Health Information and Quality Authority
Regulation Directorate

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

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

Centre name:	Cahercalla Community Hospital
Centre ID:	OSV-0000444
Centre address:	Cahercalla Road, Ennis, Clare.
Telephone number:	065 682 4388
Email address:	generalmanager@cahercalla.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Cahercalla Community Hospital Limited
Provider Nominee:	Claire Welford
Lead inspector:	Vincent Kearns
Support inspector(s):	Anna Delany
Type of inspection	Unannounced
Number of residents on the date of inspection:	94
Number of vacancies on the date of inspection:	15

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 2 day(s).

The inspection took place over the following dates and times

From:	To:
27 February 2017 08:00	27 February 2017 17:00
28 February 2017 08:00	28 February 2017 16:30

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

Outcome	Our Judgment
Outcome 02: Governance and Management	Compliant
Outcome 03: Information for residents	Substantially Compliant
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Substantially Compliant
Outcome 07: Safeguarding and Safety	Non Compliant - Major
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 09: Medication Management	Compliant
Outcome 11: Health and Social Care Needs	Non Compliant - Moderate
Outcome 12: Safe and Suitable Premises	Non Compliant - Major
Outcome 13: Complaints procedures	Substantially Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Non Compliant - Moderate
Outcome 18: Suitable Staffing	Compliant

Summary of findings from this inspection

This report sets out the findings of a two day unannounced inspection, in which 12 outcomes out of a possible 18 outcomes were reported upon. The purpose of the inspection was to monitor on-going compliance with the Care and Welfare Regulations and the National Standards.

Cahercalla Community Hospital & Hospice was divided into 5 floors/units in two buildings which were joined together and provided residential, respite and hospice care, which according to the centres' statement of purpose was supported by Milford Care Centre, Limerick. The centre was registered to accommodate 109 residents and on the days of inspection there were 94 residents living in the centre. The premise was originally opened as a hospital in 1951 and there had been significant extensions and renovations since then however, the overall design and layout of the premises was largely reflective of a hospital from this period. The core structure of the premise

had largely remained while extensions were added over the years most recently in 2008. A major refurbishment of the premises was undertaken by the provider and completed in 2013. The refurbishment was completed to a high standard and substantially addressed the issue of multi-occupancy bedrooms but did not however address the lack of sufficient communal, dining and recreational space identified at the time of the very first HIQA inspection of the centre in May 2010.

As part of the inspection process, inspectors met with residents and their representatives, healthcare assistants, clerical staff, staff nurses, the unit nurse manager, the person in charge and the provider representative. Inspectors observed practices and reviewed documentation such as policies and procedures, care plans, medication management, staff records and accident/incident logs. Residents told inspectors that they were happy living in the centre and that they felt safe there. Overall the findings of this inspection indicated that residents received care to a good standard and staff were able to demonstrate good knowledge of the residents' care needs when speaking with inspectors.

From the 12 outcomes reviewed during this inspection; four of the 12 outcomes were compliant and three outcomes substantially compliant with the regulations. However, the following three outcomes were deemed to be moderately non-compliant; health and safety and risk management, health and social care needs, rights, dignity and consultation. In addition, there were two outcomes found to be at major non-compliance; safeguarding and safety and suitable premises. These non-compliances are discussed throughout the report and the action plan at the end of the report identifies where improvements are needed to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Standards for Residential Care Settings for Older People in Ireland.

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

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

Findings:
Since the last inspection there was a new provider representative appointed in November 2016 and she was a registered nurse with a number of additional relevant academic qualifications including a PhD in Nursing Gerontology. She was an experienced manager having held a number of significant management and clinical roles in nursing practice, nursing education, nursing management and nursing practice development.

The governance system included the following arrangements; the management team consisted of a full-time general manager, who worked as the provider representative on behalf of the board of directors. She was supported by the person in charge and a number of senior support management in areas including catering, financial and fundraising. These senior managers met on a monthly basis at a quality and safety meeting which had as standing agenda of items that included; quality and risk, health and safety and corporate risks. Inspectors were informed that this group discussed all aspects of governance including complaints, policies and procedures and staff training and development. The general manager and person in charge were also supported within the centre by a team of unit nurse managers. This multi-disciplinary team also met on a monthly basis and the inspectors noted from the minutes of the monthly management meetings that the following issues were included at these meetings: clinical indicators of care, residents' dependency levels, staff training, staff retention and recruitment, incident analysis, clinical practice and development of activities were recorded. Staff to whom inspectors spoke also confirmed that these meeting were held and that a number of changes were instigated from these meetings including policy and procedural changes in the centre.

There was a system in place to monitor quality and safety of care provided. This included the collection of data on a monthly basis on key performance indicators (KPI's) of clinical care such as; falls: pressure injuries: restraint: medication errors: care

planning and nutrition management. These KPI's were used as a way to assess the standard of care being delivered in the centre. The data collected was used to enable meaningful analysis, learning and drive improvements. A quality assurance programme to continuously review and monitor the quality and safety of care was established through a complete audit cycle. Most audits viewed included a degree of learning and actions required to improve practice however, when the action was implemented there was not always a review to determine effectiveness of such actions.

Judgment:
Compliant

Outcome 03: Information for residents
A guide in respect of the centre is available to residents. Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

Theme:
Governance, Leadership and Management

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

Findings:
Inspectors reviewed the available documentation for matters detailed in Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. Up-to-date, site specific policies and procedures were in place.

Records checked against Schedule 2 in respect of documents to be held in relation to members of staff were adequate. Records to be maintained by the centre, in accordance with Schedule 3, such as a complaints log, records of notifications and a directory of visitors were available.There was a guide to the centre available for residents that included a summary of the services & facilities available, the terms and conditions of residency, the procedure respecting complaints and the arrangements for visits.

The contracts of care reviewed contained details of the care and welfare of the resident and included details of the services to be provided, whether under the Nursing Homes Support Scheme or otherwise, to the resident concerned. The inspectors reviewed a sample of contracts of care in place and noted that written details of the additional service charges levied were clearly outlined in the schedule of information with each contract. However, the contracts did not include the terms relating to the bedroom to be provided to the resident and the number of other occupants (if any) of that bedroom, "after" the terms.

There were suitable resident records in place and these included care plans, care assessments, medical notes, nursing records and also a directory of residents which incorporated the necessary biographical information. Maintenance records for equipment

including hoists and fire-fighting equipment were also available. A plan for responding to emergencies including fire and evacuation procedures was in place. Records and documentation available were securely controlled, maintained in good order and retrievable for monitoring purposes.

Judgment:
Substantially Compliant

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

Theme:
Governance, Leadership and Management

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

Findings:
The person in charge was a registered nurse and has been employed in the centre since 1980. The person in charge was an experienced nurse who was suitably qualified and evidence of her current registration with her regulatory body was in place. For example, the person in charge had clinical and managerial experience as a unit manager for 11 years prior to becoming the person in charge and she has over 30 years experience in the care of the older person. The person in charge managed the centre with authority and accountability; inspectors saw she was present in each unit at different times speaking to residents and staff and was familiar with the residents and their health and social care needs. The person in charge was supported by unit nurse managers on a day to day basis. Inspectors met a senior unit nurse manager who had notified HIQA that she was a person participating in management. This also meant that she was available to replace the person in charge whenever the person in charge was absent from the centre. The person in charge worked full-time and was present in the centre from Monday to Friday. Each morning the person in charge visited each unit and was fully informed of each resident's holistic requirements and demonstrated sound evidence based nursing knowledge and exercised her role, her professional and her regulatory responsibilities to a good standard. Systems were in place for the transmission of learning for example the person in charge attended each morning handover meeting and inspectors observed the person in charge and staff discussed a number of residents health and social care needs and progress.

Judgment:
Compliant

Outcome 05: Documentation to be kept at a designated centre
The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and

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

Theme:
Governance, Leadership and Management

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

Findings:
Copies of both the standards and regulations were maintained on site. Records checked against Schedule 2 in respect of documents to be held in relation to members of staff were adequate. Most of the records to be maintained by the centre, in accordance with Schedule 3, such as a complaints log, records of notifications and a directory of visitors were available however, there were issues in relation to complaints records which were detailed in outcome 13 of this report. In addition, there were issues under Schedules 3 and 4 of the Regulations as there were residents' care plans that were not adequate in relation to end of life care and this finding was detailed under outcome 14 of this report.

Overall suitable resident records and maintenance records for equipment including hoists and fire-fighting equipment were available and a plan for responding to emergencies including fire and evacuation procedures was in place.

Most records and documentation available were securely controlled, maintained in good order and retrievable for monitoring purposes however, inspectors noted that a white board in a rear office located behind one of the nurses stations contained details of some residents on this white board to guide staff in care provision. However, such details were potentially visible to anyone on the corridor and therefore this arrangement could potentially compromised some residents' confidentiality.

Judgment:
Substantially Compliant

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

Theme:
Safe care and support

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

Findings:
Inspectors noted that there was a culture of promoting a restraint free environment. Inspectors noted the positive changes towards a reduction in the use of restraints, such as bedrails which had reduced since the last inspection and the use of alternative measures such as low-low beds, mat and bed alarms had increased. There were clear rationale in residents care plans in relation to the use of bed rails. Inspectors looked at a sample of the decision making tools used when considering the use of restraints. The documentation of alternatives considered or trialled in some risk assessments was clear. Balancing risk with residents choice was evidenced for example following suitable risk assessments; residents and when appropriate their representatives were proactively consulted/involved in relation to such residents continuing to mobilise with the least restrictive supports possible. In conversations with residents, inspectors were told by a number of residents that they felt safe and secure in the centre and relatives also confirmed that they did not have any concerns for the safety of their loved ones.

There was a policy on responsive behaviours (a term used to describe how persons with dementia represent how their actions, words and gestures are a response to something important to them). Staff had been provided with training in the centre on responsive behaviours and were knowledgeable in suitable de-escalating techniques. There was evidence that residents who presented with responsive behaviour were reviewed by their General Practitioner (GP) and referred to other professionals for review and follow up as required. Inspectors saw evidence of positive behavioural strategies and staff spoken to outlined suitable practices to prevent responsive behaviours. Care plans reviewed by inspectors for residents exhibiting responsive behaviours were seen to reflect the positive behavioural strategies proposed including staff using person-centred de-escalation methods.

Inspectors saw that there was positive and respectful interactions between staff and residents and that residents were comfortable in asserting themselves and bringing any issues of concern to the staff, unit managers or to the person in charge. Residents and relatives spoken to articulated clearly that they had full confidence in the staff and expressed their satisfaction in the care being provided. Inspectors reviewed the system in place to manage residents' money and found that overall reasonable measures were in place and implemented to ensure the management of resident's finances were fully safeguarded. Each resident had a safe in their bedroom to store if they wished, small amounts of money and valuables.

Inspectors were satisfied that there were policies and procedures in place for the protection of residents. The person in charge was actively engaged in the operation of the centre on a daily basis. There was evidence of adequate recruitment practices including some verification of references and a good level of visitor activity. Staff had received training on the prevention of elder abuse and all staff spoken too were clear on their role and responsibilities in relation to reporting abuse. Staff were also knowledgeable in recognising the possible signs and symptoms, responding to and

managing abuse. Procedures to protect residents, such as a structured staff induction process and a continuous comprehensive staff development and training were also in place. There were arrangements for the review accidents and incidents within the centre and all residents had received a falls risk assessment completed as part of their care planning process. While there was an adequate policy dated as reviewed in December 2015 in place for the prevention, detection and management of any protection issues however, inspectors noted that the provider had not fully complied with this policy and had not taken all appropriate action in relation to an allegation of abuse. For example a recent alleged theft of money from a resident and a separate allegation of theft from a staff member in the centre had not been reported to the Garda Siochána as per the centre's safeguarding policy.

Judgment:
Non Compliant - Major

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:
The circulation areas, toilets and bathrooms were adequately equipped with handrails and grab-rails. Staff confirmed that personal protective equipment such as latex gloves and plastic aprons were available and the inspectors noted that specially designed cupboards had been installed as a control measure to safely store the latex gloves in each unit. Systems to support staff knowledge and implementation of best practice to ensure good infection prevention and control were in place including regular training. Overall the centre including the communal areas and bedrooms were generally found to be clean and there was adequate standard of general hygiene at the centre. However, there were a number of infection control issues including:
● while there was a cleaning schedule available however, inspectors noted that two cleaning schedules were not up-to-date for example the date recorded on one cleaning schedule was February 2 2017
● there was a large opened container of cream stored in a public bathroom in one unit without any residents' identifying details
● there was a urinal and a bedpan unsuitably stored in the assisted bath
● there were was a large number of bags of rubbish and clutter unsuitably stored in a number of sluice rooms on the first day of the inspection.

Documentation seen indicated that hoists required for moving techniques in resident care were serviced regularly. Care plans contained a current manual handling assessment and plan that referenced the specific equipment required for resident and

staff safety. Manual handling practices observed were seen to be in line with current best practice and the training matrix recorded that all staff were trained in manual handling.

Emergency lighting and fire fighting equipment, directional signage and appropriate fire procedures were available throughout the centre. The internal and external premise and grounds of the centre appeared safe and secure, with appropriate locks installed on all interior and exterior doors. A closed circuit television (CCTV) system was in place that covered some service corridors and external areas and a register of all visitors to the centre was maintained at the main entrance.

Completed logs were maintained on daily, weekly, monthly and quarterly tests and checks of fire equipment, doors, exit routes and emergency lighting. Certification of testing and servicing of extinguishers, fire retardant materials and the alarm system were documented. The building's fire and smoke containment and detection measures were in place however, inspectors noted that one designated fire evacuation exit was partially obstructed by the storage of four laundry trolleys. The person in charge ensured that these trolleys were immediately removed. All staff had received training in fire safety within the past 12 months, and were familiar with what actions to take in the event of a fire alarm activation and with the principles of horizontal evacuation. Practiced fire drills were held, that included simulation of an evacuation to determine the competency of staff to use evacuation equipment such as evacuation sheets. Inspectors viewed records of the practiced fire evacuation drills which identified where improvements to the procedure could be made. All residents had personal emergency egress plans (PEEPs) which identified the level of mobility and evacuation mode of each resident. These plans included the level of cognitive understanding, the need for supervision or the level of compliance of each resident in an emergency situation.

There were appropriate arrangements for investigating and learning from serious incidents/adverse events which identified residents who were at risk of falls and put in place appropriate measures to minimise and manage such risks. The arrangements in place to review accidents and incidents within the centre were adequate for example residents, who had fallen, had falls risk assessments completed after the falls, and care plans were updated accordingly. Suitable governance and supervision systems were in place to monitor residents at risk of falls, wandering or negative interactions including the maintenance of a residents' monitoring record. Such arrangements were reviewed on an on-going basis. There was an up-to-date risk management policy that addressed the identification and assessment of risks and the controls that were in place. However, the risk management policy did not address all the requirements of the regulations. For example, the policy did not adequately address the management of, and the controls in place to mitigate against, self harm and abuse.

The centre had other policies relating to health and safety and the safety statement had been reviewed in March 2016. There was a plan in place for responding to major emergencies likely to cause death, injury, serious disruption to essential services or damage to property. There was a record of incidents and accidents in the centre which recorded slips, trips and falls and records seen were adequate to ensure arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents.

There was a risk register available in the centre however, inspectors found that the hazard identification process was inadequate. On the days of inspection, a number of potential hazards were identified by inspectors that had not been adequately risk assessed including:
● the stair bannisters in the centre required an updated risk assessment
● the enclosed nurses station required a risk assessment
● the risk assessment in relation to the smoking room was not adequate for example in relation to the arrangements for observation of residents' while smoking and the regular emptying of ashtrays in the smoking room
● there was unrestricted access to "O'Gormans Café", which contained a number of potential hazards including a hot water boiler
● the paths in the external enclosed garden had a dark green and blackish film which was slippery and potentially hazardous to residents, particularly residents' with reduced mobility
● there was unrestricted access to a storage room in "Garden Wing unit" that contained cleaning agents and chemicals
● the arrangements for monitoring residents while having their meals required risk assessing for example there were occasions when there were no staff monitoring residents in the ground floor dining room during lunch time on the second day of the inspection.

Judgment:
Non Compliant - Moderate

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

Theme:
Safe care and support

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

Findings:
Inspectors found that there were written operational policies in place in the centre relating to the ordering, prescribing, storage, and administration of medicines to residents. Medicines were supplied to the centre by a retail pharmacy business. Medicines were stored securely in the centre in medication trolleys or within locked storage cupboards. A secure fridge was available to store all medicines and prescribed nutritional supplements that required refrigeration, and temperatures were checked and recorded on a daily basis. Controlled drugs were stored securely within a locked metal cabinet, and balances of all controlled drugs were recorded in the controlled drugs register. Nursing staff checked and documented the balances of all controlled drugs twice daily at the change of shift. Nursing staff were familiar with the procedure for disposing of unused or out of date medicines. Nursing staff were observed administering

medicines to residents and the administration practice was in line with current professional guidance. Medication audits were conducted in the centre and covered some aspects of medication management practices such as; storage, labelling, administration records, controlled medicines and temperature controls on medicine refrigeration.

Judgment:
Compliant

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

Theme:
Effective care and support

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

Findings:
Inspectors was satisfied that each resident's wellbeing and welfare was maintained by an adequate standard of evidence-based nursing care and appropriate medical and allied healthcare. At the time of inspection there were 94 residents living in the centre and staff had assessed the level of residents' dependence in their activities of daily living as follows; 15 low, 21 medium, 19 high and 39 maximum dependency. This equated to the majority (62%) of residents as being assessed as high to maximum dependency level. Inspectors observed staff in the delivery of care to residents, interacted with staff and reviewed records including medical records, nursing records, correspondence from other healthcare facilities and clinical audits. The centre had a care planning system in place and most resident's assessed needs were set out in residents' care plans. Assessments and care plans were reviewed four-monthly or more frequently as required. A daily nursing record of each resident's health, condition and treatment given was maintained and these records seen were adequate and informative. Each resident's vital signs were recorded regularly with action taken in response to any variations. Systems were in place for the assessment, planning, implementation and review of healthcare needs. This included nursing assessments, care plans and clinical risk assessments. Based on a random sample of care plans reviewed; overall inspectors were satisfied that the care plans generally reflected the resident's assessed needs, assessment was supported by a number of evidenced-based assessment tools and plans of care to meet most identified needs. However, there were a number of improvements required in relation to the care planning including:
● some of the care plans did not have adequate details of the nursing care to guide practice for example in two care plans of residents' requiring end of life care did not

have an end of life care plan
● there was an inadequate assessment of residents' social care needs
● some care plans contained unsuitable language for example the term ''patient'' was extensively used for residents that were not actively unwell and many staff spoken to also described residents as ''patients''
● the reviews of care plans although regular did not always consider the effectiveness of the interventions to manage and/or treat the identified need
● not all plans of care were written in a person centred and holistic manner
● not all risk assessments, care plans and nursing progress notes were not fully linked to give an overall picture of residents' current condition.

There was evidence that timely and appropriate access to medical review and treatment was provided and was supported by the medical records seen by inspectors. There was documentary evidence of adequate access to other health professionals including speech and language therapy, dietetics, tissue viability, optical review and chiropody. On the inspection inspectors observed that a number of residents required transferral to and from the centre. Suitable referral and discharge records and records of the information provided when a resident was temporarily transferred or discharged from the centre were maintained.

There were measures identified in falls prevention care plans and evidence of falls being monitored in the centre. There were reassessments of falls risks and the updating of the falls prevention care plans by staff after each fall. Falls were reviewed individually to identify any possible antecedents or changes as appropriate. Inspectors were satisfied that all staff spoken with were familiar with each resident's needs and care plans and overall few deficits were identified between planned and delivered care. Residents and their representatives to whom inspectors spoke were very complementary of the care, compassion and consideration afforded to them by staff in the centre.

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:
Cahercalla Community Hospital and Hospice was divided into 5 floors/units in two

buildings which were joined together and provided residential, respite and hospice care which according to the centres' statement of purpose was supported by Milford Care Centre, Limerick. The centre was registered to accommodate 109 residents and on the days of inspection there were 94 residents living in the centre. The premise was originally opened as a hospital in 1951 and while there had been significant extensions and renovations since then however, the overall the design and layout of the premises was largely reflective of a hospital from this period.
There were extensions added over the years and most recently in 2008. A major refurbishment of the premises was undertaken by the provider and completed in 2013.The refurbishment was completed to a high standard and substantially addressed the issue of multi-occupancy bedrooms but did not however, address the lack of sufficient communal, dining and recreational space identified at the time of the very first HIQA inspection of the centre in May 2010.

The centre was bright, clean, warm and well ventilated and since the last inspection there had continued to be on-going redecorating in the centre however, as identified on previous inspections the design and layout of the premise was not adequate to meet the individual and collective needs of residents on a daily basis. There were a number of improvements required in relation to the premise including:
● there was inadequate sitting, recreational and dining space other than a resident's private accommodation
● there was unsuitable storage in the centre with wheelchairs and hoists for example stored in corridors and cleaning and laundry trolleys stored in sluice rooms
● some wooden door frames were chipped
● some walls and doors were in need of re-painting
● the premise retained a hospital appearance and considerable improvements were required to make the centre more homely
● the garden on the ground floor had a secured enclosed perimeter however, it was inadequate and uninviting as there were only seating for four residents and no planting or areas of interest provided.

Resident accommodation was provided in 60 single bedrooms and 24 twin bedrooms. There was only one remaining three bed multi-occupancy room on the "Garden Wing First Floor unit". The bedroom was convenient to the nurse's station, was spacious, bright and contained a large bay window. The person in charge informed inspectors that there were two vacancies currently in this bed room and that one of these beds in particular was usually "kept as the last bed to be filled". However, this bedroom was not adequate to meet the needs of three residents due to the design and layout of the bedroom. For example one bed was unsuitably positioned against the bedroom wall with the back of this bed facing away from the bedroom door. Due to the position of the bed the overhead bedroom light was unsuitable located and inaccessible to the resident. The residents' locker was inaccessible as it was located at the foot of the bed as there was no space for it to be located adjacent to the residents' bed and there was inadequate room for the residents' chair to be located near this residents' bed.

There were two lifts were provided between floors and there were regular service records viewed in relation to these lifts. There was some signage in the centre that had text and some pictures to help residents to identify for example "wards" and "nurses stations" and some communal rooms and to support wayfinding. However, in the

context of the dependency of residents and the confusing design and layout of the premise as a result of a number of premise extensions over the years; improvements were required in relation to providing adequate visual cues and signage to support residents in navigating the various areas within the centre.

There was a functioning call bell system in place and call bells were seen to be accessible from each resident's bed and in each room used by residents. Inspectors observed that call bells were answered in a timely manner. However, inspectors also noted that there was an intercom system that could be heard throughout the centre and was used for example to communicate with staff and call staff to the phone at reception as well as make announcements. Inspectors requested that the provider review this intercom arrangement as it sounded quite loud and potentially was intrusive particularly for some residents with high needs.

Maintenance work was on-going throughout the centre. Many of the bedrooms viewed by inspectors were personalised with photos, pictures and other personal items. There was appropriate equipment provided to meet the needs of residents, hoists were maintained and used as required. There was a chapel available in the centre that was well maintained and was well used by residents, their visitors and members of the community on a regular basis.

The catering facility was monitored by the relevant Environmental Health Officer and inspection reports and records of actions taken by the provider in response to them were available for inspection.

Judgment:
Non Compliant - Major

Outcome 13: Complaints procedures
The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:
Person-centred care and support

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

Findings:
Policies and procedures which comply with legislative requirements were in place for the management of complaints and this included an appeals process. Staff spoken with were familiar with the procedure for receiving and recording complaints. Residents were aware of the process which was displayed at the main entrance to the centre. On review of the record of complaints there was evidence that complaints were documented, investigated and outcomes recorded. Complainants were notified of the outcome of their complaint however, the records did not always show whether they were satisfied.

Reviews to ascertain the satisfaction of the complainant, further to issues being resolved, were not carried out for all complaints.

Judgment:
Substantially Compliant

Outcome 16: Residents' Rights, Dignity and Consultation
Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

Theme:
Person-centred care and support

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

Findings:
There was evidence that residents were consulted with and participated in the organisation of the centre. Overall, residents' rights, privacy and dignity were respected, during personal care, when delivered in their own bedroom or in bathrooms. Moreover, residents had the right to receive visitors in private and there were no restrictions to visiting in the centre and inspectors observed several visitors throughout the two day inspection. Residents right to choice, and control over their daily life, was facilitated in terms of times of rising /returning to bed and whether they wished to stay in their room or spend time with others in the communal rooms.

Evidence that residents and relatives were involved and included in decisions about the life of the centre was viewed. Regular meetings were held where residents were consulted through the residents' forum which had been launched in June 2012 with the aim to facilitate and improve the quality of life and care in the centre. It was set up to ensure that residents' actively participate in decision making, to provide and receive feedback and influence policy and procedures of the centre. The provider representative, the person in charge and the activities coordinator met every month to review any issues raised at the forums and there was evidence of changes having been made as a result of these meetings. For example there had been an issue about the noise levels on one unit at meal times and alternative arrangements were put in place to reduce this noise. Inspectors noted that the residents' forum was facilitated by the activities coordinator and the forum met regularly to also discuss issues such as future activities or outings. Feedback and suggestions were recorded with an action plan and timeframes. A programme of varied internal activities and external trips was in place for residents. Information on the day's events and activities was prominently displayed in the centre. A team of three activities coordinators delivered the programme which included both group and one to one activities. Inspectors were told that one to one time

was scheduled for residents with more severe dementia or cognitive impairment or who would not participate in the group activities and that this time was used for sensory stimulation such as providing hand massages. Other dementia relevant activities were included in the programme. Inspectors were told that residents spiritual needs were met through daily rosary and Mass was celebrated in the centre's chapel. Inspectors were informed that any other religious denominations were catered for as necessary. Outside of religious ceremonies, the chapel was available as a quiet space for residents to pray and reflect. However, as has been identified under outcome 12 premises due to the limited/unsuitable communal space; the facilities for occupation and recreation were not adequate.

Closed circuit television cameras (CCTV) were in operation at a number of locations including the reception area and on corridors and there was policy in place dated March 2016 governing the use of CCTV cameras. There was signage indicating there were CCTV cameras in the centre.

A resident satisfaction survey had been completed in December 2016 and was complementary about the care and support provided in the centre. There was evidence of residents participation in their care plan development and reviews. Residents had access to a number of informative documents including copies of the HIQA standards, copies of REACH (HIQA newsletter for residents in residential care), there were details of a national advocacy agency available and copies of the local community/parish newsletter were also available. All those spoken too praised the staff for the cheerful and respectful manner in which they delivered care. However, as identified under outcome 11 some care plans contained unsuitable language in relation to residents for example the term "patient" was extensively used for residents that were not actively unwell and many staff spoken to also described residents as "patients".

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:

The person in charge informed inspectors that copies of the regulations and HIQA standards had been made available to all staff and from a review of minutes of staff meetings inspectors noted that a number of issues such as care standards, HIQA inspections and notifications were discussed with staff. Staffing included at least one staff nurse was on duty in each of the five units within the centre, at all times. From speaking to residents, staff and the person in charge and a review of the staff rota; inspectors was satisfied that there were sufficient staff with the right skills, qualifications and experience to meet the assessed needs of residents. 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 and actual and planned rosters were in place. There was a unit manager who was a person who participated in the management as well as the person in charge and both were on duty during the two days of inspection. The unit manager supported the person in charge in her duties and replaced her for any planned absences. The provider representative was also a qualified nurse and staff confirmed that she had occasionally worked both on day and night shifts alongside staff in order to support and supervise staff in the delivery of care. The provider representative informed inspectors that she was also available for staff to contact her outside of hours, if required.

Staff confirmed to the inspectors that they had been facilitated in accessing continuing professional education by the provider representative and records reviewed showed that staff had been provided with good opportunities to receive updated training in a number of areas including: safeguarding, moving and handling, fire safety, first aid, dementia care and food hygiene, pressure ulcer prevention, assessment and care planning. Inspectors reviewed samples of attendance records which were also suitably maintained.

Good recruitment processes were in place including a Garda vetting process. Inspectors noted that all care staff received an induction of three 11 hour shifts; working supernumerary and shadowing another staff member using a "buddy system", to ensure that the new member of staff was able to become familiar with residents, their needs , the policies and procedures and acquire suitable mandatory training such as fire safety and manual handling training. There was a system for annual staff appraisal's which the provider representative stated was being reviewed. The inspector reviewed a sample of staff files which included the information required under Schedule 2 of the regulations. All nursing staff were on the live register with Bord Altranais agus Cnáimhseachais na hÉireann, or Nursing and Midwifery Board of Ireland and many of the support staff had completed the Further Education and Training Awards Council (FETAC) level five qualifications.

The person in charge confirmed that there were currently five volunteers attending the centre and that all had been suitably supported and monitored, including ensuring that volunteers were clear in relation to their roles and responsibilities while in the centre. Appropriate and respectful interactions were observed throughout the day between residents and staff.

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:

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Regulation Directorate
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Regulation Directorate

Action Plan

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

Provider's response to inspection report[1]

Centre name:	Cahercalla Community Hospital
Centre ID:	OSV-0000444
Date of inspection:	27/02/2017
Date of response:	04/04/2017

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 03: Information for residents

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
To ensure the agreement referred to in regulation 24 (1) relates to the care and welfare of the resident in the designated centre and includes details of the services to be provided, whether under the Nursing Homes Support Scheme or otherwise, to the resident concerned including the terms relating to the bedroom to be provided to the resident and the number of other occupants (if any) of that bedroom, "after" the terms.

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

1. Action Required:
Under Regulation 24(2)(a) you are required to: Ensure the agreement referred to in regulation 24 (1) relates to the care and welfare of the resident in the designated centre and includes details of the services to be provided, whether under the Nursing Homes Support Scheme or otherwise, to the resident concerned.

Please state the actions you have taken or are planning to take:
The contract of care has now been amended to include the terms relating to the bedroom to be provided to the resident and the number of other occupants (if any) of that bedroom.

Proposed Timescale: 20/03/2017

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:
To maintain the records specified in Schedule 2, 3 and 4 in such manner as to be safe and accessible and maintains residents" confidentiality.

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:
This was addressed immediately during the inspection. Resident care information is no longer visible in this nurses station or in any of the other nurses' stations.

Proposed Timescale: 27/02/2017

Outcome 07: Safeguarding and Safety

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
To take all reasonable measures to protect residents from abuse including complying fully with the centres' prevention detection and response to elder abuse policy dated 02/12/2015.

3. Action Required:
Under Regulation 08(1) you are required to: Take all reasonable measures to protect residents from abuse.

Please state the actions you have taken or are planning to take:
Each resident has their own personal safe for their own personal use and are advised both on admission and on an ongoing basis not to keep large sums of money on their person.
We conducted full and thorough investigations into both incidents at the time of their occurrences but these investigations did not lead to any conclusions.
All of our staff attended safeguarding training subsequent to these incidents and in addition to this we have a protective disclosure/whistleblowing policy which supports staff with raising concerns.
We have now contacted the local Garda station and they are going to provide a safety awareness session on the hospital premises on 11th. April 2017.

Proposed Timescale: 11/04/2017

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:
To ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.

4. Action Required:
Under Regulation 26(1)(a) you are required to: Ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.

Please state the actions you have taken or are planning to take:
Policy CO-008 was updated and circulated in March 2016. This is due for review in March 2018. It describes the risk management procedure which includes hazard identification and assessment.

The additional hazards identified during the inspection have now been addressed. The risk register has now been updated to incorporate the risks identified during the inspection.

Proposed Timescale: 20/03/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
To ensure that the risk management policy set out in Schedule 5 includes the measures

and actions in place to control abuse.

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

Please state the actions you have taken or are planning to take:
The hospital policy CS-030 is up-to-date. Risk management education takes place in March every year as part of the continuous education programme. This is currently underway with all staff. All risks are reviewed monthly at the Quality and Safety meetings.
All staff have attended up-to-date safeguarding education and are aware of the relevant policies CS-030, HR-009 and CS-047.
The risk register has been updated and risk of theft has been upgraded to High Risk.

Proposed Timescale: 20/03/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
To ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control self-harm.

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

Please state the actions you have taken or are planning to take:
This is complete, in addition to the centres policy for self-harm; the measures and actions to be taken to control same have been added to the risk register.

Proposed Timescale: 27/02/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
To ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.

7. Action Required:
Under Regulation 27 you are required to: Ensure that procedures, consistent with the

standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.

Please state the actions you have taken or are planning to take:
The container of cream, the clean urinal and the clean bedpan which were found in the assisted bathroom were removed immediately on the morning of the inspection and all staff have been reminded to store items appropriately.

The provider nominee immediately budgeted for extra hours for the hospitality department for the weekends in order to ensure that there is no build up of waste in the sluice rooms on a Monday morning. This is now being monitored and it can be reported that this action has addressed this issue. The sluice rooms continue to have their waste bags collected daily and the floors subsequently cleaned. Clinical staff have been reminded to keep the sluice rooms clean and tidy.

Cleaning schedules are up-to-date.

Proposed Timescale: 27/02/2017

Outcome 11: Health and Social Care Needs

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
To arrange to meet the needs of each resident when these have been assessed in accordance with Regulation 5(2) including the following:
● some of the care plans did not have adequate details of the nursing care to guide practice for example in two care plans of residents' requiring end of life care did not have an end of life care plan
● there was an inadequate assessment of residents' social care needs
● some care plans contained unsuitable language for example the term patient was extensively used for residents that were not actively unwell
● the reviews of care plans although regular did not always consider the effectiveness of the interventions to manage and/or treat the need
● not all plans of care were written in a person centred and holistic manner
● not all risk assessments, care plans and nursing progress notes were not fully linked to give an overall picture of residents' current condition.
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8. Action Required:
Under Regulation 05(1) you are required to: Arrange to meet the needs of each resident when these have been assessed in accordance with Regulation 5(2).

Please state the actions you have taken or are planning to take:
Prior to the Inspection a new post for Practice Development (with a specific 6 month remit for enhancing the care plans) had been advertised internally on the 23rd.

February 2017. This person will work with the clinical staff on enhancing the documentation so that person centredness is fully captured and so that all assessments link together in order to ensure the effectiveness of care interventions. This will augment the current system whereby all care plans are peer audited and four monthly reviews clearly documented. This four monthly review document gives a clear updated snapshot of the residents current needs. In addition to this the management team will continue to meet with the activities co-ordinator monthly in order to continue to review each residents social needs and their subsequent care plan. We will continue to review the care plans with our residents and/or their representatives. In January 2017, life story work commenced and many of the residents have comprehensive life story books alongside their clinical care plans. These books tell us a lot about the resident and their likes and dislikes, their hobbies and interests and the things that are important to them. The end of life care plans reviewed during the course of the inspection were hospice residents admitted on the Friday before the inspection and their care plans were in progress and were completed in time for their end of life wishes to be addressed. A post death evaluation is completed for all residents in order for the team to reflect on their death and ensure that their wishes were met. We look forward to enhancing the documentation further and ensuring a comprehensive, holistic guide for all or our residents care.

Proposed Timescale: 30/11/2017

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:
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.

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

Please state the actions you have taken or are planning to take:
There are five dining rooms available to the residents in Cahercalla. In addition to this the café is often used by residents when they wish to eat with their visitors. There is a family room available in the garden wing and this has a dining table, sofa beds and fully equipped kitchenette. The activities are scheduled to take place throughout the hospital and the residents attend these on wards other than their own. Hence rather than residents only having access to one day room they have access to five and they move around accordingly and as they so wish. The inspector was presented with architectural plans for a large sun room/dining room which will be built out onto the courtyard area thus enhancing the outdoor and indoor recreational facilities. Plans to progress this immediately have now commenced.

The two chipped door frames identified during the inspection have now been painted. Regular painting of walls and doors and upkeep is part of the weekly maintenance schedule and going forward we plan to introduce more use of colour and visual orientations to enhance the way finding within the centre.
A significant investment took place in 2016 in relation to making the centre more "homely". The residents and staff assisted with the redecoration of the dining rooms and bedrooms were reduced in order to maximise the recreational space. We plan to continue with re-decorating the centre in a homely way.

Prior to the inspection the management team had commenced work on stock and storage management and aim to have this project complete by the end of the second quarter. This should improve storage facilities.

A review of the only three bedded room is underway in order to ensure that each resident has equal access to lighting, lockers and TV.

The intercom system has been reviewed and a trial of only announcing urgent/emergency messages is now underway.

Proposed Timescale: 31/03/2018

Outcome 13: Complaints procedures

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
To ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.

10. Action Required:
Under Regulation 34(1)(f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.

Please state the actions you have taken or are planning to take:
The complaints management team had recently begun to trend and track complaints and to ascertain whether or not the complainant was satisfied or not. This will continue. The complaints procedure is displayed throughout the hospital and it outlines the appeals procedure in the event that a complainant is not happy. All complaints are investigated fully in line with the hospital complaints policy.

Proposed Timescale: 20/03/2017

Outcome 16: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
To make staff aware of the matters referred to in Regulation 9(1) as respects each resident in a designated centre including suitably referring to residents in all correspondents including residents' care plans and any communications.

11. Action Required:
Under Regulation 09(4) you are required to: Make staff aware of the matters referred to in Regulation 9(1) as respects each resident in a designated centre.

Please state the actions you have taken or are planning to take:
Due to the nature of the services provided which includes Hospice residents the use of the word "patient" has been used for residential residents. All staff have now been asked to refer to all service users as "Residents".

Proposed Timescale: 28/02/2017

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
To provide for residents facilities for occupation and recreation.

12. Action Required:
Under Regulation 09(2)(a) you are required to: Provide for residents facilities for occupation and recreation.

Please state the actions you have taken or are planning to take:
The activities are provided by a dedicated and trained team. Cahercalla also has a number of volunteers. Activities are scheduled to take place throughout the hospital and the residents often attend on wards other than their own. For example exercises might be on one ward and SONAS on another and residents choose the activity they wish to attend. Daily mass as part of the parish masses takes place every morning and is well attended by the community and the residents. Residents who are unable to attend the mass have the option of watching it in their own bedrooms on their TVs. Hence rather than residents only having access to one day room they have access to five and they move around accordingly. A family room and a café are also available for the residents to meet with visitors. The inspector was presented with architectural plans for a sun room which will be built out onto the courtyard area thus enhancing the outdoor and indoor recreational facilities. Plans to progress this immediately have now commenced.

Proposed Timescale: 31/03/2017