<table>
<thead>
<tr>
<th>Centre name</th>
<th>Ferndene Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID</td>
<td>OSV-0000759</td>
</tr>
<tr>
<td>Centre address</td>
<td>Deansgrange Road, Blackrock, Co. Dublin.</td>
</tr>
<tr>
<td>Telephone number</td>
<td>01 236 0028</td>
</tr>
<tr>
<td>Email address</td>
<td><a href="mailto:info@williscaregroup.ie">info@williscaregroup.ie</a></td>
</tr>
<tr>
<td>Type of centre</td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
</tr>
<tr>
<td>Registered provider</td>
<td>SRCW Limited</td>
</tr>
<tr>
<td>Lead inspector</td>
<td>Nuala Rafferty</td>
</tr>
<tr>
<td>Support inspector(s)</td>
<td>Ann Wallace</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Announced Dementia Care Thematic Inspections</td>
</tr>
<tr>
<td>Number of residents on the date of inspection</td>
<td>114</td>
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<tr>
<td>Number of vacancies on the date of inspection</td>
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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 announced and took place over 1 day(s).

**The inspection took place over the following dates and times**
From: 18 April 2018 09:30  
To: 18 April 2018 19:00

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

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Provider's self assessment</th>
<th>Our Judgment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome 01: Health and Social Care Needs</td>
<td>Compliance demonstrated</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 02: Safeguarding and Safety</td>
<td>Compliance demonstrated</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 03: Residents' Rights, Dignity and Consultation</td>
<td>Compliance demonstrated</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 04: Complaints procedures</td>
<td>Compliance demonstrated</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 05: Suitable Staffing</td>
<td>Compliance demonstrated</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 06: Safe and Suitable Premises</td>
<td></td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 08: Governance and Management</td>
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**Summary of findings from this inspection**
This inspection report sets out the findings of an unannounced thematic inspection which focused on six specific outcomes relevant to dementia care. The purpose of this inspection was to determine what life was like for residents with dementia living in the centre. The inspection also followed up on actions required from the previous inspection and considered information received by the Health Information and Quality Authority (HIQA) in the form of notifications and other relevant information. This inspection was erroneously announced to the provider three weeks prior to the inspection taking place.

The provider had completed a self-assessment tool on dementia care and had assessed the compliance level of the centre as compliant for all six outcomes.
This inspection agreed with the providers assessment for outcomes including health and social care needs, safeguarding, complaints and rights, dignity and consultation. Inspectors found premises to be substantially compliant and staffing was assessed as moderately non-compliant. The governance and management of the centre was also reviewed on this inspection following an increase in the capacity of the centre since the last inspection.

Inspectors found that residents received a good standard of care from staff and all interactions observed were respectful. Efforts to deliver care in a person-centred manner were also observed although consistency was not yet embedded into practice.

Residents' had access to medical officers and allied health professionals, such as physiotherapy and speech and language therapists, and access to community health services was also available.

The premises were designed and furnished to offer resident's comfortable accommodation. Bedrooms were appropriately furnished and there was adequate wardrobe and storage space for clothing and personal possessions. The centre was appropriately and pleasantly decorated and well maintained.

Overall, there was a good level of compliance with the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and the National Standards for Residential Care Settings for Older People in Ireland. A good system of governance was in place but would benefit from improvements to operational supervision of practice. Some areas of ongoing improvement were identified with regard to recording care interventions, recruitment processes, staff supervision and way-finding for residents.
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:
Residents had access to medical care, out-of-hours doctor services and a full range of other services available on referral, including occupational therapy, speech and language therapy, dietitian, chiropody, dental services and optical services.
Evidence of referral and review was available and viewed, with early recognition of the signs of clinical deterioration and appropriate management.
Samples of clinical documentation including nursing and medical records were reviewed. These showed that all recent admissions to the centre were assessed prior to admission.
The pre-admission assessment was generally conducted by the person in charge who looked at both the health and social needs of the potential resident.
Transfer of information within and between the centre and other healthcare providers was good. Discharge letters for those who had spent time in acute hospital and results of blood tests and other health screening detailing findings after clinic appointments were maintained.
Evidence of referral and review was available and viewed with early recognition of the signs of clinical deterioration and appropriate management. Regular review of all residents by a medical officer as needs changed or every four months was found.

The systems in place to make sure healthcare plans reflected the care delivered and were amended in response to changes in residents’ health, were implemented by the nursing team. Care plans were detailed enough to guide staff on the appropriate use of interventions to manage the identified need, and reviews considered the effectiveness of the interventions to manage or treat the need. Comprehensive risk assessments on which to base care plans were in place and there were efforts to plan and deliver care in a person-centred manner. However, evidence was not available to assure inspectors that care interventions outlined in the care plans of some residents were being implemented. This finding is included under outcome 5 staffing.

Menus were available and all residents were offered a choice at each meal. The inspectors observed residents having their lunch in the dining rooms. All staff sat beside the resident to whom they were giving assistance and were noted to patiently and gently encourage the resident throughout their meal.
Residents on modified diets were provided with the same choices and each element of
the meal was separately presented on the plate. Residents' weights were checked on a monthly basis, and, where required, daily intake charts were to be put in place to monitor food or fluid intake. However, inspectors found that records were not adequately maintained across all units in the centre for some residents identified as at risk of dehydration. These findings are included under outcome 5 of this report.

There were written operational policies relating to the ordering, prescribing, storing and administering of medicines to residents. Nursing staff were observed administering medicines to residents and following appropriate administration practices. The nurse knew the residents well, and was familiar with the residents' individual medication requirements. Inspectors observed that the nurse took time to ensure each resident was comfortable before administering their prescribed medicines in a person-centred manner. Details of all medicines administered were correctly recorded. Prescribed medicines were regularly reviewed by a medical officer. Medicine audits were conducted in the centre and a process for recording medicine errors was also in place.

**Judgment:**
Compliant

<table>
<thead>
<tr>
<th>Outcome 02: Safeguarding and Safety</th>
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<tbody>
<tr>
<td><strong>Theme:</strong> Safe care and support</td>
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| Outstanding requirement(s) from previous inspection(s): |
| No actions were required from the previous inspection. |

| Findings: |
| There were procedures in place for the prevention, detection and response to abuse, and residents were provided with support that promoted a positive approach to the behaviours and psychological symptoms of dementia. Residents spoken with confirmed they felt safe and knew who they would speak too if they were concerned. Residents who were unable to verbalise their thoughts, did not exhibit behaviours associated with fear or distress. |

Staff spoken with by inspectors confirmed that they had received recent training on safeguarding and were familiar with the reporting structures in place. The inspector observed staff interactions with residents and noted their person-centred approach using good communication skills in a patient, calm manner.

Efforts to establish and maintain a restraint free environment were on-going and inspectors found a low level of use of restrictive practices such as bed rails, lap-belts or medicinal restraints such as anti-psychotics or anxiolytics to manage responsive behaviours. Residents were assessed to determine the most appropriate measures to
ensure their safety, and alternatives to restraints were available. Inspectors were told by the provider representative and person in charge that they were not involved in assisting the management of financial affairs for any of their residents.

The safety of residents in the centre and their ability to raise any issues of concern to them was protected. The person in charge and the senior management team fostered a culture of zero tolerance to abuse, and also fostered an open reporting culture to ensure staff, residents and relatives could freely report concerns. The person in charge had forwarded a number of notifications to HIQA since the last inspection, and the inspectors discussed them with the provider representative. Where concerns were identified these were thoroughly and completely investigated by the person in charge and the provider in accordance with national policies. Inputs were sought from the general practitioner, family, staff and other relevant practitioners. Where the outcomes of some these investigations upheld the allegations, appropriate actions were taken.

**Judgment:**
Compliant

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**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:**
Inspectors observed that residents' rights, privacy and dignity were respected with personal care delivered in their own bedroom or in bathrooms with doors closed, and the right to receive visitors in private. There were no restrictions to visiting in the centre and some residents were observed spending time with family or friends reading or chatting in their bedrooms. Choice was respected and residents were asked if they wished to attend activity sessions. Control over their daily life was also facilitated in terms of times of rising or returning to bed and whether they wished to stay in their room or spend time with others in the communal rooms. Residents' religious needs were met through regular Mass service in the centre.

Inspectors observed good verbal and non-verbal communication with residents and there was evidence that residents' were listened too. Staff were responsive to residents' needs and acted as advocates for them. Independent advocacy was also available. Communications with families and relevant others were strengthened with the appointment of a family resource manager who facilitated the transition from home and community living to life in the centre. Regular meetings were held during to support families and the resident during the initial admission process and continued if difficulties were experienced.
Evidence that residents and relatives were involved and included in decisions about the life of the centre was viewed. A meeting was held regularly where residents were consulted about future activities or outings. Minutes of these meetings were viewed. Inspectors took time to observe the interactions between staff and residents during different periods throughout the day. These observations revealed a mix of interactions with some good meaningful engagements while other interactions were supervisory and instructive rather than socially orientated. However, inspectors noted that all interactions were respectful and residents spoken with said all staff were kind and helpful.

A programme of activities was tailored to meet the interests and needs of residents that included a range of activities designed to meet the needs of residents at all stages of dementia. Inspectors observed that some residents appeared to engage in, and enjoy, the planned activities provided and others were content to read the newspapers and chat to each other and visitors.

Judgment:
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:
A complaints process was in place to ensure the complaints of residents, their families or next of kin, including those with dementia, were listened to and acted upon. The process included an appeals procedure.

The complaints policy met the regulatory requirements. Some residents spoken with could tell inspectors who they would bring a complaint too. In a sample of complaints viewed it was noted that they were dealt with promptly with the outcome and satisfaction of the complainant recorded.

Judgment:
Compliant

Outcome 05: Suitable Staffing

Theme:
Workforce

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

**Findings:**
Suitable and sufficient staffing and skill mix were found to be in place to deliver a good standard of care to the current resident profile.
The staff rota was checked and found to be maintained with all staff that worked in the centre identified.
A specific staff allocation system was in place that identified the staff for each area on every floor in the centre. All staff were aware of the system which was implemented in full.
There were also sufficient support staff available including household, catering, administration and maintenance staff. Arrangements to replace staff to fill unexpected absences were in place. The inspector was told that part-time staff were available to fill unexpected absences and agency staff were not used. This helped to provide more consistency of practice in delivering quality care.

The capacity of the centre had increased by an additional 26 bed places since the last registration inspection. As part of the application to the regulator to increase the size of the centre, the provider submitted a plan to increase the number of direct care staff to deliver the expansion in the service. The provider had committed to increasing the clinical management team by one additional clinical nurse manager (CNM). A further four full-time care assistants on the day shift with additional care assistant staffing hours on evening shifts up to 11pm on each floor were also proposed to facilitate the expansion.

On review of the rosters since the service increased in July 2017, inspectors found that the full-time increase of one CNM and four care assistants were put in place. However, the additional evening hours were not rostered. The findings of this inspection did not identify any serious negative impacts to residents associated with an overall lack of staff, but some findings suggest the need to keep staffing under ongoing review. This was discussed with the provider representative and person in charge at the conclusion of the inspection. Subsequent to the inspection the provider forwarded evidence of recent staffing reviews and gave assurances that staffing is monitored as part of a continuous process by the management team.

Staff were up to date in their mandatory training in fire safety, safeguarding of vulnerable adults, and manual handling. There was a tracking system in place to identify staff due to attend training sessions and to notify them of same. There was a good range of supplementary training facilitated by the centre, including management of restrictive practices, responsive behaviours, dementia care and end-of-life care. However, inspectors observed some instances of unsafe moving and handling practice during the inspection.

Improvements were required to ensure records of care were consistently and adequately maintained in a timely manner, and were easily accessible and available for inspection. Evidence was not available to assure inspectors that care interventions outlined in the care plans of some residents, were being fully implemented. In a sample of computerized and written care records reviewed, staff had not always documented that they had provided assistance to residents to meet their care needs in respect of, for example, personal care, nutrition or continence. This was discussed with the provider
who told inspectors that, due to technical difficulties, the computerized system had not been available for use in the 48 hours prior to the inspection and that all care would have been recorded in hard copy. However it was found that these records were not maintained on all care interventions for all residents. It was noted that an improved level of oversight was needed by the person in charge, clinical nurse managers and nursing teams to supervise care practices and ensure that all care interventions were delivered and recorded in a timely manner. A process of verification to ensure that care is delivered in line with each resident's individual care plan was required.

A comprehensive written operational staff recruitment policy in place, however it was not being fully implemented at the time of this inspection. Evidence that recruitment processes were completed, such as induction, probation period, competence and performance assessments, was not available on a sample number of personnel files for staff who had recently commenced in the centre. It was also found that all of the required documentation was not in place, on some files viewed, in line with the requirements of Schedule 2 of the Regulations. These included: evidence of qualifications, references from most recent previous employer or full employment history.

**Judgment:**
Non Compliant - Moderate

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**Outcome 06: Safe and Suitable Premises**

**Theme:**
Effective care and support

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

**Findings:**
The designated centre is a purpose-built building with 105 single bedrooms and 5 twin and 1 triple bedroom across three floors. Inspectors noted that the centre was appropriately and pleasantly decorated and well maintained. Residents were observed strolling independently throughout the day, and this was facilitated by safe and even floor covering, grab rails on hallways and adequate corridor space to navigate a wheelchair or walking frame.

Bedrooms and communal areas were comfortable and of adequate size for the number and requirements of residents, and were furnished and decorated in a non-clinical, home-like fashion. Bedrooms were personalised to the residents' preferences with decorations and photographs, and some residents had availed of the option to have some of their own furniture in the centre.

Efforts to provide appropriate signage and cueing to support freedom of movement for
residents with dementia were found but these were primarily on the Fern Lodge which is identified as a dementia focused unit. Inspectors noted that way-finding for residents could be improved throughout the centre using dementia design initiatives for navigation. Also, the use of colour contrast to aid residents with confusion or impaired vision such as on grab rails, bathroom doors and toilet seats in bathrooms would be of benefit.

There was an adequate amount of storage space for residents' equipment, and bathrooms were not used for storing equipment.

An enclosed garden at the back of the centre, provided a secure and relaxing space to enable residents enjoy the outdoor landscaped garden and safe walk ways. inspectors observed staff encouraging residents to take advantage of the warm sunny afternoon to enjoy the garden.

Judgment:
Substantially Compliant

Outcome 08: Governance and Management

Theme:
Governance, Leadership and Management

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

Findings:
Management systems were in place to ensure that the service delivered to residents was safe and contributed to a good quality of life.

The management team consisted of the provider representative on behalf of the provider entity, person in charge, family support manager and a team of clinical nurse managers. This team was supported by additional managerial and administrative personnel in the centre and from the broader provider entity of Willis Care Group.

Since the last registration, the provider had successfully applied for a variation to the conditions of registration. This variation increased the capacity of the centre from 92 to 118 places. In making the application the provider had committed to extending the premises and increasing staffing levels. A detailed, structured admissions process was also submitted to HIQA that gave assurance for the safe, appropriate and timely admission of each new resident. Additional resources were to be allocated to manage the admission of an additional 26 residents over a short term period.

Inspectors reviewed the management of the admission process during this inspection. It was found that the provider had put in place a specific admissions team with responsibility to support the transition of all new residents into the centre. This included discussions with the new resident, and relevant others, to ensure care needs were identified and care plans were formulated to meet those needs. The admissions team
also communicated with each clinical nurse manager to facilitate the smooth handover of the care of each resident to the care team at unit level.

A further quality initiative was implemented by the provider to support both existing and new residents and their families. This took the form of a family support manager who works across the two centres in the provider entity care group. Inspectors spoke with the family support manager who explained the role was, in the first instance, to reassure, support and help residents adapt to the change from independent community living to life in a care environment. Inspectors were told that the role also supported the residents’ families and friends with the transition. Communications with residents and families by the support manager also included dealing with complaints or any other difficulties that may arise in conjunction with the clinical management team and person in charge.

Other quality improvement systems included monitoring and review processes to assess the quality of the care delivered, identify any risks associated, and determine the impact on residents' lives. These included an external review process by independent consultants on aspects of the service such as residents rights to privacy and dignity and information, health and safety and medication management. An audit of recruitment processes, file management systems and record keeping, by the independent body, also commenced in February 2018. Although this was process was not completed at the time of the inspection, findings, included under outcome five of this report, identifies where further improvements in this area are required.

**Judgment:**
Compliant

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**Closing the Visit**

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

**Acknowledgements**

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

**Report Compiled by:**

Nuala Rafferty  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority
Provider’s response to inspection report

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<thead>
<tr>
<th>Centre name:</th>
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<tr>
<td>Centre ID:</td>
<td>OSV-0000759</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>18/04/2018</td>
</tr>
<tr>
<td>Date of response:</td>
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Requirements

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

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

Outcome 05: Suitable Staffing

Theme:
Workforce

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Evidence that some polices, such as recruitment and selection, retention of records, and health and safety and risk management policies, were being fully implemented was not found.

1. Action Required:
Under Regulation 04(1) you are required to: Prepare in writing, adopt and implement

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:

a. Please see actions 2(c) and 4(b) below.

b. All policies and procedures are currently undergoing a comprehensive process mapping project with external consults and an internal project manager to ensure efficient and effective alignment with all applicable legislation, standards and local objectives. As part of this project a gap analysis will be performed to identify and address any gaps that may exist between current practice and redefined policies, procedures and processes.

Proposed Timescale: 01/01/2019

Theme: Workforce

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

Although a significant number of staff had attended training opportunities relevant to their role, further training in key areas such as, recording of care, dementia care, management of responsive behaviours and moving and handling were identified as required.

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

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

a. All staff have completed and have access to formal training in mandatory areas including safe moving and handling practices.

b. At the time of the inspection, based on training needs analysis and prioritisation, a cycle of training in MAPA and End of Life Care was underway in small group settings to promote meaningful engagement in training material. For those that had not yet attended such training and were assessed as requiring training in same, they were scheduled for attendance. This training program continues to be delivered as intended.

c. During the inspection, it was rightly assessed that there were short-comings in the timing of recording or care interventions. The system that is employed to record daily care interventions assessed as high risk or very high risk to a resident has been changed to strengthen the ability of line-managers to review, in a time appropriate manner, any gaps in documenting the implementation of such care intervention in practice. This is augmented by the standardisation of terms of reference for midday handover meetings to include an exhaustive review, at this time of the day, the outcome of early care interventions assessed as high risk or very high risk. Nursing and care staff will be receiving formal training in the revised policies and procedures for same.
d. Where possible, it is the policy of the home to develop in-house “trainers” to enhance follow-up supervision. The implementation of such training in practice remains under day to day supervision to ensure effective implementation in practice. Where instances of poor implementation or practice are observed or identified in the course of daily monitoring and supervision activities, targeted training (on an individual level or a group level) is scheduled if it is appropriate to do so.

Proposed Timescale:
  a. Complete
  b. Ongoing
  c. 30/06/18
  d. Ongoing

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<tr>
<td>Theme: Workforce</td>
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**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There was a lack of oversight by the person in charge, clinical nurse managers and nursing teams to supervise care practices and ensure that all care interventions were delivered and recorded in a timely manner.

Instances of unsafe moving and handling practice were observed during the inspection.

**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:
  a. Please see Action 2(c) and Action 2(d) above.

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<td>Theme: Workforce</td>
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**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
Records of care were not consistently and adequately maintained in a timely manner, and were not easily accessible and available for inspection. Evidence was not available to assure inspectors that care interventions outlined in the care plans of some residents, were being implemented.

All of the required documentation was not in place, in line with the requirements of Schedule 2 of the Regulations. These included evidence of qualifications, references from most recent previous employer or full employment history.
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:**
a. Please see Action 2(c) and Action 2(d) above in relation to the records as set out in Schedule 3.

b. With regards to the records as set out in Schedule 2, all such records were in the process of undergoing migration project to a HRIS (HR Information System) at the time of inspection. Following the preliminary findings of the inspection, an initial review of all such files was completed confirming all staff members were vetted under the National Vetting Bureau Act 2012. Hard copy records are still in the process of undergoing transfer to an electronic HRIS and are receive a comprehensive audit as part of the transfer process. Where any deficits are identified, they will be assessed and actioned accordingly depending on the record with which a shortcoming is identified.

Proposed Timescale:
a. 30/06/18
b. 15/06/18

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**Proposed Timescale:** 30/06/2018

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**Outcome 06: Safe and Suitable Premises**

**Theme:**
Effective care and support

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
Some improvements to the premises to facilitate meeting the needs of residents with dementia were identified such as improved use of navigational signage and colour contrasting for residents with dementia and visual impairment.

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

**Please state the actions you have taken or are planning to take:**
he Fern Lodge (first floor) predominantly accommodates residents with mid to end stage dementia. It is the Provider’s understanding, based on the inspection undertaken, that the above findings relate to areas outside of the Fern Lodge that also accommodate residents with dementia. Notwithstanding the above, a review of all areas of the home, with persons possessing the appropriate knowledge, has been scheduled for completion on 8th June 2018, to ensure that elements such as the improved use of
navigational signage and colour contrasting can enhance the functionality in a manner that upholds a pursuit to maintaining an elegant décor for residents of the home. The Authority will be provided with an update on the outcome of this review and where necessary corrective actions are indicated, timebound plans will be provided to address same.

Proposed Timescale:
a. 08/06/18 (to complete review), 15/06/18 (to submit findings to Authority)

**Proposed Timescale:** 15/06/2018