Health Information and Quality Authority
Regulation Directorate

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

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>St Joseph's Community Hospital</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>ORG-0000625</td>
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<tr>
<td>Centre address:</td>
<td>Stranorlar, Donegal.</td>
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<tr>
<td>Telephone number:</td>
<td>074 913 1038</td>
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<tr>
<td>Email address:</td>
<td><a href="mailto:kieran.doherty@hse.ie">kieran.doherty@hse.ie</a></td>
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<tr>
<td>Type of centre:</td>
<td>The Health Service Executive</td>
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<tr>
<td>Registered provider:</td>
<td>Health Service Executive</td>
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<tr>
<td>Provider Nominee:</td>
<td>Kieran Woods</td>
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<tr>
<td>Person in charge:</td>
<td>Kathleen Doherty</td>
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<tr>
<td>Lead inspector:</td>
<td>Geraldine Jolley</td>
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<td>Support inspector(s):</td>
<td>Mary McCann</td>
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<td>Type of inspection:</td>
<td>Unannounced</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>61</td>
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<td>Number of vacancies on the date of inspection:</td>
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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.
This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor compliance with specific outcomes as part of a thematic inspection. This monitoring inspection was un-announced and took place over 1 day(s).

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

<table>
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<th>From:</th>
<th>To:</th>
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<tr>
<td>20 May 2014 08:00</td>
<td>20 May 2014 15:30</td>
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The table below sets out the outcomes that were inspected against on this inspection.

| Outcome 04: Records and documentation to be kept at a designated centre |
| Outcome 11: Health and Social Care Needs |
| Outcome 14: End of Life Care |
| Outcome 15: Food and Nutrition |

**Summary of findings from this inspection**

This inspection report sets out the findings of a thematic inspection which focused on two specific outcomes, End of Life Care and Food and Nutrition. In preparation for thematic inspections providers and persons in charge had the opportunity to attend an information seminar and had completed self-assessments that indicated compliance in relation to both outcomes. The inspector reviewed the policies relevant to the two outcomes and analyzed surveys which relatives submitted to the Authority. During the inspection the inspectors talked to residents, visitors and staff. The delivery of care and the service of two meals, breakfast and the midday lunch were observed. Documents such as care plans and training records were reviewed to determine compliance with the two outcomes.

This was the eighth inspection of the centre. The inspectors found during the last inspection conducted in September 2013 and this inspection that the provider and staff had worked hard to meet compliance requirements across the service particularly where improvements to the physical facilities were required. The centre is divided into three units - Barnes View where residents admitted for long term care are accommodated, Finn View where residents are admitted for respite care, rehabilitation or convalescence and Woodville- which is a designated dementia care unit and accommodates residents who need ongoing care or who are admitted for assessment or respite care.

Residents expressed satisfaction with the care they experienced in St. Joseph’s and were positive about how staff consulted with them in relation to their personal care, menus, food preferences and their ongoing and future care needs. Residents described the food as “lovely, plenty of choice and always well presented”, “there is
a good variety” and one resident said “I am not a big eater and I can ask for what I like if I don’t want a full meal”. They also said the catering staff and carers knew their preferences and ensured that they received the meals they liked. There were systems in place to ensure that particular dietary needs were accommodated and where factors such weight changes were evident these were identified and monitored. However, the inspectors noted that improvements were required to record keeping as care plan evaluations did not always summarize responses to treatment or describe residents' current conditions. Records of nutrition required improvement as it was not possible to determine residents' food or liquid intake exactly which compromised the monitoring arrangements and measures put in place to safeguarded residents’ health.

Care at end of life and establishing residents’ wishes in respect of their care at this time were both a high priority for staff and overall was addressed to a satisfactory standard. Staff conveyed very positive views on end-of-life care and the factors that contributed to quality care and comfort at this time. Staff could describe a range of care initiatives that they had in place to ensure residents’ comfort and well being. This included having good working relationships with the local palliative care team, providing hospitality for relatives and friends, being vigilant and monitoring closely changes in health and ensuring that relatives were informed and included in decisions. Their comments reflected that care was delivered in a holistic way that included meeting spiritual care needs, providing empathy, personal contact and knowledge of resident’s wishes.

There were systems in place to assess, manage and monitor risks which in the context of the outcomes examined included the assessment and management of residents with low weights and unintentional weight loss, swallowing problems, pressure area risks and respiratory problems. The person in charge and provider were ensuring that staff had appropriate training in nutrition management and end-of-life care and there was an ongoing training schedule in place. The inspectors noted that staff were appropriately supervised and that there was discussion on day to day issues relevant to residents at hand-overs and at other times during the day. There was evidence of ongoing quality improvements to the service and facilities and there was an audit programme in place. Residents were consulted and the outcome of audits was made available to residents and displayed on notice boards.

Overall the inspectors found that staff were working towards full compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland in relation to both outcomes. There were some non-compliances identified in relation to the policy that outlined end-of-life care procedures, some residents with end of life care needs did not have a coordinated care plan in place although there were extensive arrangements being made for their ongoing care including plans for transfers home. The periodic care plan reviews did not provide adequate summaries of the care and treatment provided or current health status and some nutrition records needed improvements to ensure that the information recorded enabled anyone inspecting the record to determine if the diet was satisfactory as required by legislation.
Section 41(1)(c) of the Health Act 2007 Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.

Outcome 04: Records and documentation to be kept at a designated centre
The records listed in Part 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) 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 2009 (as amended).

Theme:
Leadership, Governance and Management

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

Findings:
The records related to food and nutrition did not provide a complete overview of the diet provided and consumed by residents which made it difficult to determine in all cases if the dietary intake was appropriate to their needs and in accordance with treatment plans.

Judgement:
Non Compliant - Minor

Outcome 11: Health and Social Care Needs
Each residents wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each residents 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:
Some action(s) required from the previous inspection were not satisfactorily implemented.
**Findings:**
There were significant improvements noted in the standard of care planning from the last inspection with assessments linked to care plans and meaningful personal information recorded to enable staff to provide individualised care. However, there were improvements required in record keeping and care planning related to food and nutrition. Overall, the inspectors concluded that the menus and arrangements around meal times met the needs of residents but that records did not reflect the good practices in place, did not provide appropriate information to ensure staff were fully informed on residents' nutritional intake, and care plan evaluations did not summarise progress and current health status. This is discussed under outcome 15 - Food and Nutrition.

**Judgement:**
Non Compliant - Minor

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**Outcome 14: End of Life Care**
*Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.*

**Theme:**
Person-centred care and support

**Outstanding requirement(s) from previous inspection:**
Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**
An action plan following an inspection of the service required that care plans include end of life care and that resuscitation status should be reviewed regularly and the findings of this inspection indicate that this had been partially addressed but that improvements continued to be required.

There was good emphasis placed on treating people with dignity and respect and the inspectors saw that this ethos was relevant for all staff. Contacts with residents were noted to be respectful, timely and helpful. Residents who were frail and were spending long periods resting were visited by staff regularly, were talked to about their comfort needs and had call bells readily accessible.

The assessments, care practices and facilities in place to support residents to receive care at end of life described by staff and evidenced in records examined indicated that residents’ comfort and well being was a high priority. The inspectors reviewed a sample of care plans to determine if residents had the opportunity to discuss their end-of-life care, how this was documented and if care plans were adequate to guide care and reflected residents' wishes. Care plans were found to provide some details to guide staff at end of life however some residents who had palliative care needs did not have an end-of-life care plan. In general medical views, discussions with residents and relatives and decisions made were recorded in medical and daily nursing records however in
some instances there were no care plans that reflected the extensive arrangements being made to coordinate a transfer home in accordance with a resident’s wishes or the medical, nursing and allied health professional decisions that were made in the interests of resident’s well being and requirements for follow up care. The planned move was an excellent example of respecting a resident’s wishes to return home and of good multidisciplinary practice between the centre and community staff. However the information available in care plans did not reflect the arrangements being put in place or discussed. The care plan did not identify if the resident was aware of their condition which was essential information for staff providing care. There was evidence that care plans were reviewed every three months and when care needs changed. Residents confirmed to an inspector that staff talked to them about their long-term care and said that family members were also included in these discussions.

Residents were provided with a choice as to the place of death, including the option of a single room. Residents in shared rooms are offered a single room where possible. The small number of single rooms available and the multiple occupancy layout of the majority of accommodation provided means that this option is not always available. Family and friends were facilitated to be with residents when they were dying. Refreshments and meals were provided as required but the centre does not have overnight facilities.

There were six completed questionnaires returned by relatives and acknowledgements sent by relatives to the centre that the inspector read conveyed that the support provided to family and friends was highly valued at this time. Relatives said that it enabled them to spend additional time with loved ones that would not have been possible without the support and hospitality offered by staff. They also said that staff had kept them up to date on their relatives changing condition and all expressed appreciation for the care and attention provided to their loved one prior to and at the time of death. Comments indicated that family were usually present during the duration of the end of life period. The feedback indicated that the provision of a single room was a high priority for end of life care. Family members indicated that this offered a level of privacy and enhanced the time spent with their loved ones that could not be achieved in the multiple occupancy rooms.

The centre had access to the local palliative care service. Regular consultation and visits by the team take place according to residents’ needs. Advice is also provided to staff by telephone. The inspector viewed records that indicated that referrals were made in a timely manner and that staff worked collaboratively to ensure good outcomes for residents. There was a staff training programme in place and seven nursing staff had received training on end-of-life care throughout 2012, 2013 and 2014. Five nurses had attended the End of Life/ Final Journeys training and two had advanced qualifications in palliative care. Staff could describe the priorities for care practice at this time such as ensuring residents’ comfort, pain management, facilitating family and friends to be with the resident and if family members cannot be with them ensuring that staff can be there so that they are not alone and ensuring medical assistance is sought when needed.

The inspectors were informed that 48 residents had died in the last two years. 44 had died in the designated centre, 3 in the acute hospital and one had died at home. There had been 75 transfers due to acute care precipitated by problems such as falls (6),
respiratory infections (6) and the remainder were due to other acute medical needs including cardiac or vascular problems.

The end-of-life policy that guided practice was being reviewed. The current policy included relevant information such as:
- care and privacy prior to and after death
- procedures including the verification of death, last offices, the care of personal possessions
The inspectors identified that the procedure would benefit from the inclusion of additional information such as indicators for referral to the palliative care team and the process for completing care plans and establishing residents wishes to provide more effective guidance for staff.

Staff were alert to the impact on residents of the deaths of relatives and fellow residents. One resident told the inspector that care and nursing staff let them know when other residents died and gave them time to talk about their feelings which helped them come to terms with their loss. Residents said they valued the staff that supported them at such times.

There was a large church within the centre which was used for Mass, prayer and quiet reflection. The religious and spiritual convictions of residents were known to staff including where residents had more secular beliefs or non-religious lifestyles and these were recorded to inform staff actions at end of life. Clergy from all denominations were welcomed to support residents and enable them follow their beliefs. Residents including residents admitted for respite care told an inspector that they found comfort from their relationships with friends, family and from the support staff provided.

The inspectors reviewed the staff rotas and the deployment of staff. There were adequate numbers of care, nursing and ancillary staff available during the day. All units had two nurses on duty throughout the day. A review of staffing levels including skill mix was due to commence the inspectors were told. This was being undertaken by an external consultant.

**Judgement:**
Non Compliant - Minor

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**Outcome 15: Food and Nutrition**

*Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.*

**Theme:**
Person-centred care and support

**Outstanding requirement(s) from previous inspection:**
Some action(s) required from the previous inspection were not satisfactorily implemented.
Findings:
The inspectors found that there were appropriate arrangements in place to ensure that residents had a varied and nutritious diet. There were policies in place to guide practice and these included:

- the assessment of nutrition status and the referral to allied health professionals if required
- the organisation of care plan to ensure appropriate nutrition and hydration
- communication of information regarding resident’s diet and nutrition and
- the maintenance of weight records

Validated nutrition assessment tools were used to identify residents at potential risk of malnutrition or dehydration on admission and were reviewed at three month intervals or if residents’ care needs changed.

Residents and their visitors told inspectors that there was a good variety of food served and that choices were available at each meal. The inspectors saw the service of two meals, breakfast and the mid day meal. There was a planned menu and all food was cooked on the premises. The inspector reviewed the menu and discussed options available to residents. There were snack options available between meals to ensure adequate calorie intake particularly for residents on fortified diets and residents who had restless behaviours associated with their dementia care needs. Residents confirmed that they could have tea, coffee or snacks whenever they wished including during the night. Drinks, including water, juices and soft drinks were readily available and the inspectors saw care staff offer residents drinks regularly throughout the day. Meals were well spaced with breakfast served from 8 am, midday meals from 12.30, tea between 4.30 and 5 pm and supper from 7.30 to 8 pm.

There was dining space on each unit. In Barnes View and Woodville units the dining areas had been refurbished over the last year and provided attractive spaces for residents to have their meals. The dining space in Woodville, the dementia care unit was noted to be bright, spacious and contained items of memorabilia associated with kitchen/dining rooms such as a side board, old crockery and a tea caddy to prompt residents’ memory. Menus were displayed and care staff asked residents what they would like and reminded them of their choices. The inspectors noted that residents were assisted in a manner that protected their dignity. Staff allowed residents to move around when restless, reminded them of the food they were eating and ensured the atmosphere remained calm and enabled residents to finish their meals. Staff described changes that they were considering might benefit the service of meals such as ensuring the serving trolley and associated equipment were not on view and having a focal point in the garden area outside the ding room window to prompt conversation with residents. Residents’ food preferences were recorded and meals in all units were served in accordance with their choices and dietary restrictions. The inspector noted that care staff asked residents what cereals and drinks they would like for breakfast and said “we always ask even if they choose the same thing every day as they may change their minds and it is expected that we give choice where possible”.

Food including food that was pureed was attractively presented and reflected the menu of the day. The instructions for foods and liquids that had to have a particular consistency to address swallowing problems were outlined in care plans and available to catering and care staff. Staff interviewed could describe the different textures of food
and liquids that had to be given to residents with specific requirements.

There was regular monitoring of residents vital signs including weight checks. Where residents were identified as losing or gaining weight they were referred to the dietician or the speech and language therapist as appropriate. A record of the assessments and instructions for staff were available. Nurses could make direct referrals for consultation to these services and there were no access problems reported. The inspectors noted from an examination of records that changes in weight did not always alert staff to monitor residents more closely. For example a care record described a weight loss of 3 kilogrammes in a month and while a dietetic review had been requested the inspectors were concerned that this had not been addressed soon after admission as there was information in the record of a cumulative weight loss of 10 kilogrammes over the past year.

There were some good examples of nutrition care plans reflecting residents needs and the actions staff had in place to ensure appropriate hydration and nutrition however there were some that did not provide instructions that were specific enough to ensure nutrition was adequate. Aspects of nutrition management that required attention were outlined in the action plan generated from the inspection undertaken in April 2013 and improvements were noted during the inspection conducted in September 2013. This inspection however some areas continued to require attention. For example one record described the need “to maintain adequate intake and prevent weight loss” however there were no measures outlined to guide staff on how this was to be achieved. Records of food served also required improvement as some of the records examined did not indicate portion size, the addition of liquids or how much was consumed. The periodic care plan evaluations described the monitoring systems in place but did not provide an overview of residents’ progress over time and in the case of residents who required nutritional supplements did not convey if the treatment plan was proving effective. Suitable equipment was available to weigh residents.

There were six notifications that described pressure area problems during 2014. Four of these were present on admission and two arose in the centre due to vascular problems. All wounds were documented clearly and treatment plans had been effective in resolving or improving wounds. An inspector reviewed the medication prescriptions for some of these residents and noted that supplements were being administered as prescribed.

Overall the inspectors concluded that the menus and arrangements around meal times met the needs of residents but that records did not reflect the good practices in place, did not provide appropriate information to ensure staff were fully informed on residents nutritional intake and evaluations did not summarise progress and current conditions.

Judgement:  
Non Compliant - Moderate
Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings, which highlighted both good practice and where improvements were required.

Acknowledgements

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

Report Compiled by:

Geraldine Jolley
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider’s response to inspection report

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<td>Date of inspection:</td>
<td>20/05/2014</td>
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<tr>
<td>Date of response:</td>
<td>23/06/2014</td>
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Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure Compliance with Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.

Outcome 04: Records and documentation to be kept at a designated centre

Theme:
Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The records of nutritional intake did not adequately outline the diet provided and consumed in sufficient detail to enable any person inspecting the record to determine whether the diet is satisfactory, in relation to nutrition or otherwise as required in schedule 4 records.

Action Required:
Under Regulation 22 (1) (i) you are required to: Maintain the records listed under Schedule 3 (records in relation to residents) and Schedule 4 (general records) in a manner so to ensure completeness, accuracy and ease of retrieval.

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

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
The Community Dietician has provided education and training to 30 staff members and will continue to do so until all staff have been trained and will include emphasis on food / nutrition records/charts and the updating of nutritional care plans as outlined in Schedule 3 and Schedule 4, Regulation 22 (1) (I).

The Community Dietician will continue to record nutrition updates once residents have been reviewed by her to record progress and to ensure that records are clear and communicated in writing to staff and progress reports on review patients recorded.

All staff will be reminded at handover times and meetings that a food record chart is being completed on a certain resident and that it must be recorded accurately. In relation to recording progress staff will comment on weight checks rather than just recording that a weekly/monthly weight has been taken. If residents are on a supplement due to weight loss staff will comment on weekly/monthly weights if the supplement has had a positive result.

There was a gap identified in the dietetic service to St Josephs from January to March 2014 which resulted in reviews not taking place as required. This would have led to nutrition updates not being recorded especially where improvements were seen. This was addressed by the Director of Nursing with the Community Dietician Manager and Service Manager for Older People and the service has now been restored. Urgent referrals will in future be prioritised by dietetic services.

**Proposed Timescale:** 30/09/2014

**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:**
The care plan evaluations described the monitoring systems in place to meet residents needs but did not provide a summary of residents care and progress and did not reflect changing needs and conditions.

**Action Required:**
Under Regulation 8 (2) (b) you are required to: Keep each residents care plan under formal review as required by the residents changing needs or circumstances and no less frequent than at 3-monthly intervals.

**Please state the actions you have taken or are planning to take:**
All nursing staff will continue to receive training in care planning with particular emphasis on evaluations which will include a summary of residents care and progress to meet their changing needs and conditions as outlined in Regulation 8 (2) (B)

19 nursing staff to date have had one to one training in care planning and the remaining 9 will be completed by the end of September.
**Proposed Timescale:** 30/09/2014

**Outcome 14: End of Life Care**

**Theme:**

Person-centred care and support

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

The centre's design and layout includes several multiple occupancy bedrooms and single rooms and overnight facilities cannot always be provided.

**Action Required:**

Under Regulation 14 (2) (c) you are required to: Facilitate each resident's family and friends to be with them when they are dying and provide overnight facilities for their use.

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

The facilities currently provided for relatives include recliner chairs, kitchen facilities for availing of snacks and beverages, a shower room and a separate visitors room.

**Proposed Timescale:** 23/06/2014

**Theme:**

Person-centred care and support

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

Care plans did not reflect end of life care wishes or the arrangements in place or being made to meet residents needs and wishes.

The policy and procedure to guide staff when providing end of life care needed review to include areas such as the process for compiling care plans, indicators for referral to the palliative care service and the procedures for planning transfers home if that is the resident's wish.

**Action Required:**

Under Regulation 14 (1) you are required to: Put in place written operational policies and protocols for end of life care.

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

Care planning training will continue to be given to all nursing staff with particular emphasis put on reflecting end of life care wishes to meet the needs of residents by the development and implementation of a checklist which will be attached to the end of life care policy to guide nursing staff in their practice.

The end of life care policy will be reviewed to guide nursing staff when providing end
of life care to include the process for compiling care plans, indicators for referral to palliative care services and the procedure for planning transfer home if the resident so wishes and in order to meet Regulation 14 (1)

19 staff have had one to one training in care planning and the remaining 8 will receive training before 30th September 2014.

Proposed Timescale: 30/09/2014

Outcome 15: Food and Nutrition

Theme: Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some of the records in use to monitor nutrition particularly the nutrition records did not provide adequate information on residents nutritional care to inform practice. The policy and guidelines for nutrition management required review to ensure staff had appropriate guidance to ensure monitoring records were appropriately maintained.

Action Required:
Under Regulation 20 (7) you are required to: Implement a comprehensive policy and guidelines for the monitoring and documentation of residents nutritional intake.

Please state the actions you have taken or are planning to take:
The policy on Nutrition will be reviewed to provide guidelines for the monitoring and documentation of residents nutritional intake and to ensure that the records used to monitor nutrition will provide adequate information on residents nutritional care and to guide practice.

Proposed Timescale: 30/09/2014