**Health Information and Quality Authority**
**Social Services Inspectorate**

# Inspection report
# Designated centres for older people

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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|---|---|
| **Centre name:** | Falcarragh Community Hospital |
| **Centre ID:** | 0619 |
| **Centre address:** | Falcarragh<br>Co. Donegal |
| **Telephone number:** | 074 9135104 |
| **Fax number:** | 074 9135133 |
| **Email address:** | Geraldine.McLean@hse.ie |
| **Type of centre:** | ☒ **Private** ☐ **Voluntary** ☒ **Public** |
| **Registered providers:** | Health Service Executive |
| **Person in charge:** | Geraldine McLean |
| **Date of inspection:** | 8 March 2012 |
| **Time inspection took place:** | **Start:** 08:45 hrs **Completion:** 15:00 hrs |
| **Lead inspector:** | Geraldine Jolley |
| **Support inspector:** | N/A |
| **Type of inspection:** | ☒ Announced ☐ Unannounced |
| **Purpose of this inspection visit:** | ☐ Application to vary registration conditions<br>☐ Notification of a significant incident or event<br>☐ Notification of a change in circumstance<br>☐ Information received in relation to a complaint or concern<br>☒ Follow-up inspection |

## About the inspection

The purpose of inspection is to gather evidence on which to make judgments about the fitness of the registered provider and to report on the quality of the service. This is to ensure that providers are complying with the requirements and conditions of their registration and meet the Standards, that they have systems in place to both safeguard the welfare of service users and to provide information and evidence of good and poor practice.

In assessing the overall quality of the service provided, inspectors examine how well the provider has met the requirements of the Health Act 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

Additional inspections take place under the following circumstances:

- to follow up matters arising from a previous inspection to ensure that actions required of the provider have been taken
- following a notification to the Health Information and Quality Authority's Social Services Inspectorate of a change in circumstance for example, that a provider has appointed a new person in charge
- arising from a number of events including information received in relation to a concern/complaint or notification to the SSI of a significant event affecting the safety or wellbeing of residents
- to randomly "spot check" the service.

All inspections can be announced or unannounced, depending on the reason for the inspection and may take place at any time of day or night.

All inspection reports produced by the Health Information and Quality Authority will be published. However, in cases where legal or enforcement activity may arise from the findings of an inspection, the publication of a report will be delayed until that activity is resolved. The reason for this is that the publication of a report may prejudice any proceedings by putting evidence into the public domain.

## About the centre

### Description of services and premises

Falcarragh Community Hospital is located in the town of Falcarragh in North West Donegal. The centre is a purpose-built facility of single-storey design situated adjacent to the town's primary care centre. Up to 35 residents can be accommodated. There are 12 places designated for long-term care, eight places for respite care, three places for assessment, 10 places for rehabilitation and convalescent care and two places for palliative care. The centre also accepts emergency admissions. At the time of inspection, occupancy level was being maintained at 30. There is also a day hospital on site that provides care for up to 25 older people. The centre is in a Gaeltacht area and serves the population of the surrounding area and Tory Island.

There is an accessible entrance that leads to the reception area, administration offices, day hospital and the designated centre. The communal facilities include a sitting room, a large dining room that residents share with day care clients, a smoking area, laundry, hairdressing room, kitchen and office areas for nursing staff and the person in charge. Residents are accommodated in 17 single and six three-bedded rooms. There are accessible toilets and showers near the communal and bedroom areas. The centre conveyed a warm and welcoming atmosphere and was maintained in a clean hygienic condition.

There is an enclosed garden that has been cultivated and landscaped to provide interest for residents. Car parking spaces are available to the front and side of the building.

### Location

Falcarragh Community Hospital is located in the Donegal Gaeltacht area and is just off the town's main street and the main N56 link road. It is adjacent to the Health Service Executive (HSE) primary care building. There is a daily bus service from the town to Letterkenny.

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| **Date centre was first established:** | 1984 |
| **Number of residents on the date of inspection:** | 21* |
| **Number of vacancies on the date of inspection:** | 14 |

* two residents in hospital are not included in this number

| Dependency level of current residents | Max | High | Medium | Low |
|---|---|---|---|---|
| **Number of residents** | 15 | 2 | 4 | 0 |

## Management structure

The centre is operated by the Health Service Executive (HSE). The nominated person on behalf of the Provider is Kieran Doherty, General Manager. The Person in Charge is Geraldine McLean, who leads a team of three Clinical Nurse Managers (CNM) (one is responsible for the day-care service), nurses, healthcare assistants and ancillary staff. She reports to the Service Manager for Older Persons, Gwen Mooney who in turn reports to Kieran Doherty. The CNM take responsibility for the service in the absence of the Person in Charge.

| Staff designation | Person in Charge | Nurses | Care staff | Catering staff | Cleaning and laundry staff | Admin staff | Other staff |
|---|---|---|---|---|---|---|---|
| **Number of staff on duty on day of inspection** | 1 | 6* | 4 | 4 | 2 | 2 | 3** |

* this number includes two CNMs
** this number includes staff designated to activities

## Background

This was the third inspection of the centre carried out by the Health Information and Quality Authority (the Authority) and was undertaken to review progress on the actions required from the registration inspection carried out on 31 May and 1 June 2011. The report of this inspection outlined that improvements were required in areas such as risk management and fire safety, policies and procedures and the provision of activities for residents. There were also some premises improvements required. Some areas needed painting and decoration and multiple occupancy rooms that accommodated more than two residents needed additional wash-hand basins.

## Summary of findings from this inspection

The inspector found that the provider and person in charge had made good progress with completing the actions required from the previous inspection. Ten actions had been outlined and the inspector found that four actions were fully complete and the remaining six were partially complete and work was in progress towards full compliance. The actions completed included production of a report on the quality and safety of care and quality of life in accordance with Regulation 35 and updating the complaints procedures. Improvements to risk management such as ensuring that hot water was dispersed at a safe temperature and improvements to aspects of fire safety had also been completed.

The inspector talked with a small group of residents about their experience of living in the centre. They talked about their daily routines and how they spent their time. All reported satisfaction with the quality of care they received and said that staff were always available to and attended to them when they needed assistance. They all knew the person in charge and staff team and said they were approachable if they wished to discuss any issues.

The centre was noted to be clean and appropriately warm. Residents were sitting in the varied sitting rooms and some were in their rooms. Staff were friendly and welcoming and were observed to be available to residents in communal areas and when they needed assistance. Interactions between staff and residents were noted to be positive with staff taking time to talk and chat about the events of the day as they went about their duties. Nurses and other staff answered the inspectors' queries in an informed and professional manner.

The actions that were not complete are outlined for attention at the end of this report. No new actions were added.

## Issues covered on inspection

### Fire Precautions and Records

The inspector reviewed fire records which showed that the fire equipment, emergency lighting and the fire alarm system were recently serviced. There were records to indicate that fire exits were checked daily and that regular checks of the fire alarm system and fire fighting equipment were undertaken. The fire alarm was checked from different point each week and was noted to have been checked on 17 February 2012 and 24 February 2012. The generator that provides a power supply in an emergency was also checked weekly. The inspector saw that the exits were unobstructed. A fire risk assessment had been carried out and areas that need attention had been identified. These included enhancing internal emergency lighting and the installation of more fire detectors and fire doors. This work was due to commence following a tendering process. All staff were noted to have attended fire training and four sessions of training were scheduled annually.

### General Welfare and Protection

The inspector found that a policy in place on the prevention, detection and response to elder abuse was in place and that staff were aware of the procedures to follow if an incident that could be indicative of abuse was reported. The person in charge and staff interviewed could clearly describe the centre's procedure for investigating incidents of abuse.

### Use of Restraint

Restraint measures are only used as a last resort in this centre and this was demonstrated by the low use of bedrails and the comprehensive assessments undertaken to assess the need for restraint in the first instance. The use of any restraint measure is assessed and reviewed in line with best practice standards. Seven bedrails were in use and four of theses were used at residents' request to help them move in bed. All staff had attended training on the new national policy and were committed to promoting a restraint free environment. There was a high standard of knowledge demonstrated by all staff about the use of restraint and the need for comprehensive assessment and the trial of alternative measures to promote safety before a restraint measure is introduced.

### Risk Management Procedures

The inspector found that practice in relation to the health and safety of residents and the management of risk sufficiently promoted the safety of residents, staff and visitors. There was a health and safety statement in place. Accidents and incidents were reviewed monthly. Slips, trips and falls were analysed in relation to the time, location and the nature of the event. The reports for December 2011 and February 2012 were provided to the inspector. It was noted that where a resident was vulnerable to falls there was evidence-based falls risk assessment in place and varied strategies put in place to reduce the risk. This included assessments for memory problems that would impact on capacity to understand the need to ring the call bell, the use of low to floor beds and protective mattresses.

## Care Practice

The centre was noted to have a high level of admission and discharge activity. There were 12 places allocated for long-term care. The remaining 23 places were devoted to respite, rehabilitation, convalescent and palliative care as required and this generated most of the turnover with 325 admission episodes recorded during 2011 of which only nine related to long-term care. The inspector found a good standard of care was provided to residents and care plans outlined residents' care needs with regular reviews and changes in health care status recorded. Residents with complex conditions were noted to have input from a range of professionals and their specialist needs were identified and addressed comprehensively by nursing and care staff. The inspector noted in one instance that the input from staff had resulted in improved communication pathways for the resident which was a very positive outcome.

End-of-life care was noted to include aspects of good practice such as ensuring where possible that residents were facilitated to make their own decisions. Staff use some of the material produced by the Irish Hospice Foundation and care practice was based on the person-centred care model.

While there were a number of residents who had maximum and high dependency care needs there were no critical care problems or no pressure area problems receiving attention.

## Actions reviewed on inspection:

**1. Action required from previous inspection:**

The information from quality improvement initiatives were not formulated into a report in accordance with Regulation 35 (Review of the Quality and Safety of Care and Quality of Life). The provider was required to make a report in respect of any review conducted by the registered provider for the purposes of Regulation 35(1), and make a copy available to the Chief Inspector.

This action was complete.

A report had been prepared in accordance with Regulation 35 and was made available to the inspector. The report covered the impact of the involvement of residents in the residents' forum and the changes that had been made as a result of their suggestions which included the provision of more TVs and radios in residents' bedroom areas. The report also outlined the regular audits that take place and changes that are made as a result of the findings to improve safety and quality of life for residents. For example, an environmental audit identified that signage to guide and prompt residents with memory problems was needed and this had been put in place. Actions taken to respond to requirements of the Authority's reports were also included. The admission and discharge activity highlighted that the majority of episodes were for care associated with assessment, respite, convalescence, palliative or rehabilitation needs and conveyed that admission and discharge activity for the service was significant.

**2. Action required from previous inspection:**

The complaints procedure and records did not identify timescales for responding to and investigating complaints and did not indicate if the complainant was satisfied with the outcome. The Authority was identified as part of the appeals process. The provider was required to maintain a record of all complaints detailing the investigation and outcome of the complaint and whether or not the resident was satisfied.

The provider was required to review the complaints procedure to outline the appeals process and revise the reference to the Authority.

This action was complete.

The complaint procedure had been updated in accordance with Regulation 39. A new form had been introduced that provided a better format to record the complaint and included space to record if the resident or other complainant were satisfied or otherwise with the outcome of the investigation.

**3. Action required from previous inspection:**

There were improvements needed to health and safety and risk management and these included:

- the risk management policy was in draft format and needed to be finalised
- the accident records were completed on poor quality photocopies which made information difficult to complete and to decipher
- there was a deficit in the fire safety arrangements as there was a lack of signage to guide personnel when outside the building to the assembly area and there was no arrangement to carry out essential fire checks in the absence of the maintenance staff. Some fire exit paths were hazardous as paths were covered in moss. The statutory fire safety certificate was outstanding
- the emergency plan needed revision to identify the arrangements for managing medication and essential equipment for residents in an emergency situation
- there were no controls in place to ensure the temperature of hot water was restricted to 43°C at outlets and the inspectors found hot water very hot to touch.

The provider was required to pat in place a comprehensive written risk management policy and implement this throughout the designated centre and to provide a clear format to record accidents and incidents. The provider was also required to provide to the Chief Inspector, together with the application for registration or renewal of registration, written confirmation from a competent person that all the requirements of the statutory fire authority have been complied with and to make adequate arrangements for reviewing fire precautions, and testing fire equipment, at suitable intervals. It was also required have in place arrangements to ensure that essential checks of the fire safety arrangements are carried out as required in the absence of maintenance staff and to provide adequate means of escape in the event of fire. It was also required that the emergency plan was amended to provide guidance for the provision of medication and equipment in an emergency situation and to have in place measures that ensure that hot water is dispensed at a safe temperature.

This action was partially complete.

The risk management policy and associated procedures had been finalised and were in use. The format for recording accidents and incidents had been revised and was noted to be clear and legible. There was a system for analysing accidents and incidents each month to identify trends and to prompt improvements. Thermostatic mixer valves had been fitted to hot water outlets to ensure that water was dispersed at a safe temperature.

The fire safety arrangements had been improved and further improvements were scheduled as a result of a fire risk assessment. Work was underway on removing the moss from the paths which was a slip hazard. Fire safety checks were now undertaken by a member of nursing staff when the maintenance person was off duty.

The emergency arrangements had been amended to ensure the safety of residents if the centre had to be evacuated and there was information to guide staff of the actions to take which included the transfer of medication charts and essential supplies of medication.

The actions outstanding relate to the work identified by the fire safety officer and the provision of the fire safety document that indicates the centre is in compliance with fire safety matters.

**4. Action required from previous inspection:**

Some medication management policies were outlined in draft format. These included the policy for the management of PRN (as required) medication and the policy outlining the arrangements for the disposal of medication. The medication administration charts did not identify the maximum dose of PRN medication to be administered in a 24 hour period.

The provider was required to pat in place appropriate and suitable practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents and ensure that staff are familiar with such policies and procedures. It was also required that suitable arrangements and appropriate procedures and written policies in accordance with current regulations, guidelines and legislation for the handling and disposal of unused or out-of-date medicines were put in place and to ensure staff are familiar with such procedures and policies.

This action was complete.

The inspector found that medication administration charts outlined the maximum dose of PRN medication to be administered in 24 hours and all medication prescribed was individually signed. The inspector noted good practice in medication management with reviews of medication and health care carried out at regular three month intervals.

**5. Action required from previous inspection:**

There was a lack of continuity and planning for social care. It was not possible to determine what activity might take place each day and the approach did not facilitate all residents having access to social activity. The provider was required to pprovide opportunities for each resident to participate in activities appropriate to his/her interests and capacities.

This action was complete.

There was significant improvement in the way social activity for residents was organised and there was more consistency in the provision of the activities provided. A member of staff was now dedicated to overseeing the activity schedule and one of the clinical nurse managers planed activities a week ahead in discussion with residents. The person in charge said that staff respond to what residents themselves indicate they would like to do as the resident group is generally able to articulate their preferences and choices. Most days, staff read the local papers with residents, discuss the news and locality events and undertake a specified activity according to resident's choice. Residents said that they enjoyed life in the centre and said that they had plenty of people to talk to and enough to do. Two members of staff had attended a study day to assist them when organising activity for residents with dementia.

There was good involvement from the local community that enhanced life for residents. One example was from a local school where transition year students had introduced residents to new technology and had helped residents do quizzes on lap tops. This had been very enjoyable for all concerned according to feedback from residents.

**6. Action required from previous inspection:**

The centre's policy on nutrition management was in draft form and the menu records did not describe the range of food prepared or any special diets prepared for individual residents. The person in charge was required to implement a comprehensive policy and guidelines for the monitoring and documentation of residents' nutritional intake. It was also required that a record of the food provided for residents in sufficient detail to enable any person inspecting the record to determine whether the diet is satisfactory, in relation to nutrition and otherwise, and of any special diets prepared for individual residents was maintained.

This action was complete.

A record was now maintained of any meals/food provided that varied from the daily menu. These changes were recorded on the menu sheets. Catering staff were found to be very knowledgeable about residents needs and said they were informed of special requirements by nursing staff. The chef was undertaking specialist training one day a week and said that this was improving her knowledge and skills. Two residents interviewed by the inspector said that the food was of a very good standard and that there was a good choice provided each day.

**7. Action required from previous inspection:**

The policy to guide and inform staff on communication was in draft form and had not been finalised. The provider was required to have in place a policy on communication as required by legislation.

This action was partially complete.

The policy that provided guidance to staff on communication was complete and a second policy that was relevant to communication with residents had been prepared but had not been finalised.

**8. Action required from previous inspection:**

Evidence of medical and physical fitness was not available in the staff files inspected in accordance with Schedule of the Regulations. The provider was required to pat in place recruitment procedures to ensure that no staff were employed in the designated centre unless they are physically and mentally fit for the purposes of the work which they are to perform and was also required to have all the required documents under Schedule 2 of the Regulations for inspection when requested.

This action was partially complete and work on procuring this information was in progress the inspector was told.

**9. Action required from previous inspection:**

The following premises matters need attention:

- there were more than two residents in multiple-occupancy bedrooms
- shared bedrooms accommodating three residents had one wash-hand basin which was below the recommended ratio of one wash-hand basin for every two residents
- the laundry had one point of entry
- the hairdressing room was not adequate for this purpose
- the signage on some rooms needed alteration to indicate their purpose and to identify the presence of potentially hazardous substances
- some areas needed painting and decoration.

The provider was required to pprovide a plan to the Chief Inspector that outlines how accommodation and facilities for residents will be provided in accordance with the Standards within the timeframe allowed and was also required to provide a hairdressing area that is appropriate for this purpose, to review the signage to ensure that it conveys accurate information and identifies the presence of specific substances. The provider was also required to keep all parts of the designated centre clean and suitably decorated and to carry out a review of the premises and redecorate the areas that need redecoration.

This action was partially complete.

The general premises issues such as the provision of wash-hand basins and improving the standard of decoration within the required time frame were receiving attention according to the person in charge. The other matters had been addressed. The laundry layout had been revised and there was now an entry and exit point to enable staff to manage the separation of clean and soiled laundry more effectively to reduce infection control risks. The oxygen storage area was now clearly identified as containing a hazardous substance. Inappropriate signage had been removed.

**10. Action required from previous inspection:**

Some of the required records needed amendment to fully comply with the Regulations. These included employment records for staff, the complaints records and procedure, records of food served, and the visitors' record. Policies on nutrition, risk management and the creation of and destruction of records were in draft form.

The provider was required to have in place full and satisfactory information and documents specified in Schedule 2 of the Regulations in respect of each person employed at the centre.

The provider was also required to maintain a record of all complaints detailing the investigation and outcome of the complaint and whether or not the resident was satisfied and to provide final copies of policies on nutrition, risk management and the creation of, access to, retention of and destruction of records.

This action was partially complete.

The complaints procedure and complaints record had been revised and was found to contain the required information as outlined in the Regulations. Appropriate records of food served were maintained and there was a record of visitors entering and leaving the centre. The remaining policies on nutrition and the creation and destruction of records had been presented to the policy and procedure group and were waiting to be finalised. The person in charge continues to work towards completing staff records with all the appropriate Schedule 2 documentation.

***Report compiled by:***

Geraldine Jolley

Inspector of Social Services
Social Services Inspectorate
Health Information and Quality Authority

18 May 2012

| Chronology of previous HIQA inspections | |
|---|---|
| **Date of previous inspection:** | **Type of inspection:** |
| 31 May and 1 June 2011 | ☒ Registration<br>☐ Scheduled<br>☐ Follow-up inspection<br><br>☒ Announced<br>☐ Unannounced |
| 18 August 2010 | ☐ Registration<br>☒ Scheduled<br>☐ Follow-up inspection<br><br>☐ Announced<br>☒ Unannounced |

**Health Information and Quality Authority**
**Social Services Inspectorate**

**Action Plan**

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

## Provider's response to inspection report *

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| **Centre:** | Falcarragh Community Hospital |
| **Centre ID:** | 0619 |
| **Date of inspection:** | 8 March 2012 |
| **Date of response:** | 6 June 2012 |

## Requirements

These requirements set out what the registered provider must do to meet the Health Act, 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

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| **1. The provider has failed to comply with a regulatory requirement in the following respect:**<br><br>There were aspects of fire safety identified in the fire risk assessment that required attention and the statutory fire safety compliance document was outstanding. |
| **Action required:**<br><br>Provide to the Chief Inspector, together with the application for registration or renewal of registration, written confirmation from a competent person that all the requirements of the statutory fire authority have been complied with. |
| **Action required:**<br><br>Attend to the fire safety matters identified in the fire risk assessment. |

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

| **Reference:**<br>Health Act, 2007<br>Regulation 31: Risk Management Procedures<br>Regulation 32: Fire Precautions and Records<br>Standard 26: Health and Safety | |
|---|---|
| **Please state the actions you have taken or are planning to take with timescales:** | **Timescale:** |
| Provider's response:<br><br>Upgrade works are in progress with emergency lighting being installed at time of response. All risks identified have been prioritised and included in risk register. | 23/06/2012 |

| **2. The provider has failed to comply with a regulatory requirement in the following respect:**<br><br>The policy to guide and inform staff on communication was partially complete but was not available to guide staff or inform residents on how communication was managed in the centre. | |
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| **Action required:**<br><br>Have in place a policy on communication as required by the Regulations. | |
| **Reference:**<br>Health Act, 2007<br>Regulation 10: Residents' Rights, Dignity and Consultation<br>Regulation 11: Communication<br>Standard 18: Routines and Expectations | |
| **Please state the actions you have taken or are planning to take with timescales:** | **Timescale:** |
| Provider's response:<br><br>Policy on Communication together with policy on Information for Residents implemented since inspection. | |

| **3. The provider has failed to comply with a regulatory requirement in the following respect:**<br><br>Evidence of medical and physical fitness was not available in the staff files inspected in accordance with Schedule 2 of the Regulations. |
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**Action required:**

Put in place recruitment procedures to ensure that no staff members are employed in the designated centre unless they are physically and mentally fit for the purposes of the work which they are to perform.

**Action required:**

Have all the required Schedule 2 of the Regulations documents available for inspection when requested.

**Reference:**

Health Act, 2007
Regulation 18: Recruitment
Standard 22: Recruitment

| **Please state the actions you have taken or are planning to take with timescales:** | **Timescale:** |
|---|---|
| Provider's response:<br><br>Continue to collate Schedule 2 documents for all staff. | <br><br>31/12/2012 |

**4. The provider has failed to comply with a regulatory requirement in the following respect:**

The following premises matters need attention:

- there were more than two residents in multiple-occupancy bedrooms
- shared bedrooms accommodating three residents had one wash-hand basin which was below the recommended ratio of one wash-hand basin for every two residents
- some areas needed painting and decoration.

**Action required:**

Provide a plan to the Chief Inspector that outlines how accommodation and facilities for residents will be provided in accordance with the Standards.

**Action required:**

Keep all parts of the designated centre clean and suitably decorated. Carry out a review of the premises and redecorate the areas that need redecoration.

**Reference:**

Health Act, 2007
Regulation 19: Premises
Standard 25: Physical Environment

| Please state the actions you have taken or are planning to take with timescales: | Timescale: |
|---|---|
| Provider's response:<br><br>Discussions are ongoing on delivering a plan in relation to how this Centre will meet the required accommodations standards. Painting of areas of this Unit have been included in Minor Capital Works 2012. | 01/02/2015 |

| **5. The provider has failed to comply with a regulatory requirement in the following respect:**<br><br>Some of the required records needed amendment to fully comply with legislation. These included employment records for staff. Policy documents such as the management of nutrition and the policy on the creation of and destruction of records were in draft form. | |
|---|---|
| **Action required:**<br><br>Have in place full and satisfactory information and documents specified in Schedule 2 of the Regulations in respect of each person employed at the centre. | |
| **Action required:**<br><br>Provide final copies of policies on nutrition and the creation of, access to, retention of and destruction of records. | |
| **Reference:**<br>Health Act, 2007<br>Regulation 27: Operating Policies and Procedures<br>Regulation 22: Maintenance of records<br>Standard 29: Management Systems | |
| **Please state the actions you have taken or are planning to take with timescales:** | **Timescale:** |
| Provider's response:<br><br>The policy for creation and destruction of records has been finalised and is now in place. A policy on nutrition is also nearing completion and will be implemented in the next number of months. Staff employment records will continue to be compiled in accordance with the Standards. | 31/12/2012 |

**Any comments the provider may wish to make:**

**Provider's response:**

The residents, staff and management wish to thank the inspector for her courtesy and the professional manner in which the inspection was conducted. We welcome the guidance in the report on where the care experience for residents can be enhanced and appreciate the acknowledgement of existing good practice in Falcarragh Community Hospital. The guidance in the report will be used to promote continuous improvement of the care experience for our residents

**Provider's name:** Kieran Doherty
**Date:** 6 June 2012