<table>
<thead>
<tr>
<th>Centre name:</th>
<th>St Phelim’s Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000395</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Dromahair, Leitrim.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>071 916 4966</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:stphelims@hotmail.com">stphelims@hotmail.com</a></td>
</tr>
<tr>
<td>Type of centre:</td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>Flanagan’s Nursing Home Limited</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Mary Flanagan</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>PJ Wynne</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>None</td>
</tr>
<tr>
<td>Type of inspection:</td>
<td>Unannounced</td>
</tr>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>64</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>1</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).
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 2 day(s).

The inspection took place over the following dates and times
From: To:
27 September 2016 09:45 27 September 2016 18:30
28 September 2016 09:45 28 September 2016 15:40

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>
</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>
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<tr>
<td>Outcome 05: Documentation to be kept at a designated centre</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 06: Absence of the Person in charge</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 07: Safeguarding and Safety</td>
<td>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>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 12: Safe and Suitable Premises</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 13: Complaints procedures</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 14: End of Life Care</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 15: Food and Nutrition</td>
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</tr>
<tr>
<td>Outcome 16: Residents' Rights, Dignity and Consultation</td>
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<tr>
<td>Outcome 17: Residents' clothing and personal property and possessions</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 18: Suitable Staffing</td>
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Summary of findings from this inspection
This report sets out the findings of an unannounced inspection, carried out by the Health Information and Quality Authority (HIQA). The centre can accommodate a maximum of 65 residents who need long-term care, or who have respite, convalescent or palliative care needs. The inspector reviewed progress on the action plan from the previous inspection. Notifications of incidents received since the last inspection were reviewed on this visit.
The inspector met with the management team who displayed a good knowledge of the regulatory requirements. The registered provider also fulfils the role of the person in charge. Two deputies are notified to HIQA to deputies in the absence of the person in charge.

The building was warm and comfortably decorated. During conversations with the inspector residents confirmed that they were well looked after and they felt safe. There was a choice of a variety of well presented food.

Policies and procedures were in place to guide staff in the management of residents' medication. Residents had good access to general practitioner (GP) services. There was evidence of regular medical reviews by the GP.

There was an adequate complement of nursing and care staff on each work shift. Staff had the proper skills and experience to meet the assessed needs of residents. Staff supported residents to maintain their independence where possible.

Aspects of the service identified for improvement in this report include, a review of some of the fire safety precautions and the system to evaluate care plans. The mealtime arrangements require review as there was very limited use of the dining room. To ensure practice is line with national policy on promoting a restraint free environment, further work is required.

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 (as amended) 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 detailed the aims, objectives and ethos of the centre. It outlined the facilities and services provided for residents and contained all information in relation to the matters listed in schedule 1 of the regulations.

The provider understood that it was necessary to keep the document under review. It was updated in the aftermath of the last registration renewal inspection. The provider was aware of the requirement to notify the Chief Inspector in writing before changes could be made which would affect the purpose and function of the centre.

**Judgment:**

Compliant

**Outcome 02: Governance and Management**

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

**Theme:**

Governance, Leadership and Management

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

**Findings:**

There was a defined management structure in place with clear lines of authority, accountability and responsibility for the provision of the service. The provider was involved in the governance, operational management and administration of the centre.
on a consistent basis. The provider worked full-time in the centre.

During the inspection the provider demonstrated good knowledge of the legislation and of her statutory responsibilities. Records confirmed that she was committed to her own professional development.

There were sufficient resources to ensure the delivery of care in accordance with the Statement of Purpose. There was evidence of investment in upgrading the facilities and services, professional development of staff and sufficient staff deployed to meet residents’ care needs.

The registered provider also fulfils the role of the person in charge. She is a qualified nurse and has engaged in continuous professional development. She has good clinical experience and management skills. She routinely attends training to implement current evidenced based best practice in care of the older person.

She is well known to residents and their families. It was evident she had in-depth knowledge of residents’ healthcare and psychosocial care needs.

There is a system to review the quality and safety of care and quality of life in place. A system of audits is planned to include clinical data, environmental matters and document control management.

Audits were completed to review the use of physical restraint management (the use of bedrails), the administration of psychotropic or night sedative medicines and any falls sustained by residents. An improvement plan was developed in some cases. However, each area audited did not have an action plan. The goal of the audit from the outset was not well defined for some quality management reviews. While the use of bedrails was audited periodically, 35 residents have two bedrails raised as an enabler. There was no review to determine if some residents only required one bedrail raised. The purpose and objective of some audits completed requires review to ensure the audit leads to an improved outcome for residents.

An annual report on the quality and safety of care was compiled with copies made available to the residents or their representative for their information as required by the regulations. This was an area identified for improvement in the action plan of the previous inspection.

**Judgment:**
Substantially Compliant

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

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

Findings:
There was a residents’ guide developed containing all the information required by the regulations. This detailed the visiting arrangements, the term and conditions of occupancy, the complaints procedure and a copy of the most recent inspection report by HIQA.

All residents accommodated had an agreed written contract. The contract included details of the services to be provided and the fees payable by the residents. The inspector reviewed a sample of three contracts of care. All contracts were signed by relevant parties.

Expenses not covered by the overall fee and incurred by residents were identified in an appendix attached to the contract. This detailed the additional charges per individual item for example, the social care programme, hairdressing, air mattresses, sensor alarms, hip protectors and clothes labels. This was an area identified for clarity in the action plan in the previous inspection report.

The contract of care did not specify for residents whether the bedroom to be occupied was single, twin or multi-occupancy.

Judgment:
Substantially Compliant

Outcome 04: Suitable Person in Charge
The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:
Governance, Leadership and Management

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

Findings:
The person in charge fulfils the criteria required by the regulations in terms of qualifications and experience.

The person in charge has not changed since the last inspection. She is a registered nurse and holds a full-time post. She was known by residents. She had good knowledge of residents care needs. She could describe in an informed way where residents had specific needs and how staff ensured that their care needs were met appropriately.

She maintained her professional development and attended mandatory training required
by the regulations. During the inspection she demonstrated that she had good knowledge of the regulations and standards pertaining to the care and welfare of residents.

She is supported in her role by an assistant director of nursing who had a good knowledge of each resident’s specific care needs. There is dedicated time allocated to manage the clinical governance and administration duties required by the post of person in charge.

**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):**

**Findings:**
Records listed in Schedules 2, 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People Regulations 2013 (as amended) were stored, maintained in a secure manner and easily retrievable.

A sample of records was reviewed by the inspector. These included records relating to fire safety, staff recruitment and residents' care, as well as the centre's statement of purpose.

A record of visitors was maintained. The directory of residents’ contained all information required by schedule three of the regulations and was maintained up to date. The details of the most recent transfer of a resident to hospital and death were updated in the directory.

A current certificate of insurance cover was available. The registered provider was adequately insured against risks, including loss or damage to a resident's property.

A sample of staff files was reviewed and found to be compliant with the regulations.

The inspector also reviewed operating policies and procedures for the centre, as
required by Schedule 5 of the regulations. Policies listed in Schedule 5 were in place, including those on health and safety of residents, staff and visitors, risk management, management of medicines, end-of-life care, management of complaints and the prevention, detection and response to abuse. Policies read had been reviewed by the person in charge and were maintained up to date.

**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 the requirement to notify the Chief Inspector of the proposed absence of the person in charge for a continuous period of 28 days.

Two deputies are notified to HIQA to deputise in the absence of the person in charge. Both deputies were available to meet the inspector on the day of inspection. They assisted to facilitate the inspection well. A review of their staff files evidenced engagement of continuous professional development. Mandatory training required by the regulations and ongoing professional development and engagement in education was evident.

**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):**

**Findings:**
There were effective and up-to-date safeguarding policies and procedures in place. Measures were in place to protect residents. The management team demonstrated their
knowledge of the designated centre’s policy. They were aware of the necessary referrals to external agencies including the Health Service Executive (HSE) adult protection case worker.

One notifiable adult protection incident which is a statutory reporting requirement to HIQA had been reported since the last inspection. Timely, thorough and responsive action was undertaken by the person in charge. A comprehensive system analysis report was completed. This was undertaken to provide an overview of the matter and inform any required learning and provide reassurance of best practice in safeguarding.

Staff members spoken with had received training and understood how to recognise instances of abusive situations. They were aware of the appropriate reporting systems in place. Staff identified a senior manager as the person to whom they would report a suspected concern. Staff spoke confidently of being able to relay any issues and confirmed they are always listened to and their concerns are acted on.

During conversations with the inspector residents confirmed that they were well looked after and they felt safe. They attributed this to the support and care provided by the staff team. Residents spoken with stated “I would prefer to be able to live at home but here is the next best thing”, “the food is very good, I always enjoy my dinner”, “I am well looked after and the staff always have time for a chat with me”. Access to the centre was secured with a coded key pad.

The financial controls in place to ensure the safeguarding of residents’ finances were examined. There was a policy outlining procedures to guide staff on the management of residents’ personal property and possessions. A petty cash system was in place to manage small amounts of personal money for 11 residents. A record of the handling of money was maintained for each transaction. Two signatures were recorded for each transaction. The provider is not a nominated agent to manage a pension on behalf of any resident.

Through observation and review of care plans it was evident that staff were knowledgeable of residents’ needs. Staff provided support that promoted a positive approach to the behaviours and psychological symptoms of dementia (BPSD). Staff were seen to reassure residents and divert attention appropriately to reduce anxieties.

There is a policy on the management of responsive behaviour. Staff could describe particular residents’ daily routines very well. Staff had received training in responsive behaviours and caring for older people with cognitive impairment or dementia. One staff member was trained as a dementia champion and advocated for people with dementia and provided a source of information and support for co-workers.

There was a policy on restraint management (the use of bedrails and lap belts) in place. At the time of this inspection there were 43 residents with two bedrails raised. Thirty five were considered an enabler and nine a restraint measure in the best interest of the resident’s safety. A risk assessment was completed prior to using bedrails. Signed consent was obtained. There was evidence of multi-disciplinary involvement in the decision making process including the GP and physiotherapist. A restraint or enabler register was maintained. This recorded the times bedrails were raised and taken down.
All residents were checked periodically throughout the night.

In line with national policy on promoting a restraint free environment further work is required. As discussed in Outcome 2, Governance and Management, 35 residents have two bedrails raised as an enabler. There was no review to determine if some residents only required one bedrail raised or continued evidence of exploring alternative less restrictive measures through audits and individual care plan reviews.

**Judgment:**
Substantially Compliant

### Outcome 08: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

**Theme:**
Safe care and support

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

**Findings:**
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. The health and safety statement was revised in September 2015.

The inspector identified some hazards requiring risk assessment;

Some bedroom doors fitted with self closing devices for fire safety swung shut rapidly. This may pose a fall risk to residents. The self closing devices require review and adjustment to minimise the risk of injury on entering or exiting.

En-suite showers in some bedrooms did not have grab rails and others showers had a grab-rail on one side only.

A review of some of the fire safety precautions is required. The fire policy did not provide guidance to reflect the centre’s procedures of progressive horizontal evacuation. Staff had completed refresher training in fire safety. An external trainer visits the centre at intervals annually to train staff on fire safety. However, all staff spoken with were not familiar with how to evacuate an immobile resident and to where they should be moved in an immediate instance to ensure their safety.

The needs of the residents had been assessed to outline their evacuation requirements in the event of a fire occurring. Personal emergency evacuation plans were developed for residents and detailed in their individual care plans. However, they were not collated and outlined collectively in the fire register for ease of reference in the event of an
emergency. Evacuation sheets were fitted to each resident’s bed.

Records indicated fire drill practices were completed. However, the procedures to complete and record fire drills require review. While the name of staff and the month was documented, the fire drill records did not record the scenario or type of simulated practice, including the time taken to respond to the alarm, for staff to discover the location of a fire and safely respond to the simulated scenario. There was no documented evaluation of learning from fire drills completed to help staff understand what worked well or identify any improvements required.

There were arrangements in place for appropriate maintenance of fire safety systems such as the fire detection and alarm system. Fire safety equipment was serviced quarterly and annually in accordance with fire safety standards. Fire exit signage was in place. Action notices detailing the procedures to take in the event of discovering a fire or on hearing the alarm were displayed around the building.

There were procedures to undertake and record internal fire safety checks. Regular checks of the fire extinguishers were undertaken to ensure they were in place and intact, and that the fire panel and automatic door closers were operational. Records were maintained evidencing the fire escape routes were checked.

There were procedures in place for the prevention and control of infection. Hand gels were located along the corridor. Audits of the building were completed at intervals to ensure the centre was visibly clean. There were a sufficient number of cleaning staff rostered each day of the week. There was a coded cleaning system to minimise the risk of cross contamination. The cleaning system was being changed to a flat mop system in the best interest of infection control. A separate sluice and cleaning room was provided.

Training records evidenced 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. Each resident’s moving and handling needs were identified in plans of care and changes communicated to staff at shift handover. The type of hoist and sling size required was specified in risk assessments.

There was a contract in place to ensure hoists and other equipment including electric beds and air mattresses used by residents were serviced and checked by qualified personnel to ensure they were functioning safely.

Hand testing indicated the temperatures of radiators or dispensing hot water did not pose a risk of burns or scalds. Restrictors were fitted to windows. Access to work service areas to including the kitchen and sluice room was secured in the interest of safety to residents and visitors.

The arrangements in place for recording and investigating incidents and near miss events require review. Near-miss events were not documented in the accident register. Therefore action to prevent a near-miss event becoming an incident was not undertaken.

The system to investigate accidents and ensure learning from adverse events was not in
place. One resident sustained bruising to her face following an accident against the bedrails. While the nursing notes outlined continuous observation of the injury, no immediate action was taken to mitigate against a repeat occurrence. Similarly another resident pulled a jug of water from their bedside locker and sustained a superficial tissue injury. The incident report was not completed in full. The accident report did not detail any action or precautions to mitigate against a similar reoccurrence.

There was evidence of neurological observations being recorded where a resident sustained an unwitnessed fall or a suspected head injury. Residents were reviewed by the GP if immediate medical treatment was not required.

While falls sustained by residents were audited periodically, a post-incident review was not completed in the immediate aftermath of a fall to identify any contributing factors for example, suspected infection or the impact of changes from medication.

There was a small number of residents who smoked at the time of this inspection. A smoking room was provided. Risk assessments were completed. Protective equipment was provided including a smoking apron. No residents held cigarettes or lighters on their person following risk assessment at the time of this inspection.

**Judgment:**
Non Compliant - Moderate

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**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):**

**Findings:**
Policies and procedures were in place to guide staff in the management of residents’ medicines. They included information on the prescribing, administering, recording, safekeeping and disposal of unused or out-of-date medicines. Practices were satisfactory to ensure each resident was adequately protected by all medicines management procedures.

There were no residents self medicating at the time of this visit. Medication was dispensed from blister packs. These were delivered to the centre on a monthly basis by one pharmacist and weekly by another pharmacist supplying the centre.

On arrival, the prescription sheets from the pharmacist were checked against the blister packs to ensure all medication orders were correct for each resident.

The inspector reviewed a sample of drugs charts The prescription sheets reviewed were
Regular medication, prn medicines (a medicine only taken as the need arises) and short-term medication were identified separately on the prescription sheets. Photographic identification was available on the drugs chart for each resident to ensure the correct identity of the resident receiving the medication. The maximum amount for (p.r.n) medication was indicated on the prescription sheets examined.

Nursing staff transcribed most medications. Transcribed medication was countersigned by a second nurse in each of the sample of records examined in accordance with An Bord Altranais guidance on medication management.

There were no medicines being crushed for any residents at the time of this inspection. The medication administration sheets viewed were signed by the nurse following administration and recorded the name of the drug and time of administration. Medicines 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.

**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 inspector reviewed a record of incidents or accidents that had occurred in the centre and cross referenced these with the notifications received from the centre.

Quarterly notifications had been submitted to HIQA as required.

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

**Findings:**
There were 64 residents in the centre during the inspection. All residents were residing in the centre for continuing care.

Residents were in advanced old age with many complex medical conditions. Half of the residents had a diagnosis of either dementia, cognitive impairment or Alzheimer’s disease as their primary or secondary diagnosis. Twenty residents required either full or partial assistance with all their meals. Fifteen of the residents required the use of a hoist to meet all their moving and handling needs safely as they were unable to bear weight.

A comprehensive assessment of needs was completed on admission. 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, continence needs and mood and behaviour. Risk assessments were regularly revised.

There were plans of care in place for each identified need. In the sample of care plans reviewed there was evidence care plans were updated at the required four monthly intervals or in a timely manner in response to a change in a resident’s health condition. There was evidence of consultation with residents or their representative in all care plans reviewed of agreeing to their care plan.

There was a good emphasis on personal care and ensuring personal wishes and needs were met. Staff were knowledgeable of residents preferred daily routine, their likes and dislikes.

The system to evaluate care plans requires review. While care plans were being reviewed they were mainly signed and dated. The evaluations did not document or highlight changes or a professional judgment of the effectiveness of the care plan in place. A conclusion or professional judgment of the effectiveness care pathway being followed was not indicated. The review of a nutritional care plan for a resident did not reflect downward weight loss and the outcome of the specialist advice recommended by the dietician, for example.

Similarly, wound assessment charts were not completed each time dressings were changed. It was difficult to establish if the frequency of change of dressing was in accordance with the plan of care. Nursing notes did not outline a clinical evaluation of the progress of the wound and it was difficult to determine healing progress. The nursing notes in one file did not document any clinical note on a wound for a four week
period. There was no evidenced based reporting and evaluation as to the progress of the adequacy of the type and frequency of the care interventions and dressings applied.

Residents had good access to GP services. There was evidence of medical reviews at least three monthly and more frequently when required. Medical records evidenced residents were seen by a GP within a short time of being admitted to the centre. The GP’s reviewed and re-issued each resident’s prescriptions every three months. This was evidenced on reviewing medical files and drug cards.

Access to allied health professionals, including dietician and physiotherapist, was available to residents. The provider has employed a physiotherapist for four hours each week. The physiotherapist is available to review all residents and assist completing moving and handling risk assessments for new admissions.

While specialist chairs were provided, a small number of residents were noted to have inadequate support. There was no evidence of seating assessments or specialist advice being obtained from an occupational therapist in the recent past.

**Judgment:**
Substantially Compliant

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**Outcome 12: Safe and Suitable Premises**

The location, design and layout of the centre is suitable for its stated purpose and meets residents’ individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

**Theme:**
Effective care and support

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

**Findings:**
The building was well maintained, warm, comfortably decorated and visually clean. There is two sitting rooms available for use by residents. The dining room is suitable in size to meet residents’ needs and is located off the kitchen. Other facilities include a visitors’ room and a smoking room.

Bedrooms accommodation comprises of 12 single and nine twin bedrooms. There are 10 multi-occupancy bedrooms. There are six bedroom accommodating three residents and three bedrooms accommodating four residents each. There is one bedroom accommodating five residents. Curtains were provided between each bed and each resident had their own bedside locker and wardrobe for the storage of clothes.
There was a call-bell system in place at each resident’s bed. Suitable lighting was provided and switches were within reach. There were a sufficient number of toilets, baths and showers provided for use by residents. Toilets were located close to day rooms for residents’ convenience.

The provider has submitted an action plan from the last inspection indicating there are plans to extend the premises to comply with Schedule 6 of the regulations to reduce the number of residents accommodated in multi-occupancy bedrooms. This was discussed with the provider and works have progressed to the tendering stage.

Emergency call facilitates were not provided in the day sitting rooms. While a socket was available there was no call-bell in place.

Staff facilitates were provided. Separate toilets facilitates were provided for care and kitchen staff in the interest of infection control.

A safe enclosed garden provided with seating was available to residents.

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:**
There was a complaints policy in place. The person in charge explained issues of concern are addressed immediately at local level without recourse to the formal complaints procedure, unless the complainant wishes otherwise.

A designated individual was nominated with overall responsibility to investigate complaints. The timeframes to respond to a complaint, investigate and inform the complainant of the outcome of the matter raised by them was detailed.

No complaints were being investigated at the time of this inspection. A complaints log was in place. A revised form was implemented since the last inspection. This contained the facility to record all relevant information about complaints. The form sought complainants views on how the management team should rectify matters raised.

The independent appeals process if the complainant was not satisfied with the outcome
of their complaint meets the requirements of the regulations. The contact details of the office of the Ombudsman were outlined.

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<th>Judgment:</th>
<th>Compliant</th>
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**Outcome 14: End of Life Care**

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

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

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

**Findings:**

The policy of the centre is all residents are for resuscitation unless documented otherwise. There was one resident with a do not attempt resuscitation (DNR) status in place at the time of this inspection.

Further development of plans of care for end-of-life needs is required to implement advanced care planning. Decisions concerning future healthcare interventions with regard to transfer to hospital if of a therapeutic benefit were not documented in end-of-life care plans reviewed.

Staff provided end-of-life care to residents with the support of their GP and the community palliative care team. The person in charge confirmed they had good access to the palliative care team who provided advice to monitor physical symptoms and ensure appropriate comfort measures. There were no residents under the care of the palliative team at the time of this inspection.

There was evidence frail residents were receiving good care. Pain relief needs were well managed and interventions described in detail in nursing records.

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<th>Judgment:</th>
<th>Substantially Compliant</th>
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**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:
The inspector reviewed the menu and discussed options available to residents. There were nutritious snack options available between meals to ensure sufficient or optimum calorific intake, particularly for those on fortified diets. A trolley served residents mid morning and afternoon offering a choice of soup, tea or coffee, buns and biscuits.

All residents were appropriately assessed for nutritional needs on admission and were subsequently reviewed regularly. Records of weight checks were maintained on a monthly basis and more regularly where significant weight changes were indicated. At the time of this inspection 27 residents were prescribed supplements to help maintain a healthy nutritional status.

Residents spoken with were complimentary of the food and told the inspector they could have a choice at each mealtime. Requests for an option other than those on the menu were facilitated.

The instructions for foods and liquids that had to have a particular consistency to address swallowing problems were outlined in care plans and available to catering and care staff.

Residents were provided with a modified diet on the direction of nursing staff when swallowing difficulties were observed. However, there was limited evidence of specialist advice being obtained from a speech and language therapist in some cases. One resident was on a pureed diet on the judgement of nursing staff. Another resident’s modified diet was changed from a minced moist to a pureed consistency. Specialist advice from a dietetic service had not been obtained to support the clinical decision in either case. In one file reviewed a dietician recommended a modified diet.

The inspector observed meal times on each day of the inspection. There was a choice of a variety of well-presented food. Portion were individually plated and generous in size. Approximately 20 residents require either full or partial assistance with their meals. There was a sufficient number of staff available to assist those requiring help at all times.

Judgment:
Substantially Compliant

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

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

### Findings:
There was evidence of a good communication among residents, the staff team and person in charge.

There was a good emphasis on personal care and ensuring the physical care needs of residents were met. Personal hygiene and grooming were well attended to by care staff. The inspector observed staff interacting with residents in a courteous manner and respecting their privacy at appropriate times.

Residents were able to exercise choice regarding the time they got up. Personal care was provided in bedrooms with doors closed.

Residents could receive visitors in private. Residents were facilitated to engage in hobbies that interested them such as reading newspaper, quizzes, bingo games and music. An activity coordinator was employed to facilitate a programme of activities.

Residents were facilitated to practice their spiritual or religious beliefs. Weekly Mass was available for residents.

The mealt ime arrangements require review. There was very limited use of the dining room. Mealtimes were not a social occasion, or an opportunity to provide a change of environment or promote mobility for residents. On the first day of inspection 28 residents had their dinner in the large sitting room and 15 in the small sitting room. Similarly on the second day of inspection only a minority of the residents had their meals in the dining room. There was limited space between the chairs and some residents were engaged in different activities while others were eating their dinner. Access to appropriate dining space to eat meals in comfort is required.

Access to the dining room between mealtimes was restricted. Both sitting rooms were occupied to full capacity throughout the day. Residents had limited personal space in the day sitting rooms. Consideration to use the spacious dining room between mealtimes for some group activities would promote quality of life for residents.

### Judgment:
Substantially Compliant
theme: Person-centred care and support

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

findings:
There were arrangements in place for regular laundering of personal clothing, linen and the safe return of clothes to residents.

Each resident was provided with their own wardrobe. The centre provided the service to laundry all residents’ clothes and families had the choice to take home clothes to launder if they wished.

A staff member was assigned to the laundry each day of the week. A property list was completed with an inventory of all residents’ possessions on admission. There was a labelling system in place to ensure all clothes were identifiable to each resident.

judgment:
Compliant

outcome 18: suitable staffing
There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in schedule 2 of the health act 2007 (care and welfare of residents in designated centres for older people) regulations 2013 are held in respect of each staff member.

theme: Workforce

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

findings:
There was an adequate complement of nursing and care staff on each work shift. Staff had the proper skills and experience to meet the assessed needs of residents at the time of this inspection. The supervision arrangements and skill-mix of staff were suitable to meet the needs of residents 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. This was evidenced by a review of staff files. Staff confirmed to the inspector they undertook an interview and were requested to submit names of referees. Staff who communicated with the inspector confirmed that they were supported to carry out their work by the provider and the management team. A low staff turnover was noted ensuring continuity of care and familiarity for residents.

There was a training matrix available which conveyed that staff had access to ongoing education and a range of training was provided. In addition to mandatory training required by the regulations, staff had attended training on infection control, nutritional care, cardio pulmonary resuscitation techniques and end-of-life care. All nursing staff were facilitated to advance their clinical skills and supported by management to engage in continuous professional development.

**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:**

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>St Phelim's Nursing Home</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000395</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>27/09/2016</td>
</tr>
<tr>
<td>Date of response:</td>
<td>02/11/2016</td>
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</tbody>
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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 purpose and objective of some audits completed requires review to ensure the audit leads to an improved outcome for residents.

The goal of the audit from the outset was not well defined for some quality management reviews.

1. Action Required:

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Under Regulation 23(c) you are required to: Put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

Please state the actions you have taken or are planning to take:
A comprehensive review of the quality improvement plans was undertaken by the person in charge and all audits will be actively monitored at monthly meetings. A new audit template has been devised which identifies the goal of the audit.

Proposed Timescale: Completed

Proposed Timescale: 02/11/2016

Outcome 03: Information for residents

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The contract of care did not specify for residents whether the bedroom to be occupied was single, twin or multi-occupancy.

2. Action Required:
Under Regulation 24(1) you are required to: Agree in writing with each resident, on the admission of that resident to the designated centre, the terms on which that resident shall reside in the centre.

Please state the actions you have taken or are planning to take:
The contract will now specify whether the bedroom to be occupied is a single, twin or multi occupancy.

Proposed Timescale: Completed/Ongoing.

Proposed Timescale: 02/11/2016

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:
In line with national policy on promoting a restraint free environment further work is required. Thirty five residents have two bedrails raised as an enabler. There was no review to determine if some residents only required one bedrail raised or continued evidence of exploring alternative less restrictive measures through audits and individual
3. **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:**
The person in charge has completed a comprehensive review of all residents who have a bedrail in place. All residents assessed as requiring bedrails have had alternatives to the use of bed rails documented. The person in charge continues to audit and monitor bedrail usage within the centre as per national policy.

Proposed Timescale: completed

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**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:**
Some bedroom doors fitted with self closing devices for fire safety swung shut rapidly. This may pose a fall risk to residents. The self closing devices require review and adjustment to minimise the risk of injury on entering or exiting.

Each ensuite showers in some bedrooms did not have grab rails and others showers a grab rail on one side only.

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

**Please state the actions you have taken or are planning to take:**
The self-closing devices have been adjusted.
Grab rails will be fitted to all showers on both sides.

Proposed Timescale: 02/12/2016

**Theme:**
Safe care and support
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Near miss events were not documented in the accident register.

The system to investigate accidents and ensure learning from adverse events was not in place.

While falls sustained by residents were audited periodically a post incident review was not completed in the immediate aftermath of a fall to identify any contributing factors for example, suspected infection or the impact of changes from medication.

5. Action Required:
Under Regulation 26(1)(d) you are required to: Ensure that the risk management policy set out in Schedule 5 includes arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents.

Please state the actions you have taken or are planning to take:
Near miss events will now be documented in the accident register.
A post incident review will now be conducted following an adverse event by the person in charge and this review will be communicated to nursing and care staff.

Proposed Timescale: 02/12/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The fire policy did not provide guidance to reflect the centre’s procedures of progressive horizontal evacuation.

Personal emergency evacuation plans were developed for residents. However, they were not collated and outlined collectively in the fire register for ease of reference in the event of an emergency.

6. Action Required:
Under Regulation 28(1)(c)(ii) you are required to: Make adequate arrangements for reviewing fire precautions.

Please state the actions you have taken or are planning to take:
The fire policy has been updated to reflect the centre’s progressive horizontal evacuation procedures.
Personal emergency evacuation plans for each resident have been collated in the fire register.

Proposed Timescale: Completed
Proposed Timescale: 02/11/2016

Theme: Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The procedures to complete and record fire drills requires review. The fire drill records did not record the scenario or type of simulated practice, including the time taken to respond to the alarm, for staff to discover the location of a fire and safely respond to the simulated scenario. There was no documented evaluation of learning from fire drills completed to help staff understand what worked well or identify any improvements required.

7. Action Required:
Under Regulation 28(1)(e) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and residents are aware of the procedure to be followed in the case of fire.

Please state the actions you have taken or are planning to take:
Fire drills include simulated practice and scenarios throughout the centre. These drills audit the time taken to respond to alarm, location of the fire and the evacuation of a unit. The person in charge will evaluate the learning experience from the fire drills and the outcome of these fire drills will be communicated to all staff.

Proposed Timescale: 02/12/2016

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:
The system to evaluate care plans requires review.

8. Action Required:
Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident’s family.

Please state the actions you have taken or are planning to take:
All care plans are reviewed 4 monthly. Nursing staff have been educated to ensure that resident and family communications regarding care plan updates are consistently documented in the narrative communication section to reflect ongoing practice.
**Proposed Timescale:** 02/12/2016  
**Theme:** Effective care and support  

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
Wound assessment charts were not completed each time dressings were changed. Nursing notes did not outline a clinical evaluation of the progress of the wound and it was difficult to determine healing progress. There was no evidenced based reporting and evaluation as to the progress of the adequacy of the type and frequency of the care interventions and dressings applied.

**9. 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:  
The person in charge undertook a review of the care plan that addressed wound care. The updates required have been actioned. A wound care plan is in place which reflects the wound care management plan. Wounds are reassessed after every change of dressing. Wound care plans are updated quarterly or more frequently if required. Actions have been communicated to all nursing staff at their monthly meetings.

Proposed Timescale: completed

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**Proposed Timescale:** 02/11/2016  
**Theme:** Effective care and support  

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**  
There was no evidence of seating assessments or specialist advise being obtained from an occupational therapist in the recent past.

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

Please state the actions you have taken or are planning to take:  
Access to occupational therapist is availed of when required on a referral basis. All
Residents have comprehensive assessments carried out and care plans developed in line with the resident’s needs.

**Proposed Timescale:** 02/12/2016

### Outcome 12: Safe and Suitable Premises

**Theme:**
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Emergency call facilitates were not provided in the day sitting rooms.

**11. 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:**
Emergency call bell facilities will be connected to the sitting rooms.

**Proposed Timescale:** 02/12/2016

### Outcome 14: End of Life Care

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

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Further development of plans of care for end-of-life needs is required to implement advance care planning. Decisions concerning future healthcare interventions with regard to transfer to hospital if of a therapeutic benefit were not documented in each sample of end-of-life care plans reviewed.

**12. Action Required:**
Under Regulation 13(1)(a) you are required to: Provide appropriate care and comfort to a resident approaching end of life, which addresses the physical, emotional, social, psychological and spiritual needs of the resident concerned.

**Please state the actions you have taken or are planning to take:**
Resident involvement in the decision making process relating to end of life care will be addressed as part of the care plan review. Nursing staff will continue to ascertain from residents and families their end of life preferences and wishes. Decisions regarding future health care interventions will be discussed with the resident and their G.P and documented in their care plan.
Proposed Timescale: 02/12/2016

Outcome 15: Food and Nutrition

Theme:
Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was limited evidence of specialist advise being obtained from a speech and language therapist

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

Please state the actions you have taken or are planning to take:
Speech and language therapists visited the centre 09/2016.

Proposed Timescale: 02/12/2016

Outcome 16: Residents' Rights, Dignity and Consultation

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The mealtime arrangements require review. There was very limited use of the dining room. Mealtimes were not a social occasion, an opportunity to provide a change of environment or promote mobility for residents.

Access to the dining room between mealtimes was restricted. Both sitting rooms were occupied to full capacity throughout the day. Residents had limited personal space in the day sitting rooms.

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:
We actively encourage residents to dine in the dining room. Some residents choose to have tray service in their bedrooms or in the sitting rooms. Some residents enter and leave the dining room at various times during meal time. Some residents like to dine in the dining room at quieter times.
On the inspection days a new floor was been replaced in the corridors of the centre, during this improvement work the centre had temporary environmental restrictions resulting in two sitting rooms been occupied to full capacity. The dining room is now used between meals for group activities.

**Proposed Timescale:** 02/12/2016