

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	New Ross Community Hospital
<b>Centre ID:</b>	OSV-0000602
<b>Centre address:</b>	Hospital Road, New Ross, Wexford.
<b>Telephone number:</b>	051 421 305
<b>Email address:</b>	don@newrosscommunityhospital.com
<b>Type of centre:</b>	Health Act 2004 Section 39 Assistance
<b>Registered provider:</b>	New Ross Community Hospital Limited
<b>Provider Nominee:</b>	Mark Walsh
<b>Lead inspector:</b>	Sheila Doyle
<b>Support inspector(s):</b>	None
<b>Type of inspection</b>	Unannounced Dementia Care Thematic Inspections
<b>Number of residents on the date of inspection:</b>	35
<b>Number of vacancies on the date of inspection:</b>	2

## **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 2 day(s).

**The inspection took place over the following dates and times**

From:	To:
21 August 2017 10:00	21 August 2017 18:00
22 August 2017 09:00	22 August 2017 17:00

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	Non Compliant - Moderate	Non Compliant - Moderate
Outcome 02: Safeguarding and Safety	Compliance demonstrated	Non Compliant - Moderate
Outcome 03: Residents' Rights, Dignity and Consultation	Substantially Compliant	Substantially Compliant
Outcome 04: Complaints procedures	Compliance demonstrated	Substantially Compliant
Outcome 05: Suitable Staffing	Non Compliant - Moderate	Compliant
Outcome 06: Safe and Suitable Premises	Non Compliant - Moderate	Compliant

**Summary of findings from this inspection**

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

Prior to the inspection, the person in charge completed the provider self-assessment and scored the service against the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland. The previous table outlines the centre's and inspector's rating for each outcome.

The inspector met with residents and staff members during the inspection. The journey of a number of residents with dementia was tracked within the service. Care practices and interactions between staff and residents who had dementia were observed using a validated observation tool. Documentation such as care plans, medical records and staff training records were reviewed.

New Ross Community Hospital occupies the ground floor of a two-storey facility built in the 1930s and is located on Health Service Executive (HSE) grounds. Extensive renovation works have now been completed to a high standard and 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.

Each resident was assessed prior to admission to ensure the service could meet their needs and to determine the suitability of the placement. Residents had a comprehensive assessment undertaken. However, the arrangements to meet each resident's assessed needs were not consistently set out in an individual care plan and some improvement was required around medication management practices, nutritional care and end-of-life assessments.

The health needs of residents were met to a high standard. Residents had access to general practitioner (GP) services, to a range of other health services. Safe and appropriate levels of supervision were in place to maintain residents' safety.

There were policies and procedures in place around safeguarding residents from abuse. However improvement was required around the use of restraint and the management of responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

Improvement was also required to ensure that confidential information was securely maintained.

These are discussed further in the report and included in the Action Plan at the end of this report.

**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:**

The inspector was satisfied that each resident's wellbeing and welfare was maintained by appropriate evidence-based nursing, medical and allied health care. However the arrangements to meet each resident's assessed needs were not consistently set out in an individual care plan and some improvement was required around medication management practices, nutritional care and end-of-life assessments.

The inspector reviewed a sample of care plans and saw that in some cases they had not been updated to reflect the recommendations of various members of the multidisciplinary team. For example the inspector saw that a resident had been referred to a speech and language therapist (SALT). Specific recommendations were made regarding providing assistance at meals. However the care plan had not been updated to reflect this. A similar issue was noted when specific instructions regarding dietary requirements were made by the dietician. Although the inspector was satisfied that practices were correct, the care plans did not reflect this.

Other gaps were also identified in the care planning document relating to putting specific plans in place to address assessed needs. This was notable around the use of restraint and the management of responsive behaviours and is discussed under Outcome 2.

The inspector found that care plans were reviewed on a regular basis after consultation with residents or if appropriate, their relatives. This had been identified as an area for improvement at the last inspection.

The inspector reviewed a sample of administration and prescription records and noted that some improvement was required around medication management practices. Some residents required medication as and when required (PRN). However it was noted that nurses were administering the medication even though the maximum dose that could safely be administered in a 24 hour period was not consistently recorded.

The inspector noted that the medication fridge was unlocked. Fridge temperatures were

now recorded on a daily basis which was a requirement from the last inspection. However there was a notice on the fridge outlining the acceptable temperature range. This was not in line with national guidelines. It was also noted that the temperature of the fridge was recorded as outside of the correct range on a regular basis.

The inspector found that some improvement was required to ensure that residents' nutritional requirements were met. The inspector visited the dining room on both days of inspection. It was noted on day one that adequate assistance was not available to ensure that all residents had their meal in a timely manner. The inspector saw that one resident in the dining room did not get her dinner until most of the other residents were finished. The inspector also noted that some residents did not have glasses or drinks available to them.

Otherwise the inspector saw evidence of good practices. Residents were screened for nutritional risk on admission and reviewed regularly thereafter. Residents' weights were checked on a monthly basis. There were choices available to each resident at each meal. The inspector saw that the same choices were available for residents who required a modified consistency diet. The inspector also saw residents being offered a variety of snacks and staff regularly offered drinks to residents.

The inspector visited the kitchen and noticed that it was well organised. The staff on duty discussed the special dietary requirements of individual residents and information on residents' dietary needs and preferences.

Although there were several examples of good practice in relation to end of life the inspector found that in some cases, there was limited documented evidence to show that residents were afforded the opportunity to outline their wishes regarding end of life. These wishes and preferred priorities of care could then direct the care provided.

Otherwise the inspector was satisfied that caring for a resident at end-of-life was regarded as an integral part of the care service provided. The practices were supported by an end-of-life policy. The inspector saw that advice and support was available from the local palliative care team. Previous initiatives relating to end-of-life care continued. Staff had linked with the hospice friendly hospital (HfH) initiatives such as the use of the spiral symbol to alert others to be respectful whenever a resident was dying. Family handover bags were also in use for the return of possessions.

Staff spoken with confirmed that meals and refreshments were made available to relatives and facilities were set aside if relatives wished to stay overnight. An annual remembrance mass was held and bereaved relatives were invited to attend.

The inspector was satisfied that there were suitable arrangements in place to meet the health and nursing needs of residents with dementia. Residents were satisfied with the service provided. Residents had access to GP services and out-of-hours medical cover was provided. A full range of other services was available on referral including speech and language therapy (SALT), dietetic services, physiotherapy and occupational therapy (OT) services. Chiropody, dental and optical services were also provided. The inspector reviewed residents' records and found that some residents had been referred to these services and results of appointments were written up in the residents' notes.

Transfer of information between the centre and other healthcare providers was found to be good. The inspector saw samples of discharge letters for those who had spent time in an acute hospital and letters from consultants detailing findings after clinic appointments.

**Judgment:**

Non Compliant - Moderate

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

**Theme:**

Safe care and support

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

No actions were required from the previous inspection.

**Findings:**

The inspector found that measures were in place to protect residents from harm or suffering abuse and to respond to allegations, disclosures and suspicions of abuse. Improvement was required around the use of restraint and the management of responsive behaviours.

The inspector reviewed the use of restraint and found that risk assessments were completed prior to use. However there was no documented evidence that any alternatives had been tried prior to the use of bedrails. In addition, it was noted that the care plans did not adequately detail the use of restraint, or the supervision and observation of a resident while restraint was in use. There was no documented evidence that safety checks were completed when bed rails were in use. The inspector read the policy and saw that the practice seen was not in line with the policy.

Some residents had episodes of responsive behaviours. However care plans were not in place to guide the care practices. Specific details such as possible triggers and interventions were not recorded. Despite this, the inspector saw that staff were familiar with appropriate interventions to use. During the inspection staff approached residents with responsive behaviours in a sensitive and appropriate manner and the residents responded positively to the techniques used by staff. The inspector noted that additional training had been provided for staff. Support and advice were available to staff from the psychiatry services.

There was an elder abuse policy in place that covered prevention, detection, reporting and investigating allegations or suspicion of abuse. Staff had received training and all staff spoken with were clear on the action they would take should there be an allegation of abuse. Residents spoken with confirmed that they felt safe in the centre.

Some residents' monies were managed within the centre. Balances checked on

inspection were correct. There was a policy in place to guide the practice. The inspector was satisfied that the system was sufficiently robust.

**Judgment:**

Non Compliant - Moderate

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

**Theme:**

Person-centred care and support

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

No actions were required from the previous inspection.

**Findings:**

Although there were many examples of good practice the inspector found that improvements were required to ensure that residents' privacy and dignity was respected.

The inspector found that some information of a confidential nature was on a notice board in the staff dining room. The dining room was used by all grades of staff and some external contractors and the door was not locked. The inspector was concerned that this information was then available to people who did not require access to it. In addition the inspector heard staff discussing some personal / private/confidential details about a resident while in the residents' dining room where residents were having their dinner.

The inspector noted the policy in place in the centre regarding the creation of, access to, retention of and destruction of records stated that the centre had a policy of maintaining records in accordance with good practice which ensures the confidentiality of information concerning the medical condition of residents. It went on to state that records will only be made available to medical professionals, residents themselves and where appropriate residents' relatives or representatives. Also included was that 'all records shall be stored securely and access granted to relevant and approved persons only'. The inspector found that this was not the practice observed during inspection.

Both of these issues were discussed in detail at the end of inspection.

As part of the inspection, the inspector spent a period of time observing staff interactions with residents with dementia. The observations took place in the day rooms and dining room. Observations of the quality of interactions between residents and staff for selected periods of time indicated that 50% of interactions demonstrated positive connective care, 25% reflected task orientated care while 25% indicated neutral care. The interactions that demonstrated positive connective care mainly took place during planned activities, some of which were very suitable for residents with dementia. These results were discussed at the end of inspection, as the inspector found that there were

some missed opportunities for positive connective care at other times.

The inspector saw many example of good practice. Residents' religious and civil rights were supported. Mass and religious services were held on a weekly basis. There was an oratory located in the centre which provided a quiet space for residents to pray and reflect. Each resident had a section in their care plan that set out their religious or spiritual preferences.

Staff said and residents confirmed they had been offered the opportunity to vote at the recent elections. The inspector observed that some residents were spending time in their own rooms and enjoyed reading and watching TV, or taking a nap. Other residents were seen to be spending time in the different communal areas of the centre. Newspapers and magazines were available and the inspector saw some staff reading to residents.

The inspector found that residents were consulted about how the centre was run and were enabled to make choices about how to live their lives. There was a residents' committee and meetings were held on a regular basis. Staff told the inspector that the views of all residents were taken on board.

Residents' religious and civil rights were supported. Mass and Church of Ireland services were held on a weekly basis. Some residents chose to attend local services in the community.

Staff spoken with outlined details of independent advocacy services that were available to the residents. Internal advocates were also appointed. There was evidence that residents' rights, privacy and dignity was respected with personal care delivered in their own bedroom or in bathrooms with privacy locks. There were no restrictions to visiting in the centre other than at mealtimes and some residents were observed spending time with family or friends in the various communal areas of the centre.

Staff were observed to interact with residents in a warm and personal manner, using touch, eye contact and calm reassuring tones of voice to engage with those who became anxious restless or agitated.

An activity programme included activities arranged for the mornings and afternoons such as music, quizzes, bingo, exercises and relaxation therapies. The activities co-ordinator told the inspector that one to one time was scheduled for residents with more severe dementia or cognitive impairment who could not participate in the group activities. Other dementia relevant activities were included in the programme such as reminiscence, imagination gym and Sonas (a therapy with a focus on promoting communication, especially for people with dementia).

**Judgment:**

Substantially Compliant

***Outcome 04: Complaints procedures***

<p><b>Theme:</b> Person-centred care and support</p>
<p><b>Outstanding requirement(s) from previous inspection(s):</b> No actions were required from the previous inspection.</p> <p><b>Findings:</b> The inspector was satisfied that the complaints of each resident including those with dementia, his or her family, advocate or representative and visitors were listened to and acted upon and there was an effective appeals procedure.</p> <p>There was a complaints policy in place which met the regulatory requirements. However this was not displayed in a prominent position in the centre as required by the regulations.</p> <p>A review of complaints recorded to date showed that they were all dealt with promptly and the levels of satisfaction of the complainants were all recorded. There was an appeals process if needed.</p>
<p><b>Judgment:</b> Substantially Compliant</p>

***Outcome 05: Suitable Staffing***

<p><b>Theme:</b> Workforce</p>
<p><b>Outstanding requirement(s) from previous inspection(s):</b> No actions were required from the previous inspection.</p> <p><b>Findings:</b> The inspector was satisfied that at the time of inspection there were appropriate staff numbers and skill mix to meet the assessed needs of residents including residents with dementia. However it was noted that staff nurses did not always get off duty on time and this is something that will need to be reviewed by the provider and person in charge.</p> <p>All staff were supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The inspector reviewed a sample of staff files and saw that all documents required by Schedule 2 were in place. Assurance was given by directors spoken with that Garda Síochána (police) vetting was in place for all staff.</p> <p>Staff were supervised to their role. An actual and planned roster was maintained in the centre with any changes clearly indicated. The inspector reviewed staff rosters which</p>

showed that absences were covered.

The provider and person in charge promoted professional development for staff and were committed to providing ongoing training to staff. A training matrix was maintained. Training records showed that extensive training had been undertaken and staff spoken with confirmed this. This included training in continence care and nutrition. Training on dementia and responsive behaviours was also provided. Records read confirmed all staff had completed mandatory training in areas such as safeguarding and prevention of abuse, fire safety and moving and handling. The inspector saw that additional training was planned for the coming months. Some staff also told the inspector they were scheduled to attend HACCP (Hazard Analysis and Critical Control Point) training in the coming weeks.

Several outsourced service providers attended the centre and provided very valuable activities and services which the residents said they thoroughly enjoyed and appreciated. The inspector saw that they had been vetted appropriate to their role and had their roles and responsibilities set out in writing as required by the regulations. The inspector also noted that some training had been provided. In particular the inspector saw that many volunteers had attended training on safeguarding vulnerable adults.

**Judgment:**

Compliant

***Outcome 06: Safe and Suitable Premises***

**Theme:**

Effective care and support

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

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

**Findings:**

The location, design and layout of the centre are suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way.

The centre occupies the ground floor of a two-storey facility built in the 1930s. It is located on Health Service Executive (HSE) grounds.

Extensive renovation works have now been completed and centre now has 13 single rooms, eight of which are en suite, 9 twin rooms and two three bedded rooms. Adequate screening was available in the shared rooms. Rooms were nicely personalised with photographs and memorabilia. Staff discussed plans to enhance the bedrooms even more with input from family members.

Other rooms available included a day room, an activity room, quiet room, prayer room, kitchen, dining room, treatment room and offices.

Two sluice rooms were also available and both had bed pan washers. The laundry was located in a building at the rear of the premises.

All corridors have handrails which have been painted a different colour to aid orientation. The inspector also noted that there were contrasting colours in toilets and bathrooms. Dementia friendly signage was in place around the building.

Appropriate assistive equipment such as profiling beds, hoists, pressure relieving mattresses and cushions, wheelchairs and walking frames was available. Servicing contracts were in place. Corridors were wide which enabled residents including wheelchair users' unimpeded access.

The environment was bright, clean and well maintained throughout. Adequate arrangements were in place for the disposal of general and clinical waste.

There was now a large secure garden area for residents' use in addition to a secure recently renovated courtyard. Some parking was available at the front of the building which is set aside for visitors. There is also access to a shared car park on the grounds.

**Judgment:**

Compliant

## Closing the Visit

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

### **Acknowledgements**

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

### ***Report Compiled by:***

Sheila Doyle  
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>	New Ross Community Hospital
<b>Centre ID:</b>	OSV-0000602
<b>Date of inspection:</b>	21/08/2017 and 22/08/2017
<b>Date of response:</b>	05/09/2017

### 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 consistently updated to reflect the recommendations of various members of the multidisciplinary team.

#### **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

<sup>1</sup> The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.

that resident's admission to the designated centre.

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

A log book is being created which confirms the date NRCH refers to MDT service, this log will also track the response from MDT service and its' recommendation(s). The current system will be changed to provide that The Allocated Nurse will be responsible for inputting the recommendation from MDT service into the resident's Care Plan within a period of two working shifts. The PIC will audit this process via epic care management reports system. Care Planning Training for Nurses took place on 23rd August 2017 as per the Training Schedule for 2017.

**Proposed Timescale:** 06/09/2017

**Theme:**

Safe care and support

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

There was limited documented evidence to show that residents were afforded the opportunity to outline their wishes regarding end of life.

**2. Action Required:**

Under Regulation 13(1)(a) you are required to: Provide appropriate care and comfort to a resident approaching end of life, which addresses the physical, emotional, social, psychological and spiritual needs of the resident concerned.

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

PIC and Activities Co Ordinator are devising an End of Life Form which will confirm a resident's wishes regarding his/her needs approaching end of life. This form will be kept in the resident's file at the front accessible to all members of the Healthcare Team.

**Proposed Timescale:** 02/10/2017

**Theme:**

Safe care and support

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

Adequate assistance was not available at mealtimes.

**3. Action Required:**

Under Regulation 18(3) you are required to: Ensure that an adequate number of staff are available to assist residents at meals and when other refreshments are served.

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

The dependency levels of the residents will be reviewed specifically on a weekly basis by PIC to ensure the dining room has an adequate number of staff present. The

dependency levels can vary weekly due to the admission of respite and short-term residents. Additional staff are rostered for duty as the need is identified and/or arises.

**Proposed Timescale:** 05/09/2017

**Theme:**

Safe care and support

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

Some residents required medication as and when required. Nurses were administering the medication even though the maximum dose that could safely be administered in a 24 hour period was not consistently recorded.

**4. 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:**

In conjunction with the GP Service the resident's Medication Chart has been revised to include a Maximum Daily Dose for PRN Medication.

**Proposed Timescale:** 11/09/2017

**Theme:**

Safe care and support

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

The medication fridge was unlocked.

Inaccurate information regarding the acceptable temperature range was used to monitor the fridge temperature.

**5. Action Required:**

Under Regulation 29(4) you are required to: Store all medicinal products dispensed or supplied to a resident securely at the centre.

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

A lock was fitted to the fridge on the day of the inspection (21/8/2017). The signage regarding temperature range was revised and affixed to fridge on 21/8/2017.

**Proposed Timescale:** 21/08/2017

## Outcome 02: Safeguarding and Safety

### 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 in place to guide the care practices for responsive behaviours.

Specific details such as possible triggers and interventions were not recorded.

### 6. Action Required:

Under Regulation 07(2) you are required to: Manage and respond to behaviour that is challenging or poses a risk to the resident concerned or to other persons, in so far as possible, in a manner that is not restrictive.

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

The Care Plans which require updating will be reviewed and updated by 31/12/2017. The Care Plans will reflect the care practices regarding responsive behaviours

### Proposed Timescale: 31/12/2017

### Theme:

Safe care and support

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

There was no documented evidence that any alternatives had been tried prior to the use of bedrails.

Care plans did not adequately detail the use of restraint, or the supervision and observation of a resident while restraint was in use.

There was no documented evidence that safety checks were completed when bed rails were in use.

### 7. 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 procedure for safety checks for bed rails has been revised to ensure where bed rails are used they are checked on a two hourly basis. A new document has been created "Bed Rail Two Hourly Check Form" and this will document checks.

The Care Plans for all residents in long-term care will record evidence that alternatives had been tried prior to the use of bed rails.

**Proposed Timescale:** 31/12/2017

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

**Theme:**

Person-centred care and support

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

Some information of a confidential nature was on a notice board in the staff dining room which was not locked.

Staff were heard discussing some details about a resident while in the residents' dining room where residents were having their dinner.

**8. 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:**

All information was erased from whiteboard in the "Staff Room" on 21/08/2017. The door to the Staff Room will be affixed with a coded lock to ensure it will only be accessed by hospital staff, signage will be put in place to say "Authorised Access Only." Non-hospital personnel will be accommodated in the Visitor's Room. All staff are bound by confidentiality agreements. Signage will be placed in Staff Room reminding all of the importance of confidentiality and protection of a resident's dignity.

**Proposed Timescale:** 08/09/2017

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

**Theme:**

Person-centred care and support

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

The complaints procedure was not displayed in a prominent position.

**9. Action Required:**

Under Regulation 34(1)(b) you are required to: Display a copy of the complaints procedure in a prominent position in the designated centre.

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

The Complaints Policy/Procedure was re-designated to a prominent location in the front hall way on day of inspection. Since then a Complaints Flowchart has been designed and added to the document for ease of reference.

<b>Proposed Timescale:</b> 21/08/2017