annual memorial service which relatives were invited to.

Inspectors reviewed a sample of resident’s end of life assessments and care plans which contained information on the residents’ physical, spiritual and social needs. A priest is available to the centre and a Chaplin is based on site. End of life care plans reviewed contained a good level of detail to guide care.

'Do not attempt resuscitate’ orders were recorded for some residents and inspectors saw that these were discussed with the residents family and general practitioner (GP) and reviewed regularly.

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:**
Inspectors observed that the dining space available in unit 5 did not provide sufficient space to accommodate all of the residents in the unit in one sitting and no alternative arrangements had been made to provide a second meal sitting to improve the overall dining experience. On the day of the inspection the dining room was observed to be very congested and this impacted negatively on the residents dining experience. Two residents ate in the sitting room. There were 13 residents seated and most residents required assistance from staff with their meal. 12 staff members were in the dining room during the meal. Several residents had their own supportive chairs and a food trolley used to transport food from the main kitchen was also positioned in the room. An action requiring the provider to address the mealtime arrangements has been included under outcome 16.

Staff were observed to assist residents discreetly and chatted with residents during the meal. Those with poor nutritional intake were monitored closely. Staff told inspectors that some residents choose to dine in their own bedrooms, and this was facilitated.

A list of residents on special diets including diabetic, high protein and fortified diets and residents who required modified consistency diets and thickened fluids was communicated to catering and care staff. Residents told the inspectors they were happy with the quality and choice of food and said snacks were freely available between meals. Residents were weighed monthly. Those identified as at risk of weight loss were weighed more frequently and referred to a dietician for advice. The inspector saw that advice from specialists such as the dietician or speech and language therapist was recorded in residents’ care plans and relayed to catering staff in the main kitchen in Merlin Park acute hospital.

Nutritional care plans were available however those reviewed did were not linked to the nutritional assessments completed and did not always include details of the foods the residents liked or disliked. An action has been included under outcome 5 to address this.

**Judgment:**
Substantially Compliant

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**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:
Some residents with high dependency needs were still accommodated in multiple occupancy bedrooms. These residents also had higher hygiene needs due to impaired mobility. The inspectors asked a staff member to illustrate the procedure for showering residents. While a level access ensuite shower was located in all multiple occupancy bedrooms, these were too small to accommodate the two staff members required to assist residents to undress and consequently the practice was to undress the resident at their bed and transfer them by hoist to a wheelchair or shower chair and before bringing them to the shower. While the staff ensured that residents were covered with a sheet/towel and privacy screens were pulled around the bed during this process, the arrangements impacted negatively on the privacy and dignity of the residents.

The provider had made efforts to adapt the premises and make it less clinical and more home like. The occupancy of multiple occupancy bedrooms had been reduced to provide residents with more space. Efforts had been made to personalise the residents’ individual space around their beds and photographs and personal belongings were seen in some rooms. Privacy screens were provided in all shared bedrooms however these had not been adapted in one multiple occupancy bedroom to match the new reduced occupancy and consequently the reduction in bed numbers had not benefited the resident. While privacy screens were observed to be in use, they did not ensure privacy during personal care or communication.

The inspectors reviewed care planning around social care and the provision of meaningful activities. There was a good range of activities available to residents. One staff member coordinated the programme which included activities such as bingo, card games, passive exercise sessions, live music sessions, arts and crafts and therapeutic activities for people with dementia. Sonas (a therapeutic activity for residents with dementia) was also provided weekly in each unit. Documentation was available which recorded the names of those who attended and their level of participation. There was a comprehensive social assessment completed for each resident however there was no apparent link between these and the activity schedule available in the centre.

Staff interactions with residents were seen to be courteous and person-centred and the staff demonstrated a good knowledge and understanding of residents’ backgrounds and personal interests.

As discussed under outcome 15, the dining room was observed to be congested and this impacted negatively on the residents dining experience. No alternative arrangements had been made to arrange a second sitting so that residents dining experience could be enhanced.

Judgment:
Non Compliant - Moderate

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:**
Residents spoken with said they could chose what they wanted to wear with the assistance of staff. They confirmed that their clothing was laundered and returned to them afterwards. Some residents sent their laundry home with their families for laundering. A system was in place to ensure that clothing was returned to the correct resident from the laundry.

Each resident had storage space in their bedrooms that comprised a wardrobe and a locked cupboard where they could store personal valuables. One staff member was responsible for looking after residents clothing and wardrobes were observed to be organised. Clothing was labelled to identify the resident who it belonged to however some labelling had faded and the residents names were no longer legible. There were also poor facilities available in the laundry for segregating residents clothing after it was washed and dried.

There was a policy available on the management of residents’ personal property. A record of person property was completed on admission and the inspector saw that this was updated as new items of clothing were brought in.

There was a policy on the management of residents’ personal property and possessions which the inspector noted was consistent with practice. An up to date property list was maintained for each resident which was viewed by the inspector.

**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):**
No actions were required from the previous inspection.

**Findings:**
The centre is arranged in two distinct units. Each unit had its own allocation of staff and staffing rota. The staffing rosters were reviewed by the inspectors. These were not recorded using a 24-hour clock as required by employment regulations. The normal allocation of staff during the day in each unit was three nurses and eight/nine care assistants. This reduced to two nurses and five care assistants in the evening. A care assistant worked a twilight shift in each unit from 19.30 until 00.30. There were two nurses and one carer on duty in each unit from midnight until 08.00. An allocation sheet was available showing the rooms and residents each staff member was allocated to.

During the inspection the inspectors observed very pleasant interactions between residents and staff members and staff were observed to be readily available to assist residents. Communal areas were supervised at all times during the inspection. The residents and relatives spoken with said the centre's staffing levels were appropriate for the number and needs of the residents.

The inspectors saw that mandatory training was completed by most staff however three staff were overdue training in manual handling. Additionally training was provided in clinical areas to help maintain staff skills. All staff members had completed training in managing responsive behaviours. Seven of the nurses had completed a diploma in Gerontology and three nurses had completed training in palliative care and two had done wound care training.

Inspectors reviewed a sample of personnel files and found them to contain all documentation required under Schedule 2 of the regulations. There was evidence of vetting by the HSE’s liaison department for the staff whose files were reviewed however a copy of the declaration certificate from An Garda Síochána was not present on some files reviewed as is required by the regulations. The person in charge agreed to forward these following the inspection.

The staff files were well organised and the information easily accessible. All nurses active in the centre had confirmation of their 2017 registration with An Bord Altranais agus Cnáimhseachais na hÉireann. There was evidence of regular staff meetings of all staff grades.

**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:

Marie Matthews  
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

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Merlin Park Community Nursing Unit 5&amp;6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000635</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>24/01/2018</td>
</tr>
<tr>
<td>Date of response:</td>
<td>06/04/2018</td>
</tr>
</tbody>
</table>

Requirements

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

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

Outcome 01: Statement of Purpose

Theme:
Governance, Leadership and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The Statement of Purpose omitted details of a registration condition applied by the Chief Inspector and did not include a clear description of the centre layout. It also omitted details of the centre's emergency plan.

1. Action Required:
Under Regulation 03 (1) you are required to: Prepare in writing a statement of purpose.

1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
containing the information set out in Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

**Please state the actions you have taken or are planning to take:**
The centre layout and emergency plan is now included in the Statement of Purpose.

**Proposed Timescale:** 06/04/2018

<table>
<thead>
<tr>
<th>Outcome 02: Governance and Management</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theme:</strong> Governance, Leadership and Management</td>
</tr>
<tr>
<td><strong>The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:</strong> The annual report completed lacked detail and did not accurately summarise the findings from various audits or include an improvement plan to address areas of non-compliance.</td>
</tr>
<tr>
<td><strong>2. Action Required:</strong> Under Regulation 23(d) you are required to: Ensure there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.</td>
</tr>
<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong> The annual report is under review to include the findings of audits carried out in the centre and the improvement plans that are drawn up.</td>
</tr>
<tr>
<td><strong>Proposed Timescale:</strong> 30/04/2018</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Theme: Governance, Leadership and Management</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:</strong> The provider's response to identified risks had not ensured safe outcomes for residents.</td>
</tr>
<tr>
<td><strong>3. Action Required:</strong> 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.</td>
</tr>
<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong> We have carried out a full review of our identified risks and we have drawn up an action plan with our maintenance department.</td>
</tr>
</tbody>
</table>
Proposed Timescale: 06/04/2018

**Outcome 03: Information for residents**

**Theme:**
Governance, Leadership and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The cost of any services not included in the fee were not recorded in the contracts of care occupancy of the room was not clearly stated.

4. **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.

**Please state the actions you have taken or are planning to take:**
The contract of care includes details of room occupancy and fees for residents the only fee is the hairdressing service for the residents.

Proposed Timescale: 06/04/2018

**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:
Some care records were poorly completed or contained generic information that did not give a good overall picture of the resident clinical status or care needs.

Some risk assessments completed prior to using a restraint were poorly completed and where a bedrail was in place to support the resident, the enabling function was not always clearly recorded.

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

**Please state the actions you have taken or are planning to take:**
We have completed an audit of the restraint documentation in use and the enabling function is clearly documented and completed on all restraint assessments now in use.
**Proposed Timescale:** 06/04/2018

**Outcome 07: Safeguarding and Safety**

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There was not always clear person centre guidance to help staff to identify the triggers that might cause an escalation of the behaviours of residents with responsive behaviour and or proactive and reactive strategies to help reduce the residents’ anxieties.

6. **Action Required:**
Under Regulation 07(2) you are required to: Manage and respond to behaviour that is challenging or poses a risk to the resident concerned or to other persons, in so far as possible, in a manner that is not restrictive.

**Please state the actions you have taken or are planning to take:**
A full review of all care plans has been completed and all responsive behaviour care plans have been updated to include a behavioural support plan based on the ABC chart that reflects clear guidance to staff to identify triggers.

**Proposed Timescale:** 06/04/2018

**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:**
Protective gloves were stored in dispensers along corridors however these were not secured to protect residents who may be at risk of ingesting items due to their dementia.

7. **Action Required:**
Under Regulation 26(1)(c)(iii) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control accidental injury to residents, visitors or staff.

**Please state the actions you have taken or are planning to take:**
All the glove dispensers in the units have been removed of the corridors. We carried out a unit risk assessment and we currently do not have any resident at risk of ingesting a non food item.
Proposed Timescale: 06/04/2018

Theme:
Safe care and support

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
The arrangements for identification, recording, investigation and learning from serious or adverse events involving residents were inadequate.

8. **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:
We have carried out a review of all identified risks in the unit and a risk assessment plan has been compiled for these risks. We have reviewed our policy with our unit health and safety committee. There are weekly meeting with the provider to discuss incidents.

Proposed Timescale: 06/04/2018

Theme:
Safe care and support

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
The measures and actions in place to control the unexplained absence of any resident were not adequate to protect those at risk.

9. **Action Required:**
Under Regulation 26(1)(c)(ii) 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 unexplained absence of any resident.

Please state the actions you have taken or are planning to take:
An audit has been carried out on the current arrangements and risks. We have also carried out a missing person drill with staff and recorded our findings.

Proposed Timescale: 06/04/2018

**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:
Care documentation for respite residents was different to that of long stay residents and while an assessment was completed on admission, it was difficult to see what care plans were enacted. Some care plans were generic and had been pre printed and staff did not always add further information to make these care plans more person centred.

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 care plans are completed within 48 hours of admission we have delegated a staff nurse to complete all documentation on admission days. We have installed a computerised care planning system to aid the admission documentation which is currently being commissioned.

Proposed Timescale: 30/04/2018

Theme:
Effective care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Care practices in relation to respite residents did not ensure that their health, personal, and social needs were met.

11. Action Required:
Under Regulation 06(1) you are required to: Having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care for a resident, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais.

Please state the actions you have taken or are planning to take:
A respite documentation audit has been carried out to identify omissions and gaps in the documentation. An action plan was devised for each area to guide staff with the findings.

Proposed Timescale: 06/04/2018

Outcome 12: Safe and Suitable Premises

Theme:
Effective care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory
The registered provider had failed to provide premises which conformed to the matters set out in Schedule 6 of the Regulations as follows:

- Multiple occupancy bedrooms did not meet the individual or collective needs of residents
- Ensuite bathroom facilities did not provide sufficient space to allow residents to shower with dignity and privacy
- Removal of beds from one communal rooms had not resulted in additional space for residents and curtains were still configured based on increased occupancy
- There was inadequate dining space in unit 5 for all residents to eat together and no arrangements had been made to have two sittings
- The enclosed garden was poorly maintained and did not provide a safe accessible space for residents.

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:**
1. A new building has been approved and a design team appointed since the inspection.
2. We have completed a full MDT review regarding shower space and showering practice please see attached MDT report.
3. The curtain configuration based on 6 spaces is only in one room and we are pricing the cost of an overhead hoist instillation and change to curtain configuration in that multi occupancy room and reconfiguring to 3 bed spaces.
4. The dining area in unit 5 was a trial to identify a space for all residents to have their meals together. We acknowledge that it is congested and we are purchasing new dining tables as current tables are round and very large. We have consulted with the residents regarding two sittings and they are discussing it at their residents committee meeting.
5. The garden will be tidied up and new plants and bedding planted as soon as weather allows. We currently have a men’s shed in the unit and they have been planting indoors and are hoping to do some outdoor planting as soon as weather allows.

**Proposed Timescale:**
1. 08/03/2018
2. 23/03/2018
3. 30/05/2018
4. 30/04/2018
5. 30/05/2018

**Proposed Timescale:** 30/05/2018
The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Practice in relation to showering some residents was institutional and impacted negatively on their privacy and dignity.

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

Please state the actions you have taken or are planning to take:
We have completed a full MDT review regarding shower space and showering practice please see attached MDT report.

Note: HIQA did not agree this part of the action plan with the provider despite affording the provider two attempts to submit a satisfactory response regarding how to achieve compliance to ensure that each resident may undertake personal activities in private.

**Proposed Timescale:** 23/03/2018

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The dining room was observed to be very congested and this impacted negatively on the residents dining experience. No alternative arrangements had been made to arrange a second sitting so that residents dining experience could be enhanced.

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:
The dining area in unit 5 was a trial to identify a space for all residents to have their meals together. We acknowledge that it is congested and we are purchasing new dining tables as current tables are round and very large. We have consulted with the residents regarding two sittings and they are discussing it at their residents committee meeting.

**Proposed Timescale:** 30/04/2018

**Outcome 17: Residents' clothing and personal property and possessions**

**Theme:**
Person-centred care and support
The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There were poor facilities available for segregating residents' clothing after it was washed and dried and many labels were observed to have faded and the residents names were no longer legible.

15. **Action Required:**
Under Regulation 12(b) you are required to: Ensure each resident’s linen and clothes are laundered regularly and returned to that resident.

**Please state the actions you have taken or are planning to take:**
The laundry room is being reconfigured to include a facility for sorting clothes and an individual box trolley to return laundered clothes to residents is in use.
A new labelling system is in place for all residents clothing.

**Proposed Timescale:** 30/04/2018