

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Nazareth House
Centre ID:	OSV-0000149
Centre address:	Malahide Road, Clontarf, Dublin 3.
Telephone number:	01 833 8205
Email address:	maura.hooper@nazarethcare.com
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Sisters of Nazareth
Provider Nominee:	Maura Hooper
Lead inspector:	Nuala Rafferty
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	86
Number of vacancies on the date of inspection:	1

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

Please note the definition of the following term used in reports: responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

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 ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 12 April 2017 10:00 To: 12 April 2017 19:30

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

Outcome	Our Judgment
Outcome 02: Governance and Management	Substantially Compliant
Outcome 05: Documentation to be kept at a designated centre	Substantially Compliant
Outcome 08: Health and Safety and Risk Management	Substantially Compliant
Outcome 11: Health and Social Care Needs	Non Compliant - Moderate
Outcome 12: Safe and Suitable Premises	Non Compliant - Moderate
Outcome 18: Suitable Staffing	Compliant

Summary of findings from this inspection

This was an unannounced inspection by the Health Information and Quality Authority (HIQA). The purpose of the inspection was to monitor ongoing compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and the National Standards for Residential Care Settings for Older People in Ireland.

The findings of the last inspection, a registration inspection in June 2016, and progress on some of the actions arising from that inspection, were also considered.

The inspector met and spoke with residents and relatives during the one day inspection. All expressed satisfaction about the services and highlighted the caring attitude of staff and management. They were also very complimentary of the meals provided. There were measures in place to protect residents from being harmed or suffering abuse and those spoken too confirmed they felt safe in the centre. These measures included good recruitment processes and on samples of personnel files viewed the inspector found all staff were vetted in accordance with the appropriate legislation.

Residents were afforded choice in their daily routine and were observed spending time in various parts of the centre that offered diversity of location and interest, such as the coffee dock and reception areas. There were a variety of opportunities

available for residents to participate in activities including; exercise, prayer, arts and crafts, reading and movies.

The Action Plan at the end of this report identifies areas where further improvements are required to comply 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

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 02: Governance and Management

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

Theme:

Governance, Leadership and Management

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

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

Findings:

Actions were required following the registration inspection in June 2016 to improve audit processes and systems that monitored and developed staff skills to meet the needs of residents. These actions were partially addressed.

Staff appraisals were carried out and included the identification of training and development needs on an individual basis. Some staff had undertaken training further to the appraisals, including medicine management and palliative care. A training plan was being drafted to include other identified courses, such as auditing and analysis which was identified as a requirement on the registration inspection. The inspector was told that the senior management team had sourced training on quality monitoring and auditing last autumn, but found that the course did not meet their needs, and had not yet found more suitable training.

Actions required, to develop more effective monitoring systems, including a complete audit cycle, were not addressed. Systems established to monitor and review the quality and safety of care delivery were not being fully implemented. The inspector found that although data was still being collated on key performance indicators (KPIS) of clinical care such as: pressure ulcers, antibiotics and bed rail use. However, analysis of the information, to assess the appropriateness of the measures in place, or identify improvements required did not take place. On review of audit records, it was noted that audits on care planning and assessment, or medication management, were not undertaken since February and September 2016 respectively. The last recorded audit on pressure ulcer management was for 2015.

The provider's action plan to the registration inspection had identified weekly governance and management team meetings.

The inspector viewed samples of the minutes of the meetings. The meetings, although not held on a weekly basis, were held on a regular basis. The minutes of the meetings

referenced discussions on both clinical and non-clinical risks and issues. Recurrent agenda items included: health & safety, risk management, maintenance, recruitment, and updates on the new build in progress. However, the minutes did not evidence that the management team were consistently implementing quality assurance practices. The inspector noted that the minutes of a management team held on the first week of January identified that audits were due to be completed on care planning and assessments by December 2016. However, these audits were not completed at the time of the inspection and there were no further references to them in the minutes of subsequent management meetings. Findings under outcome 11 of this report evidences where improvements to care planning and assessment were required.

Issues arising from meetings of the health and safety committees were referenced in the minutes, but no references were made to any learning derived, or improvements identified, as a result. For example, the inspector viewed evidence of regular fire drills, some of which included simulations of evacuation procedures. Concise reports of this good practice were viewed. The information contained in all of the reports, when collated and analysed offered valuable learning where improvements could be made. However, they had not been reviewed by the management team and learning and improvements were not initiated.

Judgment:

Substantially Compliant

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

Theme:

Governance, Leadership and Management

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

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

Findings:

Actions required from the registration inspection to review some policies were addressed. The missing persons' policy was updated to give improved guidance to staff on the management of such an incident. Personal emergency exit plans (peeps) were also revised. The revised peeps included reference to the consideration of other needs or risks such as: sensory impairments or responsive behaviours. It also references level of understanding in relation to the fire alarm and whether supervision is required when

mobilising. These peeps are also referenced under outcome 11 of this report.

However, actions required to improve records management were not fully addressed. Fragmentation of records persisted with a mixture of hard copy and computerised templates in place for some records, in particular for risk assessments. Although the computerised system had been updated with additional risk assessments, not all were available. For example, clinical risk assessments for moving & handling, wound care and pain management were available in hard copy only and were not on the computerised system where the majority of the healthcare records were maintained. This created a risk for nurses who may miss updating these assessments when they are due for review. It was also noted that risk assessments for infection prevention and control were not available in either format.

Judgment:

Substantially Compliant

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

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

Health and safety and risk management systems related primarily to the impact of construction works within the grounds of the centre were reviewed. Changes to the layout of the existing building were minimal and consisted of the closure of a doorway to the former chapel and the change of function of a clothes sorting room to an internal rear lobby for safety purposes. All fire exits were clear and directional signage was in place. There was no change to the location of previous fire exits.

As referenced previously under outcome 2, regular simulated fire drills were recorded and clear reports were available from which learning, to improve the evacuation processes, could be derived. All staff spoken too were very familiar with all of the principles of fire evacuation and responding to the fire alarm. Although most were also familiar with all of the fire evacuation procedures, some new members of staff had not yet received full fire training. They were not sure on the location of fire assembly points or who was the responsible person for managing a night time evacuation. This was discussed with the provider and acting person in charge. Subsequent to the inspection the provider informed the inspector that full formal training was scheduled for these staff on 4 May next. The inspector looked at the fire evacuation procedure and noted that it did not give enough guidance to staff in these areas. A revised procedure was drafted and awaiting sign off, the inspector noted, that, although this also directed staff to use the principles of phased horizontal evacuation, it did not reflect the process of

further evacuation of the centre should it be necessary.

In conversation with some residents, they could recognise the fire alarm when it activated. Some were familiar with the weekly fire alarm checks each Tuesday and were also aware of the means of evacuation using evacuation sheets tied to mattresses. One resident recounted how he was involved in a simulated fire drill with staff and how long it took to complete.

Risk management systems to monitor visitors through the building were in place with visitor sign in at reception. A receptionist was on duty for 12 hours each day. Staff were familiar with the construction workers on site and the inspector was told that they entered the building only when necessary and staff were informed. Time constraints to limit the negative impacts of the construction on residents' daily lives were in place. Work was limited to the hours of 8am and 8pm and also stopped during lunch from 12:30 to 13:30.

Judgment:

Substantially Compliant

Outcome 11: Health and Social Care Needs

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

Theme:

Effective care and support

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

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

Findings:

The findings of the last inspection required actions to improve care planning and assessment processes to make them more specific and ensure they meet residents' needs. On the last inspection it was found that the care plan system was not sufficiently detailed to guide staff and assessments were inadequate. These findings were recurrent on this inspection.

Evidence of timely referral and review by a range of medical and allied health professionals was found with documented visits, assessments and recommendations by dietician, and speech and language therapists, physiotherapy and occupational therapist reviews.

Samples of clinical documentation including nursing and medical records were reviewed. These showed that all residents were assessed prior to initial admission to the centre.

However, it was noted that some residents who had recently spent time in the acute hospital services, were not assessed on re-admission to the centre. Transfer of information within and between the centre and other healthcare providers was good. Discharge letters for those who had spent time in acute hospital and letters from consultants detailing findings after clinic appointments were maintained.

Systems were in place for the assessment, planning, implementation and review of healthcare needs. This included nursing assessments, care plans and clinical risk assessments. Samples of these clinical records were viewed. The inspector found that these contained the minimum information required to manage the health problem. The information was general and not person centred. Some assessment forms viewed were not fully completed. As referenced earlier, a comprehensive re-assessment of needs was not completed for all residents who had recently returned from hospital. It was also noted that care plans were not updated following re-admission and a baseline record of vital signs and weight on which to measure signs of clinical improvement or deterioration was not taken. Examples of care plans not updated included: end-of-life care, eating and drinking and moving and handling care plans. Risk assessments not reviewed included: risk of pressure ulcer development, constipation, moving and handling and comprehensive activities of daily living. All aspects of the assessments for personal emergency exit plans (peeps) were not fully completed. Information to indicate the level of co-operation that could be expected, detail on cognitive ability, method of evacuation for both day and night time and details on supervision requirements after evacuation was not always included.

The clinical documentation and recording of care delivered to residents was not fully linked to give an overall picture of residents' current condition. Some nurses daily progress notes referenced reviews of residents' needs and abilities by allied health professionals, consultants or nurse specialists but were not linked to revised care plans and assessments.

Judgment:

Non Compliant - Moderate

Outcome 12: Safe and Suitable Premises

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

Theme:

Effective care and support

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

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

Findings:

The majority of actions required, to address the challenges posed by the premises, in line with the regulations and standards for older persons services were in progress on this inspection. As part of the registration inspection process in 2016 the provider forwarded a comprehensive plan to address the deficiencies of the premises. This involved a separate building development on the grounds of the existing centre which is currently underway. The proposed completion of phase 1 of the new development was originally scheduled for June 2017 with completion of Phase 2 by December 2017. However, these dates have since been revised and the expected completion date for phase 1 is now October 2017 with phase 2 commencing in 2018.

The existing premises were noted to be maintained to a good standard and evidence of ongoing maintenance, such as painting and repairs to the fabric of the building was found. The centre was visually clean and walkways were free of clutter. Evidence, of any negative impact, of the on-site construction works, on residents' daily life, was not found.

In conversation with residents and relatives the inspector heard that they were kept well-informed on progress on the new building. The inspector also noted that a notice board with regular updates was located near the main foyer and was well signposted.

Actions required to improve signage and cueing, to support freedom of movement for residents with dementia, within the centre, were partially addressed. Signs identifying the names of units were in place and although picture and colour cueing were not fully evidenced, some picture cueing was in place. The inspector was informed that the provider planned to progress this when the new build was complete.

Judgment:

Non Compliant - Moderate

Outcome 18: Suitable Staffing

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

Theme:

Workforce

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

No actions were required from the previous inspection.

Findings:

Sufficient staffing and skill mix were found to be in place to deliver a good standard of

care to the current resident profile.

The staff rota was checked and found to be maintained with all staff that worked in the centre identified.

Systems were in place to provide relief cover for planned and unplanned leave. Actual and planned rosters were in place. Cover for planned and unplanned leave was provided, primarily through a bank of relief staff.

Records reviewed showed that staff had been provided with opportunities to receive updated training in areas such as: safeguarding, moving and handling, fire safety and first aid. Samples of attendance records were also viewed.

A staff allocation system was in place to deliver care in a timely manner to residents on all levels of the centre.

Staff were familiar with resident's needs and preferences and appropriate and respectful interactions were observed throughout the day between residents and staff.

Good recruitment processes were in place including a Garda Síochána (police) vetting process. Samples of staff files reviewed showed all staff were verified through a Garda Síochána vetting process.

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:

Nuala Rafferty
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 report¹

Centre name:	Nazareth House
Centre ID:	OSV-0000149
Date of inspection:	12/04/2017
Date of response:	18/05/2017

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 02: Governance and Management

Theme:

Governance, Leadership and Management

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

The management systems in place were not being fully implemented to ensure the service provided was consistently and effectively monitored.

1. Action Required:

Under Regulation 23(c) you are required to: Put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

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

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

The Registered Provider and acting Person in Charge commenced a comprehensive review of three audit tools following the inspection - nutrition, falls and care planning, to ensure that they are centre specific and benchmarked against the clinical policies currently in place.

It is planned to progress to other audits (such as restraint) following the successful completion of the above three.

The data collected from the KPI's will be subjected to a root cause analysis which the PIC will then bring forward to the weekly Clinical Governance meeting for appropriate action followed by implementation and monitoring.

A format to guide Clinical Governance meetings, in line with the KPI's is presently being drawn up. This will involve the PIC meeting with the ADON and CNM's each week and the RP monthly. It will ensure action plans for improvement are identified and allocated to the relevant staff member with effective time frames for monitoring purposes. The guide will include an area for discussion to ensure other issues arising are dealt with in a timely manner.

The minutes from the Health and Safety meetings will be incorporated into the monthly Clinical Governance meetings also.

As a quality improvement initiative Safety Crosses for KPI's on falls/pressure damage/infections will be introduced and made visible for all staff as a cue to enhance communication and increase awareness. These will be up-dated every 24 hours by the nurse on night duty in each unit.

Proposed Timescale: 30/06/2017

Outcome 05: Documentation to be kept at a designated centre

Theme:

Governance, Leadership and Management

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

Fragmentation of records did not enable ease of access or review for staff.

2. Action Required:

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

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

The resident's individual folders have been updated with a revised front sheet which clearly identifies all the records required and where the documentation is to be recorded i.e. on CareSys or on paper. This will enable CNM's and nurses to cross check that all documentation is present.

Proposed Timescale: Completed May 9th

Proposed Timescale: 09/05/2017

Outcome 08: Health and Safety and Risk Management

Theme:

Safe care and support

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

All staff had not yet received full fire training although it is acknowledged dates were scheduled for May 4 2017

3. Action Required:

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

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

Staff that had not received fire training on the day of the inspection received it on the 4th of May.

Further training is planned for May 25th for new and existing staff.

On induction new staff are orientated on the principles of fire evacuation, responding to the fire alarm and shown where fire exits are located and the fire fighting equipment is kept.

New staff are not being allowed to commence on night duty without having done Fire training.

Fire instructions now reflect further evacuation details, should it be necessary.

Proposed Timescale: Completed May 4th.

Proposed Timescale: 04/05/2017

Outcome 11: Health and Social Care Needs**Theme:**

Effective care and support

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

Assessment and care planning were not specific enough to direct the care to be delivered or guide staff on the appropriate use of interventions to consistently manage the identified need.

Comprehensive nursing assessments were not completed in respect of every resident on re-admission to the centre.

4. Action Required:

Under Regulation 05(2) you are required to: Arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to the designated centre.

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

CNM's have commenced a mentoring programme with nurses to ensure assessments and care plans are detailed and person centred.

Nurses are now partnering, on a formal basis, with care assistants and activities coordinators when carrying out assessments and drawing up care plans.

A new "return from hospital" check list has been created which details all the information to be recorded to ensure a comprehensive reassessment of needs is carried out within 48 hours of readmission. Any changes identified will be reflected in the care plans.

PEEPS have been up-dated to include cognitive ability, the method of evacuation for both day and night and details of supervision required post evacuation.

Proposed Timescale: 03/05/2017

Theme:

Effective care and support

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

A care plan based on a comprehensive re-assessment of needs was not prepared within 48 hours, in respect of all residents re-admitted to the centre.

5. 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.

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

A new "return from hospital" check list has been created which details all the information which must be recorded to ensure a comprehensive reassessment of the resident's needs is carried out within 48 hours of readmission. Any changes identified will be reflected in the care plans.

Details of return of residents from acute care facilities will be included in the weekly Clinical Governance meetings to ensure compliance.

The introduction of the new auditing tools will also assist in the timely recognition of areas of non-compliance.

Proposed Timescale: Completed May 1st 2017 and June 30th 2017

Proposed Timescale: 30/06/2017

Theme:

Effective care and support

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

Reviews of care plans did not include a determination of the effectiveness of the plans

to manage the needs identified.

6. 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:

Following a review of the four monthly risk assessments we will use this information to benchmark against the care plans, to determine their effectiveness.

The ADON will meet with individual nurses on a weekly basis to provide guidance and training leading to best practice.

Proposed Timescale: 22/05/2017

Outcome 12: Safe and Suitable Premises

Theme:

Effective care and support

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

Plans previously forwarded by the provider to address the challenges posed by the premises with an expiry date of 30 June 2017 were accepted by HIQA. However there have been delays to the original schedule and a revised timeframe that ensures the conditions of registration are not breached is required.

7. 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:

Dementia signage was put in place following the last inspection and will be extended into the new building. Ramped areas have been further marked to aid recognition.

The proposed completion of Phase 1 of the new development had to be changed from June 2017 to November 14th 2017. The delay is largely due to the Mechanical and Electrical contractors going into liquidation in April 2017 and a suitable replacement contractor having to be appointed.

The proposed completion of Phase 2 of the new development, originally scheduled for December 2017, will now be completed in May 2018.

HIQA will be provided with monthly progress up-dates from July 2017 and notified of any variations in the time-frame.

Proposed Timescale: November 2017 and May 2018

Proposed Timescale: 31/05/2018