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

Centre name:	St. Peter's Nursing Home
Centre ID:	OSV-0000122
Centre address:	Sea Road, Castlebellingham, Louth.
Telephone number:	042 938 2106
Email address:	stpeters@trinitycare.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Costern Unlimited Company
Lead inspector:	Leanne Crowe
Support inspector(s):	Una Fitzgerald
Type of inspection	Unannounced Dementia Care Thematic Inspections
Number of residents on the date of inspection:	62
Number of vacancies on the date of inspection:	7

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:
12 June 2018 07:30	12 June 2018 17:00
12 June 2018 07:30	12 June 2018 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	Substantially Compliant	Non Compliant - Moderate
Outcome 02: Safeguarding and Safety	Substantially Compliant	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	Compliance demonstrated	Compliant
Outcome 08: Governance and Management		Non Compliant - Moderate
Outcome 10: Suitable Person in Charge		Compliant

Summary of findings from this inspection

This report sets out the findings of a thematic inspection which focused on specific outcomes relevant to dementia care in the centre. A change of management had taken place in May 2018; the centre's assistant director of nursing had been promoted to director of nursing and person in charge, with a clinical nurse manager consequently occupying the assistant director of nursing role.

Inspectors reviewed the assessed care needs of residents and tracked the journey of a sample of residents with dementia within the service. The inspectors met with residents, relatives and staff and reviewed documentation such as nursing

assessments, care plans, medical records and examined relevant policies including those submitted prior to inspection. Inspectors observed care practices and interactions between staff and residents who had dementia using a validated tool. Prior to the inspection, the provider completed the self-assessment questionnaire in relation to six outcomes. The self-assessment and inspection judgements are set out on the table above.

Inspectors also followed up on the action plan from the previous inspection in July 2017, and findings indicated that one of the five actions had not been adequately progressed. While inspectors acknowledge that progress had been made in addressing areas of non-compliance, the findings of this inspection demonstrate that further improvement was required to bring the centre into full compliance with the regulations.

The findings are discussed in the body of the report and improvements are outlined in the compliance 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):
No actions were required from the previous inspection.

Findings:
Inspectors focused on the experience of residents with dementia and tracked the journey prior to and from admission. 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. Residents' needs were met through timely access to medical treatment. Residents had good access to a general practitioner (GP) and allied healthcare professionals. Inspectors saw good evidence that advice received from the multidisciplinary team was followed up in a timely manner. The detail of reviews carried out was clearly evident within the records.

Resident files held a copy of their Common Summary Assessments (CSARS), which detailed assessments undertaken by professionals such as a geriatrician and members of the multidisciplinary team. Systems were in place to ensure that all relevant information about residents with dementia was provided and received when they are absent or return from another care setting, home or hospital. On admission, all residents had a nursing assessment. The assessment process involved the use of validated tools to assess each resident's dependency level, risk of malnutrition, level of mobility, falls risk assessment and skin integrity. The inspectors observed that initial care plans were written within the 48-hour timeframe, as per the regulations. The development of care plans for a high percentage of the residents' files reviewed did not guide staff. The required documentation was not in place for some of the individual needs of residents to ensure that their medical and nursing needs can be met. These gaps in documentation posed a risk to residents. In addition, care plan reviews were not carried out in consultation with the resident or family every four months as per regulatory requirements.

Staff provided end-of-life care to residents with the support of their GP and had access to specialist community palliative care services if required. Each file reviewed had an end-of-life care plan. This care plan is kept under review and was updated in consultation with the resident and where appropriate a family member. There was no resident receiving end-of-life care on the day of the inspection. The centre had accommodation for families to stay with their relatives if required, with facilities for

refreshment available. Staff outlined how religious and cultural practices were facilitated within the centre.

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. The processes in place ensured that residents with dementia did not experience poor nutrition and hydration. Inspectors 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 residents' likes and dislikes. Dining arrangements were set up in two separate locations. Within the main dining room, the chef served the food from a counter. This meant that residents could visually see what the choices were and were making the decision at the time and not hours in advance. While the majority of residents had their meals at set times inspectors were told that alternative times to meet individual requests could be 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.

At the time of the inspection there were four residents with pressure sores. Two grade two pressure sores developed in the centre and two other residents were admitted to the centre with a healing grade 4 pressure sore and a grade 2 pressure sore, which were being treated. Residents were routinely assessed to identify their risk of developing pressure-related skin injuries. Residents at risk had specific equipment in place to mitigate level of risk, such as repositioning regimes and pressure relieving mattresses and cushions. Tissue viability specialist services were available to support staff with management of any residents' wounds that were deteriorating or slow to heal. Inspectors reviewed a number of care plans specific to wound management. Inspectors were not satisfied that the care plans in place appropriately guided care for some residents. For example, there was evidence that dressings changes did not take place as frequently as directed in a resident’s care plan. This was discussed during the feedback meeting and with the person in charge.

There were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents. The policies had all been reviewed in May 2017. Nursing staff were observed administering medicines to residents and practices reflected professional guidelines. Residents were not rushed and the rationale for the medication was explained. Appropriate storage and checking procedures were in place for medicines controlled under misuse of drugs legislation and medicines requiring refrigerated storage. There were procedures for the return of out-of-date or unused medications. Systems were in place for recording and managing medication errors. To date in 2018 there was no medication errors reported.

Judgment:
Non Compliant - Moderate

Outcome 02: Safeguarding and Safety

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:
There were systems in place to protect all residents from being harmed or suffering abuse. There was a policy and procedures in place for safeguarding residents. Inspectors found that appropriate action was taken in response to any allegations of abuse. However, training records reviewed by inspectors indicated that seven staff did not have up-to-date training in the prevention, detection and response to abuse. Inspectors were informed that training to capture outstanding staff had been scheduled to take place in the weeks following the inspection. Residents who spoke with inspectors stated that they felt safe in the centre.

A restraint-free environment was promoted throughout the centre. Restraint was being used in relation to a small number of residents, with alternative equipment being implemented where possible. While risk assessments had been completed for these residents, a recent internal audit had identified a number of issues in relation to the management of restraint that required action. The management team confirmed that work was ongoing to rectify the issues identified. An action from the previous inspection is restated in this report, as inspectors found that there were gaps in the records of the duration of restraint, safety checks and releases. Inspectors could not be assured that residents using restraint were being appropriately monitored by staff, in line with the centre's policy.

There was a policy and procedure in place to support residents with responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). Inspectors were informed that there were no residents currently exhibiting responsive behaviours in the centre.

There were systems in place to safeguard residents' finances. The centre was a pension agent for a number of residents, and inspectors found that the arrangements in place to manage this were in line with the Department of Social Protection guidelines.

Judgment:
Non Compliant - Moderate

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

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

Findings:

Inspectors found that residents were consulted with and participated in the organisation of the centre. Residents' meetings took place on a monthly basis and were attended by large numbers of residents, including those with dementia. Minutes of these meetings indicated that residents' feedback was regularly sought on a variety of topics including activities, staffing, food and the environment. It was evidenced that any actions arising from residents' feedback were communicated to relevant staff or management for completion. A seasonal newsletter was published each quarter, and was circulated to residents.

Residents' relatives were also given opportunities to provide feedback on the services provided. A relatives' meeting took place on a regular basis, and a family survey had recently been conducted. Inspectors reviewed the completed surveys and found the responses to be mostly positive in nature. Relatives and visitors who met with inspectors on the day of the inspection spoke very positively of the service provided to their loved ones.

At the time of the inspection, one activities co-ordinator was employed 35 hours per week, working Monday to Friday. The management team confirmed to inspectors that an additional activity co-ordinator had recently been recruited to initially provide an additional 15 hours per week. Inspectors found that a comprehensive activity programme was being provided to residents, combining in-house activities and regular outings. On the day of the inspection, six residents were attending an event at a local men's group, an external provider was leading an exercise class and smaller group activities were being carried out in various areas, including bingo and movies. The activities co-ordinator outlined how a number of external providers visited weekly, fortnightly or monthly, to provide activities like art classes, live music, exercise or hand massage. Recent events that had taken place included a visit from an animal farm and an outing to Bellingham Castle. The activities co-ordinator was currently completing training to provide more sensory-based activates to residents, particularly those with dementia.

Inspectors reviewed a number of activity assessments and records detailing residents' life histories and activity preferences. Some of these lacked sufficient detail to inform the provision of activities to these residents, in line with their interests and capabilities. In addition to this, records of residents' engagement in activities were not well-maintained, as the documents reviewed did not contain any information between February 2018 and 6 June 2018.

Inspectors observed the quality of interactions between staff and residents using a validated observational tool to rate and record these interactions at five minute intervals in two dining-rooms, one activity room and one lounge. Scores for the quality of interactions are +2 (positive connective care), +1 (task orientated care), 0 (neutral

care), -1 (protective and controlling), -2 (institutional, controlling care). The scores reflect the quality of the interactions with the majority of residents. Inspectors' observations concluded that the majority of interactions consisted of positive connective care, where staff took opportunities to socially engage with residents in a meaningful manner. It was clear from observing these engagements that staff were knowledgeable of residents' lives, interests and histories. However, some instances of task orientated care also observed, where staff did not avail of opportunities to socially engage with residents.

Residents were facilitated to exercise their civil, political and religious rights. Residents were supported to vote in the centre and arrangements had been made to facilitate voting in the recent referendum. Residents of the various faiths could practice their religions. A local priest visited on a monthly basis to carry out religious services.

Independent advocacy services were accessible to residents, and residents could be supported to engage with these services if required.

The layout and décor of the building supported residents' privacy and meeting with visitors in communal areas or more private settings, in line with their preferences.

Local news from the community was accessed by residents through newspapers or radio. While wireless internet was currently restricted to specific areas within the building, work was ongoing to make it available throughout the nursing home. A tablet computer and portable telephone was available for use by residents.

Judgment:
Substantially Compliant

Outcome 04: Complaints procedures

Theme:
Person-centred care and support

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

Findings:
There was a policy and procedures in place regarding the management of complaints.

The person in charge was the nominated person to investigate and manage complaints. Verbal and written complaints were recorded in a complaints log that was maintained in the centre. Inspectors reviewed this log and found that it contained the information required by the regulations. Complaints were found to be addressed and resolved in a timely manner, and the satisfaction of complainants with the outcome of their complaint was recorded. A second person was nominated to ensure that all complaints were appropriately recorded and responded to, and there was evidence that complaints were

being reviewed on a quarterly basis.

An appeals process was outlined for any complainants that were unsatisfied with the outcome of their complaints. Residents who spoke with inspectors were aware of the complaints process and felt that any dissatisfaction they may express would be listened 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. For example: an additional healthcare assistant was working an evening shift to ensure resident needs were met. The majority of staff spoken with confirmed that they had sufficient time to carry out their duties and responsibilities. The person in charge explained the systems in place to supervise staff. Staff spoken with also felt supported by the person in charge and the provider.

Staff were seen to be supportive of residents and responsive to their needs. Inspectors spoke with a number of residents' relatives who were highly 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. Although some gaps were identified the centre had evidence that additional training had been scheduled to capture any outstanding staff.

Recruitment and induction procedures were in place. All documents as required by Schedule 2 of the regulations for staff were maintained.

The inspectors were informed there were no people involved on a voluntary basis within the centre at this time.

Judgment:
Compliant

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:
The centre is purpose-built and can accommodate up to 69 residents. The actions required from the last inspection had been completed. Due to the installation of hoist equipment, all residents, including those with varying mobility, now have the option to take a bath. There are 63 ensuite single bedrooms and three twin ensuite bedrooms. The design and layout of twin occupancy rooms met the current residents' needs and there was appropriate screening in place to ensure that their privacy and dignity was not compromised. The centre had a dementia specific unit which accommodates 20 residents in total.

Sitting rooms, lounges and dining rooms were spacious and decorated to a high standard with colourfully co-ordinated soft furnishings. The centre was found to be well-maintained, warm, comfortable and visibly clean throughout. Heating and ventilation was adequate and the temperature of the building met requirements in bedrooms and communal areas where residents sat during the day. There were multiple communal rooms for resident and family use, outside of their bedrooms. Within the dementia specific unit, inspectors noted that residents with dementia who were mobile had little directional signage or cues to support them navigate the centre and locate their bedrooms, indoor and outdoor communal areas and bathroom facilities. The management had identified this gap and were addressing the issue.

Corridors and door entrances used by residents were wide and spacious to facilitate movement with aids used and required by residents. Bedrooms were spacious to accommodate personal equipment and devices required by existing residents. Handrails were available in all circulation areas throughout the building, and grab rails were present in all toilets and bathrooms. Furniture and equipment seen in use by residents was in good working condition and appropriate to their needs. Supportive equipment such as call bell facilities, hoists and mobility aids were seen in use by residents that promoted their independence.

Inspectors found that the privacy and dignity of residents was promoted in each bedroom and by its layout. Rooms were personalised with photos, memorabilia and decorative objects. Residents confirmed that they were encouraged to bring in items from their homes. Some rooms had clocks which helped to orientate residents to time.

Catering and laundry facilities were available in the centre.

Judgment:

Compliant

Outcome 08: Governance and Management

Theme:
Governance, Leadership and Management

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

Findings:
A change of management had occurred since the previous inspection. In May 2018, the centre's assistant director of nursing had been promoted to director of nursing and person in charge, with a clinical nurse manager consequently occupying the assistant director of nursing role. As a result, one clinical nurse manager post was vacant at the time of the inspection. The person in charge displayed good knowledge of the residents within the centre, and was aware of their responsibilities under the regulations.

Following the previous inspection where the centre had increased their capacity by 30 beds, the centre's management had agreed to abide by a schedule of the admission of residents to the centre. It was agreed that a maximum of four residents would be admitted to the centre per week, between Monday and Thursday only. This was to ensure that the centre could appropriately assess and meet the needs of residents that were newly admitted. Inspectors had concerns that the management team had breached this agreement on more than one occasion. This was discussed with the management team at the conclusion of the inspection.

While the management team had good knowledge of the findings from the previous inspection in July 2017 and had been working to address the actions, inspectors found that one of the five actions from the inspection had not been adequately progressed, as outlined in Outcome 2:
*Records of the duration of restraint and safety checks or releases were not consistently recorded.

Inspectors found that more in-depth auditing was being carried throughout the service since the beginning of the year. These audits had identified areas of improvement, and action plans had been developed to address this issues. However, inspectors noted that some of these action plans had not been progressed in a timely manner and had not been completed at the time of the inspection. There was some progress made in the development of systems to ensure that the service provided was monitored and safe, but further improvement was required.

Inspectors acknowledged the management's willingness to ensure that the centre returns to full compliance with the regulations. Clear lines of accountability and authority were evident in the centre. Policies and procedures were in place to guide practice and service provision.

An annual review of the quality and safety of care delivered to residents for 2017 was completed.

Judgment:
Non Compliant - Moderate

Outcome 10: Suitable Person in Charge

Theme:
Governance, Leadership and Management

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

Findings:
The centre was managed by a suitably qualified and experienced nurse who is in position since May 2018. Having previously been in the centre since February 2018 as Assistant Director of Nursing, the person in charge had a strong presence within the centre and was known to the residents and families. They held authority, accountability and responsibility for the provision of the service. They facilitated the inspection process, had good knowledge of residents' care and conditions and was focused on developing a culture of quality improvement and learning to drive improvements in the standard of care delivered to residents.

During the inspection he clearly demonstrated that he had sufficient knowledge of the regulations and standards pertaining to the care and welfare of residents in the centre. Residents and relatives spoke positively about the person in charge throughout the inspection. Staff stated that they felt supported by the person in charge and were confident that any issues brought to his attention would be addressed appropriately.

Judgment:
Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Leanne Crowe
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. Peter's Nursing Home
Centre ID:	OSV-0000122
Date of inspection:	12/06/2018
Date of response:	

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 Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The development of care plans for a high percentage of the residents' files reviewed did not guide staff. The required documentation was not in place on the individual needs of residents to ensure that their medical and nursing needs can be met. These gaps in documentation posed a risk for residents.

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 05(3) you are required to: Prepare a care plan, based on the assessment referred to in Regulation 5(2), for a resident no later than 48 hours after that resident's admission to the designated centre.

Please state the actions you have taken or are planning to take:
All residents care plans will be reviewed to ensure that they appropriately guide staff whilst ensuring that their medical and nursing needs are met

All care plans well be reviewed on at least a four monthly basis.

A percentage of care plans will be audited on a monthly basis ensuring that actions identified are completed, followed up and signed off.

Bespoke one to one training will be provided to each nurse by the Assistant Director of Nursing to further enhance their knowledge of the care planning process.

Proposed Timescale: 31/08/2018

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Care plan reviews were not carried out in consultation with the resident or family every four months as per regulatory requirements.

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

Please state the actions you have taken or are planning to take:
Care plans reviews will be carried out every four months in consultation with the resident and if appropriate the residents family.

Proposed Timescale: Outstanding reviews by 31st August 2018 and four monthly thereafter.

Proposed Timescale: 31/08/2018

Outcome 02: Safeguarding and Safety

Theme:
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Gaps were identified in the records of the duration of restraint, safety checks and releases.

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

Please state the actions you have taken or are planning to take:
Management have met with care staff and staff nurses on the 18th and 19th June 2018. As part of the meeting it was reiterated the importance of recording the duration of the restraint, safety check and release.

Management have put revised processes in place to ensure that all residents who have restraints applied have safety checks and /or release consistently carried out and recorded as per care plan and local policy.

Proposed Timescale: 31/07/2018

Theme:
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Training records indicated that seven staff did not have up-to-date training in the prevention, detection and response to abuse.

4. Action Required:
Under Regulation 08(2) you are required to: Ensure staff are trained in the detection and prevention of and responses to abuse.

Please state the actions you have taken or are planning to take:
Whilst Training records indicated that seven staff did not have up-to-date training in the prevention, detection and response to abuse the training matrix did highlight that training was scheduled to take place on the 25th June 2018.

Proposed Timescale: 25/06/2018

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:
Person-centred care and support

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

A number of activity assessments and records detailing residents' life histories and activity preferences review by inspectors lacked sufficient detail to inform the provision of suitable activities to these residents. Records of residents' engagement in activities were not well-maintained, as the documents reviewed did not contain any information between February 2018 and 6 June 2018.

5. 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:
All residents activity assessments and records detailing life histories and activity preferences will be reviewed to ensure that they have sufficient detail to inform the provision of suitable activities.

A record of residents engagement in activities will be documented accordingly and in a timely manner by the appropriate staff.

Proposed Timescale: 31/08/2018

Outcome 08: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Inspectors noted that some of these action plans arising from audits had not been progressed in a timely manner and had not been completed at the time of the inspection.

6. 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:
The centre has a robust governance management system in place that includes a suite of internal audits that are completed on a weekly, fortnightly and monthly basis. The PIC will ensure that all these audits are conducted, and action plans generated. Going forward they will ensure that these actions are processed in a timely manner.

Proposed Timescale: 31/8/18 and as required thereafter.

Proposed Timescale: 31/08/2018