

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	The Cottage Nursing Home
<b>Centre ID:</b>	OSV-0004587
<b>Centre address:</b>	70 Irishtown, Clonmel, Tipperary.
<b>Telephone number:</b>	052 612 2605
<b>Email address:</b>	paddy@wnh.ie
<b>Type of centre:</b>	A Nursing Home as per Health (Nursing Homes) Act 1990
<b>Registered provider:</b>	Tipperary Healthcare Limited
<b>Provider Nominee:</b>	Paddy Fitzgerald
<b>Lead inspector:</b>	Gemma O'Flynn
<b>Support inspector(s):</b>	None
<b>Type of inspection</b>	Unannounced Dementia Care Thematic Inspections
<b>Number of residents on the date of inspection:</b>	24
<b>Number of vacancies on the date of inspection:</b>	1

## **About Dementia Care Thematic Inspections**

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

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

**Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality Standards for Residential Care Settings for Older People in Ireland.**

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

**The inspection took place over the following dates and times**

From:	To:
12 September 2016 09:45	12 September 2016 18:00
13 September 2016 06:55	13 September 2016 15:45

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

<b>Outcome</b>	<b>Provider's self assessment</b>	<b>Our Judgment</b>
Outcome 01: Health and Social Care Needs	Compliance demonstrated	Non Compliant - Moderate
Outcome 02: Safeguarding and Safety	Compliance demonstrated	Non Compliant - Major
Outcome 03: Residents' Rights, Dignity and Consultation	Substantially Compliant	Non Compliant - Moderate
Outcome 04: Complaints procedures	Compliance demonstrated	Non Compliant - Moderate
Outcome 05: Suitable Staffing	Compliance demonstrated	Non Compliant - Major
Outcome 06: Safe and Suitable Premises	Non Compliant - Moderate	Non Compliant - Major
Outcome 07: Health and Safety and Risk Management		Non Compliant - Major
Outcome 08: Governance and Management		Non Compliant - Major
Outcome 12: Notification of Incidents		Substantially Compliant

**Summary of findings from this inspection**

This report sets out the findings of an unannounced, two day, dementia thematic inspection conducted by the Health Information and Quality Authority (HIQA). This inspection focused on specific outcomes relevant to dementia care in the centre. The inspection also followed-up on progress of completion of the action plan from the last inspection of the centre in June 2016, and included a review of provider self-assessment documentation, notifications and other relevant information.

There were 23 residents in the centre on the days of inspection, one resident was in hospital and there was one vacancy. Residents with dementia were integrated with the other residents in the centre.

There were 13 actions for completion detailed in the action plan from the last inspection. The findings of this inspection were that six actions had been completed to a satisfactory standard. The ongoing issues are discussed in this report.

As part of the thematic inspection process, providers were invited to attend information seminars given by HIQA. In addition, evidence-based guidance was developed to guide the providers on best practice in dementia care and the inspection process. Prior to the inspection, the person in charge completed the self-assessment document by comparing the service provided with the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

The inspector met with residents, relatives and staff members during the inspection. The inspector tracked the journey of four residents with dementia within the service and reviewed aspects of care for others. Care practices and interactions between staff and residents who had dementia were observed and evaluated using a validated observation tool.

Inspectors also reviewed documentation such as care plans, medical records and staff files. Inspectors examined the relevant policies including those submitted prior to inspection.

Overall, the inspector found that the layout and design of the centre were not in line with the statement of purpose and did not enhance the lives of the residents living there. The centre had received a renewal of its registration in 2015, upon which HIQA had placed a condition that refurbishment works be progressed in line with the plans the provider had submitted in May 2015 and completed by 1 December 2016. The inspector found that while works had commenced, the progress was slow and the works would not be completed by 1 December. While a definitive plan was in place for the communal areas, the plans for refurbishing the remaining parts of the centre were less defined and the provider was unable to set out how he intended on completing the project. Three bedrooms had been completed to date as had the installation of a new heating system, call bell system and phone system.

A number of non-compliances were identified throughout the course of the inspection as set out in the table above. The provider's self-assessment and the inspector's judgments are set out in the table above. The findings of the inspection are discussed in detail throughout the report and in the action plan at the end of the report.

**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: Health and Social Care Needs***

**Theme:**

Safe care and support

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

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

**Findings:**

Residents' healthcare needs were met through timely access to medical treatment. The centre accessed the services of nine local general practitioners (GP) who visited the centre as required and also conducted three monthly resident reviews. Evidence of these reviews were documented in a sample of residents' files reviewed by the inspector.

There was evidence of good access to allied health professionals. Files reviewed by the inspector demonstrated input from professionals such as dieticians, physiotherapists and speech and language therapists. Chiropody services were available and links with a local optician were also in place. The file of a resident with dementia, that the inspector was tracking, demonstrated that the resident had been referred for optical review in 2014 and 2015. The person in charge stated that there was no access to dental service on site and that residents would need to attend local clinics if the need arose. All files seen by the inspector had a care plan pertaining to oral care.

Monthly checks were carried out to encourage the prevention and early detection of ill health such as monthly weights and blood pressure checks. Annual bloods were completed and the person in charge showed the inspector records of same. Residents were seen to participate in group physiotherapy morning sessions and exercise posters were displayed in the corridor leading to the day sitting room. Resident meeting minutes showed that staff discussed health promotion topics such as the importance of good nutrition and regular exercise

A range of assessments were completed for a sample residents' files reviewed. For example, risk assessments relating to nutritional status, falls risk, skin integrity, continence and independence levels. There was manual handling assessments tools and physiotherapist reassessment charts completed every three months. These were all up to date except for a smoking risk assessment which is discussed and actioned under the outcome relating to health and safety.

Care plans were in place and gave some insight into the care required but the information was not always person centred and did not contain the information elicited following the related risk assessment. Care plans also did not reflect the knowledge that staff displayed when speaking with the inspector. For example, a falls care plan did not specify that two staff were required to assist a resident to mobilise, despite this being highlighted in the associated risk assessment.

A file was reviewed for a resident who was at risk of developing pressure sores and this did not have an adequate care plan in place. For example, there was no reference to the frequency of positional changes or to the exercises the person in charge stated occurred every afternoon. Entries pertaining to these on the electronic record system were inconsistent and there were occasions whereby positional changes were recorded by day staff only and no night records were completed. There was no reference to a specific pressure relieving device recommended by a physiotherapist.

A care plan for a resident who required oxygen saturation checks did not specify the frequency of these checks and daily notes evidenced gaps in the documentation of these checks. However, it was evident at staff handover and communication with relevant health professionals that these checks had been undertaken but was not being reflected in the documentation.

Nutritional care plans did not set out sufficiently detailed care for residents. For example, it was observed that some residents were woken at 7am for breakfast. The person in charge stated that breakfast was only to be offered if residents were already awake. This did not concur with the routine as set out by a range of different staff nor with what the inspector observed. The care plan for these residents did not clearly set out the residents' needs or preferences in this instance. An audit completed in July 2016 identified that care plans were not always relevant to residents' needs; however, this remained an outstanding issue at the time of the inspection.

Relatives who spoke with the inspector confirmed that they were involved in the development of care plans. Residents with dementia were seen to be afforded the right to refuse care.

If a resident was discharged temporarily, a summary page was generated from the resident's electronic file that included information about diagnosis and relevant needs. It also included the last five entries from the daily notes.

There were written operation policies in place for end-of-life care. However, an action required following the previous inspection had not been completed as per the provider's timeline in that it did not set out the arrangements in place for removing the remains of a deceased resident on the first floor, in the absence of a suitably sized elevator. End-of-life care plans were in place and these set out the residents' preferences for place of death, whether they were to be resuscitated and any religious interventions that they would like. A record of anointing that had taken place in 2016 was maintained. There was a weekly mass celebrated in the centre and residents were facilitated to receive Holy Communion on Sundays. The person in charge discussed links with the local palliative care services and stated that pain control methods such as syringe drivers could be implemented via liaison with this service. The centre also provided

subcutaneous fluids if required in an effort to minimise transfer to hospital.

There was a policy in place for the monitoring and recording of nutritional intake and this was seen to be implemented in practice. Care staff had access to the electronic files that allowed daily input of care interventions. Records demonstrated that food and fluid intake was consistently recorded. There was access to fresh drinking water and other alternatives such as juices and these were seen to be offered by staff on a regular basis over the course of the inspection. Bowls of fresh fruit were also available in the day sitting room. Staff were observed to assist residents to eat in a discreet manner. Special dietary requirements were addressed and the cook who spoke with the inspector demonstrated a very good knowledge of residents' needs and likes or dislikes. She was seen to visit the communal areas to ensure residents enjoyed their meal and offered alternatives if a resident so requested.

There were written operational policies in place for the management of medication. Medication administration records were reviewed and found to correspond with the relevant prescription. The inspector observed the handover and processes of controlled medications and this was found to be in line with relevant guidance for nurses. Medication management was subject to audit.

**Judgment:**

Non Compliant - Moderate

***Outcome 02: Safeguarding and Safety***

**Theme:**

Safe care and support

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

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

**Findings:**

There was a policy in place for the prevention, detection and response to abuse. Although the person in charge had made some changes to the policy since the last inspection, the policy required further review as it gave inaccurate information regarding the role of HIQA in the event of such an occurrence. As identified on the previous inspection, the policy did not adequately guide staff in the event of an allegation being made against a member of senior management.

Staff had received training on the prevention, detection and response to abuse. All staff who spoke with the inspector were very clear on what they should do if they had any concerns relating to the safeguarding of residents. Residents who spoke with the inspector spoke very highly of the staff working in the centre and confirmed that they felt safe there. Relatives who spoke with the inspector said that they were satisfied that their loved ones were looked after in the centre.

However, the inspector was not reassured that a gap in care identified by the relative of

a resident, that had resulted in an unsatisfactory outcome for the resident, had been appropriately investigated. There were no records maintained of the investigation carried out by the person in charge. The provider was not aware of the incident and the learning outcomes that would help minimise a recurrence of such an event were inadequate. The person in charge was asked to submit a notification retrospectively to HIQA with a full account of the investigation and the resulting learnings.

The management of residents' finances was examined on a previous inspection two months earlier and were found to be satisfactory.

There was a policy in place for working with residents who have behaviours that challenge and for the management of restraint. However, care plans lacked sufficient detail to guide staff in providing a consistent approach to care. For example, the care plan for a resident who required support to manage verbal and physical outbursts did not set out triggers for such behaviour nor did it set out the management strategies that all grades of staff were able to discuss with the inspector. Overall, all staff who spoke with the inspector demonstrated good awareness of how to support residents with behaviours that challenge, however, it was not evident that all staff were consistent in their approach at all times and the inspector observed care interventions that did not recognise when to leave the resident and give them space. Where a negative outcome had occurred for staff following a care intervention the care plan did not reflect this nor set out guidance for minimising a similar event. Monthly meetings were held to review residents who had behaviours that challenge to enhance and develop a person-centred response to their care. However the results of these meetings did not always feature in the care plans.

Medication was used infrequently to manage behaviours that challenged but its use required review as it was not in line with the national policy on restraint. For example, a resident who was prescribed p.r.n. medicine (medicine only taken as the need arises) to modify behaviour did not have a care plan in place to identify triggers and set out management strategies before medication was used. Medication administration records and nursing notes evidenced that PRN medication had been administered three times in three months for one particular resident. However, the rationale for administering such medication was not clear, alternative strategies were not recorded and there was no evaluation of the effectiveness of the medication which was administered. The person in charge confirmed that not all staff had received training in behaviours that challenge.

However, it was evident that efforts were made to reduce or eliminate restraint. Evidence of review by specialist health professionals were on file with references to staff observations of residents being drowsy and requesting medication review. Where restraint, such as a lap belt, had been deemed necessary, efforts had been made to eliminate the need for such equipment. However, again documentation was not on file to guide and ensure consistent practices. For example, where a restraint was in the process of being eliminated, the care plan had not been updated to reflect this. When the restraint had been in place there was no guidance for adequate checks and release plans. Overall, the management of bed rails was satisfactory. However, whether or not alternatives had been trialled prior to the implementation of bed rails was not recorded.

**Judgment:**

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

**Theme:**

Person-centred care and support

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

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

**Findings:**

Residents with dementia were consulted about how the centre was planned and run. This was evidenced in records of residents' meetings. Relatives were also invited to attend these meetings and have a say. It was apparent that staff and management responded to residents' requests and this included requests from residents with dementia. There was access to an independent advocacy service and information notices were displayed throughout the centre.

The inspector found that that the wishes and preferences of residents did not consistently inform their daily routine. Residents' personal preferences did not consistently inform the times they had breakfast or retired at night. This was due to inadequate staffing resources and is discussed under Outcome 5: Staffing. The physical environment impacted on the welfare and social lives of residents.

There was no separate room to meet with visitors in private. The day room was crowded when visitors joined residents there.

The dining room was too small to accommodate all residents at the one time and 11 residents were seen to dine in the small sitting room on bedside tables and other residents dined in their bedrooms. These residents had a solitary dining experience and missed out on the social aspect of sharing a meal, if they so wished to take part. Residents who spoke with the inspector said that the management did their best with the space that they had and the relatives who spoke with the inspector expressed a desire to see the renovation works completed in the near future.

The inspector completed a quality of interactions tool to evaluate the type of care delivered to residents in the centre. The care observed could fall into five categories: positive connective care; task-orientated care; neutral care; protective and controlling care and institutional care. Overall the care observed was positive connective care, with some episodes of task-orientated care and neutral care also evident.

Staff interacted with residents in a caring, genuine manner and acknowledged their needs. Staff made efforts to ensure residents with dementia were included in conversation. It was evident from observing conversations that staff knew residents and their personal histories well. There were lots of laughter and joking between staff and residents. Consent was sought before giving care and staff were respectful if a resident declined a specific intervention. Staff were seen to spend time chatting with residents and the activities coordinator was observed visiting and spending time with residents in their bedrooms.

Religious needs were met via a weekly mass celebrated in the centre and Holy Communion was received on Sundays. The person in charge confirmed that at the time of the inspection there were no residents of any other religious denomination but all denominations would be catered for if admitted to the centre. The person in charge advised that those wishing to vote were low in number, but that families often took residents out to do same or it could be arranged to occur in the centre also.

There was limited communal space in the centre and there was no dedicated visitors' room. The person in charge stated that the dining room was available throughout the day should anyone wish to use it. Residents had access to newspapers, radio and television and were part of the local community. The activities coordinator and person in charge had arranged a recent tea day that raised money for a local charity. The person in charge spoke about how a local choir came to the centre at Christmas to sing for residents.

Notices regarding the use of Closed Circuit Television (CCTV) were displayed in the centre. This was an action in the previous inspection report.

There was an activities schedule in place for residents and overall, the inspector observed good engagement with what was on offer. Residents with dementia were supported to participate within their own capabilities. There was an exercise class on the first morning of the unannounced inspection and the afternoon consisted of baking biscuits. There was very good participation with residents seen to enjoy themselves. Those that opted not to take part appeared to enjoy observing the activity. Residents were seen to participate in a group quiz and there was good competition and camaraderie between the residents. Questions were appropriately challenging for all capabilities and residents were enjoying themselves. The activities coordinator conducted assessments for each resident and of those files reviewed, a care plan was in place. The inspector spoke with the person in charge about enhancing activities further by introducing an assessment tool that would ensure residents' capabilities were fully assessed when determining a suitable activity. Staff identified outings as an area for improvement and stated that they were aiming to have an outing to a local attraction before the end of October. The activities coordinator was also scheduled to start a course in September designed to meet the sensory needs of residents with dementia.

**Judgment:**

Non Compliant - Moderate

***Outcome 04: Complaints procedures***

**Theme:**

Person-centred care and support

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

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

**Findings:**

There was a complaints policy for the management of complaints. This did not set out who was nominated to oversee that complaints were appropriately responded to and records kept. This person is separate to the person nominated to deal with complaints and is a requirement of the regulations. The complaints procedure was framed on a wall in the entrance corridor but did not identify the correct person to whom to make a complaint. This was rectified by the person in charge prior to the close of the inspection.

Complaints were submitted in 2016 and upon review of same it was evident that the families of residents with dementia were aware of the complaints process. However, an adequate record detailing the investigation, responses and outcome of such investigations were not maintained. Learning from complaints was inadequate. All fields were not completed on the complaints form. There was no electronic signature on the electronic form adjacent to where it was documented that the complainant was satisfied, therefore it was not possible to ascertain if the complainant's satisfaction had been determined.

**Judgment:**

Non Compliant - Moderate

***Outcome 05: Suitable Staffing*****Theme:**

Workforce

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

No actions were required from the previous inspection.

**Findings:**

There was a full complement of staff on duty on the day of inspection, however, the inspector found that there were not enough staff on duty at all times. This was evidenced by the fact that, at times, the centre's routine was dictated by the lack of staff as opposed to the needs of the residents, as also referenced in the outcome relating to Rights, Dignity and Privacy. For example, residents who required assistance with eating their breakfast were being woken up from sleep to take their breakfast. The inspector was told this was to alleviate pressure on the day staff. Residents in the day room were assisted to their beds or bedrooms by staff on the day shift, as there was insufficient staff on duty to supervise residents in the day room after 8:00pm. Two residents had sensor mats, the use of which is normally to reduce falls. These were being used to alert staff if the resident was mobile and to prompt a check on their safety. Senior staff confirmed that these devices were being used in the absence of adequate supervision which is not their intended purpose. Relatives who spoke with the inspector said that they were not sure that there was enough staff on a night.

On the days of inspection in the centre there was one person in charge available 8am to -4pm; one nurse 8am-8pm, five health care assistants from 8am to-1pm and 4 health

care assistants from 1pm to -8pm. There was one nurse from 8pm to -8am and one health care assistant 8pm to -8am.

It is acknowledged that staff arrangements during the day had been amended to ensure that there was a member of staff supervising the day sitting room at all times during the day shift (8am to -8pm). An activities coordinator was also present seven days per week.

Staff had access to ongoing training. Mandatory training was up to date, however as discussed and actioned in the outcome relating to safety and safeguarding, not all staff had received training in behaviours that challenge. Staff completed training online, where there were deficits in the overall result, the person in charge said that she went over the questions with the relevant staff member, however, there was no documentary evidence of this. Staff discussed the online training and said that they found it beneficial. Staff who spoke with the inspector said that the training they received on dementia gave good insight into the condition and helped them in delivering care. However, further training in the promotion and provision of person-centred care was required as staff were observed having conversations with each other and not always including the resident. Some staff used inappropriate language, for example, referring to a resident as 'poor little' when addressing a resident and referring to the number of 'feeds' when speaking about residents who required assistance with eating. Using 'pet names' is an issue that had been identified by the person in charge and had been discussed at staff meetings as evidenced in staff meeting minutes.

Staff appraisals were ongoing for 2016 and the person in charge had completed appraisals on file which she showed to the inspector.

Staff meetings occurred approximately monthly and minutes were maintained for these. Items on the agenda included the importance of day sitting room supervision, an update following allied health professionals review of residents and resident privacy.

Staff files had been reviewed at the previous inspection, two months earlier. There had been one new member of staff since then. This staff members file was reviewed but it did not contain evidence of qualifications as required by the regulations.

**Judgment:**

Non Compliant - Major

***Outcome 06: Safe and Suitable Premises***

**Theme:**

Effective care and support

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

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

**Findings:**

The design and layout of the centre was not in line with the statement of purpose. The premises did not meet the needs of all residents nor did it promote the dignity, independence and wellbeing of residents with a diagnosis of dementia.

A condition had been placed on the registration of the centre that refurbishment works would be completed by 1 December 2016. Plans had been submitted to HIQA as assurances that the internal centre would be brought into compliance with the regulations and National Standards. As discussed in the Governance & Management outcome, works started late and were significantly behind schedule. Three bedrooms had undergone refurbishment and these were completed to a good standard. They were bright, airy and modern with adequate storage. A new heating system had been installed, wiring of the building had been completed and a new phone and call-bell system was in operation. However, some of the newly completed works were already damaged such as a wardrobe door and a door leading into a bedroom. Following the previous inspection in June 2016, bedrooms consisting of three beds had been reduced to two to afford privacy and dignity to residents.

Overall, the premises required significant refurbishment and decoration. There were areas of the centre that were not adequately cleaned. For example, there was a strong odour in the day sitting room on both days of the inspection. Cobwebs were noted in abundance on the ceiling of the sitting room. The sitting room was scheduled to have works done as part of the refurbishment process as it was small and did not offer adequate space. There was limited space for visitors to sit in the sitting room. Chairs in a bedrooms were visibly dirty when cushions were lifted. Paint was peeling or stained in many areas, pipework was exposed in the ceilings and the floor covering in some bedrooms did not reach the wall which did not allow for effective cleaning nor did it provide an attractive space. Where a radiator had been removed from the wall in the corridor leading to the day room, the pipes remained exposed as did a piece of metal that secured the radiator to the wall. A twin bedroom had only one chair for residents use. Floor surfaces in bedrooms were damaged and peeling.

Residents were facilitated to add their own touches to their bedrooms and photographs and soft furnishings were seen throughout. Bedrooms had a lockable safe to store valuable belongings. Staff had made efforts to create homely communal spaces with the addition of photographs of residents participating in activities or posters with specific words that residents had been asked to express their thoughts on when they heard the word. Residents' answers were written next to the word and words included 'love'; 'place'; 'music' and 'family'.

There was a dining room that accommodated only eight residents. Tables were set and included little vases with a flower, however, table mats were worn with peeling surfaces. Eleven residents were seen to dine in the small sitting room on bedside tables and other residents dined in their bedrooms on the days of inspection.

There was very limited signage for residents with dementia to assist in orientating them to the layout of the building. Doors to toilets and bathrooms were not painted contrasting colours nor were contrasting colours used in the toilet and bathroom areas.

There was an elevator in place to assist residents transferring from one floor to another. As discussed in previous inspection reports, this elevator could not accommodate an ambulance stretcher. It didn't have a risk assessment for its use as also identified in the previous inspection.

As identified in the previous inspection whilst handrails and grabrails were in place in most areas, some circulation areas were lacking handrails and a handrail adjacent to a steep ramp leading to the nurses' office and a two-resident bedroom was placed at a level that did not provide adequate support to residents when mobilising.

The outside space available to residents was very limited and unattractive in its appearance. It consisted mainly of a small space of concrete and flowers in pots. On the days of inspection this area was not well maintained. There was debris that could pose a slip hazard to residents such as copious amounts of wet leaves. There was cigarette butts discarded on the ground and rubbish such as an empty cigarette box and plastic bag. Flower pots were overturned. The entire area required review and improvement in order for it to be a therapeutic space for residents and in particular residents with dementia.

These issues were discussed at length with the provider and the person in charge. The provider was able to discuss the plans for the communal space and was hopeful of these works being completed in the required time despite works being behind schedule at the time of inspection. However, there was no clear plan in place for addressing the extensive refurbishment and decorative works required in the remainder of the centre. The provider was unable to commit to any timeframes or plan of work at the time of inspection but stated he was aware of the need for the works to be completed.

**Judgment:**  
Non Compliant - Major

### ***Outcome 07: Health and Safety and Risk Management***

**Theme:**  
Safe care and support

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

**Findings:**  
Some aspects of this outcome were examined as part of the thematic inspection. Overall, the inspector found that health, safety and risk were not managed in a planned, safe manner.

There was a risk management policy in place and risk assessments had been completed.

However, there was no formal hazard identification process that would identify new or changing hazards in the centre, such as, an old building, undergoing significant building works. This was also identified at the last inspection. Due to the lack of a hazard identification process, hazards were not being identified nor was there any formal plan in place to address issues. For example, an extension cable was seen trailing across a bedroom floor posing a slip or trip hazard. There were door wedges and waste paper bins propping open fire doors. Large televisions were sitting unsecured in parts of the bedrooms that had a lot of traffic. The centre had recently had a new heating system installed. As a result, linoleum covering a circulation area had been removed and not replaced. The floor of a resident's bedroom had been drilled and left open with pipes exposed. There were no clear plans in place to address these matters in a timely fashion.

After the previous inspection, the provider submitted a plan of works to HIQA, however, where it had been identified that residents would not have access to a particular area, the alternative arrangements in place were not set out. There were building works taking place daily in the centre, but there was no communication between the person in charge and the construction workers to determine what tasks were taking place each day to ensure adequate precautions could be taken where necessary. On the day of inspection, equipment used by residents was seen to be covered in dust from works to the ceiling of the corridor the equipment was kept in.

Risk assessments that were in place for some planned works were not comprehensive as they did not consider all risks associated with the works. For example, the possibility of residents becoming disorientated, the use of tools and equipment and the fact that flooring had to be drilled or removed leaving uncovered surfaces and exposed piping.

The inspector found that the management of fire safety was not robust. There was no signage that clearly advised residents, staff and visitors about what to do in the event of a fire. This was identified at the previous inspection. Fire drills were taking place but it was not clear as to how they were improving practice or testing staff or resident responses as the documentation did not record this information; for example, the time it took staff to respond to the alarm or evacuate the relevant area. Senior staff told the inspector that on the day of a drill staff would be told in advance that the alarm would be set off during the day.

The management of smoking in the centre was not robust. Smoking risk assessments for residents with a cognitive impairment were not up to date. Where a risk was identified, for example, smoking in a non-designated smoking area, robust control measures were not in place. Some staff who spoke with the inspector were not aware of the identified risk and told the inspector that they were not aware of nor did they implement any control measures to ensure the safety of all residents. There was a strong odour of cigarette smoke on the day of inspection in a non designated smoking area of the centre. The person in charge and the provider were asked to implement immediate controls to address this matter. The person in charge forwarded a plan to address these issues to the inspector after the close of the inspection.

Manual handling practices were observed. Outdated and potentially unsafe techniques were observed being utilised by all grades of staff. Hand gels used to help minimise the

spread of infection required attention as the pumps that were used to dispense the gel were noticeably dirty in appearance. The provider had undertaken to replace hand gel pumps in the previous action plan response but this action remained outstanding. Some items were worn, with peeling surfaces that prevented robust cleaning such as place mats on the dining tables and floor surfaces.

Incident records were maintained but documentation was not fully completed as it did not always set out the learning following review of an event. It was also evident that incidents were discussed at staff meetings and were the subject of audit.

**Judgment:**

Non Compliant - Major

***Outcome 08: Governance and Management***

**Theme:**

Governance, Leadership and Management

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

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

**Findings:**

There was a clearly defined management structure that identified who was in charge and accountable. Staff were clear on what the reporting structure was.

The inspector found that management systems were not in place to ensure that the centre's premises were reconfigured as per the plans submitted to HIQA in May 2015. HIQA had placed a condition on the provider's registration to ensure these works would be completed by 1 December 2016 and the provider had agreed to undertake same. It was evident that works were behind schedule and the refurbishment planned to the year end of 2016 was not in line with the plans that had been previously submitted. This was discussed in detail with the provider who was able to identify when the communal areas would be completed but had no clear plan was in place to address the remaining premises issues.

Inspectors found that the governance and management of the centre was inadequate given that five major non compliances were found on this inspection. The majority of the action plans to address non-compliances on the previous inspection were not completed. The provider had not taken adequate measures to ensure the health and safety of residents while refurbishment works were in progress. Measures to safeguard residents from abuse were found to be inadequate and staffing levels did not meet the needs of residents.

**Judgment:**

Non Compliant - Major

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## ***Outcome 12: Notification of Incidents***

**Theme:**

Effective care and support

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

No actions were required from the previous inspection.

**Findings:**

The use of chemical restraint had not been included in the previous quarterly notification as is required by the regulations. Other notifications had been submitted as required.

**Judgment:**

Substantially 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:***

Gemma O'Flynn  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority

## Health Information and Quality Authority Regulation Directorate

### Action Plan



### Provider's response to inspection report<sup>1</sup>

<b>Centre name:</b>	The Cottage Nursing Home
<b>Centre ID:</b>	OSV-0004587
<b>Date of inspection:</b>	12/09/2016
<b>Date of response:</b>	18/10/2016

### Requirements

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

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

### Outcome 01: Health and Social Care Needs

#### Theme:

Safe care and support

#### **The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The centre's End of Life Care Policy did not set out the arrangements for the removal of the remains of residents who would pass away on the first floor of the premises.

The centre's Safeguarding Policy required review to ensure it gave correct and clear guidance to staff in the event of an allegation of abuse being made against senior management.

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

**1. Action Required:**

Under Regulation 04(1) you are required to: Prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.

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

We have sourced a company to manufacture a modified system that will assist in the transfer of residents on the first floor of the building in a safe and dignified manner using the current lift. This system has been ordered and because it is a one off specialised system it will take 6-8 weeks. The policy on end of life has also been reviewed and changes amended to policy. The policy on responding to abuse has also been reviewed and updated to give clear and correct guidance to staff in the event of an allegation of abuse.

**Proposed Timescale:** 30/11/2016

**Theme:**

Safe care and support

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

Care plans were in place and gave some insight into the care required but the information wasn't always person centred and didn't contain the information elicited following the related risk assessment nor did they reflect the knowledge that staff displayed when speaking with the inspector. For example, a falls care plan didn't specify that two staff were required to assist a resident to mobilise, despite this being highlighted in the associated risk assessment.

Care plans didn't always reflect advice from allied health professionals. For example, references to specific pressure relieving equipment.

Daily records were inconsistent in documenting the care given, for example, there were gaps in the electronic records relating to oxygen saturation levels and positional changes.

**2. 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:**

All residents' care plans have been reviewed and care plans personalised to meet the needs of each individual resident. All information as per allied health professionals have been reviewed and appropriate care plans updated. Nursing meeting conducted and all nursing staff aware to input all observations to be input on the epic care system as required to reflect the needs and care of residents.

**Proposed Timescale:** 29/09/2016

**Outcome 02: Safeguarding and Safety**

**Theme:**

Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Care plans did not sufficiently identify triggers or set out strategies for safely and consistently supporting residents with behaviours that challenge.

Strategies that were outlined by staff for the management of behaviours that challenge were not seen to be implemented on a consistent basis.

Not all staff had received training to support residents who exhibited behaviour that challenges.

**3. Action Required:**

Under Regulation 07(1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.

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

All staff have being assigned training on behaviours that challenge and are in the process of completing the course. Care plans on behaviours that challenge have being reviewed and updated to demonstrate in detail triggers and management strategies to support residents with behaviours that challenge. Staff meetings conducted to inform all staff of the residents with behaviours that challenge and the strategies put in place by nursing staff to manage the behaviours safely.

**Proposed Timescale:** 01/10/2016

**Theme:**

Safe care and support

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

The management of restraint both physical and chemical was not in line with the national policy on restraint.

**4. 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:**

An audit on restraint has being completed and action plans reviewed. Meetings and in house training conducted with all nursing and care staff to discuss the use of restraint to ensure we are in line with the national policy on restraint. All associated risk assessment and care plans reviewed to ensure compliance with the national policy

**Proposed Timescale:** 30/09/2016

**Theme:**

Safe care and support

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

Where a gap in care resulting in an unsatisfactory outcome for a resident had been identified by a relative, appropriate action was not documented by the person in charge and therefore there was no evidence that an appropriate response had been implemented. Learnings following the event were inadequate in ensuring a similar event did not reoccur.

**5. Action Required:**

Under Regulation 08(1) you are required to: Take all reasonable measures to protect residents from abuse.

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

All appropriate documentation have being competed including meeting with staff and learning outcomes and management in the prevention of a similar event occurring. This documentation has being sent to the inspector as requested. All staff attended meetings to ensure a similar event does not occur again. Improvements to documentation have being discussed between management and nursing staff and all staff has reviewed the policy on protection on vulnerable adults. All trainings are up to date.

**Proposed Timescale:** 17/09/2016

**Outcome 03: 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:**

Residents personal preferences did not consistently inform the times they had breakfast or retired at night. This was determined by the staffing resource.

The limitations of the physical environment impacted on the rights of residents

\*Residents could not meet visitors in private. There was no separate room to meet with visitors in private. The day room was crowded when visitors joined residents there.

\*Not all residents could take their meals in the dining room if they choose to do so. The

dining room was too small to accommodate all the residents and 11 residents were seen to dine in the small sitting room on bedside tables and other residents dined in their bedrooms. These residents had a solitary dining experience and missed out on the social aspect of sharing a meal.

**6. 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:**

All care plans updated to inform staff of residents personal preferences around breakfast time and retiring to their beds at night. Under the purposed renovations a new dining room will be completed as per work schedule. There will be new communal spaces completed for upstairs and downstairs with sub dining spaces along with a private section for visitors. Due to the building constraints, we are unable to provide a visiting room. Supporting documents can be attached regarding the refurbishments. A lot of residents prefer to remain in the dayroom and this will be reflected in the residents care plans. The new communal spaces will allow for more space and choice for all residents.

**Proposed Timescale:** 31/01/2017

**Outcome 04: Complaints procedures**

**Theme:**

Person-centred care and support

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

Adequate records of complaints and their subsequent investigations were not maintained.

**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:**

Meeting conducted between management and nursing staff to review and improve our documentation of incidents and complaints. The policy on complaints and incident reporting have being reviewed to ensure all staff are aware of the procedures to follow if a future complaint is lodged.

**Proposed Timescale:** 30/09/2016

**Theme:**

Person-centred care and support

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

There was no person nominated to oversee that all complaints were appropriately responded to.

**8. Action Required:**

Under Regulation 34(3) you are required to: Nominate a person, other than the person nominated in Regulation 34 (1)(c), to be available in a designated centre to ensure that all complaints are appropriately responded to and that the person nominated under Regulation 34 (1)(c) maintains the records specified under in Regulation 34 (1)(f).

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

A person has now being nominated to oversee that all complaints were appropriately responded to and this has being updated in the complaints policy

**Proposed Timescale:** 21/07/2016

**Outcome 05: Suitable Staffing**

**Theme:**

Workforce

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

The inspector found that there were not enough staff on duty at all times. This was evidenced by the fact that, at times, the centre's routine was dictated by the lack of staff as opposed to the needs of the residents. Residents were assisted to eat their breakfast early and put to bed early in order to relieve the pressure on staff.

**9. Action Required:**

Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

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

A new twilight shift (6pm-10pm) is currently being developed to alleviate pressure from the night shift. All residents breakfast routines are being reviewed to ensure their personal preference is met instead of staff convenience

**Proposed Timescale:** 10/10/2016

**Theme:**

Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

There was no evidence to demonstrate that sufficient follow up was completed with staff who had completed online training to ensure that learning outcomes were achieved.

**10. Action Required:**

Under Regulation 16(1)(b) you are required to: Ensure that staff are appropriately supervised.

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

Training policy for staff have being reviewed and any staff member who score under 80% will be called for a meeting to discuss areas in which they failed to answer correctly. This meeting will then be documented and put in the staff files. An extra column on the training matrix has being added to in put results of on line trainings in order to ensure compliance is met.

**Proposed Timescale:** 31/10/2016

**Theme:**

Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Further training in the promotion and provision of person centred care was required as staff were observed having conversations with each other and not always including the resident. Some staff used inappropriate language, for example, the use of the term 'poor little [resident's name]' when addressing a resident and referring to the number of 'feeds' when speaking about residents who required assistance with eating.

**11. Action Required:**

Under Regulation 16(1)(a) you are required to: Ensure that staff have access to appropriate training.

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

In house training to be conducted for all staff in the promotion and provision of person centred care. Staff meetings were held to discuss to importance of staff/resident interaction. Management highlighted to staff that the use of inappropriate language and ongoing conversations between staff while in the presence of residents is not appropriate and in line with person centred care. All staff advised to review and sign policies on residents rights, dignity and respect.

**Proposed Timescale:** 31/10/2016

**Outcome 06: Safe and Suitable Premises**

**Theme:**

Effective care and support

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

The communal rooms were too confined to accommodate the residents.

The dining room could only accommodate 8 residents and consequently residents had to take their meals in the day room or their bedrooms.

There was no separate room to receive visitors.

There was only one chair for residents in a twin room.

**12. Action Required:**

Under Regulation 17(1) you are required to: Ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.

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

Under the proposed renovations a new dining room will be completed as per work schedule. There will be new communal spaces completed for upstairs and downstairs with sub dining spaces along with a private screened section for visitors. Due to the building constraints, we are unable to provide a visiting room. Some residents prefer to remain in their rooms or dayroom for their meals. This will be identified and documented in the residents care plans. Supporting documents can be attached regarding the refurbishments. All rooms have adequate sitting provided.

**Proposed Timescale:** 01/02/2017

**Theme:**

Effective care and support

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

The plan of works submitted by the provider so as to bring the designated centre into compliance by 1 December 2016 were behind schedule.

The designated centre required significant refurbishment and decorative works besides those works already outlined in the previously submitted plans. For example, there were a number of areas with torn flooring, peeling/stained paint and exposed pipework. There was no formal plan in place to address these issues.

The elevator could not accommodate an ambulance stretcher and required a risk assessment for its safe use.

Areas of the centre were unclean.

**13. Action Required:**

Under Regulation 17(1) you are required to: Ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.

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

Ceilings are now completed and all pipe work covered. (Completed) Torn floors as a result of pipe work will be corrected and rectified. (7/10/16). Delays in plan of works was caused by unforeseen circumstances which are explained in detail in request to vary conditions which are attached. The elevator will continue to accommodate the transfer of residents via wheelchair at present. Risk assessment will be completed. Cleaning audit will be conducted to identify area of concern and actions implemented. All works will be completed as quickly as possible and on or before the dates as per the attached schedule with a final date for works listed of 1/1/18

**Proposed Timescale:** 01/01/2018

## **Outcome 07: 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:**

There was no formal process in place for identifying new or changing hazards in the centre. As a result, hazards were not being identified and lacked appropriate control measures.

Plans for building works did not identify alternative arrangements in place if residents were unable to access specific areas.

Plans for daily building works were not communicated with the person in charge to ensure suitable arrangements could be taken from a risk management perspective to ensure the safety of residents, staff and visitors to the centre.

Risk assessments in place for planned works were not comprehensive as they did not consider all risks.

### **14. 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:**

While works are ongoing, daily walk around hazard identification sheets will be conducted and following works completion, there will be weekly walk around hazard sheets/meeting conducted. In the case of building works that restrict access to area's, a meeting will be held between all management staff and a plan drawn up one week prior to the works commencing. Risk assessments will be reviewed and improvements to risk assessment conduct as per works carried out

**Proposed Timescale:** 18/10/2016

**Theme:**

Safe care and support

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

Unsafe moving and handling practices were observe which posed a potential risk to the safety of residents. The inspector formed the view that training was not being implemented to minimise the potential risk to residents.

**15. Action Required:**

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

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

We are in contact with a manual service who will provide manual handling training for all staff. Awaiting confirmation of dates. Dates will be advised to HIQA before 7/10/16

**Proposed Timescale:** 01/12/2016

**Theme:**

Safe care and support

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

Hand gels used to help minimise the spread of infection required attention as the pumps that were used to dispense the gel were noticeably dirty in appearance.

Some items were worn, with peeling surfaces that prevented robust cleaning such as place mats on the dining tables and floor surfaces.

**16. 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:**

Pumps ordered and installed in nursing home. Cleaning audit will be conducted to identify areas of concern and refurbishment actions required

**Proposed Timescale:** 18/10/2016

**Theme:**

Safe care and support

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

Documentation of fire drills did not allow for adequate review of staff/resident responses as the documentation did not clearly set out what had occurred during the drill.

**17. 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:**

We have engaged the services of a fire training company and once dates are confirmed we will send them to inspector. Improvements to fire drill documentation have also been reviewed and implemented in following fire drills.

**Proposed Timescale:** 01/11/2016

**Theme:**

Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

The procedures to be followed in the event of a fire were not clearly displayed in the centre.

**18. Action Required:**

Under Regulation 28(3) you are required to: Display the procedures to be followed in the event of fire in a prominent place in the designated centre.

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

Signs displaying procedure to be followed in the event of a fire have been put up around the nursing home and all staff/residents informed of same.

**Proposed Timescale:** 19/09/2016

**Theme:**

Safe care and support

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

The management of cigarette smoking was not robust and did not ensure the safety of all residents in the centre.

Smoking risk assessments were not up to date. Associated care plans did not guide consistent safe care.

Not all staff were aware of identified risks pertaining to cigarette smoking in the centre. Robust checks were not in place to ensure safety.

**19. Action Required:**

Under Regulation 28(1)(a) you are required to: Take adequate precautions against the risk of fire, and provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.

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

Smoking risk assessment and care plan reviewed and updated to aid all staff in the correct management of resident smoking. New form in place to ensure supervision of the resident when smoking along with compliance to ensuring resident does not have cigarettes or lighter on their person. All staff given the management plan of the resident with regards to smoking in designated areas and above form to ensure compliance is met.

**Proposed Timescale:** 15/09/2016

**Outcome 08: Governance and Management****Theme:**

Governance, Leadership and Management

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

Inspectors found that the governance and management of the centre was inadequate given that there were four major non compliances found on this inspection. The majority of the action plans to address non compliances on the previous inspection were not completed. The provider had not taken adequate measures to ensure the health and safety of residents while refurbishment works were in progress. Measures to safeguard residents from abuse were found to be inadequate and staffing levels did not meet the needs of residents

**20. Action Required:**

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

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

All areas of concern have being addressed and measures to ensure full compliance have taken. Meetings with all persons involved have being had to ensure protection of residents. All above items have being addressed in previous actions. Weekly meetings will be held and minuted with the PIC to ensure that matters that need addressing are completed in the time scale given. Additional finance has been provided to ensure the swiftest completion date of all building & refurbishment works. Contractors have been put in place to carry out the works at the precise time that will ensure the least disruption to residents by allowing them optional space . An additional day space will be in use before the existing space if being refurbished. All of this is outlined in detail on our works schedule. The time scale given below indicates dates at which these procedures and meetings are in place not date for works carried out

**Proposed Timescale:** 07/10/2016

**Outcome 12: Notification of Incidents**

**Theme:**

Effective care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Chemical restraint was not included on the quarterly return for the previous quarter.

**21. Action Required:**

Under Regulation 31(3) you are required to: Provide a written report to the Chief Inspector at the end of each quarter in relation to the occurrence of any incident set out in paragraphs 7(2) (k) to (n) of Schedule 4.

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

Previous quarterly return has being updated to include chemical restraint used and re-submitted to the inspector

**Proposed Timescale:** 15/09/2016