Health Information and Quality Authority
Regulation Directorate

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

Centre name:	St Joseph's Hospital
Centre ID:	OSV-0000537
Centre address:	Ardee, Louth.
Telephone number:	041 685 3304
Email address:	josephine.marron@hse.ie
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Maura Ward
Lead inspector:	Una Fitzgerald
Support inspector(s):	None
Type of inspection	Unannounced Dementia Care Thematic Inspections
Number of residents on the date of inspection:	16
Number of vacancies on the date of inspection:	4

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 2 day(s).

The inspection took place over the following dates and times

From:	To:
23 May 2017 09:30	23 May 2017 18:30
24 May 2017 08:00	24 May 2017 14:30

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	Substantially Compliant	Compliant
Outcome 02: Safeguarding and Safety	Compliance demonstrated	Non Compliant - Moderate
Outcome 03: Residents' Rights, Dignity and Consultation	Compliance demonstrated	Substantially Compliant
Outcome 04: Complaints procedures	Compliance demonstrated	Compliant
Outcome 05: Suitable Staffing	Substantially Compliant	Compliant
Outcome 06: Safe and Suitable Premises	Non Compliant - Moderate	Non Compliant - Major

Summary of findings from this inspection

This thematic inspection focused on the care and welfare of residents who had dementia. On arrival to the centre, the inspector met with the clinical nurse manager who was informed of the purpose of the inspection. The person in charge was present for the second day of the inspection.

Prior to the inspection, the person in charge completed a self-assessment and compared the service with the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013 and the National Standards for Residential Care Settings for Older People in Ireland (2016). The previous table outlines the centre's rating and the inspector's rating for each outcome.

The inspectors met with residents and staff members during the inspection. The case files of a number of residents including those with dementia within the service were tracked. A validated observation tool was used to observe practices and interactions between staff and residents within the centre. Specific emphasis focused on residents who had dementia. Documentation such as care plans, medicine records, medical and clinical records, policies and procedures, and staff records were reviewed.

There were three action plans from the previous inspection. The annual review had been submitted, this action plan was completed. However the two action plans related to the premises were not completed and these non compliances are restated in this report. The premises was not purpose built and was not suitable for its stated purpose. Parts of the centre are poorly maintained and in need of repair, there was inadequate storage space in bedrooms for personal possessions. Some works had been undertaken to create additional storage space, the judgment of major non compliance found on the previous inspection was repeated on this inspection. Although plans to build a new centre had been progressed to design stage, costed plans for a new building were not submitted to the Health Information and Quality Authority (HIQA).

Saint Joseph's Hospital is a registered designated centre that provides care for a maximum of 20 residents. On the day of inspection there were four vacancies, 2 residents had a formal diagnosis of dementia and a further 2 residents who had symptoms of dementia.

The inspectors observed numerous examples of good practice in areas examined which resulted in positive outcomes for residents. Staff observed were courteous and responsive to residents and visitors during the inspection. The results from the formal and informal observations were generally positive and most staff interactions with residents promoted positive connective care. In general the living environment was stimulating and also provided opportunities for rest and recreation in an atmosphere of friendliness. Residents had access to outdoor gardens that were well maintained.

There were policies and procedures available to inform safeguarding of residents from abuse. Staff spoken with adopted a positive, person centred approach towards the management of responsive behaviours. The inspector noted some area for improvement on the management of restraint within the centre.

Residents were consulted with and participate in the organisation of the centre. Overall, a culture of person-centred care was evident and staff worked to ensure that each resident received care in a dignified way that respected their privacy.

A range of staff training opportunities included dementia specific training courses were provided. A staff training programme was in place and any gaps had planned sessions booked to ensure all staff training is kept current and in line with best practice.

The findings and improvements required are discussed within the body of this report and set out in the action plan at the end for response.

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

Findings:
This outcome sets out the inspection findings relating to assessments and care planning, access to healthcare, maintenance of records and policies available governing practice. The self assessment tool (SAT) completed by the person in charge was rated as substantially compliant in this outcome with some areas for improvement highlighted.

The inspector focused on the experience of residents with dementia and tracked the journey prior to and from admission of a number of resident files. The review also looked at specific aspects of care such as nutrition, wound care, mobility, access to health care and supports, medication management, end of life care and maintenance of records. Findings were that residents' needs were met through timely access to medical treatment. Arrangements were in place to meet the health and nursing needs of resident's with dementia. Access to a general practitioner (GP) and allied healthcare professionals including physiotherapy, dietetic, speech and language, dental, ophthalmology and podiatry services were facilitated on a referral basis. Follow up where required and detail of the review carried out was also evident within the records.

Resident files held a copy of their Common Summary Assessments (CSARS), which details assessments undertaken by professionals such as a geriatrician and members of the multidisciplinary team. On admission all residents had a comprehensive nursing assessment. The inspector observed that care plans were written within the 48 hour timeframe as per the regulations. However the admissions policy allows for 72 hours. The PIC will review same and amend the policy to reflect the requirements of the regulations. The assessment process involved the use of validated tools to assess each resident’s dependency level, risk of malnutrition, falls and their skin integrity. An assessment using a validated tool of the level of cognitive impairment of resident's

admitted was recorded and subject to review. Assessment outcomes were linked to care plans that were seen to be reviewed in consultation with the resident and family at intervals of three months and more frequently when clinically indicated. Funding has been sought to implement a computerized care planning system but to date no progress has been made.

Clinical observations such as blood pressure, pulse and weight were assessed on admission and as required thereafter. A care plan was developed following admission. In the sample reviewed, information following the assessment, involvement and recommendations of allied healthcare professionals was reflected. In the main it contained sufficient information regarding the abilities and needs that guided the necessary care interventions of residents to address residents' activities of daily living needs.

A new initiative commenced in March 20017 for the management of all wounds. The initiative is called pressure ulcers to zero. The centre had one resident that was admitted with a pressure ulcers. Since admission one area has completely healed. A pressure mapping exercise is carried out each morning by the staff nurse and any resident identified to be at risk is commenced on a care plan immediately.

Staff provided end of life care to residents with the support of their GP (General Practitioner) and have access to specialist community palliative care services if required. Each file had a detailed document called "Planning for end of Life care forum" completed that was updated in consultation with the resident and where appropriate a family member. End of life care plans outlined the physical, psychological and spiritual needs of the residents. While there was no resident receiving end of life care on the days of inspection the inspector did review the file of a deceased resident. The file contained detailed notes on the condition of the resident throughout their journey. There was good evidence that the family were actively involved and that the care received was appropriate to the residents needs. The centre has accommodation upstairs for families with facilities for refreshment freely available.

Staff outlined how religious and cultural practices were facilitated within the centre. Residents have access to the church at any time. Mass in held in the church every Saturday and a Eucharistic minister also visits on a Tuesday and Thursday. Residents spoken too were satisfied with the arrangements in place.

Arrangements were in place to meet the nutritional and hydration needs of residents with dementia. There were systems in place to ensure residents' nutritional needs were facilitated and monitored. Residents were screened for nutritional risk on admission and reviewed regularly thereafter. Residents' weights were checked. Nutritional and fluid intake records were maintained including fluid volume intake and portion sizes. The processes in place ensure that residents with dementia do not experience poor nutrition and hydration. The Inspector saw that a choice of meals was offered and available to residents. There was a system of communication between nursing and catering staff to support residents with special dietary requirements. Any food allergies were clearly recorded along with resident's likes and dislikes.

Dining arrangements were set up in two separate locations. While the majority of

residents had their meals at set times there was clear evidence that alternative times to meet individual requests are also facilitated. Staff sat with residents while providing encouragement or assistance with the lunch-time meal. Assistance was given to residents with dementia in a discreet and sensitive manner.

Resident's were protected by safe medication practices and procedures. There were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents that were implemented in practice. Medicine administration records were maintained in accordance with relevant professional guidelines. As per the action plan from the last inspection some progress has been made, the centre has an agreement with a pharmacist from another service. This pharmacist is available to residents until recruitment of a pharmacist for the centre is progressed.

Staff were observed to adhere to appropriate medication administration management practices. A medication management audit was carried out in March 2017. To date in 2017 there was one medication error. The incident had been investigated and learning identified, the outcome was communicated to the clinical team. The inspector spoke with one resident who verbalized that the named nurse for his care had provided him with education on all of his medication. On review of the notes there was detailed documentation specific to this residents' medication requirements and education session given to the resident.

Medication administration is carried out from within each resident's room. Each resident has their medication stored securely either in their own bedroom or in a locked cupboard adjacent to the nurses station. On the day of inspection the inspector observed that nutritional supplements were stored at the bottom of a trolley that was not locked away. This practice is not in line with policy and once brought to the attention of the person in charge the supplements were locked away.

Judgment:
Compliant

Outcome 02: Safeguarding and Safety

Theme:
Safe care and support

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

Findings:
This outcome sets out the inspection findings relating to the management of resident protection and how the centre responds and manages responsive behaviour. The self assessment tool (SAT) completed by the provider was rated compliant in this outcome.

The centre had policies in place to protect residents from suffering abuse and to respond to allegations, disclosures and suspicions of abuse. Staff had received training on identifying and responding to elder abuse. Staff were able to explain the different categories of abuse and had knowledge of what their responsibility is should they suspect abuse. In addition staff spoken to were clear about who they would report any concerns too. Displayed throughout the centre on noticeboards was information leaflets for residents and relatives on the HSE initiative Your service your say. The centre also has the name of the local HSE safeguarding officer on display strategically throughout the centre. Residents informed the inspector that they feel safe.

The centre has a policy on and procedures in place to support staff with working with residents who have behavioural and psychological symptoms of dementia (BPSD). This policy was informed by evidence-based practice and implemented by staff. Staff spoken with adopted a positive, person centred approach towards the management of responsive behaviours that challenge. The person in charge informed inspectors that among the current residents only one resident currently has responsive behaviours. The care plan clearly identified the resident's triggers and guided the clinical team on how best to manage any incidents. All incidents are recorded by staff. During the inspection it was observed that staff approached this resident in a sensitive and appropriate manner and the resident responded positively to staff.

Restraint management within the centre requires a full review and further development. Twelve of the sixteen residents used bedrails. The inspector reviewed four files of residents that have bedrails in use. The management and the documentation on the use of restraint was discussed with the person in charge and the clinical nurse manager. The centre used the HSE management of restraint as guidance and also has an in house specific policy to guide staff. Alternative, less restrictive equipment to reduce the use of restraint was not readily available. The use of bed bumpers was confined to one low low bed. Sensor alarms were not available. Each care plan reviewed had documented that no alternative options are available. The care plans reviewed did guide practice. All residents had a bedrail risk assessment and also had a falls risk assessment. All care plans had been reviewed at required intervals. Safety checks were routinely carried out every hour and this was clearly documented.

The inspectors spoke with staff on how residents' funds were managed. As per the regulations there were systems in place to safeguard residents' money. The centre was a pension agent for three residents'. There were clear procedures and practices in place to keep residents' money safe.

Judgment:
Non Compliant - Moderate

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:
The self assessment tool (SAT) had rated this outcome as compliant.

Within the centre there was evidence that residents were consulted with and participated in the organisation of the centre. Each resident's privacy was observed to be respected. As per the regulations facilities for occupation and recreation were available. There was limited space where resident's could receive visitors in private outside of the main living areas. Resident meetings and relative forum meetings were held every three months within the centre. From a review of the minutes, there was good representation of residents with dementia in attendance at the last two meetings. Residents were consulted with and involved in the planning of special occasions. In a recent survey carried out on resident experience, 61% replied that they were satisfied with the activities offered.

Within the centre the residents had access to independent SAGE advocacy services. Contact details of the service was strategically placed throughout the centre. Residents had access to local and national newspapers. There was also access to a telephone. Hairdressing arrangements were available to support residents personal grooming. All residents within the centre had the option to exercise their right to vote. Religious services were provided for and relatives were welcome to attend.

Residents' privacy was observed to be respected by all members of staff. Inspectors observed care practices and interactions between staff and residents who had dementia using a validated tool. they observed that staff engaged positively with residents who had dementia. Overall the interactions were mostly positive. Residents availed of pet therapy as the centre has a resident dog. The dog primarily stays in the communal area but does have a feeding bowl in one residents room at the residents request. It was evident during the inspection that the residents are all in agreement with this arrangement.

The activities programme within the centre was poorly defined and supportive evidence of what had occurred had significant gaps. For example the group activities since 14th March were not recorded. The activities coordinator told the inspector who had attended the last gardening session. However in two of the files there was no reference to the activity in their activities records. On discussion with the staff it was evident that the staff knew the residents well, including their backgrounds and personal history. The activities coordinator worked within the centre two days per week. All staff were able to inform the inspector about the activities that occur. Gardening is rated highly among the current resident population. Residents partake in baking on Tuesdays. Sonas sessions are available but the current residents prefer other activities and this is respected.

There was active engagement between staff and residents. Within the day space and communal areas there were multiple photographs of resident's and staff partaking in special events. Resident with communication difficulties were accommodated within the centre. The inspector observed that a number of residents could not utilize the current

call bell system and alternatives were made available. The inspector also observed on a number of occasions that call bells were not within easy reach of the residents if they needed to call for assistance. This was brought to the attention of the clinical nurse manager and the person in charge. While all staff were knowledgeable about residents with communication difficulties, the care plans were not sufficiently detailed to guide care and ensure that the team provided a consistent approach when working with these residents. By the end of day two of the inspection the nurse manager had updated the care plans.

There was a good relationship between staff and residents in the centre, and visitors were greeted in a welcoming manner. A record of visitors to the designated centre was available and maintained. Overall, a culture of person-centred care was evident and staff worked to ensure that each resident received care in a dignified way that respected their privacy.

Judgment:
Substantially Compliant

Outcome 04: Complaints procedures

Theme:
Person-centred care and support

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

Findings:
This outcome sets out the inspection findings relating to the management of complaints. The self assessment tool (SAT) completed by the provider was rated compliant in this outcome.

There were policies and procedures for the management of complaints. The complaints process was displayed strategically throughout the centre. The inspectors reviewed the complaints log. Records indicated that complaints were minimal, only one logged to date in 2017. Residents were informed on admission of the complaints procedure and the detail is outlined within the residents guide.

The complaint received had been investigated promptly, a record of the outcome was documented and there was also detail that the complainant was satisfied with the outcome. The centre had an appeals officer and also directed the complainant to the office of the Ombudsman if unhappy with the outcome.

Residents and staff spoken with during the inspection told the inspector that they would not hesitate to make a complaint if they had one. Relatives said that they were satisfied with the care and were aware of who they could complain to if they needed to.

Judgment:
Compliant

Outcome 05: Suitable Staffing

Theme:
Workforce

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

Findings:
Inspectors reviewed actual and planned rosters for staff, and found that staffing levels and skill mix were sufficient to meet the needs of residents. Ongoing review of resident dependency and staffing levels were monitored to inform staffing levels and skill mix. Staff spoken to confirmed that they had sufficient time to carry out their duties and responsibilities and clinical nurse managers explained the systems in place to supervise staff. Staff spoken with also felt supported by the person in charge and the provider nominee.

Staff were seen to be supportive of residents and responsive to their needs. Inspectors spoke with a number of residents' who were complimentary of the staff and of the care that was received.

Evidence of current professional registration for all registered nurses was available. A staff training programme was maintained. Training records showed that extensive training had been undertaken and staff spoken with confirmed this. This included training on Safeguarding and safety, dementia training, the management of behaviours that challenge, fire training, manual handling and cardio pulmonary resuscitation. The training matrix identified which staff had attended training. While some gaps were evident within the training schedule the person in charge was able to evidence that staff were scheduled and booked into training to close out on any gaps. Recruitment and induction procedures were in place. All documents as required by Schedule 2 of the regulations for staff were maintained.

Judgment:
Compliant

Outcome 06: Safe and Suitable Premises

Theme:
Effective care and support

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

Findings:
St Joseph's Hospital is currently registered for 20 residents. The building is not purpose built. The actions from the previous inspection related to the premises not conforming to the matters set out in the legislation. The Authority had received correspondence from the HSE that a new purpose built facility will be completed and ready for occupancy by August 2021. The person in charge told the inspector that this plan is currently being progressed and is at architectural design stage due to be completed by December 2017. In the absence of any major refurbishment works to the existing premises the judgment of major non-compliance remained unchanged.

In the interim, the inspection focused on the actions from the previous inspection and findings on the day for residents living in the centre. The centre does not admit any resident with a diagnosis of dementia who are independently mobile. Grab rails are provided on one side of all corridors and within all bathrooms and toilet facilities. The centre is divided into 2 distinct units that are linked by a corridor. The centre was warm and had a homely feel. Residents own art work was framed and displayed throughout. There was a safe outdoor garden space that is easily accessible from the main dining room.

Signage and cues are not used to guide residents or visitors on how to navigate their way around the building. Bedroom doors have the name of a saint placed above the door frame to identify what room they are entering. Parts of the centre are poorly maintained and in need of repair. For example the assisted bathroom on the ground floor was in a poor state of repair. The tap had a heavy layer of crusted lime scale that could not be removed. The surface of the sink was stained. The inspector was unable to leave her hand on the radiator due to the risk of scalding. The wall mounted radiator had cobwebs.

Storage was inadequate throughout. Medical files are stored in a locked kitchen press adjacent to the nurses station. Within the nurses station is a washing machine. Bedrooms did not provide enough space for residents to keep personal belongings. For example one resident stores their coat in the linen press as the wardrobe in the bedroom does not have adequate wardrobe space.

Resident bedrooms all had a clock, a bedside locker, a chair, wardrobe and access to a locked press. Contrasting colors are used in communal bathrooms. Access to sluice rooms is unrestricted. This was identified on the centers' risk registrar and a decision was taken by the person in charge not to restrict access as no resident with dementia was at risk of entering the sluice room. This risk is kept under review.

Judgment:
Non Compliant - Major

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:

Una Fitzgerald
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:	St Joseph's Hospital
Centre ID:	OSV-0000537
Date of inspection:	23 and 24 May 2017
Date of response:	14 June 2017

Requirements

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

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

Outcome 02: Safeguarding and Safety

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Restraint management within the centre requires a full review and further development. The inspector reviewed files of residents that have bedrails in use. The inspector could not find evidence that alternatives to bedrails are considered. Additional equipment to reduce the use of restraint was not readily available.

1. Action Required:

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

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:
A full review of restraint management will be carried out. We are committed to promoting a restraint free environment. All residents using bedrails will be re assessed. Alternative equipment will be purchased to offer residents choice and a less restrictive option to bedrails.

Proposed Timescale: 26/10/2017

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:
The activities programme within the centre was poorly defined and supportive evidence of what had occurred had significant gaps. For example the records were not recorded on group activities from 14th March - date of inspection

2. Action Required:
Under Regulation 09(2)(b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests and capacities.

Please state the actions you have taken or are planning to take:
The Person in Charge will put a system in place to capture the resident's activities on a daily basis. Planned group activities will be displayed and records will be kept up to date.

Proposed Timescale: Immediate

Proposed Timescale: 14/06/2017

Theme:
Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Resident with communication difficulties were accommodated within the centre. The inspector observed on a number of occasions that call bells were not within easy reach of the residents if they wished to call for assistance.

3. Action Required:
Under Regulation 10(2) you are required to: Where a resident has specialist

communication requirements record such requirements in the resident's care plan prepared under Regulation 5.

Please state the actions you have taken or are planning to take:
A daily check will be carried out to ensure that residents have access to their call bell.

The Person in Charge will ensure that residents with communication difficulties have a Care Plan that guide staff to meet their needs.

Proposed Timescale: Immediate

Proposed Timescale: 14/06/2017

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:
Storage was inadequate throughout. Medical files are stored in a locked kitchen press adjacent to the nurses' station. Within the nurses' station is a washing machine. Bedrooms did not provide enough space for residents to keep personal belongings. For example one resident stores their coat in the linen press as the wardrobe in the bedroom does not have adequate wardrobe space.

4. Action Required:
Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

Please state the actions you have taken or are planning to take:
Stock on the ward is kept to a minimum. Alternative storage space is utilised on the first floor. The washing machine will be removed; this layout was developed as part of the Teaghlach Model of Care. The space gained will be utilised to address the lack of storage.

Proposed Timescale: 04/08/2017

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Parts of the centre are poorly maintained and in need of repair. For example the assisted bathroom on the ground floor was in a poor state of repair. The tap had a heavy layer of crusted lime scale that could not be removed. The surface of the sink

was stained. The inspector was unable to leave her hand on the radiator due to the risk of scalding. The wall mounted radiator had cobwebs.

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 Maintenance Manager has been appointed and will assess the areas in most need of attention.
Quotes currently been obtained for a new sink in the bathroom, thermostatic valve fitted to radiator and same cleaned.

Proposed Timescale: 15/12/2017