

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Mountpleasant Lodge
<b>Centre ID:</b>	OSV-0000701
<b>Centre address:</b>	Clane Road, Duncreevan, Kilcock, Kildare.
<b>Telephone number:</b>	01 610 3166
<b>Email address:</b>	mountpleasant@firstcare.ie
<b>Type of centre:</b>	A Nursing Home as per Health (Nursing Homes) Act 1990
<b>Registered provider:</b>	FirstCare Ireland Kilcock Limited
<b>Lead inspector:</b>	Sarah Carter
<b>Support inspector(s):</b>	Deirdre O'Hara
<b>Type of inspection</b>	Unannounced Dementia Care Thematic Inspections
<b>Number of residents on the date of inspection:</b>	68
<b>Number of vacancies on the date of inspection:</b>	13

## **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: 03 October 2019 10:00 To: 03 October 2019 18:25

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

<b>Outcome</b>	<b>Provider's self-assessment</b>	<b>Our Judgment</b>
Outcome 01: Health and Social Care Needs	Substantially Compliant	Non-Compliant - Moderate
Outcome 02: Safeguarding and Safety	Substantially Compliant	Substantially Compliant
Outcome 03: Residents' Rights, Dignity and Consultation	Substantially Compliant	Substantially Compliant
Outcome 04: Complaints procedures	Compliance demonstrated	Compliant
Outcome 05: Suitable Staffing	Substantially Compliant	Substantially Compliant
Outcome 06: Safe and Suitable Premises	Substantially Compliant	Substantially Compliant

**Summary of findings from this inspection**

This inspection report sets out the findings of a thematic inspection which focused on specific outcomes related to dementia care.

As part of this thematic programme, providers had been invited to attend information seminars given by the Authority. In addition evidence based guidance was developed to guide providers on best practice in dementia care and the inspection process.

While this centre did not have a dementia-specific unit, the inspectors focused on the care of resident's with dementia during the inspection. Approximately 87% of residents had dementia or a condition similar to dementia. The inspectors met with residents and relatives throughout the inspection, and tracked the journey of a number of resident's with dementia within the service. In addition they observed care practices and interactions between staff and residents using a validated observation tool (the QUIS tool). Documentation was reviewed; including policies,

information on staffing and clinical records. On the day of inspection, 84% of the centre's beds were occupied.

In addition, inspectors also followed up the issues identified during the previous inspection and unsolicited information that had been received by the chief inspector since the last inspection.

The centre is a purpose built, two-storey building designed around a central courtyard. It was found to be clean, warm and nicely decorated. All bedrooms are single en-suite bedrooms. The courtyard was accessible from different areas of the building. There were different sized dining areas available on each floor, and a variety of seating areas, including a foyer that had been decorated with sofas and a fireplace.

The inspectors found that residents' overall healthcare needs were met and they had access to appropriate medical and allied healthcare services and the daily support of a general practitioner. Residents had opportunities to participate in activities across 7 days a week, and the activity programme included activities that were specifically designed to meet residents with dementias needs. Individual staff interactions with residents was observed to be pleasant and warm, however during the mealtimes staff interaction was task orientated or neutral in its content. There had been a turnover of staff in the centre, with a mix of new and existing or longer term staff on every shift. Staff vacancies were being supplemented by agency workers, and efforts were made to have the same personnel from the one agency. Some agency staff had been employees of the centre.

The collective feedback from residents was positive and indicated they were satisfied with their care. Feedback from relatives and visitors was also positive, but included concerns about staff turnover.

Improvements were identified in the various outcomes and these will now be described in more detail and the action plan at the end of the report will indicate the centre's response to these issues.

**Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.**

***Outcome 01: Health and Social Care Needs***

**Theme:**

Safe care and support

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

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

**Findings:**

Records seen showed that all new residents to the home had a comprehensive assessment in place prior to taking up residence. This ensured that the home was able to meet the needs of the resident through the development of person centred care plans for each individual resident. However one resident's care plan had not been completed within 48 hours of the residents' admission to the centre. Records observed showed that residents and families were involved in the development of care plans.

Inspectors found that when the nursing and medical care needs of residents were assessed appropriate interventions and treatment plans were being implemented accordingly. The care planning process was difficult to navigate as there were occasionally two care plans for the same issue, for example there was one combined care plan for; falls, mobility, health and safety and use of specialist chairs and a separate individual care plan for; falls and health and safety. This increased the risks arising from duplication of information and of misinforming staff of the most up to date care plan.

A project to improve care planning was underway in the centre, with nursing staff having attended training on person-centred care plans.

Inspectors found that a small number of care plans had not been reviewed within four months. There was evidence of a range of evidence based assessment tools being used to monitor areas such as the risk of falls, malnutrition, cognition, depression, pain, mobility and skin integrity.

Residents had access to medical care, provided by a general practitioner (GP) who visited the centre once a week and had telephone contact with the centre daily. There was evidence of access to specialist and allied health care professionals to assess and meet the care needs of residents. Residents had appropriate access to optical, dental and chiropody and upon referral could access dieticians, wound care specialists, occupational therapy, physiotherapy and speech and language professionals.

The inspectors found that there were specific care plans in place so that residents received end-of-life care in a way that met their individual needs and wishes. Having

reviewed a sample of care plans, the inspector was satisfied that each resident or their relative, where appropriate, had been given the opportunity to outline their wishes regarding their end of life care.

There were systems in place to ensure residents' nutritional needs were met, and that they did not experience dehydration. Residents were screened for nutritional risk on admission and reviewed regularly thereafter. Residents' weights were recorded on a monthly basis and more regularly when clinical needs indicated. Nutritional care plans were in place that detailed residents' individual food preferences, and outlined the recommendations of dietitians, speech and language as appropriate. The inspectors observed residents at mealtimes in the dining rooms, and saw that a choice of meals and varied menu was offered daily. Menus were not displayed in a dementia friendly way, or displayed on tables in the dining areas observed on the day. There was an effective system of communication between nursing and catering staff to support residents with special dietary requirements, and sufficient staff available to discreetly support and assist them.

When residents required hospital treatment, they were transferred quickly and upon their return to the centre any recommendations from specialists were updated in the resident's care plan.

The designated centre had written policies and procedures which related to the administration, transcribing, storage, disposal and transfer of medicines. Medication practices were overseen and were audited by the pharmacy who provided medication to the centre. Medications were stored safely in the centre. Some issues with medication management were identified:

- Sharps bins were not observed to contain information for when the bin was opened and the temporary closure mechanisms were not engaged when the sharps bins were not in use.
- Inspectors found that the top surface of drug trolleys and tablet crushers were not clean.
- Insulin pens were not labelled with individual residents details.
- An ointment was not dated when it had been opened.

The person-in-charge was immediately informed of these risks. There was good evidence of documentation and hand hygiene practices during drug administration rounds. Medicines that were out-of-date or no longer required were securely stored and disposed of appropriately.

**Judgment:**

Non-Compliant - Moderate

***Outcome 02: Safeguarding and Safety***

**Theme:**

Safe care and support

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

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

**Findings:**

A restraint-free environment in line with the national policy was promoted. There was evidence seen that the home had trialled least restrictive options as a means to reduce the level of the restrictive practice. The rationale for the use of restrictive practices and relevant consent forms were also seen in resident files. There was a register of restrictive practices in the centre however it did not contain details of when lap belts on wheelchairs were used.

There was a responsive behaviour policy in place within the centre. Due to their medical conditions, some residents had responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). Staff knew the residents well and were knowledgeable about each resident's potential reasons and triggers for agitation and responsive behaviours. Staff offered discrete support and encouragement for residents at these times and were able to communicate with and reassure those residents who became agitated.

Care plans for responsive behaviour were person-centred and clearly guided staff to support residents. There was clear guidance for staff when to use PRN medication (medication only taken as the need arises) contained within these care plans.

A safeguarding policy was in place and all staff were facilitated to attend training on safeguarding residents from abuse. Staff were knowledgeable of the signs of abuse and were clear about their roles and responsibilities.

Residents who spoke with inspectors said they felt safe within the service and would speak with the person in charge or a staff member if they had a concern. The person in charge had investigated any allegations of abuse received in the center, and took appropriate action if the allegation was upheld.

**Judgment:**

Substantially Compliant

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

Person-centred care and support

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

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

**Findings:**

Resident's rights to dignity and privacy were supported in the centre by respectful staff

practices and an environment where all residents had their own private bedrooms and bathrooms.

Residents meetings were held in the centre approximately every 6 months. The minutes seen indicated that this meeting was well attended by residents and was chaired by the person in charge. Issues raised had been responded to by a named person. Residents had a variety of choices for their recreation. There were a number of community based activities which residents participated in, for example a men's shed and a choir in a nearby town. Residents had access to advocacy, could vote, had TVs in their bedrooms and in communal spaces, and could access the newspapers if they wished. Residents religious needs were also being met in the centre.

Residents' attendance at activities was being clearly recorded by staff, and these records captured the quality and level of their engagement. There were specific activities on the activity programme specially designed for residents with dementia, although all residents were encouraged to attend activities, and there was an open-door approach in place.

A family support meeting was also taking place in the centre, which was facilitated by a relative and gave feedback to the person-in-charge, if appropriate.

There was a visitors policy in place, and no restrictions were in place. Due to the layout of the centre, there was several communal seating areas and more private sitting rooms available for residents to meet their visitors.

There were two separate policies in place guiding the provision of information to residents. The policies were not sufficiently detailed, and one was out of date. One of these policies set out the guidelines for staff to use when displaying information to residents, however staff practices were not consistently following this. Noticeboards were under-used throughout the centre, and occasionally timetables or information of importance to residents was displayed at a height. There were no orientation prompts in high traffic areas, for example a display of the day, date or weather or key information about the day's current affairs. A residents guide was available in the centre, contained all the required key information and was available in standard A4 print.

As part of the inspection the inspectors spent periods of time observing staff interactions with residents. The inspector used a validated tool (the quality of interactions schedule, or QUIS) to rate and record at five minute intervals the quality of interactions between staff and residents in the communal areas. The scores for the quality of interactions are +2 (positive connected care), +1 (task orientated care), 0 (neutral care), -1 (protective and controlling), -2 (institutional, controlling care). The inspectors observed meal times in three different dining areas, and the beginning of a large activity session. During the dining experiences, the interactions of staff were either task centered or neutral, and during the activity session staff interactions were positive and connected. In both situations, it was observed that staff knew the residents needs and were provided them with discrete and dignified assistance.

**Judgment:**  
Substantially Compliant

### ***Outcome 04: Complaints procedures***

**Theme:**

Person-centred care and support

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

No actions were required from the previous inspection.

**Findings:**

An accessible and effective complaints procedure was in place. Residents' complaints and concerns were listened to and acted upon in a timely, supportive and effective manner. There was evidence that residents and other complainants were satisfied with measures put in place in response to their complaint.

Relatives who spoke with inspectors said that any concerns they had were dealt with quickly by the person in charge.

The complaints procedure was displayed in the centre but often at a height higher than eye level for most residents. Records of complaints were maintained separately to residents' care plans. There was a nominated person in the complaints policy to review the designated complaints person's work.

**Judgment:**

Compliant

### ***Outcome 05: Suitable Staffing***

**Theme:**

Workforce

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

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

**Findings:**

There were staff vacancies in nursing and health care assistant roles in the centre on the day of the inspection. There were also 13 resident vacancies, which meant 16% of the beds in the center were vacant on inspection.

During this period of lowered occupancy, the staff vacancies on the roster were being managed by:

- Using agency staff, and pre-booking the same staff.
- Pairing new or agency staff with established staff to ensure adequate supervision.
- Clinical nurse managers (CNM) were allocated to clinical duties.

There was a management strategy in place to address staff vacancies and attempts

were underway to recruit staff. The provider was continuing to admit residents to the centre, with an admission in the fortnight before the inspection day.

Staff supervision and appraisals had been identified on the last inspection as requiring improvement. Staff who were in the centre long term had had an annual review. New staff in the centre were subject to 9 month probationary period, and in a small number of cases the end of probation review had not been completed.

There was both in-house and external training provided to staff, and there were some minor gaps in the completion of mandatory training topics. Staff had attended dementia care training, and some training on managing challenging behaviours. Training in person-centred care planning was also ongoing. There were dates for training set across the months following inspection.

There were volunteers in the centre. They had a role description and garda vetting disclosures in place. They supported residents involved in different activities within the centre.

**Judgment:**

Substantially Compliant

***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 premises was well maintained, clean and bright. It is a purpose built two-storey building designed around a large central courtyard. There was a good variety of communal spaces such as dining and sitting rooms, activity rooms and a conservatory. The premises was pleasantly decorated, and there were handrails on all corridors.

Bedrooms seen were personalised with residents' belongings and trinkets, and several had additional patchwork crochet blankets made by the resident's knitting group. All bedrooms were single and ensuite and there was sufficient storage on both floors for adaptive equipment. In some shared bathrooms, there were no handrails, however during the inspection residents were observed not using these facilities and returning to their own ensuites. There were different décor and colour schemes on the ground and first floor, for example bedroom doors were decorated differently. Flooring was non-slip, level and had a gentle colour contrast throughout the centre. Corridors required some additional seating that could assist residents to rest during their walks, as seating outside of communal rooms was limited. Residents were seen moving freely about the centre throughout the day.

There was some signage on bedroom doors, however directional signage in the centre

required improvement. Signs referred to unit names no longer in use and was displayed at height, sometimes above the doorways. There was little signage directing residents to communal rooms or the dining areas in the different parts of the centre. Features to orientate residents, for example clocks, were not in key locations and a review was required to ensure all communal seating areas had call bells for residents to get help.

The courtyard area had been pleasantly planted, and was accessible from different corridors and rooms in the building. On the morning of the inspection two of the doors to the courtyard from one communal sitting room were locked, and obscured by furniture, however this was immediately addressed by staff, and residents were observed using these doors and the courtyard area throughout the remainder of the day.

There was an additional enclosed garden area towards the rear of the building which had been permanently closed. However several high dependency residents lived in this part of the building and many used rollators, walking frames and large recliner seating daily. This area could be more accessible and useful to them than the central courtyard if it was re-instated. This was discussed with the management team on the day, and in the self-assessment questionnaire the provider reported there is a plan to re-instate this area in 2020.

**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:***

Sarah Carter  
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<sup>1</sup>

<b>Centre name:</b>	Mountpleasant Lodge
<b>Centre ID:</b>	OSV-0000701
<b>Date of inspection:</b>	03/10/2019
<b>Date of response:</b>	18/11/2019

### 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:**

Care plans were not fully developed within 48 hours of a residents admission to the centre.

#### **1. Action Required:**

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.

<sup>1</sup> 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:**

Prior to the inspection, a full review of care planning practices had been carried out, and the new admission policy (implemented 2 June 2019) outlines the process to be followed when a resident is admitted to the home, to further ensure all residents admitted to the home have their care plan based on their assessment, completed within 48 hours. As per regulatory requirements, on admission a comprehensive assessment is carried out and a care plan is commenced/ prepared, based on the assessed needs of the residents and updated/ reviewed over the following weeks, to ensure that the plan in place adequately reflects the residents care needs. All nursing staff have attended care plan training and have been made aware of policy changes. The Person in Charge and the Clinical Nurse Manager will continue monitoring the care plans of all new admissions.

**Proposed Timescale:** 30/11/2019

**Theme:**

Safe care and support

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

Not all care plans had been reviewed at four monthly intervals.

**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:**

All clinical aspects of the care plans have been reviewed and updated within the past 4 months, the social & wellbeing aspects of care are currently under review and will be complete by 20/12/19

**Proposed Timescale:** 20/12/2019

**Theme:**

Safe care and support

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

Some medicine was being administered in a manner that was not in accordance with the appropriate use of the product.

**3. Action Required:**

Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident

concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.

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

As identified during inspection there are systems in place to support safe medication management and the issues identified during inspection were addressed immediately. Subsequent to the inspection a review was carried out and the monitoring system has been amended to include labelling of insulin pens, ointments (opening dates).

There was and is a system in place for cleaning the medication trolleys and any equipment used in the storage or administration of medicines, there is a rota system whereby nursing staff document the cleaning schedule. All nursing staff have been reminded to adhere to the rota.

Clinical rooms are currently being upgraded; once this remedial work is complete instructional guidelines will be displayed for staff regarding safe medication management best practice. This work is anticipated to be complete by 30/11/19

**Proposed Timescale:** 30/11/2019

**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:**

The record of restrictive practices in use in the center did not include the occasional use of lap belts for residents who used wheelchairs.

**4. 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:**

The record of occasional use of the lap belt has been added to the restraint register.

**Proposed Timescale:** 15/11/2019

**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:**

Policies relating to the provision of information to residents required review to ensure they were clear and could guide staff practice.

**5. Action Required:**

Under Regulation 04(1) you are required to: Prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.

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

The policies which relate to the provision of information to residents is currently being reviewed to ensure that they include clear information and guide staff. This will be complete by 31/01/20.

**Proposed Timescale:** 31/01/2020

**Theme:**

Person-centred care and support

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

A policy relating to the provision of information to residents had not been reviewed within three years and required updating to include best practice.

**6. 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:**

The policy relating to the provision of information to residents is currently being reviewed and will be complete by 31/01/20

**Proposed Timescale:** 24/01/2020

**Outcome 05: Suitable Staffing**

**Theme:**

Workforce

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

There were some gaps in training amongst staff in the centre.

**7. 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:**

There is a comprehensive and robust training programme in place for all staff which includes mandatory training. The training matrix records training dates for all staff and is also used to highlight when updates in training are required.

As discussed on the day of inspection, the Home Manager had reviewed the training matrix and identified what training was required and had arranged training dates to ensure all staff had up to date mandatory training. Due to unforeseen circumstances the training did not take place on the planned dates and has been rescheduled for 04/12/19.

**Proposed Timescale:** 04/12/2019

**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:**

Suitable directional signage and information displays are required to assist residents manage the environment.

**8. Action Required:**

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

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

Directional signage is in place throughout the home however, as stated in the report it is displayed above doors or mounted on walls.

In order to further assist residents navigate throughout the home more direction / dementia focused signage is currently being researched, to ensure that it meets residents' needs. This project to supplement current signage is underway and will be complete by 31/01/20. In the self-assessment questionnaire mentioned on page 11 of the inspection report, the provider reported that there is a plan to reinstate the garden area toward the end of the building. This garden area was closed for health and safety reasons due to structural issues following storm damage. Following completion of remedial works this garden area will be reopened before the end of 2019.

**Proposed Timescale:** 31/01/2020

**Theme:**

Effective care and support

**The Registered Provider (Stakeholder) is failing to comply with a regulatory**

**requirement in the following respect:**

Call bells are required in all rooms used by residents.

**9. Action Required:**

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

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

The call bell for the small sunroom has been ordered and estimated delivery date is 30/11/19. Call bells covering all other areas of the home are in place, have been checked, and are functioning.

**Proposed Timescale:** 30/11/2019