<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Áras Deirbhle Community Nursing Unit</th>
</tr>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000644</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Belmullet Community Hospital,</td>
</tr>
<tr>
<td></td>
<td>Belmullet, Ballina, Mayo.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>097 81 301</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:belmullet.hospital@hse.ie">belmullet.hospital@hse.ie</a></td>
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<tr>
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<td>The Health Service Executive</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>Health Service Executive</td>
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<tr>
<td>Provider Nominee:</td>
<td>Julie Silke-Daly</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Mary McCann</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>None</td>
</tr>
<tr>
<td>Type of inspection:</td>
<td>Unannounced</td>
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<td>Number of residents on the date of inspection:</td>
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<td>Number of vacancies on the date of inspection:</td>
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About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

- Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider’s compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- to carry out thematic inspections in respect of specific outcomes
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority’s Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or wellbeing of residents.

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.

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).
This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times
From: 22 February 2017 09:00 To: 22 February 2017 17:30

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

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Our Judgment</th>
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<tbody>
<tr>
<td>Outcome 01: Statement of Purpose</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 02: Governance and Management</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 04: Suitable Person in Charge</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 05: Documentation to be kept at a designated centre</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 07: Safeguarding and Safety</td>
<td>Compliant</td>
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<tr>
<td>Outcome 08: Health and Safety and Risk Management</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 09: Medication Management</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 11: Health and Social Care Needs</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 12: Safe and Suitable Premises</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 18: Suitable Staffing</td>
<td>Substantially Compliant</td>
</tr>
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Summary of findings from this inspection
This unannounced monitoring inspection was carried out as part of the Health Information and Quality Authority’s (HIQA’s) regulatory monitoring function to check progress on actions from the previous inspection which was carried out on the 19/20 February 2015 and to monitor compliance with the Health Act 2007 (Care and Welfare of residents in Designated Centres for Older People) Regulations 2013.

Aras Deribhle is a community nursing unit, built in 1975, located half a kilometre from the town of Belmullet on the same site as Belmullet District Hospital under the management of the Health Service Executive (HSE). It is a single-storey building. It is registered with the Health Information and Quality Authority (HIQA) to provide care to 37 residents. A restrictive condition is contained in the registration of this centre which states that the physical environment in the designated centre must be reconfigured as outlined in the plans submitted to the Chief Inspector on 1 April 2016. The reconfiguration must be complete by December 2017. This work was in progress at the time of the inspection with a proposed completion date of May 2017. Post this work the maximum number of residents who will be accommodated will be 30 with no more than two persons resident in any bedroom. Older persons who need
long term care, people who have dementia care needs and people under the age of 65 requiring residential care who prefer to remain in the local area are admitted. There is an enclosed garden provided with seating. All entrance and exit doors are ramped ensuring ease of access for residents. There is ample parking to the side of the building.

The inspector met with residents, relatives and staff members. All residents and relatives spoken with were very complimentary of the service provided and the staff. They stated they” were happy living in the centre, their loved ones were always made feel welcome, there was always something to do and the staff were pleasant, treated them well and helped them everyday”. The inspector observed practices and reviewed documentation such as staff files, complaints log, care/medical files, accident and incident log and key policies and procedures. Notifications received since the last inspection were reviewed prior to and during this inspection with the person in charge.

The inspector found that the health-care needs of residents were well met and residents had good access to General Practitioner (GP) services. The numbers and skill mix of staff was appropriate to the assessed needs of residents and the size and layout of the centre. Sitting rooms were supervised at all times and call bells were answered promptly. There were seven actions detailed post the last inspection, four of these were complete and one was partially completed this related to documentation. One action was in process – this related to the premises and one relating to fire safety had not been addressed.

The action plan at the end of this report identifies where improvements are required to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Standards for Residential Care Settings for Older People in Ireland.
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: Statement of Purpose
**There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.**

**Theme:**
Governance, Leadership and Management

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

**Findings:**
At the time of the last inspection some of the required information in the statement of purpose was unclear, such as the organisational structure, staffing whole time equivalents and the arrangements for residents to receive visitors. The statement of purpose has been reviewed and includes all matters listed in schedule 1 of the Health Act 2007 (Care and Welfare of residents in Designated Centres for Older People) Regulations 2013. The person in charge was aware that it would be necessary to review the statement of purpose post the completion of the refurbishment and reflect changes made.

**Judgment:**
Compliant

### Outcome 02: Governance and Management
**The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.**

**Theme:**
Governance, Leadership and Management

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

**Findings:**
There was a defined management structure in place with clear lines of authority,
accountability and responsibility for the provision of the service. The provider representative was involved in the governance of the centre and met regularly with the person in charge. The person in charge stated her priority was to ensure a high quality of care was offered to residents and the rights of residents were upheld. She described how she was trying to ensure that there was good availability of local services in order that residents did not have to travel long distances to access services.

There were sufficient resources to ensure the delivery of care in accordance with the statement of purpose. While a system was in place to monitor and review the quality and safety of the care provided, this required further development to ensure when deficits were addressed an action plan was put in place to ensure these deficits were addressed. Audit had been completed in areas such as medication, hand hygiene, nutrition and care documentation. An annual review of the quality and safety of care delivered to residents in the designated centre had not been completed.

Judgment: Non Compliant - Moderate

**Outcome 04: Suitable Person in Charge**
The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.

**Theme:**
Governance, Leadership and Management

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

**Findings:**
The person in charge is in post since 2013. She qualified as nurse in 1994 and has many years experience of working in elderly care. She works full-time and also manages the 30 bedded district hospital which is adjoined the designated centre. She has completed an advanced diploma in health service research, a course in teaching and assessing in clinical practice, a course in principles of palliative care, a certificate in management studies and other various shorts courses in infection control, dementia care and in medication management.

She was familiar with the residents’ health and social care needs and displayed a positive attitude towards compliance and ensuring the rights of residents were protected and their views were sought and listened too.

Her mandatory training in safeguarding vulnerable adults and manual handling and her registration was up to date with an Bord Altranais agus Cnáimhseachais na hÉireann (Nursing and Midwifery Board of Ireland) (ABA) were all in date.

Judgment: Compliant
Outcome 05: Documentation to be kept at a designated centre
The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:
Governance, Leadership and Management

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

Findings:
At the time of the last inspection the quality of some of the recorded entries in the register of accidents and incidents was poor as the writing was faint and illegible. This was partially addressed. Some entries were legible and clear while others were difficult to read. Also at the time of the last inspection the inspector found that the addresses of residents’ next of kin were not consistently recorded in the directory of residents. This had been addressed.

Another action documented was some residents’ health care files lacked sufficient detail to guide staff in the delivery of care. This had been addressed and is documented further under Outcome 11.

The staff rosters required review to ensure the full name of staff working was recorded. The inspector noted on some occasions the Christian name was only recorded.

Some policies had not been reviewed in the previous three years. For example, the policy risk and incident escalation procedure made available to the inspector was due for review on n the 3/12/2013 but there was no evidence that this had been reviewed. The risk management policy failed to details all of the requirements of the regulations, for example procedure in place for the management of self harm or direct staff to other relevant risk policies.

Judgment:
Non Compliant - Moderate

Outcome 07: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a
positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe care and support

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

Findings:
Measures were in place to safeguard residents. Staff spoken with were knowledgeable of the policies and procedures to ensure residents were safeguarded against abuse. All staff had undertaken training in recognising and responding to allegations of abuse. The Health Service Executive (HSE) policy on "Safeguarding Vulnerable Persons at Risk of Abuse" 2014 was available in the centre.

The person in charge was familiar with the procedures on how to investigate an allegation, suspicion or disclosure of abuse. A visitor’s book was maintained and all visitors were required to sign in and out of the centre. The entrance was secure and required a key pad code to open the doors. Residents spoken with stated they felt safe and secure in the centre.

A culture of promoting a restraint free environment with evidence of alternatives such as low-low beds and/or alarm mats was in place. The national policy, ‘Towards of Restraint Free Environment in Nursing Homes (2011)’ was available in the centre. 17 residents had bedrails in place. In discussion with the person in charge on the use of bedrails she described how most were used as enablers to enhance resident functioning. Records indicated that restraint was only used following a risk assessment and there was evidence of discussion with the resident and/or their representative.

There was a policy on the management of responsive behaviours. At the time of inspection there was one resident who presented with responsive behaviours. A person centre positive behaviour support plan was in place to ensure a consistent approach when working with this resident. Staff informed the inspector how they manage the behaviour and described how they interpret her communication; this was documented in the care plan. For example, will express need for tea of coffee by pointing towards kitchen door. There was very good evidence of access to psychiatry of later life and the Community mental health nurse and the psychiatrist attend the centre regularly to assess and support residents.

Judgment:
Compliant

Outcome 08: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Safe care and support

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

**Findings:**
At the time of the last inspection the inspector found that some systems were not effective in reducing the spread of fire. A door and a screening shutter between the dining room and the kitchen did not automatically close when the fire alarm was activated. This had not been addressed. The person in charge informed the inspector that this would be addressed as part of the refurbishment that was currently being undertaken.

The risk management policy failed to details all of the requirements of the regulations, for example procedure in place for the management of self harm or direct staff to other relevant risk policies.

There was a centre-specific emergency plan that took into account a variety of emergency situations. Clinical risk assessments were undertaken, including falls risk assessment, nutritional care assessments and neurological observations were completed post falls to monitor neurological function. All staff had attended fire safety training.

While fire drills were carried out by staff, there was poor evidence that these were carried out regularly. Consequently, not all staff were participating in regular fire drills to ensure safe swift evacuation of residents. Additionally, fire drill records did not demonstrate what had occurred or whether there were any obstacles to safe evacuation or the duration of the drill.

Fire records showed that fire equipment had been regularly serviced. The fire alarm had been serviced quarterly. The inspector found that all internal fire exits were clear and unobstructed during the inspection. The provider has contracts in place for the regular servicing of all equipment and the inspectors viewed records of equipment serviced. Equipment such as specialist beds, wheelchairs and mattresses were provided in accordance with residents' needs. There were moving and handling assessments available for all residents, however, two staff did not have up to date training in manual handling. This was planned for both staff.

**Judgment:**
Non Compliant - Moderate

**Outcome 09: Medication Management**
Each resident is protected by the designated centre’s policies and procedures for medication management.

**Theme:**
Safe care and support

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

Findings:
At the time of the last inspection the inspector found that nurses administered crushed medication to residents although it was not prescribed as such. This had been addressed. All medications that were being crushed were prescribed as safe to crush.

Additionally the inspector found all medications that required strict control measures (MDAs) were not counted by two nurses at each change of shift in keeping with professional guidelines. This had been addressed. Medications that require strict control measures (MDAs) were now being counted by two nurses at each change of shift. A medication policy included information on the prescribing, administering, recording, safekeeping and disposal of unused or out of date medication was available.

There was photographic identification on the front of each resident’s prescription card. There was evidence that general practitioner (GPs) reviewed residents’ medication on a regular basis.

The inspector observed a nurse administering part of the evening medication round and found that medication was administered in accordance with the policy and An Bord Altranais guidelines. The medication administration sheets were signed by the nurse following administration. Medicines were administered within the prescribed timeframes. There was space to record when medication was refused on the administration sheet.

Judgment:
Compliant

Outcome 11: Health and Social Care Needs
Each resident’s wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident’s assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

Theme:
Effective care and support

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

Findings:
Prospective residents were assessed prior to admission by the person in charge to determine if the centre could meet their needs. On admission a comprehensive assessment was completed and updated in response to changing needs thereafter. Residents had access to the services of a general practitioner (GP) and allied health services such as dietetics, speech and language, physiotherapy and palliative care.
The inspector reviewed a sample of residents' nursing care documents found that each identified need had a care plan outlining the care required by the resident to meet that need. For example, where a resident was assessed as a risk of nutritional deficit a care plan was in place to address this need. Care plans were person centred and detailed the residents’ likes and dislikes.

Care plans were generally reviewed at four monthly intervals and there was some evidence of consultation with residents and where appropriate their families. To ensure that this is meaningful consultation a narrative note should be recorded to ensure the resident and/or their family have input into the care plan. Some staff knew the residents and their families prior to their admission to the centre and staff demonstrated good knowledge and understanding of each resident’s background in conversation with the inspector. A daily narrative note was documented for each resident but this was medical in nature and did not detail psychological and social aspects of care. It also failed to document what meaningful activities the residents engaged in even though residents and relatives informed the inspector of a variety of activities which occurred regularly.

**Judgment:**
Substantially Compliant

**Outcome 12: Safe and Suitable Premises**

The location, design and layout of the centre is suitable for its stated purpose and meets residents’ individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

**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:**
At the time of the last inspection the inspector found that some parts of the building were not designed and laid out to fully meet the needs of residents. A restrictive condition is contained in the registration of this centre which states that the physical environment in the designated centre must be reconfigured as outlined in the plans submitted to the Chief Inspector on 1 April 2016. The reconfiguration must be complete by December 2017. This work was in progress at the time of the inspection with a proposed completion date of May 2017. This will address deficits identified with regard to the premises to include no more than two persons will be accommodated in any bedroom, all residents will have their own wardrobe and individual lockable storage space will be available for all residents. Two bathrooms will be installed which is part of the refurbishment programme. A new smoking room is also planned.
The inspector observed that a number of residents had personalised their rooms with personal items including photos. There was a functioning call bell system in place within the centre.

**Judgment:**
Compliant

**Outcome 18: Suitable Staffing**
There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

**Theme:**
Workforce

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

**Findings:**
Based on observations by the inspector and a review of staff rosters there were adequate staff on duty to meet the needs of residents. There were registered nurses on duty at all times and the person in charge or the clinical nurse manager was available. The person in charge or a clinical nurse manager was always supernumery. Generally a clinical nurse manager and two nurses were available up to 16:30 each day, with 2 nurses at all other times. There were five care assistants on duty up too up to 16; 30 with two until 21:00hrs and one on night duty. A porter also worked on night duty that was shared with the district hospital.

The inspector reviewed a sample of personnel files for different grades of staff working in the centre. These contained all documentation required under Schedule 2 of the regulations.

All nursing staff working in the centre had confirmation of their registration with the Nursing and Midwifery Board of Ireland for 2017 documented. A regular programme of staff training was in place to included specific courses to meet the needs of residents and mandatory training. A training matrix was available identifying training staff had attended and the date by which refresher training was required. As documented under Outcome 8, two staff did not have up to date safe moving and handling training.

**Judgment:**
Substantially 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:

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

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<thead>
<tr>
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<tr>
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<tr>
<td>Date of inspection:</td>
<td>22/02/2017</td>
</tr>
<tr>
<td>Date of response:</td>
<td>29/03/2017</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 02: Governance and Management

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
An annual review of the quality and safety of care delivered to residents in the designated centre had not been completed.

1. **Action Required:**
Under Regulation 23(e) you are required to: Prepare the review referred to in regulation 23(1)(d) in consultation with residents and their families.

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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:
Collate all audits taken place and complete annual review

**Proposed Timescale:** 30/04/2017

### Outcome 05: Documentation to be kept at a designated centre

#### Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some policies had not been reviewed in the previous three years. For example, the policy risk and incident escalation procedure made available to the inspector was due for review on the 3/12/2013 but there was no evidence that this had been reviewed.

2. **Action Required:**
Under Regulation 04(3) you are required to: Review the policies and procedures referred to in regulation 4(1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.

Please state the actions you have taken or are planning to take:
Review and update local risk policy.

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

#### Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The staff rosters required review to ensure the full name of staff working was recorded. The inspector noted on some occasions the Christian name only was recorded.

3. **Action Required:**
Under Regulation 21(6) you are required to: Maintain the records specified in paragraph (1) in such manner as to be safe and accessible.

Please state the actions you have taken or are planning to take:
The rosters now have full names and this will be reviewed regularly.

**Proposed Timescale:** 23/02/2017

#### Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
At the time of the last inspection the quality of some of the recorded entries in the register of accidents and incidents was poor as the writing was faint and illegible. This was partially addressed. Some entries were legible and clear while others were difficult to read.

4. Action Required:
Under Regulation 21(6) you are required to: Maintain the records specified in paragraph (1) in such manner as to be safe and accessible.

Please state the actions you have taken or are planning to take:
The current system of recording of incidents is being phased out and replaced with NIMS.

Proposed Timescale: 30/06/2017

Outcome 08: Health and Safety and Risk Management

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The risk management policy failed to details all of the requirements of the regulations, for example, procedure in place for the management of self harm or direct staff to other relevant risk policies.

5. Action Required:
Under Regulation 26(1)(c)(v) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control self-harm.

Please state the actions you have taken or are planning to take:
The risk policy will be updated to direct staff to other relevant risk policies such as self harm.

Proposed Timescale: 30/06/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
At the time of the last inspection some systems were not effective in reducing the
spread of fire. A door and a screening shutter between the dining room and the kitchen did not automatically close when the fire alarm was activated. This had not been addressed.

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

Please state the actions you have taken or are planning to take:
The door and a screening shutter between the dining room and the kitchen will be reconfigured so that it will automatically close when the fire alarm is activated.

Proposed Timescale: 30/05/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was poor evidence that fire drills were carried out regularly. Fire drill records did not demonstrate what had occurred or whether there were any obstacles to safe evacuation or the duration of the drill.

7. Action Required:
Under Regulation 28(1)(e) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and residents are aware of the procedure to be followed in the case of fire.

Please state the actions you have taken or are planning to take:
Fire drills will be carried out at suitable intervals so that staff working at the designated centre and residents are aware of the procedure to be followed in the case of fire.

Proposed Timescale: 30/09/2017

Outcome 11: Health and Social Care Needs

Theme:
Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was some evidence of consultation with residents and where appropriate their families in relation to care plan reviews. To ensure that this is meaningful consultation a narrative note should be recorded to ensure the resident and/or their family have input into the care plan.
8. **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:**
Ensure that there is a narrative note recorded demonstrating that the resident and/or family have had input into the care plan. This will be reviewed at regular intervals.

**Proposed Timescale:** 30/09/2017

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**Outcome 18: Suitable Staffing**

**Theme:**
Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Two staff did not have up to date safe moving and handling training.

9. **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:**
Training is being provided but due to sickness and maternity leave the members of staff were unable to attend the planned training. Training will be provided when the staff members are fit to attend work.

**Proposed Timescale:** 31/08/2017