**Health Information and Quality Authority**
**Regulation Directorate**

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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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|---|---|
| **Centre name:** | Cherry Orchard Hospital |
| **Centre ID:** | OSV-0000508 |
| **Centre address:** | Ballyfermot,<br>Dublin 10. |
| **Telephone number:** | 076 695 5000 |
| **Email address:** | kevint.brady@hse.ie |
| **Type of centre:** | The Health Service Executive |
| **Registered provider:** | Health Service Executive |
| **Provider Nominee:** | Catherine Dempsey |
| **Lead inspector:** | Sheila McKevitt |
| **Support inspector(s):** | Shane Walsh |
| **Type of inspection** | Unannounced Dementia Care Thematic Inspections |
| **Number of residents on the date of inspection:** | 143 |
| **Number of vacancies on the date of inspection:** | 18 |

## 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.

Please note the definition of the following term used in reports:
responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor compliance with specific outcomes as part of a thematic inspection. This monitoring inspection was un-announced and took place over 1 day(s).

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

| From: | To: |
|---|---|
| 02 November 2016 08:00 | 02 November 2016 17:00 |

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

| Outcome | Provider's self assessment | Our Judgment |
|---|---|---|
| Outcome 01: Health and Social Care Needs | Compliance demonstrated | Compliant |
| Outcome 02: Safeguarding and Safety | Compliance demonstrated | Compliant |
| Outcome 03: Residents' Rights, Dignity and Consultation | Compliance demonstrated | Non Compliant - Moderate |
| Outcome 04: Complaints procedures | Compliance demonstrated | Substantially Compliant |
| Outcome 05: Suitable Staffing | Compliance demonstrated | Non Compliant - Moderate |
| Outcome 06: Safe and Suitable Premises | Compliance demonstrated | Non Compliant - Moderate |
| Outcome 07: Health and Safety and Risk Management | Not applicable | Substantially Compliant |
| Outcome 11: Information for residents | Not applicable | Non Compliant - Moderate |

**Summary of findings from this inspection**

This was an unannounced dementia thematic inspection conducted by two inspectors over one day. The purpose of this inspection was to determine what life was like for residents with dementia living in the centre. In order to determine this inspectors focused on six outcomes and followed up on eight outcomes from the last monitoring inspection which took place in February 2015. Over ninety of the one hundred and forty three residents in the centre had a diagnosis of cognitive impairment, alzheimers disease or dementia. The centre had two dementia specific units with 16 beds located in each unit. One unit was for female the other for male residents only.

Prior to this inspection the provider had submitted a completed self- assessment document to the Authority along with relevant polices and inspectors reviewed these documents prior to the inspection. The judgments in the self-assessment differed from the inspectors findings. Inspectors found that a number of actions identified on the last inspection report had not been addressed within the proposed timescale set by the provider. These related to the complaints policy, contracts of care, fire directional signage and the premises. These action plans are repeated on this report.

Inspectors found the centre had a person-centred service approach to ensure the health care needs of residents with dementia were met. There was a minimum number of complaints and lots of evidence of positive feedback from relatives of past residents. Residents felt safe in the centre and both units were safe and secure and residents had access to a safe and secure garden. However, the provider could not confirm that all staff working in the centre had a garda vetting disclosure in place and staff files were not available on site for inspectors to review.

Staffing levels and skill mix were good. The provision of activities was not constituent in both units and interaction between staff and residents required improvement. Residents' were involved in their care plans however, there was no evidence that they were being involved in decisions regarding the unit they lived. Resident meetings were not being held. The premises did not meet the needs of residents with dementia in a holistic manner as they consisted of multiple occupancy bedrooms. However, this was being actioned with the building of a new centre due for completion by 2021.

The action plans at the end of this report reflect where improvements need to be made.

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

**Findings:**
Inspectors were satisfied that each resident living in the 2 units inspected had their wellbeing and welfare maintained by receiving appropriate evidence-based nursing, medical and allied healthcare.

Inspectors found that residents admitted to each of these units had a diagnosis of dementia. They had diverse needs; some were highly dependent and required full assistance while other residents were quite mobile and independent.

Inspectors found that there was good access to medical care in that a member of the medical team was on duty seven days per week and were available on call. A full range of other services was available on referral including speech and language therapy (SALT), occupational therapy (OT), physiotherapy and dietetic services. Chiropody, dental, audiology and optical services were also provided. Inspectors reviewed residents' records and found that they had been referred to these services and results of appointments were written up in their notes.

A multidisciplinary review of residents took place every three months. The records of these meetings were reviewed in the units. These meetings consisted of the medical team, unit nursing representatives, occupational therapist (OT), speech and language therapist (SALT) and physiotherapist and any other professional deemed appropriate to attend the meeting.

Inspectors reviewed a sample of residents' files and noted that a nursing assessment and additional clinical risk assessments were carried out for residents. Daily notes were being recorded in line with professional guidelines. Each care need identified had a care plan in place. Care plans were person-centred containing all details of care required to direct care. Inspectors saw evidence that residents and/or relatives were involved in the development of their care plans. Assessments and care plans were reviewed once every four months.

There were policies on nutrition and hydration which were being adhered to and

supported good practices. Residents were offered a choice of food at each meal time and individual preferences were readily accommodated. The nursing staff monitored the meal times closely and assistance given to residents' at lunch time was reflective of a high standard of nursing care.

Residents, who required their food to be modified, for example pureed, were served this food in individual portions and had the same choice of food at the main meal as those eating food in normal consistency. Regular fluids were provided during the day. Portion sizes were appropriate and second helpings were offered.

Inspectors found that weight records showed that residents' weights were checked monthly or more regularly if required. Nutrition assessments were used to identify residents at risk and were also repeated on a regular basis. Records also showed that some residents had been referred for and received speech and language and or dietetic review. The medical team reviewed the nutritional needs and provided treatment plans. The treatment plans for residents were recorded in their individual file. Medication records showed that supplements were prescribed by a doctor and administered appropriately. Staff provided fortified meals as a first choice as required.

All residents had an end-of-life assessment in place and their needs identified on assessment was reflected in their end-of life care plan. End-of-life care discussions had taken place with residents (where they had capacity), their families and multidisciplinary team members. There were clear records to reflect these discussions and decisions made were reflected in the residents' care plan.

This outcome was judged to be compliant in the self-assessment, inspectors also judged it as being compliant.

**Judgment:**
Compliant

## *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:**
The centre had appropriate policies and procedures in place to ensure that residents with dementia were protected from harm and from suffering abuse in the centre. An action from the last inspection relating to the management of responsive behaviours was followed up on and this was found to have been addressed.

The centre had a policy on the prevention, detection and response to abuse. Inspectors reviewed the staff training records for the two units they visited and found that all staff in the units had received up to date training around safeguarding residents. Inspectors

spoke to a number of staff and all those spoken with were knowledgeable around the signs of abuse and what to do in the event of an allegation or suspicion of abuse. Staff also stated they would have no issue in reporting any alleged incident abuse to management. Throughout the course of the inspection the residents in both units were observed to be safe and supervised appropriately.

Management in the centre confirmed post this inspection that staff working in the centre had a garda vetting disclosure in place in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012.

The centre had a policy in place on responding to residents who may display responsive behaviours. Inspectors reviewed residents' care plans and found that they detailed triggers and the various steps to be taken in order to distract or de-escalate in the event of a resident displaying responsive behaviour. On a number of occasions inspectors observed staff recognising triggers and immediately responding, calming the residents using the same steps detailed in their care plans.

Use of bed rails and restraint in the centre was low. Where bed rails were in use there was documentation to evidence alternatives had been tried, or residents had requested the bed rails. Residents were observed moving freely throughout the two units. Inspectors reviewed medication and found that the use of chemical restraint in the centre was low, and when it was required it was only administered after all other de-escalation methods had been attempted first.

This outcome was judged to be compliant in the centre's self-assessment, inspectors also judged it as being compliant.

**Judgment:**
Compliant

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

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

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

**Findings:**
Residents rights and dignity were found to be met and respected in the centre. However not all residents were actively consulted with around the running of the centre and there were varied levels of meaningful engagement with residents.

In the two units it was observed that residents had their independence promoted. Throughout the inspection residents were free to move throughout the units without restriction including residents who were assessed as needing one-to-one supervision. Residents could receive visitors throughout the day. A sensory/quiet room was available in both units if residents wished to meet visitors in private. Both units were calm and

staff did not seem rushed during the inspection.

Residents rights were protected and respected in the centre. Signs were put on the doors of bedrooms while residents were receiving personal care to ensure the privacy and dignity was respected. Residents could maintain control of their own personal possessions. Religious rights were also met. Mass was held daily on the campus and all residents were facilitated to attend if they wished to. At the time of the inspection all residents in both units were Roman Catholic, however inspectors were informed that all religions or faiths were accommodated for in the centre. Residents were facilitated to vote in the centre. Residents would receive their voting cards at the time of an election and if they wished to vote this was facilitated in the centre. While there was advocacy details on display in the centre, staff were uncertain as to if advocacy was available or how to contact advocates.

As part of the inspection inspectors spent a period of time observing staff interactions with residents with dementia in both units. Inspectors used a quality of interactions schedule, or QUIS tool to record and rate the interactions between staff and residents in the day room of both units. The findings are as follows:

In the male unit the interactions were found to be limited. Overall while the residents could move freely throughout the unit, there was minimal interaction between staff and residents. There was music playing quietly in the room while the television was turned on with no sound. The majority of residents sat quietly in chairs in the day room; some staff sat beside residents but did not engage in any meaningful conversation, while other staff carried out writing their notes in silence. Staff presence in the room seemed to be aimed at solely maintaining the supervision of residents.

In the female unit the interactions observed were found to be more positive. Activities staff were observed engaging with seven residents' in a karaoke class. Staff consistently engaged with all residents who actively took part by singing along to the music.

Improvements were required around resident consultation. There was no evidence that residents were being consulted with about the running of the centre. Inspectors were informed that resident meetings had not taken place for over a year however, these were due to re-commence and were going to be facilitated by independent advocates.

This outcome was judged to be compliant in the centre's self-assessment, inspectors found it to be moderately non compliant.

**Judgment:**
Non Compliant - Moderate

***Outcome 04: Complaints procedures***

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

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

**Findings:**
There were systems to respond to complaints and the complaints management process was effective. However, the policy did not identify the person responsible for reviewing complaints.

All verbal complaints were recorded and dealt with at local level by the nurses and managers in the unit or by the social work department. Inspectors reviewed the complaints folder and found that there were a small number of complaints on each unit and numerous "thank you cards" on file to staff for the care delivered. Residents said they knew who to speak to make a complaint. They also said that issues they raised were addressed. Staff members were knowledgeable about their role in responding to issues raised by residents so that they did not escalate and become the subject for a complaint.

The complaints procedure was available in the centre. The complaints officer was identified on the policy. The policy did not name the person separate to the complaints officer who was responsible for reviewing complaints to ensure they were responded to appropriately and that records were being maintained as required by the Regulations. However, there was a system in place to audit complaints and the data collected by the person in charge on the numbers of complaints in the centre on a monthly basis. This included the type and action taken.

This outcome was judged to be compliant in the self-assessment, inspectors judged it as being substantially compliant.

**Judgment:**
Substantially Compliant

***Outcome 05: Suitable Staffing***

**Theme:**
Workforce

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

**Findings:**
There were appropriate staff numbers and skill mix to meet the assessed needs of residents in both the units inspected during this inspection. However, there were a high number of vacant posts in the centre including an assistant director of nursing, ten staff nurses, six health care assistants and five household staff posts. The management team had temporarily closed eight long term and four respite beds to ensure theses staff shortages did not have a negative impact on residents.

Staff had up-to-date mandatory training in place. They also have access to other education and training to meet the needs of residents with dementia. A clinical nurse manager in each of the two dementia specific units had completed a higher diploma in care of residents with dementia.

Staff were aware of the National Dementia Strategy in January 2015. Inspectors found that residents with dementia received a holistic care package from staff in one of the two units. However, inspectors found interaction between staff and residents in one of the two units was not stimulating and required improvement.

Recruitment procedures required review. Inspectors did not have access to staff files as they were held off site. The provider and person in charge were requested to confirm in writing that a sample of five staff files (names of which were selected by the lead inspector) contained all documents as outlined in schedule 2. This confirmation was received post the inspection.

There were no volunteers working in either of the two units.

This outcome was judged to be compliant in the self-assessment, inspectors judged it as being non compliant moderate.

**Judgment:**
Non Compliant - Moderate

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

**Theme:**
Effective care and support

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

**Findings:**
Inspectors focused their inspection in the two dementia specific units Beech and Poplar unit.

Beech unit caters for 16 male residents with a diagnosis of dementia in four, four-bedded bedrooms and one single room which is only used to move a resident into at their end-of-life if required. There are four toilets, none are assisted. There are two showers, one of these assisted. However, the majority of residents were independently mobile.

Poplar unit caters for 16 female residents with dementia in four, four bedded bedrooms. The main entrance is wheelchair accessible and there is a key pad locking system in place. The nursing office is located next to the main entrance. Accommodation for residents is provided on one long corridor. Facilities for residents include a sitting room which has an interconnecting door leading into the dining room. There is also a

kitchenette and small visitors' quiet room available. There were three toilets, one was assisted, two showers which were assisted, as well as a store room, linen room, treatment room, a dirty utility and cleaning room.

Inspectors saw that pictorial signage had been placed on doors within each unit. These signs were in a different colour then the doors which enabled residents with dementia to orientate themselves to the room they were entering. However, overall inspectors observed that both units for use by residents with dementia were not designed in accordance with best practice for residents with dementia. The layout did not include any landmarks, cueing or highly distinctive visually unique elements to help to orientate residents with dementia. These areas did not include enough appropriate signage, and did not use colour and lighting in line with best practice dementia care principles.

This outcome was judged to be compliant in the self-assessment, inspectors judged it as being non compliant moderate.

**Judgment:**
Non Compliant - Moderate

## *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:**
Inspectors followed up on two action plans identified on the last inspection report. One of these had been addressed the second remained outstanding.

This action had been addressed:
The risk management policy had been reviewed and implemented. It was available for review. It now included all aspects of fire safety clearly outlined for each unit.

This action had not been addressed:
Inspectors noted that some of the fire exits were not clearly displayed. In each of the 2 units inspected all fire exits did not have directional signage in place.

**Judgment:**
Substantially Compliant

## *Outcome 11: Information for residents*

**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:**
These non compliances identified on the last inspection had not been addressed:

Inspectors read a sample of completed contracts and saw that they did not fully meet the requirements of the Regulations. They included adequate details of the services to be provided but did not include the fees to be charged. The cost for the additional services were not included. The provider confirmed that they had not been reviewed since the last inspection.

The designated centre had all of the written operational policies as required by Schedule 5 of the Regulations. The policies in relation to restraint, behaviours that challenge and medication management policies had been finalised. However, the restraint and behaviours that challenge had not yet been implemented.

**Judgment:**
Non Compliant - Moderate

## 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:*

Sheila McKevitt
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**[1]

| | |
|---|---|
| **Centre name:** | Cherry Orchard Hospital |
| **Centre ID:** | OSV-0000508 |
| **Date of inspection:** | 02/11/2016 |
| **Date of response:** | 15/12/2016 |

## 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 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:**
Most residents had not been provided with the opportunity to provided feedback on the running of the centre through residents' meetings.

**1. Action Required:**
Under Regulation 09(3)(d) you are required to: Ensure that each resident is consulted about and participates in the organisation of the designated centre concerned.

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

**Please state the actions you have taken or are planning to take:**
Individual care plan meetings are held with the resident and nominated family member every 4 months. At these meetings the resident will be consulted with in relation to their ongoing care and the running of the centre.

Documentary evidence of these meetings will be provided in each resident's healthcare record and will be part of the criteria in the care plan audits which are conducted in Cherry Orchard.

A system for the provision of an advocacy service to conduct meetings with residents, independent of frontline healthcare staff, has been re commenced and should be completed by 31st March 2017. A number of approaches may be required in order to address the specific needs of the client group. This process will be reviewed by a steering group, established by the provider, in order to monitor its effectiveness.
A family representative from those residents in the Dementia units is on the steering group.

**Proposed Timescale:** 31/03/2017

## 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:**
The complaints policy did not meet the regulations.

**2. 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:**
The person nominated to oversee complaints as required in Regulation 34 is named, on the Complaints Protocol which has been revised to provide contact details and is on display on each unit since the beginning of December 2016. This is in keeping with the HSE complaints policy Your Service, Your Say. Each unit now displays the current complaints officer along with the full complaints process including the named review officer, independent of Cherry Orchard Hospital and option to appeal to the Ombudsman as required.

**Proposed Timescale:** 14/12/2016

## Outcome 05: Suitable Staffing

**Theme:**
Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Staff were not being appropriately supervised to ensure their interaction with residents reflected a high standard of nursing practice in one of the units inspected.

**3. 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:**
The Person in Charge will review the practices, with the appropriate Nurse Managers, within the units inspected to ensure that all residents receive a holistic care package.
Each unit is managed by a Clinical Nurse Manager 1 and a Clinical Nurse Manager 2 who reports to a Senior Nurse Manager in Nursing Administration. Every effort is made to ensure that as much as is possible a Clinical Nurse Manager is on duty every day.
10 places have been secured on an 'Enabling and enhancing wellbeing for the person with Dementia and Responsive Behaviour' courses in 2017.
Feedback will be actively sought from the residents/family members regarding their views on the provision of holistic care, at the 4 monthly care plan meetings.
Documentary evidence will be provided and audited with the healthcare records.

**Proposed Timescale:** 31/03/2017

**Theme:**
Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Schedule 2 documents were not available for inspection.

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

**Please state the actions you have taken or are planning to take:**
The Memorandum of Understanding between HIQA and the HSE facilitates the inspection of staff records held on behalf of the service in Health Business Services in Merchants Quay.
All non officer files are retained locally and are available on site.
A copy of documents required under schedule 2 has been requested from HBS in respect of staff members whose files are held in Merchant's Quay.
From current date HBS will be required to provide a copy of all documents under Schedule 2 to the Person in Charge at the time of recruitment. These will be available for inspection on site.

**Proposed Timescale:** 30/06/2017

**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 premises does not meet the needs of residents.

**5. 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:**
A design team have been appointed and our Estates Department have estimated the time frame for submission for planning permission to be the 30th June 2017.

It is anticipated that a new build will be completed by 31st December 2021.

In the interim a senior nurse manager on both units with a post graduate qualification in Dementia have been asked to forward submissions to enhance the environment in both units.
Consultation will be undertaken with residents and/or family members.

Minor capital will then be sought based on these recommendations. Proposed timescale for submission 31.03.2017

Proposed Timescales: Submission of minor capital request 31.03.2017
Submission of planning permission 30.06.2017
Completion of new build 31.12.2021

**Proposed Timescale:** 31/12/2021

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

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Some of the fire exits were not clearly displayed, there was no emergency plan and the fire procedures did not guide practice.

**6. 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:**
Emergency plan is in place and is available on each unit.
A meeting is scheduled with the Person in Charge and the Fire Officer on the 19th

December 2016 to examine the issues around fire exits and procedures. Recommendations/actions arising from that meeting will be prioritised for implementation.

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

**Outcome 11: Information for residents**

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Revised policies including the restraint and behaviours that challenge policy had not yet been implemented as required by the regulations.

**7. 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:**
The policy on restraint is complete and signed off and is in the process of being circulated and implemented in each clinical area.
The CNS in Behaviours is reviewing the policy on Behaviours that Challenge; this will be implemented by the 31st of March 2017

**Proposed Timescale:** 31/03/2017

**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 meet the requirements of the Regulations.

**8. Action Required:**
Under Regulation 21(4) you are required to: Retain the records set out in paragraphs (6), (9), (10), (11) and (12) of Schedule 4 for a period of not less than 4 years from the date of their making.

**Please state the actions you have taken or are planning to take:**
All residents and/or family representatives are notified by the Nursing Home Support Office as to their individual contributions towards their cost of care. Those not covered under the NHSS are notified in accordance with HSE policy.

The contract of care is offered to each resident on admission. The current contract of care will be amended to reflect what services are included in respect of each individuals contribution, along with any separate charges that are applicable.

The new contract of care will be available to all persons admitted from 31st March 2017. Engagement with remaining residents will commence from 1st April 2017 in relation to agreeing a new contract of care.

A uniform contract of care is currently being devised across all residential units in CHO 7. This contract will outline the charges applicable for services covered under the appropriate legislation.

Proposed Timescale: 31.03.2017

31.12.2017 standard contract of care will be completed.

**Proposed Timescale:** 31/12/2017