

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Dunboyne Nursing Home
Centre ID:	OSV-0000185
Centre address:	Waynestown, Summerhill Road, Dunboyne, Meath.
Telephone number:	01 825 5232
Email address:	dunboyne@arbourcaregroup.com
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Dunboyne Nursing Home Limited
Provider Nominee:	Donal O'Gallagher
Lead inspector:	Sonia McCague
Support inspector(s):	Leanne Crowe
Type of inspection	Announced
Number of residents on the date of inspection:	51
Number of vacancies on the date of inspection:	10

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 Quality Standards for Residential Care Settings for Older People in Ireland.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor compliance with specific outcomes as part of a thematic inspection. This monitoring inspection was announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 16 November 2016 09:00 To: 16 November 2016 19:30

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

Outcome	Our Judgment
Outcome 01: Statement of Purpose	Compliant
Outcome 02: Governance and Management	Compliant
Outcome 03: Information for residents	Compliant
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Substantially Compliant
Outcome 06: Absence of the Person in charge	Compliant
Outcome 07: Safeguarding and Safety	Substantially Compliant
Outcome 08: Health and Safety and Risk Management	Substantially Compliant
Outcome 09: Medication Management	Non Compliant - Moderate
Outcome 10: Notification of Incidents	Compliant
Outcome 11: Health and Social Care Needs	Non Compliant - Moderate
Outcome 12: Safe and Suitable Premises	Compliant
Outcome 13: Complaints procedures	Compliant
Outcome 14: End of Life Care	Compliant
Outcome 15: Food and Nutrition	Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Substantially Compliant
Outcome 17: Residents' clothing and personal property and possessions	Compliant
Outcome 18: Suitable Staffing	Compliant

Summary of findings from this inspection

This report sets out the findings of a one day inspection, the purpose of which was to inform a decision for the renewal of the centre's registration.

During the course of the inspection, the inspectors met with residents, relatives and staff, the person in charge and the provider nominee. The views of residents, relatives and staff were listened to, practices were observed and documentation was reviewed. Surveys completed by residents and/or their relatives or representatives

were also reviewed.

Overall, the inspectors found that care was delivered by trained staff who knew the residents well and who discharged their duties in a respectful and dignified way.

The management and staff in the centre were striving to improve the quality of the service and the outcomes for residents. Residents appeared well cared for and expressed satisfaction with the care they received and confirmed that they felt safe and had a choice in their daily routine. Residents spoke positively about the staff who cared for them.

Reasonable systems and appropriate measures were in place to manage and govern this centre. The provider nominee, person in charge and staff team responsible for the governance, operational management and administration of services and resources demonstrated sufficient knowledge and an ability to meet regulatory requirements.

Actions required following the last inspection in February 2016 were followed up. The storage of records had been addressed and while the role of the activity co-ordinator had been reviewed following the previous inspection it was subject to a further review following this inspection.

Compliance or substantial compliance with the Regulations was found in 15 of the 18 outcomes inspected with improvements required in outcomes related to assessments, care planning, clinical decision making procedures, recording practices, medicine management and a review of policies.

The findings are discussed throughout the report and actions required are outlined in the action plan at the end of this report.

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

Outcome 01: Statement of Purpose

There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The updated statement of purpose was available that detailed the aims, objectives and ethos of the centre, outlined the facilities and services provided for residents and contained information in relation to the matters listed in schedule 1 of the Regulations.

The provider understood that it was necessary to keep the document under review and notify the Chief Inspector in writing before changes could be made which would affect the purpose and function of the centre.

Judgment:

Compliant

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):

No actions were required from the previous inspection.

Findings:

There were sufficient resources in place to ensure the effective delivery of care as described in the statement of purpose.

The inspectors found that there was a clearly defined management structure that identifies the lines of authority and accountability, specifies roles and details responsibilities for the areas of care provision. This was outlined in the statement of purpose and staff were familiar with their duty to report to line management.

Management had governance systems in place to capture statistical information in order to compile reports and an annual review of the quality and safety of care delivered to residents. For example audits were carried out and analysed in relation to accidents, complaints, medication management and skin care outcomes.

Residents and relatives were familiar with management arrangements. Interviews of residents and relatives during the inspection and satisfaction surveys from resident and relatives were in the main positive in respect of the facilities and provision of services and care provided. Some areas highlighted for improvement such as activities and supervision of moving and handling practices were communicated to the provider nominee and person in charge for follow up, as the practices observed on this inspection were safe and appropriate.

There was evidence of consultation with residents and or their representatives in a range of areas, for example, care planning and review process, involvement in social and recreational activities and meals provided.

An annual review of the quality and safety of care delivered to residents for 2015 was completed that informed the service plan being implemented in 2016.

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:

A Residents' Guide was available in the centre. The guide had recently been updated and contained all of the information required by the Regulations.

Each resident had a written contract that was agreed on admission. Inspectors reviewed a sample of contracts and found that they dealt with the care and welfare of the residents while in the centre, outlined the services to be provided and the fees to be charged to the resident.

Judgment:

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:

There was a change in the person in charge of the centre since the last inspection. A satisfactory fit person interview was completed with inspectors prior to this inspection and following the notification regarding this change.

Inspectors were satisfied that the centre was being managed by a suitably qualified and experienced nurse who has authority and is accountable and responsible for the provision of the service.

She is a registered general nurse, has the necessary qualifications and experience of working with older persons in excess of three years and works full time.

During the inspection she demonstrated that she had knowledge of the Regulations and Standards pertaining to the care and welfare of residents in the centre. She is supported in her role by a deputy nurse manager, along with nursing, care, administration, maintenance, kitchen and housekeeping staff, who report directly to her and she in turn to the provider nominee.

The person in charge and the staff team including the provider nominee, as representative of the registered provider, facilitated the inspection process by providing documents and information. They had good knowledge of residents' care and conditions. Staff confirmed that good communications exist within the staff team and relatives and residents highlighted the positive interactions and support provided by the staff team.

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):

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

Findings:

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 were completed, held in the centre and readily available to inspectors. While written operational policies for the centre were in place, policies on end of life, medication management, behaviours that challenge and use of restraint required review to ensure they were accurate and reflected current practice. These findings are referenced across other outcomes and included in this action plan.

Records in respect of each resident were maintained as described by the Regulations, and were retained for the required amount of time. Some improvement in records was required as outlined in outcome 7 and 11.

Inspectors reviewed a sample of staff files, and these were found to contain all of the information as required by Schedule 2 of the Regulations.

The centre was adequately insured against accidents or injury to residents, staff and visitors.

The directory of residents was maintained and contained of all the required information.

An action identified on the last inspection, relating to the secure storage of records, had been completed to ensure all records were appropriately stored.

Judgment:

Substantially Compliant

Outcome 06: Absence of the Person in charge

The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The provider and person in charge demonstrated they were aware of the responsibility to notify the Chief Inspector of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during her absence.

The deputising nurse manager appointed since the previous inspection is a nurse with a minimum of 3 years experience in the area of nursing older persons in the previous 6 years and has experience of delivering care to older people and deputising when the person in charge was on leave for short periods.

Judgment:

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:

Measures were in place to protect residents from being harmed or suffering abuse. There was a current policy which provided guidance for staff on the various types of abuse, assessment, reporting and investigation of incidences. It also included how to report and manage incidents of elder abuse.

The person in charge clearly demonstrated her knowledge of the designated centre's policy and was aware of the necessary referrals to external agencies, including the Health Service Executive (HSE).

Staff confirmed and training records indicated that staff had attended training on the prevention, detection and response to abuse. Staff who spoke with an inspector were knowledgeable about the various types of abuse, recognising abuse, and were familiar with the reporting structures in place. There were systems in place to ensure that allegations of abuse were investigated, and that pending such investigations measures were in place to ensure the safety of residents.

Great emphasis was placed on residents' safety and inspectors saw that a number of measures had been taken to ensure that residents felt safe while at the same time had opportunities for maintaining independence and fulfilment. For example there was a

keypad lock on cleaning and treatment rooms and on both entrance/exit doors. All other communal areas were accessible to residents. Inspectors saw that there were facilities in place to assist residents to retain their independence and mobility for example hand rails were fitted on corridors and circulating areas and call bell facilities in their rooms.

During interviews with an inspector residents confirmed that they felt safe in the centre due to the measures taken such as a locked door entrance and staff presence day and night. Those who completed questionnaires also confirmed that they were safe and relatives were satisfied that residents were protected from harm and were safe in the designated centre.

Systems and arrangements were in place for safeguarding resident's finances and property.

A restraint policy dated November 2014 approved by the previous person in charge was available. However, based on inspector observations, discussions with staff and a review of records available, a review of the policy, records and practices was required. Improvements are also reported in the action plans of outcomes 5 and 11.

The restraint policy in place referenced the European Convention on Human Rights (ECHR) and national policy 'working towards a restraint free environment', however, it required some improvement to clearly define restraint and outline the types of restraint used in the centre to guide the use, assessments, review and practices in accordance with the referenced material. All steps including a detailed record from an assessment detailing all those involved in the decision or review of risk, considerations of least restrictive measures or alternatives available or trialled such as sensor alarms seen available and in use in the centre, the duration of restraint and safety checks or releases were not clearly outlined in the policy to guide practice.

An aim to promote a restraint free environment in line with the national policy was described. A report outlined the use of bedrails by 45% of residents (23 of the 51), many of which were described as enablers. However, on enquiry an inspector confirmed residents were unable to easily remove the bedrail device and some were unable to use it to enable them to alter their position in bed. The management and staff team acknowledged the need to review the restraint policy and procedures and said they were undertaking regular reviews of bedrail use as seen in some resident's records and in the register maintained.

Risk assessments of restraint and enabler use and rationale forms had been completed in the sample of resident files reviewed. However, records of decisions regarding the use of bedrails did not consistently show the decision was in accordance with the resident's wish or made in consultation with the resident's named representative and or General Practitioner (GP). While decisions were recorded and made by nursing staff with reference to family and GP awareness, a record of all parties in the decisions following assessment had not been documented or been reviewed at a minimum of on a four monthly basis. For example, bedrails were in use for one resident despite the resident's expressed view not to have bedrails. This is included in the action plan of outcome 16. Records demonstrating consent and or a collaborative approach to decisions made on behalf of residents required improvement. In addition, the content of the information

contained in the existing risk assessments and care plan required review and improvement to include a full assessment, record of all involved, duration and safety checks required during application. This is referenced in outcome 11. A full review of the policy, practices and recording templates was required.

A policy entitled behaviours that challenge dated July 2014 approved by a previous staff member was available. While the policy was informative and there were other supporting documents available such as 20 tips, an observation sheet and ABC chart, they were not linked, included or sufficiently referenced within the policy to guide practice. Inspectors were informed that this policy was under review and a revised policy was due to be implemented in practice. The requirement to improve this policy is highlighted in the action plan of outcome 5.

Because of their medical conditions, some residents showed behavioural and psychological signs of dementia (BPSD). Residents were provided with support and distraction techniques that promoted a positive approach to behaviour that challenges. Good support from the community psychiatry team was reported and seen in the records reviewed. Staff spoken with were familiar with appropriate interventions to use to respond to residents behaviour that may challenge. An inspector was informed that behaviour logs formed part of the nursing assessment and care plan process and changes in behaviour were analysed for possible trends and inform reviews by the GP or psychiatric team. During the inspection staff approached residents in a sensitive and appropriate manner and the residents responded positively to the techniques used by staff. Chemical restraint was rarely used and the use of PRN (as required) medicines, including resident's or 'self' requests, to alter mood was recorded to include the rationale and effect and was subject to review by nurses and the GP.

Judgment:
Substantially Compliant

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

Theme:
Safe care and support

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

Findings:
The centre had policies and procedures in place to ensure that the health and safety of residents, visitors and staff was promoted and protected. Some improvements were required to ensure that staff were adequately trained in responding to an unexplained absence by a resident.

There was a comprehensive risk management policy in place which assessed all

identified risks, and outlined the measures and actions in place to mitigate and control such risks. An up-to-date health and safety statement was also made available to inspectors.

There was a policy in place for responding to major incidents likely to cause death or injury, serious disruption to essential services or damage to property. Arrangements were in place for preventing accidents, and for investigating and learning from serious incidents or adverse events within the centre.

Suitable fire equipment and systems was provided throughout the centre, and documentation reviewed by inspectors evidenced services were completed at appropriate intervals. The provider confirmed that all bedding and furnishings used in the centre were fire safe.

Fire exits were unobstructed and there was a proper means of escape for residents, staff and visitors. Fire evacuation procedures were displayed at various points throughout the centre. A designated staff member was responsible for ensuring that fire exits were clear on a daily basis, and these checks were documented. However, the documentation did not evidence that these checks were completed in the staff member's absence. A number of fire drills had been completed this year, with any learning clearly outlined in fire drill records.

Judgment:
Substantially Compliant

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:
There were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents. Audits and monitoring of practices was described. Learning from incidents and reported errors had brought about changes in the administration and recording procedures and policies to protect residents.

The processes in place for the handling and checking of controlled drugs were examined and procedures described were in accordance with current guidelines and legislation.

Nursing staff were observed as they administered medications. Residents were unhurried and reminded of the purpose of the medicines administered. However, recording practices required improvement in line with the centre's policy as omissions of

a nurse's signature for administration of high risk medicines were found in the sample of medicine administration records reviewed. In addition, a high risk medicine had not been written up in the prescription chart in line with the recent changes made in the policy and a faxed prescription was being used by staff. The inspector also observed that one resident administered medication at 13:00hrs that was prescribed for 17:00hrs.

Systems were in place for ordering, supply and dispensing methods. There were appropriate procedures for the delivery and collection by the pharmacy, and checking, storage, return and disposal of medicines by nurses.

A system was in place for a regular prescription review by the resident's general practitioner (GP).

Judgment:

Non Compliant - Moderate

Outcome 10: Notification of Incidents

A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector. The person in charge was aware of the legal requirement to notify the Chief Inspector regarding accidents and incidents.

A quarterly report was submitted to HIQA to notify of any of the required information set out in Schedule 4 of the Regulations.

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:

There were processes in place to ensure that when residents were admitted, transferred or discharged to and from the centre, relevant and appropriate information about their care and treatment was available and maintained, and shared between providers and services.

Residents could retain the services of their own general practitioner (GP) and they had timely access to community and acute medical services. They had access to allied healthcare professionals including occupational therapy, dietetic, speech and language, ophthalmology and podiatry services. The centre also had access to psychiatry of old age and palliative care services.

There were arrangements in place to meet the health and nursing needs of residents.

A selection of care records and plans were reviewed. There was evidence of a pre-assessment undertaken prior to admission for residents. There was a documented assessment of all activities of daily living, including communication, personal hygiene, continence, eating and drinking, mobility, spirituality and sleep. There was evidence of a range of assessment tools being used to monitor areas such as the risk of falls, malnutrition and skin integrity.

The assessment, development and review of care plans were carried out by a key worker in consultation with residents or their representatives. Each resident's care plan was subject to a formal review; however, some had not been carried out within four-monthly intervals.

Care and welfare assessments and decisions needed to be considered from a multi/interdisciplinary perspective and subject to a formal review no less frequently than at four-monthly intervals, as referenced in outcomes 7 and 14.

While a range of care plans identifying residents' abilities and needs were maintained, some improvement was required to ensure a comprehensive assessment was completed detailing how decisions were made, the rationale, who was involved and the date of the decision prior to an advanced care plan directive or decision such as not for resuscitation status was decided in a care plan.

As referenced in outcome 14 regarding end of life, decisions 'Not for cardio pulmonary resuscitation' were seen recorded in resident's care plan but were not recorded in the resident's medical notes by the GP in accordance with the centre's policy. A record to demonstrate the resident and or representative or relevant healthcare professional responsible for the resident's treatment and care was involved in decisions regarding life limiting or sustaining treatment was not maintained in practice or in line with the centre's policy dated March 2016.

As outlined in outcome 7 in relation to the use of restraint, improvement was required in this regard also. For example, in the case of a resident who had been prescribed bedrails by nursing staff due to a risk of falling, their falls history was not analysed to inform the continued decision to use bedrails. While fall risk assessments showed an increase in the risk of falling, an assessment, diary or record of the number of times the resident fell was not available. The resident told the inspector they would prefer not to have bedrails and could summon staff to help by using the call bell when they required assistance.

All identified problems or needs such as sleep disturbance and titration of medication needed to be supported by a care plan.

An inspector reviewed the management of clinical issues such as wound care and falls management and found the promotion of healing was well managed with some improvement in the recording of care plans needed. In the sample of care plans and wound records reviewed there was evidence of referral and assessment in the centre by a tissue viability specialist. However, while the recommended interventions were recorded in the nurse's daily narrative note on the day of the assessment, a care plan had not been put in place for each wound to ensure an appropriate and consistent management of each wound site was maintained to enable an evaluation of the recommended interventions. The inspector was told that a subsequent change in recommended dressings was made following a hospital assessment. However, due to the absence of a specific care plan changes in interventions and information regarding changes in care were not readily available.

Mobility and daily exercises were encouraged with weekly fitness classes incorporated into the physiotherapy schedule. Residents had suitable mobility aids and modified chairs following seating assessments by an occupational therapist and or the physiotherapist. Hand rails on corridors and grab rails of contrasting colour to the wall were seen in toilet and bathroom facilities used by residents which promoted independence.

Weight management is discussed in more detail under outcome 15.

Residents were seen enjoying various activities during the inspection. Each resident's likes and preferences were assessed and in some files reviewed relevant information was reflected in a social and recreational care plan and used to plan the individual's daily activity programme.

A dedicated activity staff member co-ordinated a weekly activity programme that was delivered by him and the staff team. An inspector saw that residents were encouraged to participate in group activities and many of the activities such as the weekly exercises, music, singing and ball games were particularly suitable or tailored for the resident group. A variety of activities were seen being provided to both small and large groups of residents. The inspector was told that opportunity for a small group and one to one hand massage activity was available. Weekly religious ceremonies/mass, bingo, games, films, reading, pet therapy and music sessions formed part of the activity programme. Overall, residents had opportunities to participate in activities that were meaningful and purposeful to them which suited their needs, interests and capacities during the day.

Inspectors were told that outings to the zoo, botanic gardens and local castle were facilitated earlier in the year.

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):

No actions were required from the previous inspection.

Findings:

The premises takes account of the residents' needs and was in line with Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

This purpose built centre consisted of 47 single occupancy bedrooms and seven twin bedrooms on the ground floor with office and guest accommodation on the first floor.

Inspectors found the premises to be designed and laid out to meet the needs of the existing residents, and all parts of the building and grounds were accessible for residents using wheelchairs or mobility aids.

The building was sufficiently heated and ventilated with plenty of natural and artificial light. The centre was kept in a good state of repair and upkeep, with full time maintenance staff.

The centre was appropriately painted and decorated, with residents' artwork and photos from events and outings displayed on the walls. Residents highlighted the homely nature of the centre.

Forty seven of the bedrooms (20 single and seven twin) had full en suite facilities (toilet, wash hand basin and shower facilities) which were spacious and could comfortably accommodate modern day equipment such as hoists and specialised seating. The remaining seven single rooms had an en suite facility with a wash hand basin and toilet facility. Communal wheelchair accessible independent bathrooms were also available to residents. They were fitted with emergency alarm systems and hand and grab rails of contrasting colour to the wall colour.

Inspectors saw that the residents' bedrooms in use were well proportioned and suitably decorated, with adequate space for storage of personal belongings, including lockable storage for valuables. Residents were encouraged to bring in their own personal mementos and furnishings which some availed of.

There were two dining rooms. Both dining rooms were sufficiently spacious and comfortable. Adequate space was available for residents who required extra time and staff assistance at mealtimes to enjoy their meals at their own pace.

There was an adequate number of large and medium size sitting rooms, day rooms for activities, and quiet space in which residents could receive visitors. On the first floor there were staff offices and a guest room with a shower and sofa bed for visitors who wished to stay overnight.

The centre had an oratory centrally located with easy access to an entry and exit area with ample car parking spaces. A variety of services were held including memorial services.

Additional services included a sensory relaxation room, on-site hairdressing salon, other therapy rooms and a well ventilated indoor smoking room. Kitchen and laundry facilities were onsite, and the kitchen was open for resident's requests throughout the night.

The centre had suitable equipment to assist residents, with adequate storage space for same. Medication storage rooms, cleaner's stores and sluicing facilities were secured and kept in good order.

The premises were safe and secure, with an internal courtyard and garden, and electronic external door locks that did not overly restrict residents' movement. Close-circuit television (CCTV) was present externally that monitored the perimeter.

All bedrooms, bathrooms and communal areas were fitted with a call bell system and large LED displays on corridors clearly identified the location of a call.

There was adequate car parking in the grounds and the external gardens and outdoor features were available to residents, weather permitting.

Judgment:

Compliant

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:

There was a policy and procedure in place for the management of complaints. A summary of the complaints procedure was also clearly displayed at various points within the centre.

There was a person nominated to deal with complaints, as well as a person nominated to ensure that complaints were appropriately recorded and responded to. A person responsible for managing appeals was also appointed. A complaints log was maintained in the centre, and this was made available to inspectors on the day of the inspection. The log was found to include the details of the investigation into the complaint, the outcome of the complaint and whether the complainant was satisfied with the outcome of the complaint.

All complaints were found to be resolved promptly. A complaints audit was completed with every 12 weeks.

Judgment:

Compliant

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(s):

No actions were required from the previous inspection.

Findings:

A policy and operational procedures for end of life were in place and available to guide staff and inform care practices implemented. The policy required a review by staff to ensure it reflected that care plan reviews of decisions were undertaken at least four monthly and not at six monthly intervals as stated in the policy. This requirements is included in the action plan of outcome 5.

At the time of inspection inspectors were informed that one resident was approaching end of life. Staff told an inspector they provided end of life care to residents with the support of their medical practitioner and the community palliative care services, if required.

The assessment of each resident's views and wishes for the end of life formed part of the admission and care planning process. For some residents information regarding decisions in relation to acute treatment and hospitalisation was recorded. A care plan to include details and information known by staff regarding preferred religious, spiritual

and cultural practices was noted in some of the records reviewed. Residents expressed wish for future care at the end of life was noted in some of the files reviewed. Some assessment and care plan improvements that were required are outlined in outcome 11.

Single rooms were available for end of life care and staff told inspectors that relatives were accommodated to stay when residents were very ill or approaching end of life.

An oratory facility was available in the centre with suitable equipment and necessary religious artefacts available to improve the level of respect shown to the deceased.

Judgment:

Compliant

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(s):

No actions were required from the previous inspection.

Findings:

Systems were in place to ascertain each resident's food preferences on admission and to facilitate residents to provide feedback on the menu options and choices, to inform improvements.

Mealtimes observed were unhurried social occasions that provided opportunities for residents to interact with each other and staff. Staff were seen in both dining rooms assisting and supporting residents appropriately, in a discrete and respectful manner. Staff preparing, serving and assisting with meals and drinks were familiar with residents dietary requirements, needs and preference. Staff offered choices and sought resident satisfaction levels during meals provided.

Systems were in place to ascertain residents' views and preferences from a varied menu on a daily basis.

There was a policy in place to guide practice and clinical assessment in relation to monitoring and recording of weights, nutritional intake and risk of malnutrition. Staff were knowledgeable and described practices and communication systems in place to monitor residents that included regular weight monitoring, recommended food and fluid consistency and arrangements for intake recording.

Communication systems were in place to ensure that residents nutritional and care needs were available to and known by staff supporting residents to eat and drink and to those preparing and serving food. A list of residents and their specific dietary needs was

maintained in the kitchen and the kitchen staff demonstrated a good knowledge of these needs.

Access to dietician and speech and language therapists was available and provided on a referral basis based on an assessment of need or change in resident condition. Residents were provided with food and drink at times and in quantities adequate for their needs. The food was properly served and presented in an appetising way.

Menus showed a variety of choices at mealtimes and there was a menu on each table.

There were sufficient staff on duty during this inspection to offer assistance to residents in a discreet and sensitive manner. There was an emphasis on residents' maintaining their own independence and appropriate equipment was provided to support this. Residents confirmed their satisfaction with mealtimes and food provided.

Staff told an inspector snacks and beverage were available to residents at intervals between main meals and the kitchen staff confirmed this saying access to the main kitchen was unrestricted and available for staff to prepare snacks at all times including at night.

Judgment:
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 had opportunities to participate in their daily routine and in the organisation of the centre. A resident's committee was facilitated by staff for residents to meet on a regular basis. Residents' family members and their involvement was promoted. A record of communication with family was seen in some of the resident files reviewed.

Access to and information in relation to the complaints process and independent advocacy services was available to residents. Residents' independence and autonomy was promoted. However some improvement was required in decisions made that

conflicted with the resident's expressed view, as referenced in outcome 7.

Practices observed demonstrated residents were offered choices. Residents who spoke with an inspector and those who completed questionnaires said they were able to make choices about how they spent their day, when and where they ate meals, rise from and return to bed. Residents knew who to complain to and had options to meet visitors in a private or in communal areas based on their assessed needs.

Communication boards, daily news papers and telephone arrangements were available. A communal laptop and free WiFi was reportedly available to all residents. The provision and use of 'skype' was to be explored by the person in charge as some residents had family living abroad.

An inspector established from speaking with residents and staff that opportunities to maintain personal relationships with family and friends in the wider community was encouraged. Arrangements were provided for residents to attend family occasions and opportunities to socialise and link with the wider community by arranged outings and visits by members from the local community was facilitated.

There was a policy on residents' access to visitors and communication. Visitors were unrestricted except in circumstances such as an outbreak of infection. A register of visitors was maintained at both entry points. Residents could receive visitors in private or in communal rooms.

An inspector saw that residents' privacy and dignity was respected and personal care was provided in private. Residents were seen to be well groomed and dressed in an appropriate manner with clothes and personal effects of their choosing.

Judgment:

Substantially Compliant

***Outcome 17: Residents' clothing and personal property and possessions
Adequate space is provided for residents' personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.***

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

There was adequate space provided for residents' personal possessions, property and mobility aids. Residents had a lockable facility within their bedrooms. A record of property on admission was maintained. This was to be subject to review and updating at suitable intervals.

There were arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.

Judgment:
Compliant

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):

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

Findings:

There were appropriate staff numbers and skill mix on duty to meet the assessed needs of residents. There were enough staff for the size and layout of the designated centre. During the previous inspection, the activity co-ordinator was found to be carrying out alternative work. While this was acknowledged as not being normal practice by the provider, during this inspection the activity co-ordinator was observed to be taking dinner orders from residents. The tasks completed by the activity co-ordinator were under review to ensure that the role is dedicated to providing social and recreational activities to residents.

Inspectors reviewed actual and planned staff rosters, which were found to reflect the number of staff on duty on the day of the inspection.

There was a recruitment policy in place which ensured that staff were selected and vetted in accordance with best recruitment practice. The staff member responsible for collating staff files confirmed to inspectors that Garda vetting was in place for all staff, which was evidenced by the relevant documentation. Inspectors reviewed a sample of staff files, and found that they contained all of the information required by Schedule 2 of the Regulations, including professional registration for nursing staff.

A comprehensive training programme was in place, which supported staff to provide care that reflected up-to-date, evidence-based practice. Training records indicated that all staff had completed mandatory training in fire safety, moving and handling practices and the prevention, detection and response to abuse.

An induction programme was in place in the centre, which included training and supervision. Staff were supervised appropriate to their role, and staff appraisals were conducted annually with any training needs identified.

The person in charge held meetings with the various levels of staff on a frequent basis, and the minutes of these meetings were reviewed by inspectors.

There were no volunteers currently operating in this centre.

Staff were seen to be kind and friendly towards residents, and being respectful towards their privacy and dignity.

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:

Sonia McCague
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	Dunboyne Nursing Home
Centre ID:	OSV-0000185
Date of inspection:	16/11/2016
Date of response:	14/12/2016

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 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:

Some written operational policies required review to ensure they were accurate and reflected current practice within the centre that included the following:

1. End of Life

End of life decisions not for cardio pulmonary resuscitation were seen recorded in resident's care plan but were not recorded in the resident's medical notes by the GP in

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

accordance with the centre's policy.

The policy required a review by staff to ensure it reflected that care plan reviews of decisions were undertaken at least four monthly and not at six monthly intervals as stated in the policy.

2. Use of restraint

The restraint policy in place referenced the European Convention on Human Rights (ECHR) and national policy 'working towards a restraint free environment', however, it required some improvement to clearly define restraint and outline the types of restraint used in the centre to guide their use, assessments, review and practices in accordance with the referenced material. As outlined in outcome 7 and 11.

3. Behaviours that challenge

A policy entitled behaviours that challenge dated July 2014 approved by a previous staff member was available. While the policy was informative and there were other supporting documents available such as 20 tips, an observation sheet and ABC chart, they were not linked, included or sufficiently referenced within the policy to guide practice. Therefore, this policy required review.

4. Medication management

Recording practices were not implemented in practice in line with the centre's policy.

1. Action Required:

Under Regulation 04(3) you are required to: Review the policies and procedures referred to in regulation 4(1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.

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

1. We will ensure that all decisions regarding end of life are clearly communicated to the residents GP and request that they are noted on the medical notes for the residents. 20/1/2017

The End of Life Policy was fully reviewed on 8/3/2016 and will be reviewed again by 28/2/2017

2. The Restraint Policy review will be conducted by 31/1/2017. This review will include the change in description and treatment of bed rail use which are currently identified as enablers.

3. The Behaviours that challenge policy review will be completed by 28/2/2017.

4. The recording practices of the medication management policy have been re-iterated to all RGN's and an immediate improvement was noted. 31/12 /2016

Proposed Timescale: 31/12/2016, 31/1/2017 & 28/2/2017

Proposed Timescale: 28/02/2017

Theme:

Governance, Leadership and Management

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

Gaps were evident in some of the records reviewed.

Records of decisions regarding the use of bedrails did not consistently show the decision was in accordance with the resident's wish or made in consultation with the resident's named representative and or General Practitioner (GP).

A record of/by all parties responsible for decisions had not been documented.

The record of information available in the existing restraint risk assessments and care plan required review and improvement to include a full assessment, record of all involved, duration and safety checks required during application.

2. Action Required:

Under Regulation 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

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

All care plans are reviewed every 3 months. Each upcoming review will ensure the recording of decisions are updated and a record of who contributed to the decision making process documented. This will be completed by 31/3/2017.

1. The planned Restraint Policy review will be conducted by 31/1/2017. This review will include the change in description and treatment of bed rail use which are currently identified as enablers.

Proposed Timescale: 31/03/2017

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:

Records demonstrating consent and or a collaborative approach to decisions made on behalf of residents required improvement.

The content of the information contained in the existing risk assessments and care plan required review and improvement to include a full assessment, record of all involved, duration and safety checks required during application or use of restraint.

A full review of the existing policy, practices and recording templates was required.

3. Action Required:

Under Regulation 07(3) you are required to: Ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.

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

1. The restraint policy will be reviewed by 31/1/2017. This review will include the change in description and treatment of bed rail use which are currently identified as enablers.

Proposed Timescale: 31/01/2017

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:

Improvements were required to ensure that all staff were knowledgeable of how to respond to an unexplained absence of a resident.

4. Action Required:

Under Regulation 26(1)(c)(ii) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the unexplained absence of any resident.

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

A fully compliant policy on the Management of a Missing Resident is in place. This will be retrained to all staff members.

Proposed Timescale: 31/01/2017

Theme:

Safe care and support

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

While there was adequate means of escape in the centre, documentation of fire exits checks indicated that these were not completed when the designated person was not rostered to work in the centre.

5. Action Required:

Under Regulation 28(1)(b) you are required to: Provide adequate means of escape, including emergency lighting.

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

Checks on all fire exits are now conducted over seven days per week.

Proposed Timescale: 30/11/2016

Outcome 09: Medication Management

Theme:

Safe care and support

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

Recording practices required improvement in line with the centre's policy as omissions of a nurse's signature for administration of high risk medicines were found in the sample of medicine administration records reviewed.

A high risk medicine had not been written up in the prescription chart in line with the recent changes made in the policy or administered on one occasion as outlined in the prescribed dose available in a faxed prescription being used by staff.

The inspector also observed that one resident administered medication at 13:00hrs that was prescribed for 17:00hrs.

6. Action Required:

Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.

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

Our Medication Management Policy requires that the administration of high risk medications requires 2 signatures: a nurse's signature and that of a competent person. This has been re-iterated to all RGN's with positive actions noted already.

Warfarin was one of the high risk drug identified and the residents Warfarin Book which was signed by a Doctor in the Warfarin clinic was in place, in addition to the faxed prescription issued to cover the administration of any changes for the period while we await the return of the Warfarin Book. We will ensure that the second required signature is present.

The residents requested to take the medication noted at 08.00 and 13.00 and this was agreed by the pharmacist. The Kardex has now been altered to reflect the choice of the resident.

Proposed Timescale: 31/12/2016

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:

Bedrails were in use for one resident despite the resident's expressed preference not to have bedrails.

The process and records demonstrating consent and or a collaborative approach to decisions made on behalf of residents required improvement to ensure a full comprehensive assessment, record of all involved, duration and safety checks required during application and use of restraint.

7. 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:

The resident identified has in the past had numerous falls from their bed and on one occasion suffered a fracture. The decision was taken at the time in conjunction with the resident, the residents partner and the Nurse Manager in the best interest of the Safety and Welfare of the resident. Following a considerable period of time we have now begun a re-trial of the non-use of bed rails and alternatives are being used: alarm mats, lo-lo bed, constant reminders of call bell use.

The Restraint Policy review will be completed by 31/1/2017

Proposed Timescale: 31/01/2017**Theme:**

Effective care and support

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

Some improvement was required to ensure a comprehensive assessment informed care plans.

An assessment detailing how decisions were made, the rationale, who was involved and the date of the decision prior to an advanced care plan directive or decision such as not for resuscitation status was decided in a care plan required improvement.

Decisions 'Not for cardio pulmonary resuscitation' were seen recorded in residents' care plans but were not recorded in the resident's medical notes by the GP in accordance with the centre's policy.

A record to demonstrate the resident and or representative or relevant healthcare professional responsible for the resident's treatment and care was involved in decisions regarding life limiting or sustaining treatment was not maintained in practice or in line with the centre's policy dated March 2016.

Improvement was required in relation to the assessment, use and review of restraint. While fall risk assessments showed an increase in the risk of falling, an analysis to inform the continued decision to use bedrails was not available.

Each identified problem or need such wound sites and sleep disturbance and titration of medication needed to be supported by a care plan.

8. Action Required:

Under Regulation 05(3) you are required to: Prepare a care plan, based on the assessment referred to in Regulation 5(2), for a resident no later than 48 hours after that resident's admission to the designated centre.

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

Both the End of Life and Restraint Policy will be fully reviewed by 28/2/2017 and 31/1/2017 respectively.

This will include reference to each identified problems as noted above.

We will ensure that all decisions regarding end of life are clearly communicated to the residents GP and request that they are noted on the medical notes for the residents. 20/1/2017. A record of all people involved in the decision making process will be documented.

The End of Life Policy was fully reviewed on 8/3/2016 and will be reviewed again by 28/2/2017

The restraint policy review will include the change in description and treatment of bed rail use which are currently identified as enablers.

A restraint rationale form will be completed outlining the decision making process, those involved and alternatives tried, etc. in relation to the use of restraint.

All identified needs with regard to a resident will have a dedicated care plan.

Proposed Timescale: 28/02/2017

Theme:

Effective care and support

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

Some care plans and decisions in relation to restraint use and end of life treatment had not been documented in accordance with guidance documents and or the centre's policy and reviewed at a minimum of on a four monthly basis.

9. Action Required:

Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.

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

Each care plan will be reviewed to reflect the documentation of the decision made and

the source of each contribution. Our care plans are reviewed under rotation every 3 months and so this will be completed as part of this cycle.

Proposed Timescale: 31/03/2017

Outcome 16: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

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

Some improvement was required in a decision made that conflicted with a resident's expressed view regarding the use of bedrails.

10. Action Required:

Under Regulation 09(3)(e) you are required to: Ensure that each resident can exercise their civil, political and religious rights.

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

The resident identified has in the past had numerous falls from their bed and on one occasion suffered a fracture. The decision was taken at the time in conjunction with the resident, the residents partner and the Nurse Manager in the best interest of the Safety and Welfare of the resident. Following a considerable period of time we have now begun a re-trial of the non-use of bed rails and alternatives are being used: alarm mats, lo-lo bed, constant reminders of call bell use.

The Restraint Policy review will be completed by 31/1/2017

Proposed Timescale: 31/01/2017