### Health Information and Quality Authority Regulation Directorate

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

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Ballard Lodge Nursing Home</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000011</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Borris Road, Portlaoise, Laois.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>057 866 1299</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:angeladuggan@hill16.ie">angeladuggan@hill16.ie</a></td>
</tr>
<tr>
<td>Type of centre:</td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
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<tr>
<td>Registered provider:</td>
<td>Springwater Home Limited</td>
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<tr>
<td>Provider Nominee:</td>
<td>Angela Duggan</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Siobhan Kennedy</td>
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<tr>
<td>Support inspector(s):</td>
<td>None</td>
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<tr>
<td>Type of inspection</td>
<td>Unannounced Dementia Care Thematic Inspections</td>
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<tr>
<td>Number of residents on</td>
<td>24</td>
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<tr>
<td>the date of inspection:</td>
<td></td>
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<tr>
<td>Number of vacancies on</td>
<td>0</td>
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<td>the date of inspection:</td>
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About Dementia Care Thematic Inspections

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor compliance with specific outcomes as part of a thematic inspection. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

<table>
<thead>
<tr>
<th>From</th>
<th>To</th>
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<tbody>
<tr>
<td>02 June 2016 12:30</td>
<td>02 June 2016 18:00</td>
</tr>
<tr>
<td>03 June 2016 09:00</td>
<td>03 June 2016 17:00</td>
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The table below sets out the outcomes that were inspected against on this inspection.

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Provider’s self assessment</th>
<th>Our Judgment</th>
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<tr>
<td>Outcome 01: Health and Social Care Needs</td>
<td>Compliance demonstrated</td>
<td>Non Compliant - Moderate</td>
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<tr>
<td>Outcome 02: Safeguarding and Safety</td>
<td>Compliance demonstrated</td>
<td>Substantially Compliant</td>
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<tr>
<td>Outcome 03: Residents' Rights, Dignity and Consultation</td>
<td>Non Compliant - Moderate</td>
<td>Compliant</td>
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<tr>
<td>Outcome 04: Complaints procedures</td>
<td>Compliance demonstrated</td>
<td>Compliant</td>
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<tr>
<td>Outcome 05: Suitable Staffing</td>
<td>Compliance demonstrated</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 06: Safe and Suitable Premises</td>
<td>Substantially Compliant</td>
<td>Non Compliant - Major</td>
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</table>

Summary of findings from this inspection

This inspection report sets out the findings of a thematic inspection focusing on dementia care.

The inspector examined the relevant policies and a provider self assessment questionnaire which was received by the Authority. The action plan which accompanied the self assessment identified the action to ensure full compliance. This related to extending the current building with the construction of a new build to the rear of the centre. The Authority had received the architectural plans and these will address the environmental deficits. The table above identifies the judgements made by the inspector in respect of the outcomes.

The matters arising from the previous inspection carried out on 3 November 2015
were completed with the exception of the premises.

On the day of the inspection there were 24 residents with no vacancies. Thirteen residents were assessed as having dementia (vascular and Alzheimer's). There was no specific dementia unit.

The inspection process entailed assessing the care provided, in particular, to residents with dementia. This involved meeting and communicating with the residents, their relatives, and staff members, observing care practices and interactions between staff and residents, reviewing residents’ care documentation such as care plans, medical records and other general records.

In the main, the health-care needs of residents were met with good access to medical and allied health care. Improvements were needed in relation to medication management.

Measures were in place to safeguard residents, however, the policy was not up-to-date. Residents with dementia were provided with support that promotes a positive approach to behaviour that challenges. Staff were working to promote a restraint free environment.

The inspector saw that staff respected the privacy and dignity of residents. The views of residents and their families/representatives were sought and acted upon. An annual review of the quality and safety of care delivered had been completed by management. Observations by the inspector showed that opportunities were provided for residents to participate in activities of their choice and staff engaged in a meaningful way with the majority of residents.

The policy and procedure in respect of managing complaints was effectively implemented.

Staffing levels were sufficient to meet the needs of residents and there was evidence that staff had participated in training opportunities in order to provide a good quality and safe service to residents. Staffs’ knowledge and skills were appropriate to their role. Documentation in relation to staffing was satisfactory.

The design and layout of the premises was not suitable for residents with dementia. Communal facilities and some bedrooms were inadequate and there was insufficient storage space, however, this will be addressed by the construction of the new building which is due to commence within the next couple of months. The provider agreed to formally inform HIQA of the commencement date.

The areas of non-compliance are detailed in the action plan of this report.
Outcome 01: Health and Social Care Needs

Theme:
Safe care and support

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

Findings:
In the main, there was evidence that residents’ needs were assessed and they and their families/representatives where involved in the development of care plans and review of care. Residents had good access to medical and Allied health care. Improvements were needed in relation to medication management.

Documentation in respect of residents’ health care was comprehensive and up-to-date. There were copies of discharge letters/correspondence from hospitals and in respect of residents who were transferred to hospital from the centre the inspector found that the transfer letter contained information about the resident’s health, medicines and personal information. Relatives were informed if a resident was transferred to hospital and in the main would accompany the resident, however if this was not possible a staff member would accompany a resident to ensure that full information was provided. The inspector was informed that a Common Summary Assessments (CSARS) was not routinely available.

There was evidence of an assessment on admission and ongoing assessments in relation aspects of nursing care. This assessment process involved gathering personal information and using validated tools to assess each resident’s risks in specific areas, for example falls, skin integrity, malnutrition, moving and handling and pain.

The inspector saw that residents’ care plans were formally reviewed on a 3 to 4 monthly basis. This was carried out by nursing staff who coordinates the care for an allocated number of residents. Health care assistants were involved to the extent that on a daily basis they provided information regarding residents’ conditions and care to the nursing staff to be written up in the residents’ daily notes which assists in determining if the care plan is implemented and effective or otherwise.

The care planning documentation did not contain a comprehensive communication plan for a resident whose communication mode was non-verbal.

Residents had a choice of general practitioners (GPs) and there was evidence that
contact was made with the resident’s previous GP if residents were admitted from outside the local area and all medical records were passed on to the GP of choice. An out of hours service was available to residents.

Resident had access to a variety of health and social care professionals including geriatrician, dietician, physio, occupational and speech and language therapists. There was evidence that residents had access to dental, ophthalmology, audiology, podiatry and psychiatry services.

Management and some staff told the inspector that residents and their family members are supported and end of life care is provided in accordance with the residents’ and their families’ wishes. These are outlined in an advance directive/end of life care plan. The residents' general practitioner and community palliative care services are available as required and provide a good support for the residential care staff team. Residents’ religious practices are facilitated within the centre. Some staff had attended training on the 20 October 2015 entitled Palliative Care – Creating a Supportive Culture.

Although there were no residents identified with pressure ulcers/wounds there were procedures and protocols in place to manage this aspect of care. These included seeking the assistance and advice of specialist tissue viability services. The inspector saw preventative measures in place for some residents such as pressure relieving cushions and mattresses. Some staff members had attended training in respect of nutrition and wounds on the 29 June 2015.

There were systems in place to ensure residents' nutritional needs were met, and that they did not experience poor hydration. Residents were screened for nutritional risk on admission and reviewed regularly thereafter. Residents' weights were checked on a monthly basis, and more frequently when indicated. Nutritional care plans were in place that detailed residents' individual food preferences, and outlined the recommendations of dieticians and speech and language therapists where appropriate. Nutritional and fluid intake records when required were appropriately maintained. The inspector found that systems and practices were in place for residents with diabetes. Some staff members had participated in training in dysphagia on the 22 April 2015 and other staff had participated in nutrition e-learning during October and November 2015.

The inspector saw that there was a choice of meals offered to residents at lunchtime and teatime. There was an effective system of communication between care and catering staff to support residents with special dietary requirements. Mealtimes in the dining rooms were social occasions with attractive table settings and staff sat with residents while providing encouragement or assistance with the meal. The lunch meal was served to meet a variety of needs of residents for example those who were on a weight reduction diet, diabetic, fortified diets and modified consistency foods including thickened fluids.

There were arrangements in place to review accidents and incidents within the centre, and residents were regularly assessed for risk of falls. Care plans were in place and following a fall, the risk assessments were revised, medications reviewed and care plans were updated to include interventions to mitigate the risk of further falls.
There were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents. The matter arising from the previous inspection which related to a medication error had been satisfactorily actioned. A pharmacist reviews each resident’s drug kardex and these findings are shared with the resident’s GP who in turn reviews the resident’s medication and make changes as appropriate. The inspector observed the administration of medication at lunchtime and found that safe medication management practices were not in place as medicines for some residents had been pre-dispensed into vials and were stored in the medicine trolley which was unlocked. In one instance medication being crushed had not been prescribed by the GP.

**Judgment:**
Non Compliant - Moderate

### Outcome 02: Safeguarding and Safety

**Theme:**
Safe care and support

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

**Findings:**
Overall measures to protect residents with dementia being harmed or suffering abuse were in place. Residents were provided with support that promotes a positive approach to behaviour that challenges and a restraint free environment was promoted.

There was a policy on safeguarding however, the policy/procedure did not reference the National Policy ‘Safeguarding Vulnerable Persons at risk of Abuse’ (2014).

The inspector saw that there were measures in place to safeguard residents, for example management had systems in place to monitor the service and an annual review in respect of the quality and safety of care of residents had been completed. This included consultation with residents and relatives. Some relatives who spoke with the inspector communicated that they were aware of the role of the person in charge, management and the staff nurse in charge and would have no hesitation in bringing any matter of concern to their attention. Residents considered that they were safe and primarily this was due to the support and care provided by the staff team. An examination of the training records identified that staff had participated in training in the protection of residents from abuse (April 2015). Staff who spoke with the inspector were knowledgeable about the various types of abuse, recognising abuse, and were familiar with the reporting structures in place. While there were no investigations into allegations of abuse the person in charge was knowledgeable of the process.

There was a policy and procedures in place that promotes a positive approach to the behaviours that challenge/psychological symptoms of dementia (BPSD) for example it
emphasises non-restrictive and non-pharmacological interventions is the preferred method of providing support.

Staff had assessed and implemented care plans for residents with behaviours that were challenging and this included the approach adopted by staff who had participated in training on the 27 May 2015 regarding preventing and responding to behaviours that challenge.

A restraint free environment was fully promoted. This was brought about by trailing enabler bars to assist residents to move in bed as opposed to using bedrails. Currently there are no low low beds but only 7 residents require the use of a bedrail on one side of the bed. The records showed that assessments and reviews had been carried out in consultation with the residents, their families and medical staff. Staff had risk assessed the alternatives. Information and data in respect of auditing restraint is collected on a monthly basis. On the day of the inspection the majority of residents were up and about during the day.

Incidents where restraint was used were notified to the Authority in accordance with the regulation.

The inspector reviewed the system in place to manage residents' money, and found that it was sufficiently comprehensive to ensure transparency and security. Residents' financial transaction records were signed and witnessed by two staff or a staff member and the resident. An examination of a resident's monies corresponded with the resident's financial records. Residents had a locked facility in their own bedrooms to secure their processions and valuables.

**Judgment:**
Substantially Compliant

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

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

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

**Findings:**
Overall, the residents’ privacy and dignity was respected, they had opportunities to participate in meaningful activities and could exercise choice and control over their lives through a variety of consultation methods.

Staff who communicated with the inspector confirmed that they worked to ensure that each resident with dementia received care in a dignified way that respected their privacy. The inspector observed staff knocking on bedroom and bathroom doors, and
privacy locks were in place on these doors. The inspector saw that staff knew the residents well and interacted with them in an appropriate and respectful manner. The inspector was informed that staff sought the permission of residents before undertaking any care task.

There was evidence that residents with dementia were involved in the consultation process with regard to the organisation of the centre. Management established a residents’ forum which takes place on a regular basis and minutes are maintained of the items discussed and action to be taken. The last meeting took place on the 17 May 2016 and 8 residents and 3 staff attended. At this meeting, residents commented on the enjoyable activities that they had participated in during March and April 2016 and their priority for action was to plant flowers for the courtyard. Residents and relatives’ questionnaires were issued in May 2016 to assess quality improvement initiatives to be carried out within the year.

Residents were able to receive visitors in private either in their own bedrooms or in the designated visitor’s room. There were restrictions on visitors during meal times but the reason for this was to ensure that residents had good nutrition. A visitor’s sign in book was available in a prominent location at the front entrance.

Residents were facilitated to exercise their civil, political and religious rights. Arrangements were in place for residents to vote during the last election and the inspector was informed that local politicians were in the centre talking to residents. Residents who communicated with the inspector were satisfied with opportunities for religious practices.

There was a variety of activities available to residents in the centre, organised by the activities staff and health care assistants. Residents’ wishes and preferences informed their daily routines. The inspector saw some residents freely move around the centre choosing to participate in the group activities or going to their own bedroom. The activity schedule advertised group activities arranged for the mornings and afternoons and individual sessions scheduled for residents with more severe dementia or cognitive impairment who could not participate in the group activities.

Activities included music, board games, arts and crafts, gardening, exercise to music, reading, reminiscence, poetry, dog therapy, watching television and hand massages. The inspector saw that some residents had a life story book which had been compiled by family and staff and the person in charge communicated to the inspector the immense value this was to the resident. Staff were careful to ensure that residents with dementia were orientated to date and time.

The staff who had responsibility for coordinating residents activities had attended a variety of training in 2015, for example practical skills associated with sonas, engaging easter and summer activities for residents in nursing homes and a hand massage training course.

Family and staff members supported residents to maintain contacts with their community, for example some families took the residents to their homes to meet up with their relatives and neighbours. Four residents and 4 staff members attended a
theatrical evening. Residents with dementia had free access to a secure well maintained
courtyard garden.

The inspector observed the quality of interactions between staff and residents using a
validated observational tool to rate and record at five minute intervals, the quality of
interactions between staff and residents in the communal sitting room.

The definition of the scoring for the quality of interactions for the period observed is as
follows: –

• +2 positive connective care – the facilitation of meaningful interaction and
  engagement with residents.
• +1 task orientated care – the provision of kind physical care, whereby
  interactions/conversation is more instructive.
• 0 neutral care – the delivery of services is passive and not stimulating.
• -1 protective and controlling – provision of individual care with the emphasis on safety
  and risk aversion.
• -2 institutional care – regarding residents as a homogeneous group who will fit into the
  established routine of the designated centre/home.

The scores reflect the effect of the interactions between staff and residents for the
majority of residents.

The findings are as follows in respect of 3 distinct observation periods during the
inspection when residents were engaged in organised activities: –

• 100% of residents experienced positive connective care as staff interacted and
  engaged with the majority of the residents.

The provider assessed this outcome as moderate non-compliant. Primarily this was due
to the deficits in the premises which are discussed in outcome 6.

Judgment:
Compliant

Outcome 04: Complaints procedures

Theme:
Person-centred care and support

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

Findings:
There was a system in place to ensure that the complaints of residents with dementia or
their representatives were listened to and acted upon, and they had access to an
appeals procedure.
The complaints policy and procedure was comprehensive and detailed the process. The information was publicised throughout the designated centre and a summary was available in the resident’s guide. Residents who communicated with the inspector were familiar with the staff and the person in charge. They communicated that if they had a difficulty they would approach any of the staff team. Relatives were satisfied that issues raised were addressed.

In addition to the designated complaints officer there was a designated person who would review the complaint and investigation process should a complainant be dissatisfied with the outcome.

The inspector saw that the independent advocacy service was advertised and the person in charge was engaging this service on behalf of a resident.

Records were maintained in a satisfactory manner. There was a complaints log which recorded the complaints, investigation of the complaint and the outcome for the complainant. In 2015 there were only 2 complaints and these were not serious issues.

**Judgment:**
Compliant

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<th>Outcome 05: Suitable Staffing</th>
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**Theme:**
Workforce

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

**Findings:**
There were appropriate staff numbers and skill mix to meet the assessed needs of residents taking into account the size and layout of the centre.

The recruitment policy/procedures in place were satisfactory. This process included induction and probationary periods for staff and checking and recording that all of the information is available for staff working at the designated centre. An examination of randomly selected documentation in relation to 2 staff members was satisfactory including up-to-date registration with the relevant professional body.

The inspector found that there were appropriate staff numbers and skill mix to meet the assessed needs of residents. There was a planned staff roster in place, with changes clearly indicated. The staffing in place on the day of inspection was reflected in the roster.

There were a variety of meetings scheduled in order to ensure that staff of various grades had appropriate knowledge to deliver services to residents. This included handover meetings at the change of shifts and performance management meetings.
The inspector found that there were opportunities for staff to participate in education and training relevant to their role and responsibility, for example all staff had participated in mandatory training in respect of fire safety, safeguarding, infection-control and hand hygiene. Staff had attended a variety of training regarding dementia care for example current developments within dementia care, implementation of the National dementia education awareness programme, evaluation of dementia care practice, preparation for dementia thematic inspection and a staff member attended the dementia specific master class. Refresher training in moving and handling and first aid was advertised to take place during June/July 2016.

The staffing arrangements provided for the supervision of residents in communal rooms and staff who communicated with the inspector were knowledgeable of residents conditions and preferences. The person in charge informed the inspector of the supervisory relationships within the centre and these were satisfactory.

The inspector saw that volunteers in the centre have their roles and responsibilities set out in writing and were vetted.

Judgment:
Compliant

Outcome 06: Safe and Suitable Premises

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 design and layout of the building does not meet the requirements of the regulations/standards as there is inadequate private and communal accommodation for residents and some bedrooms are not of a suitable size and layout to meet the needs of residents.
This was the matter arising from the previous inspection and remains outstanding as all of the necessary planning permissions have not been approved in order to commence the construction of the new building. The provider informed the inspector that it is anticipated construction will commence in July 2016.

There was only one large communal sitting room which is used for relaxing and recreational activities with the result that it was difficult to control noise levels. Storage space was insufficient throughout the centre. There is an external courtyard which was popular with residents during the period of the inspection and an extensive garden to the rear of the centre. Some of the sizes of the bedrooms and toilet facilities did not meet the needs of residents. There were grab rails and hand rails used in common areas to support residents independently walking and a functioning call bell system in place.
Although the centre is not suitable for its stated purpose and colour on walls, flooring and doors to toilets and bathrooms was not used to support residents with dementia to find their way around, it was comfortable and homely and residents and relatives who communicated with the inspector were hoping that the new building will retain the homely atmosphere.

Residents with dementia were supported to individualise their bedrooms with personal items and furnishings and many had availed of this opportunity.

The inspector saw that resident had access to appropriate equipment which promoted their independence and comfort for example hoists. The equipment was maintained and serviced. However, the fabric on some of the chairs in the sitting room were torn and the legs of some dining room chairs were rusted.

**Judgment:**
Non Compliant - Major

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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:**

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

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<tr>
<td>Date of inspection:</td>
<td>02/06/2016</td>
</tr>
<tr>
<td>Date of response:</td>
<td>28/06/2016</td>
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Requirements

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

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

Outcome 01: Health and Social Care Needs

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The particular communication requirements of a resident was not recorded in the resident’s care plan.

1. 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

1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Please state the actions you have taken or are planning to take:
All residents have care plans and each care plan has identified 'communication with the resident' within. The resident identified can communicate verbally but on occasion due to their diagnosis becomes mute. We had not identified how to communicate with the resident during these occasional episodes. This has now been identified and documented.

Proposed Timescale: 28/06/2016

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Administration of medicines was not carried out in accordance with the designated centres policies and procedures as the staff nurse pre-dispensed medicines which were contained in an unlocked trolley.

Medication being crushed was not prescribed by the GP.

2. Action Required:
Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.

Please state the actions you have taken or are planning to take:
All staff nurses attended in-service on medication management with emphasis on:
1. Dispensing Medication
2. Unlocked trolley
As regards the single item of medication that did not have crushed written beside it for a resident who has difficulty in swallowing.... This has now been rectified by the GP.

Proposed Timescale: 28/06/2016

Outcome 02: Safeguarding and Safety

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The policy/procedure in respect of safeguarding had not been reviewed to reference the National Policy 'Safeguarding Vulnerable Persons at risk of Abuse' (2014).
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:**
Our Policy has been reviewed and reference was made to the National Policy 'Safeguarding Vulnerable Persons at risk of Abuse' (2014).

**Proposed Timescale:** 28/06/2016

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**Outcome 06: Safe and Suitable Premises**

**Theme:**
Effective care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The design and layout of the centre did not meet the needs of residents with dementia and did not meet the requirements of the regulations/standards in particular schedule 6.

The fabric on some of the chairs in the sitting room were torn and the legs of some dining room chairs were rusted.

4. **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:**
Planning permission has been granted and we hope to commence the project in the coming weeks.

All items of furniture have been either removed or repaired

**Proposed Timescale:** 28/06/2016