# Compliance Monitoring Inspection report

**Designated Centres under Health Act 2007, as amended**

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Costello’s Care Centre</th>
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</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000333</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Ballyleague, Roscommon.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>043 33 21361</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:costellosnursinghome@gmail.com">costellosnursinghome@gmail.com</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>Costello’s Nursing Home Limited</td>
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<tr>
<td>Provider Nominee:</td>
<td>Shay Costello</td>
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<tr>
<td>Lead inspector:</td>
<td>PJ Wynne</td>
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<td>Support inspector(s):</td>
<td>Damien Woods</td>
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<td>Type of inspection:</td>
<td>Unannounced</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>27</td>
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<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>0</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.
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 ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 15 March 2016 10:00
To: 15 March 2016 16:00

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

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Our Judgment</th>
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</thead>
<tbody>
<tr>
<td>Outcome 01: Statement of Purpose</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 02: Governance and Management</td>
<td>Substantially Compliant</td>
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<tr>
<td>Outcome 04: Suitable Person in Charge</td>
<td>Compliant</td>
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<tr>
<td>Outcome 05: Documentation to be kept at a designated centre</td>
<td>Compliant</td>
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<tr>
<td>Outcome 07: Safeguarding and Safety</td>
<td>Substantially Compliant</td>
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<tr>
<td>Outcome 08: Health and Safety and Risk Management</td>
<td>Substantially Compliant</td>
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<tr>
<td>Outcome 09: Medication Management</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 11: Health and Social Care Needs</td>
<td>Substantially Compliant</td>
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<tr>
<td>Outcome 13: Complaints procedures</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 18: Suitable Staffing</td>
<td>Compliant</td>
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Summary of findings from this inspection

This report set out the findings of an unannounced monitoring inspection. Notifications of incidents received since the last inspection was also considered and reviewed on this visit.

The physical environment meets the needs of residents. The centre was clean, warm and pleasantly decorated. Residents were complimentary of staff and satisfied with care services provided. The staff supported residents to maintain their independence where possible.

There was evidence of medical reviews and access to allied health services.

There was an adequate complement of nursing and care staff rostered for each work shift. Mandatory training required by the regulations was completed by staff.

A total of ten Outcomes were inspected. The inspector judged four Outcomes as compliant and the remaining six Outcomes as substantially in compliance with the regulations.
The action plan at the end of this report identifies these and other areas where improvements must be made to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.
Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

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

Theme:
Governance, Leadership and Management

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

Findings:
The Statement of Purpose set out the services and facilities provided in the designated centre and contained all the requirements of Schedule 1 of the Regulations.

The statement of purpose accurately described the aims, objectives and ethos of the centre and the service that was provided.

The Statement of Purpose was revised in February 2016.

Judgment:
Compliant

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

Theme:
Governance, Leadership and Management

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

Findings:
The provider has ensured sufficient resources to ensure the delivery of care in accordance with the Statement of Purpose. There was a defined management structure
in place with which staff were familiar. The governance arrangements in place are suitable to ensure the service provided is safe, appropriate and consistent.

There was evidence of quality improvement strategies and monitoring of the services. A schedule of audits was planned for 2016. The inspector reviewed audits completed by the person in charge. Some of the areas audited included policies, complaints, medication management, the usage of bedrails and incidents including any falls by residents.

The theme of the audits focused on documentation. The outcomes resulted in polices being revised including the complaints procedures or medication management administration practices. There were regular governance meetings to discuss findings and trends noted.

The audit program requires more focus on key quality indicators for example, the usage of psychotropic or might sedative medication to inform practice to ensure enhanced individual outcomes for residents.

**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 has not changed since the last inspection. The person in charge fulfils the criteria required by the regulations in terms of qualifications and experience. She is a registered nurse and holds a full-time post.

The person in charge has maintained her professional development and attended mandatory training required by the regulations. She has maintained her clinical skills up to date.

The person in charge is well known by residents. She was knowledgeable of residents care needs and could describe in an informed way where residents had specific needs and how staff ensured that their care needs were met.

**Judgment:**
Compliant
**Outcome 05: Documentation to be kept at a designated centre**

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

**Theme:**
Governance, Leadership and Management

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

**Findings:**

The inspector found that there were systems in place to maintain complete and accurate records. Records were stored securely and easily retrievable.

Written operational policies, which were centre specific, were in place to inform practice and provide guidance to staff.

A sample of three staff files were examined to assess the documentation available, in respect of persons employed. The information required by Schedule 2 of the regulations was available in the staff files reviewed.

**Judgment:**
Compliant

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**Outcome 07: Safeguarding and Safety**

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

**Theme:**
Safe care and support

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

**Findings:**
There were effective and up to date safeguarding policies and procedures in place. Risks to individuals were managed to ensure that people had their freedom supported and respected. There were sufficient numbers of suitably qualified staff on each work shift to meet residents’ needs in a person-centred manner.

Staff had the knowledge, skills and experience they needed to carry out their roles effectively. The inspector observed and saw that residents were treated respectfully and provided with support appropriately.

Staff spoken with were able to explain the different types of abuse, signs to look out for and how to report any concerns. Staff identified a senior manager as the person to whom they would report a suspected concern. The inspector viewed records confirming there was an ongoing program of refresher training in protection of vulnerable adults.

One notifiable incident of adult protection which is a statutory reporting requirement to HIQA was reported since the last inspection. The person in charge and provider had completed a review with a report on the outcome. The incident was reported to the HSE, senior case worker for adult protection.

There is a policy on the management of responsive behaviour. Staff spoken with were familiar with resident’s behaviours and could describe particular residents’ daily routines to the inspector. Staff have participated in training in caring for people with dementia and responsive behaviours. There is an ongoing program of training in place.

Where residents had specialist care needs such as mental health problems there was evidence in care plans of links with the mental health services. Referrals were made to the consultant psychiatrist to review residents and their medication to ensure optimum health. The community mental health nurse visits the centre to provide specialist advise to support care to residents.

There was a policy on restraint management (the use of bedrails and lap belts) in place. A restraint free environment was bring promoted. At the time of this inspection there were eight residents with their bedrails raised. Signed consent was obtained by the resident or their representative. A risk assessment was completed prior to using bedrails and regularly reviewed.

When a resident requested the bedrail to be raised for use as an enabler a risk assessment was not undertaken to ensure the practice was safe. The restraint risk assessment tool requires review to take cognisance of a broader range of issues. Risks from challenging behaviour, intermittent confusion or medical conditions were not explored in the assessment tool utilised.

Judgment:
Substantially Compliant
**Theme:**
Safe care and support

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

**Findings:**
The governance arrangements to manage risk situations were specified. The risk management policy contained the procedures required by the regulation 26 and schedule 5 to guide staff. Responsibility for health and safety procedures and an organisational safety structure was included in the risk management policy and health and safety statement. There were arrangements in place for appropriate maintenance of fire safety systems including the fire detection and alarm system. Action notices detailing the procedures to take in the event of discovering a fire or on hearing the alarm were displayed. The needs of the residents had been assessed in the event of an evacuation of the centre. Personal emergency evacuation plans were developed for residents detailing their evacuation requirements.

There was an ongoing program of refresher training in fire safety evacuation. Escape route plans were displayed on corridors to show the nearest escape exit. Fire safety checks were completed and recorded in the fire register.

The building, bedrooms and bathrooms were visually clean and well maintained. A sufficient number of cleaning staff were rostered each day of the week. A separate sluice and cleaning room was not provided in the interest of best practice for infection control and minimising the risk of cross infection.

There were arrangements in place for recording and investigating untoward incidents and accidents. The inspector noted that falls and near misses were documented. In the sample of accident report forms reviewed vital signs for residents were checked and recorded. Neurological observations were recorded where a resident sustained an unwitnessed fall or a suspected head injury.

The training records showed that staff had up-to-date refresher training in moving and handling. There was sufficient moving and handling equipment available to staff to meet residents’ needs. Moving and handling risk assessments were completed for each resident. The type of hoist was specified where required. However, the sling size required by the residents was not specified in all assessment reviewed. While staff could explain the different colours of slings they were uncertain which size was associated with each colour.

There was a contract in place to ensure hoists and other equipment to include electric beds and air mattresses used by residents was serviced and checked by qualified personnel to ensure they were functioning safe.
Hand testing indicate the temperatures of radiators or dispensing hot water did not pose a risk of burns or scalds. Restrictors were fitted to windows.

**Judgment:**
Substantially Compliant

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

**Theme:**
Safe care and support

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

**Findings:**
There was a management policy in place which provided guidance to staff to manage aspects of medication from ordering, prescribing, storing and administration.

Each resident’s medication was dispensed from a blister pack individual packs. These were delivered by the pharmacy and contained a monthly supply of each resident’s medication. The drugs on arrival are checked against the prescription sheets in the signed kardex to ensure all medication orders received were correct for each resident. The blister packs had different colour codes for each medication round and the MARS was colour coded correspondingly.

The inspector reviewed a sample of drugs charts. Photographic identification was available on the drugs chart for each resident to ensure the correct identity of the resident receiving the medication. The prescription sheets reviewed were legible in all cases. The maximum amount for PRN medication was indicated. The GP’s signature was in place for each prescribed.

Drugs were being routinely crushed for a small number of residents at the time of this inspection. Two medications were being crushed prior to administration although it was identified there were unsuitable to be crushed. This was discussed at the close out meeting. The person in charge confirmed alternatives would be sourced immediately.

The medication administration sheets viewed were signed by the nurse following administration of medication to the resident and recorded the name of the drug and time of administration. The drugs were administered within the prescribed timeframes. There was space to record when a medication was refused on the administration sheet.

Medications that required strict control measures were kept in a secure cabinet which was double locked in keeping with the Misuse of Drugs (Safe Custody) Regulations. Nurses kept a register of controlled drugs. Controlled drugs were checked by two nurses at the change of each shift. At the time of this inspection three residents were
administered controlled drugs. The inspector checked a selection of the balances and found them to be correct.

**Judgment:**
Substantially 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

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

**Findings:**
There were 27 residents in the centre during the inspection and one in hospital. There were ten residents with maximum care needs. Four residents were assessed as highly dependent. Seven had medium dependency care needs. Six residents were considered as low dependency. Many residents were noted to have a range of healthcare issues and the majority had more than one medical condition.

Recognised assessment tools were used to evaluate residents’ progress and to assess levels of risk for deterioration, for example vulnerability to falls, dependency levels, nutritional care, the risk of developing pressure sores and continence needs.

The management team were in the process of transitioning to an electronic care planning system. The inspector reviewed three resident’s care plans in detail and certain aspects within other plans of care. Care plans were developed for residents based on issues identified on assessment and records indicated they were reviewed and updated on an on-going basis. Care plans provided adequate guidance on the care to be delivered. Staff were knowledgeable of residents preferred daily routine, their likes and dislikes.

However, further work is required to develop care plans that are more person-centred and individualised for resident with dementia. Care plans for residents with dementia did not identify where the resident is on their dementia journey. Information such as who the resident still recognised or what activities could still be undertaken to guide staff practice was not recorded.

Residents had access to the services of a general practitioner (GP), including out-of-hours, and there was evidence of regular review. Residents had access to allied
_health/specialist services such as speech and language therapy, dietetics, and physiotherapy. There was evidence of referral and review._

There were no residents with pressure wounds at the time of this inspection. A number of residents were provided with air mattresses. Repositioning records were completed for residents who spent long periods of time in bed due to frailty.

Nutritional screening was carried out using an evidence-based screening tool. Each resident was weighed monthly and those at risk on a more frequent basis. Food and fluid intake was monitored by staff and recorded when a risk was identified. Two residents were on subcutaneous fluids at the time of this inspection.

**Judgment:**
Substantially Compliant

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

**Findings:**
No complaints were being investigated at the time of inspection. The most recent complaint on record was from 2015. The centre was found to be using an improvement feedback log which, on review, contained information that was in real terms, a complaint. This negated the effectiveness of the actual complaints policy in the centre to record and investigate complaints as the distinction between it and the improvement feedback log was unclear.

**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:
There was an adequate complement of staff with the proper skills and experience on each work shift to meet the assessed needs of residents at the time of this inspection, taking account of the purpose and size of the designated centre.

There was a policy for the recruitment, selection and vetting of staff. It was reflected in practice. Staff confirmed to the inspector they undertook an interview and were requested to submit names of referees and complete Garda Siochana vetting.

Staff training was facilitated and updates were completed by staff. The inspector evidenced mandatory training required by the regulations was completed by staff.

Judgment:
Compliant

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

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

Report Compiled by:
PJ Wynne
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
**Provider’s response to inspection report**

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Costello's Care Centre</th>
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</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000333</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>15/03/2016</td>
</tr>
<tr>
<td>Date of response:</td>
<td>12/05/2016</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 02: Governance and Management**

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The audit program requires more focus on key quality indicators for example, the usage of psychotropic or might sedative medication to inform practice to ensure enhanced individual outcomes for residents.

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

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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:
We are reviewing our Audit Schedule to ensure more focus is placed on key quality indicators, in order to improve on our service, meet regulations and achieve full compliance.

Proposed Timescale: 31/07/2016

Outcome 07: Safeguarding and Safety
Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
When a resident requested the bedrail is raised for use as an enabler a risk assessment was not undertaken to ensure the practice was safe. The restraint risk assessment tool requires review to take cognisance of a broader range of issues. Risks from challenging behaviour, intermittent confusion or medical conditions were not explored in the assessment tool utilised.

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

Please state the actions you have taken or are planning to take:
All bed-rail usage is now assessed whether it is used as an enabler or as a restraint. We have accessed a new assessment tool, which takes cognisance of risks from challenging behaviour, confusion, etc. and are currently implementing this assessment tool.

Proposed Timescale: 31/07/2016

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

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The sling size required by the residents was not specified in all assessment reviewed. While staff could explain the different colours of slings they were uncertain which size was associated with each colour.

3. 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:**
Refresher training now includes informing staff how to identify which size sling is associated with which colour, and a chart indicating same is now located at hoist parking bay. Manual handling risk assessments are being reviewed and all residents will be assessed for sling sizes. This will be fully documented in their risk assessments.

**Proposed Timescale:** 30/06/2016

**Theme:** Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A separate sluice and cleaning room was not provided in the interest of best practice for infection control and minimising the risk of cross infection.

4. **Action Required:**
Under Regulation 27 you are required to: Ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.

**Please state the actions you have taken or are planning to take:**
A separate sluice and cleaning room will be provided, in line with best practice. We are currently sourcing this facility.

**Proposed Timescale:** 31/07/2016

**Outcome 09: Medication Management**

**Theme:** Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Two medications were being crushed prior to administration although it was identified there were unsuitable to be crushed.

5. **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:
These medications have been reviewed and switched by G.P, to medications that provide the same efficiency but are suitable for crushing.

**Proposed Timescale:** 12/05/2016

### Outcome 11: Health and Social Care Needs

**Theme:**
Effective care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Care plans for residents with dementia did not identify where the resident is on their dementia journey. Information such as who the resident still recognised or what activities could still be undertaken to guide staff practice was not recorded.

6. **Action Required:**
Under Regulation 05(1) you are required to: Arrange to meet the needs of each resident when these have been assessed in accordance with Regulation 5(2).

**Please state the actions you have taken or are planning to take:**
To date, care-plans did identify where residents are on their Dementia journey and this was care-planned and also available in their life story books and transfer sheets. However, it is not reflected in the new Epic-Care system as yet, so new resident’s care-plans did not effectively reflect this. We are currently working on the new Epic-Care system with regard to this.

**Proposed Timescale:** 31/07/2016

### Outcome 13: Complaints procedures

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

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The use of the improvement feedback log does not ensure an effective complaints procedure.

7. **Action Required:**
Under Regulation 34(1)(f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.

**Please state the actions you have taken or are planning to take:**
The feedback system was introduced to allow persons who wished to give
feedback, but strenuously stressed they did not want to make a complaint a forum by which to do so.

The feedback log contained details of feedback, which on review, constituted a complaint and was investigated and managed in line with the centres complaint policy and procedure, but continued to be filed in the feedback log. The feedback log has now been discontinued and all matters of concern / constructive criticism will be treated as complaints and managed in line with this centres complaints policies and procedures.

**Proposed Timescale:** 12/05/2016