# Health Information and Quality Authority

## Compliance Monitoring Inspection report

**Designated Centres under Health Act 2007, as amended**

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Talbot Lodge Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000182</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Kinsealy Lane, Malahide, Co. Dublin.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>01 846 2115</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:seamus@talbotgroup.ie">seamus@talbotgroup.ie</a></td>
</tr>
<tr>
<td>Type of centre:</td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>Kinsealy Properties Limited</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Seamus O'Shea</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Nuala Rafferty</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>Leone Ewings Shane Walsh</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Announced</td>
</tr>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>102</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>9</td>
</tr>
</tbody>
</table>
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).
This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration renewal decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From: 22 November 2016 09:30
To: 22 November 2016 18:00
23 November 2016 07:00
To: 23 November 2016 18:00

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

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

Summary of findings from this inspection

This was an announced inspection and formed part of the assessment of the application for renewal of registration by the provider. The inspection took place over two days.

As part of the application for renewal of registration, the provider was requested to submit relevant documentation to the Health Information and Quality Authority.
HIQA). All documents submitted by the provider, for the purposes of application to register were found to be satisfactory. The fitness of the nominated person on behalf of the provider and was assessed through an ongoing fit person process. The fitness of the recently appointed person in charge was also assessed. They demonstrated knowledge of the Health Act 2007 (Care and Welfare of Residents in Designated Centre’s for Older People) Regulations 2013 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland, through the fitness process and throughout the inspection process.

As part of the inspection, practices were observed and relevant documentation reviewed such as care plans, medical records, accident logs, policies and procedures and staff files. The views of residents, relatives and staff members of the centre were also sought. Information in the form of notifications was also considered as part of the inspection process.

Recent changes to the management team within the centre were found on this inspection, with a number of senior clinical nurse managers appointed in recent months. During the inspection process, they demonstrated satisfactory knowledge of their role and responsibilities and sufficient experience and knowledge as required by the legislation.

A number of resident's’ and relatives’ questionnaires were given to the inspectors during the inspection. The opinions expressed through the questionnaires were broadly satisfactory with services and facilities provided. In particular, they were complimentary on the manner in which staff delivered care to them.

Residents’ healthcare needs were met and they had access to medical officers and consultant geriatrician services within the centre. Access to allied health professionals, such as physiotherapy and, speech and language therapists, and to community health services was also available. However, improvements were required to some aspects of care, including medication management, documentation and the assessment, planning and recording of care. The Action Plan at the end of this report identifies areas where improvements are required to comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.
Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

### Outcome 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:**
A written statement of purpose was available that broadly described the service provided in the centre and contained all of the information required by Schedule 1 of the Regulations.

Copies of the document were available in 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):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
Sustained improvements to governance systems were found on this inspection. Actions arising from last inspection were addressed.
Talbot Lodge is part of a group of centres with an overarching governance structure. The group shares a team of managers who support the in-house management team. Within Talbot Lodge the management team consists of a full-time General Manager, who works across two centres, and also acts as the representative of the provider entity and the person in charge. Senior management support from the group includes: a Chief Executive Officer; Human Resources, Business, Accreditation, Catering and Facilities Managers. These senior managers meet, on a monthly and quarterly basis, within a governance system that includes; Quality and Risk, Health and Safety and Corporate Risk Management Teams. The teams discuss aspects of governance, clinical and non-clinical. Clinical supports within the group also included a physiotherapist, occupational therapist, consultant psychiatrist and clinical psychologist.

Evidence that monthly management meetings were held with discussions on issues such as: staff training, staff retention and recruitment, incident analysis, clinical practice and development of activities were viewed. The general manager and person in charge were also supported within Talbot Lodge by a team of clinical nurse managers. This team also met on a regular basis, to review clinical indicators of care, complaints, policies and procedures and staff training and development.

Key improvements in staffing were noted with reduced staff turnover coupled with better recruitment and retention levels. This was found to have a positive effect on resident health outcomes through: reduced dependency on agency staffing with better continuity of care, staff familiarity of residents needs and clarity on staff roles and responsibilities. Improved clinical governance, with clinical nurse managers assuming responsibilities for specific units within the centre and a clinical nurse manager to manage emergencies and oversee care delivery on night shifts was also noted.

Systems to monitor quality and safety of care were in place. This included the collection of data on a monthly basis on key performance indicators (KPI’s) of clinical care such as; falls: pressure injuries: restraint: medication errors: care planning and nutrition management. These KPI’s are used as a way to assess the standard of care being delivered in the centre. However, the data collected was not sufficiently detailed, for all KPI’s to enable meaningful analysis, learning and drive improvements. A quality assurance programme to continuously review and monitor the quality and safety of care was not fully established through a complete audit cycle. Some of the audits viewed included some learning, and actions required to improve practice, although they did not always include the actions taken to address the problem identified, when the action was implemented or reviewed to determine effectiveness.

Examples included: the restraint audit, which did not identify hazards, associated with use of alternative measures, or lack of complete assessment of entrapments: and audits conducted on aspects of medicine management practices that were not sufficiently rigorous to address issues arising from poor administration practices.

There were recent changes within the management team, including the recently appointed person in charge and the promotion of several senior nursing staff to clinical management level. Although the nursing team were clinically experienced and skilled, it was found that there was a need to identify, and fill gaps in skills and expertise such as; leadership and supervision, gerontology, auditing and analysis. The person in charge, who has extensive experience in these areas, was aware of the skill gaps and was considering a programme of competence development for the new nurse managers in these areas.
An annual review of safety and quality of care was in place. The report on the review was available. The report referenced performance indicators such as; hygiene standards; facilities and design; staff training; complaints and service developments such as improved activities. The report also included a number of recommendations to improve the service going forward but did not prioritise the recommendations nor give a commitment to implementing them within any timeframe. In addition it was noted that the report did not reference or include a consultation process with relatives as to whether or how their views informed the day to day running or development of the service.

**Judgment:**  
Substantially 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:**  
Each resident had an agreed written contract which deals with the resident's care and welfare. The contract included all details of the services to be provided for that resident and the fees to be charged. This included a list of facilities and services provided including laundry, meals, and housekeeping. Services which incurred additional fees were listed such as prescription charges. No additional fees were charged for any other services provided including activities.  
A guide to the centre was available to all residents. This described the centre services, management, complaints procedure, and contact information for useful external bodies. Communal areas such as the lobby also had information on display regarding the complaints procedure, evacuation instructions, detail’s of staff on duty and contact details for advocacy services.

**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.
## Governance, Leadership and Management

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

### Findings:
The centre was managed by a suitably qualified and experienced nurse who held authority, accountability and responsibility for the provision of the service. Through an assessment process it was noted that there was daily engagement in the governance, operational management and administration of the centre. The person in charge facilitated the inspection process by providing documents and having good knowledge of residents’ care and conditions and was focused on developing a culture of quality improvement and learning to drive improvements in the standard of care delivered to residents.

### Judgment:
Compliant

---

### Outcome 05: Documentation to be kept at a designated centre

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

---

### Theme:
Governance, Leadership and Management

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

### Findings:
Records set out in Part 6 of the Regulations were available and kept in a secure place. The Statement of Purpose and Residents' Guide were complete and available. The directory of residents was checked and was found to meet the requirements of the Regulations. It was up to date, with records of admissions, discharges and transfers maintained.

General records as required under Schedule 4 of the Regulations were maintained, including key records such as appropriate staff rosters, and accident and incidents, nursing and medical records. Planned rosters were in place in all units, and an actual working rota was maintained. All of the operational policies and procedures as required by Schedule 5 of the Regulations were available and were reviewed on a regular basis and within the three year timeframe as required by the regulations.
It was found that all records listed in Schedule 2 of the regulations were maintained in terms of accuracy and were updated regularly. The inspectors reviewed a sample of staff files and found that they met all of the requirements listed in Schedule 2.

Care provided to residents by staff, such as assistance with washing and dressing, intake of food and fluids, and assistance with toileting, was recorded on an electronic touch screen system. On a sample reviewed, it was found that, some of the care delivered was not recorded until late in the afternoon, when all of the care delivered, was inputted into the record at the same time. This meant that staff were not recording the interventions provided in a timely manner, but had to try to remember, in detail, care delivered over a period of several hours, to several residents. This posed a risk for inaccurate recording, in particular where, for example, residents require close monitoring of their food or fluid intake and output. This is further referenced under Outcome 15 Nutrition.

**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:**
Suitable arrangements were in place for periods of absence of the person in charge, and the provider complied with his responsibilities to notify the Authority when a change occurred to both the person in charge, and the nominated person to replace them. The fitness of the senior clinical nurse managers to replace the person in charge in the event of an absence was determined through observation and discussion during the inspection and had the qualifications and experience required by the legislation.

**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
Theme:
Safe care and support

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

Findings:
Staff had received training on the prevention of elder abuse and all staff spoken too were clear on their role and responsibilities in relation to reporting abuse. Staff were also knowledgeable in recognising the possible signs and symptoms, responding to and managing abuse. Procedures to protect residents, such as a robust recruitment system, staff induction and training were also in place and implemented. There were arrangements in place to review accidents and incidents within the centre, and residents who had fallen, had falls risk assessments completed after the falls, and some care plans were updated.

It was noted that there was a move towards changing the culture and promoting a restraint free environment. The use of bed rail restraint had reduced since the last inspection, and the use of alternative measures such as low-low beds, mat and bed alarms had increased. Inspectors noted the positive changes towards a reduction in the use of restraints, such as bedrails. Nevertheless, a clear rationale, for the use of bed rails was not available in all cases. Inspectors looked at a sample of the decision making tools used when considering the use of restraints. The documentation of alternatives considered or trialled in some risk assessments was not clear. In some cases it was found that, although alternatives, such as floor mattresses, were offered, they were not trialled. Reasons given for this included the identification of a floor mattress as a hazard to other residents in shared rooms. Other reasons included the family preference for using bed rails.

Additionally it was observed that where other alternatives to bed rails were in use, they were used in conjunction with, and not instead of, the bed rail which negated the benefit of using them. While it was noted that the majority of bed rails in use were integrated bed rails and did not pose a potential entrapment hazard, there were some exceptions. A small number of bed rails that were in use were non-integrated. These bed rails were observed to be loose, and were shaking when any weight was placed on them. Gaps were also evident at the top and bottom. All of which posed a risk of injury or entrapment for the resident but evidence that these risks were fully assessed was not found.

In conversations with them, inspectors were told by some residents that they felt safe and secure in the centre, and relatives also confirmed that they did not have any concerns for the safety of their loved ones.

Inspectors reviewed the system in place to manage residents' money and found that reasonable measures were in place and implemented to ensure resident's finances were fully safeguarded. The inspector viewed the computerized system in place to manage transactions related to residents’ monies. All residents were allocated an individual coded ledger where details of all transactions were recorded. It was noted that the
procedures in place did not fully reflect HIQA guidance issued to providers on the management of residents finances in that;
- Monies of residents for whom the provider acted as a pension agent were lodged to the centre’s main business account and not into an individual interest bearing bank account for each resident.
In the days immediately following the inspection, the provider advised that a client account separate to the business account was set up and arrangements made with the department of Social Protection to have all residents pensions transferred to this account.
Systems were also in place to assist a small number of residents to safeguard small sums of money, and showed the inspector the system in place. The inspector was satisfied that the system, which involved all monies given in for safekeeping and subsequently withdrawn, was recorded and signed by two persons. Receipts for purchases made were available.

**Judgment:**
Non Compliant - Moderate

---

**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):**

**Findings:**
Emergency lighting and fire fighting equipment, directional signage and appropriate fire procedures were available throughout the building. The internal and external premises and grounds of the centre appeared safe and secure, with appropriate locks installed on all exterior doors. A CCTV system was in place externally and a register of all visitors to the centre was maintained.

Completed logs were maintained on daily, weekly, monthly and quarterly tests and checks of fire equipment, doors, exit routes and emergency lighting. Certification of testing and servicing of extinguishers, fire retardant materials and the alarm system were documented. The building's fire and smoke containment and detection measures were appropriate to the layout of the building, and exits were free of obstruction. However, it was noted that smoke seals or self closure devices were not in place on the door of the staff kitchenette. This kitchenette is located at the bottom of a corridor that also contains residents' bedrooms. The room contains a number of electrical appliances such as toaster and microwave that are in frequent use throughout the day. This was brought to the attention of the person in charge who gave assurances the deficiency would be raised with the local fire officer and addressed.
All staff had received training in fire safety within the past 12 months, and were familiar with what actions to take in the event of a fire alarm activation, and with the principles of horizontal evacuation. Practiced fire drills were held, that included simulation of an actual evacuation to determine the competency of staff to use evacuation equipment such as evacuation sheets. Unfortunately the records of the practiced drills, were not sufficiently detailed to enable learning or identify where improvements to the procedure could be made. All residents had personal emergency egress plans (PEEPs) which identified the level of mobility and evacuation mode of each resident. However, these plans did not include the level of cognitive understanding, the need for supervision or the level of compliance of each resident in an emergency situation.

Appropriate arrangements for investigating and learning from serious incidents/adverse events which identified residents who were at risk of falls and put in place appropriate measures to minimise and manage the risks was in place. A risk register was established which was regularly reviewed and updated. There were arrangements in place to review accidents and incidents within the centre. Residents, who had fallen, had falls risk assessments completed after the falls, and care plans were updated. A falls awareness initiative was established by the person in charge, in response to an increase in the number of residents experiencing falls. This had focused staff on the challenge of maintaining residents' safety, and highlighted a number of areas where improvements, including supervision, was needed.

Governance and supervision systems were in place to monitor residents at risk of falls, wandering or negative interactions. These were reviewed on an ongoing basis.

Inspectors observed that staff implemented the principles of current Moving & Handling guidance when assisting residents to transfer.

Systems to support staff knowledge and implementation of best practice to ensure good infection prevention and control were in place.

**Judgment:**
Substantially Compliant

<table>
<thead>
<tr>
<th>Outcome 09: Medication Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Each resident is protected by the designated centre's policies and procedures for medication management.</td>
</tr>
</tbody>
</table>

**Theme:**
Safe care and support

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

**Findings:**
Inspectors found that there were written operational policies in place in the centre relating to the ordering, prescribing, storage, and administration of medicines to residents.

Medicines were supplied to the centre by a retail pharmacy business in a monitored dosage system. Medicines were stored securely in the centre in medication trolleys or within locked storage cupboards. A secure fridge was available to store all medicines and prescribed nutritional supplements that required refrigeration, and temperatures were checked and recorded on a daily basis. Controlled drugs were stored securely.
within a locked metal cabinet, and balances of all controlled drugs were recorded in the controlled drugs register. Nursing staff checked and documented the balances of all controlled drugs twice daily at the change of shift. Nursing staff were familiar with the procedure for disposing of unused or out of date medicines. Nursing staff were observed administering medicines to residents during the morning administration round on one of the units. The administration practice was in line with current professional guidance. Medication audits were conducted in the centre and covered some aspects of medication management practices such as; storage, labelling, administration records, controlled medicines and temperature controls on medicine refrigeration. However, it was noted that all nutritional supplements were not being stored in line with manufacturer's guidelines.

A system to record medication errors was in place. This system had been updated, in the weeks prior to the inspection, when it was found that a prolonged omission of warfarin medicine had occurred. The person in charge established a drug and therapeutics committee to discuss medication errors. The committee proposed to develop action plans that included appropriate feedback to staff, and identified and implemented any learning. The committee had reviewed the policy and procedures on Warfarin administration and it was noted that these were now being implemented. The person in charge had also commenced an investigation into the causes of the omission and a draft report was in progress. The person in charge undertook to forward the final report to HIQA. However, it was unclear whether appropriate actions were taken where residents were refusing medication. Inspectors noted that, although nurses recorded the refusal on the medicine administration sheet, further actions such as monitoring refusals and reporting to the general practitioner were not recorded. The inspectors were told that, as part of strengthening the system of medication administration, a computerised system was being introduced which would minimise risks associated with medication omissions.

**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 was maintained and, where required, notified to the Chief Inspector.

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

**Findings:**  
The findings of the last inspection required actions to improve care planning processes to link care plans and make them more specific to ensure they meet residents needs. These actions were not addressed and the findings are recurrent on this inspection.

Residents had good access to General Practitioner services. There was evidence of regular reviews of residents overall health on admission, and on readmission following return from acute hospital care, and as required when clinical deterioration was noted. There was evidence of access to specialist and allied health care services to meet the care needs of residents such as opticians, dentists and chiropody services. Access to palliative care specialists, dietitian, physiotherapy and speech and language were also available.

Systems were in place for the assessment, planning, implementation and review of healthcare needs. This included nursing assessments, care plans and clinical risk assessments. However, clinical records viewed did not contain enough detail to ensure they were effectively managing the health problem. Some were not fully completed and were not person centred. Examples included:
- Positive behaviour support plans did not include the form the behaviours might take, triggers associated with the behaviour, distraction or de-escalation techniques to manage the behaviours.
- Medicine management care plans did not reference frequency of blood monitoring required to assess effectiveness of, or side-effects to, some medications. Where side effects of medication were identified in the results of blood tests, such as anaemia or dehydration, existing care plans were not updated to manage these new needs. Nor were new care plans created.
- Residents were re-assessed following falls which included checking vital signs, review by medical doctor and physiotherapist if required. Care plans to manage the risks of further falls were in place, but these did not include all of the risks known to staff for residents at high risk of falls or all of the measures used to prevent falls.
- Care plans to manage risks associated with malnutrition did not always identify the type of diet recommended for the resident, for example, high calorie/high protein. All dietitian recommendations were not always included, such as where food should be
additionally fortified. This was of concern, in particular, for those residents who were at risk of losing weight or who were actually losing weight.

The inspectors noted that the management of some care needs were not covered by one specific care plan but elements of several different care plans. However, these care plans were not linked to direct staff to use these elements to manage all needs.

Aspects of other nursing documentation required improvements were also required to ensure it was clear and co-ordinated. These included: the reviews of care plans although regular did not always consider the effectiveness of the interventions to manage and/or treat the need. Greater efforts to plan care in a person centred and holistic manner. Risk assessments, care plans and nursing progress notes were not fully linked to give an overall picture of residents' current condition.

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 design and layout of the centre was broadly in line with the statement of purpose. The centre is a single storey building, which was purpose built and has been extended over recent years. The centre is divided into three areas, Area A, B&C and D. Bedroom accommodation consisted of:
Area A - 10 single bedrooms, eight with full en-suite bathrooms and two with wash-hand basin. There were also 17 twin bedrooms none with en-suite facilities but there were nine shower rooms with toilet in close proximity. Communal facilities included: one activity room and one sitting cum dining room, separate dining room, small garden patio.
Area B&C- Area B consists of 20 single bedrooms, four with full en-suite facilities and 16 with wash-hand basin only. There were also three shower rooms with toilet in close proximity. Area C consists of 21 single bedrooms, seven with full en-suite facilities and 14 with wash-hand basin only. There were two twin rooms and one four bedded room with wash-hand basins. There were also two shower rooms with toilet, one shower room with bath and toilet, and one with bath and toilet, in close proximity. Communal facilities
included: one dining room and separate sitting room for B&C combined.
Area D- This area consisted of 21 single bedrooms with full en-suite facilities. Communal facilities included: one dining room and two separate sitting rooms, and also a separate activities room.
Each area also contained storage rooms, dirty utility room and nurses office.
A large reception area also included a comfortable seating area for residents and visitors with coffee and tea making facilities.
However, in their feedback, some relatives expressed a preference for a more homely and domestic form of décor to improve the level of comfort in the centre.

The premises were found to be visually clean, tidy, and uncluttered. Assistive equipment was in place, available for use and in good working order, service records were up to date, and maintenance contracts were in place. Fire doors and stair wells were not obstructed and could be accessed freely in the event of an emergency.
Maintenance work was ongoing throughout the centre. Many of the bedrooms viewed by inspectors were personalised with photos, pictures and other personal items. There was a functioning call bell system in place throughout the centre.
There was a small enclosed, accessible garden with seating available to the rear of the centre. The grounds to the front were well maintained with level pathways and shrubberies.
As part of the application to renew registration, the provider has applied to increase the number of bed places in the centre by three. The centre is currently registered for 111 beds and has applied to register for 114 as part of this renewal of registration process.
The inspectors were told, and floor plans shown to the inspectors confirmed, that there were no structural alterations made to the footprint of the building. The additional bed places were created through renovation and change of the function of existing rooms.
Inspectors found that these rooms, and the overall centre, were suitable to meet residents' needs. Nonetheless, the inspectors did note that there were few areas of diversion and interest for residents. In addition overnight facilities for families were not available and designated visitors rooms were not identified.
Signage and colour cueing to facilitate way-finding for residents with cognitive impairment needed improvement but inspectors were told this was being reviewed in conjunction with changes to the names of each unit. Residents had chosen new unit names and signs were on order, a review of décor was also being considered by the residents and this would take account of signage and colour cueing.

Judgment:
Substantially 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):

Findings:
Policies and procedures which comply with legislative requirements were in place for the management of complaints. This included an independent appeals process. Residents were aware of the process which was displayed. On review of the record of complaints there was evidence that all complaints were documented, investigated and outcomes recorded. Complainants were notified of the outcome of their complaint, although the records did not show whether they were satisfied. Reviews to ascertain the satisfaction of the complainant, further to issues being resolved, were not carried out.

Judgment:
Substantially 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:
Evidence of a good standard of medical and clinical care with appropriate access to specialist palliative care services was found. However, some improvements to ensure an holistic and person-centred approach to end-of-life or comfort care provision were required. Inspectors looked at the management of end-of-life care delivered to some resident’s. Residents’ religious preferences were documented, but evidence, that the will and preference of the resident was sought, in relation to emotional, social and spiritual needs, place of death, or funeral arrangements was not always found. The inspectors found that staff were aware of the policies and processes guiding end of life care in the centre and were trying to implement them in a respectful manner. Families were notified in a timely manner of deterioration in residents’ condition and were supported and updated regularly during the end-of-life phase. Residents’ physical needs were met, and residents’ receiving end-of-life care at the time of the inspection were frequently checked to ensure their comfort and care. Some facilities to support relatives remain with their loved ones during end-of-life were available but a room to enable families remain overnight was not identified.

Judgment:
Substantially 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:**
Residents were provided with food and drink at times and in quantities adequate for their needs. Assistance was observed and was offered to residents in a discreet, patient and sensitive manner by most staff. Where some staff were observed to provide assistance in non person-centred manner, this was appropriately managed by the person in charge.

The dining experience was conducive to conversation, although it was noted that some staff did not use the opportunity to engage with the residents, to whom they gave assistance, in a meaningful way. Those residents on modified diets were offered the same choices as people receiving normal diets. A rolling menu was in place to offer a variety of meals to residents.

Most residents took their meals in the dining rooms located in each unit in the centre and tables were appropriately set with cutlery, condiments and napkins. Residents spoken with all agreed that the food provided was always tasty, hot and appetising. Food was served from a hot plate by a team of staff and was well presented. Modified consistency diets were served appropriately with each element of the meal presented in separate portions on the plate. A list of all special diets required by residents was compiled on foot of the individual residents’ reviews and copies were available in the main kitchen and in the kitchenettes on each unit.

Drinks such as water, milk, tea and coffee were available. Access to fresh drinking water at all times was available, jugs of water were observed in residents’ rooms and water dispensers were available.

Evidence of referral to relevant allied health professional including dietician or speech and language therapists was found and there was a system in place to monitor the intake of residents identified as at risk of malnutrition although inspectors were told no residents were identified as requiring same at the time of inspection. Although no resident was identified as being at risk of malnutrition, there were several residents whose intake was being closely monitored, as they were at ongoing risk of weight loss. The inspectors looked at the system in place to monitor food intake. The system of recording was not found to be consistent or detailed enough to enable meaningful analysis as to the adequacy of intake for at risk residents. For example, agreed
descriptions of portion sizes were not consistently used to establish how much of their lunch/tea the resident had actually eaten. Records did not give any detail on whether the food was additionally fortified to increase calorie intake without increasing portion size. An action related to recording is included under Outcome 5 Documentation

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

Evidence that residents and relatives were involved and included in decisions about the life of the centre was viewed. Regular meetings were held where residents were consulted about future activities or outings. Feedback and suggestions were recorded with an action plan and timeframes. The right to vote in national referenda and elections was facilitated with the centre registered to enable polling. Access to the internet was also available with wi-fi access. A programme of varied internal activities and external trips was in place for residents. Information on the day's events and activities was prominently displayed in the centre. A team of three activities coordinators delivered the programme which included both group and one to one activities. Inspectors were told that one to one time was scheduled for residents with more severe dementia or cognitive impairment or who would not participate in the group activities, and that this time was used for sensory stimulation such as providing hand massages. Other dementia relevant activities were included in the programme. Inspectors noted there was an improved emphasis on residents' mental health and well being. This was reflected in the increase in resources for activities, such as the
establishment of a full time activities team. Inspectors were told that residents spiritual needs were met through weekly visits from a local prayer group showing televised Mass on national TV in the centre's oratory. However, inspectors learned that Mass was only celebrated in the centre on an annual basis and residents had not been facilitated to attend Mass in the community up to the date of the inspection. This was brought to the attention of the provider and person in charge. Arrangements were subsequently made to include an option to bring residents to Mass in the community as part of the group outings arranged on a weekly basis every Friday.

Feedback from residents and their relatives was received through questionnaires as part of the inspection process, and in conversation during the inspection. Feedback on the level of consultation with them, and access to meaningful activities, was generally positive. All those spoken too praised the staff for the cheerful and respectful manner in which they delivered care. Some residents said staff were quick to respond to their call bells and regularly enquired if they were OK, although some said there weren't always enough staff to respond quickly to all requests for assistance. Relatives spoken to said they were kept informed of their loved ones' condition, and could speak to management if they needed too.

**Judgment:**
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 were arrangements in place for regular laundering of linen and clothing and the safe return of clothes to residents.
A policy on residents' personal property was in place and implemented using an inventory on clothes and valuables belonging to residents upon admission. In a sample of those reviewed these were updated.

Residents had access to a locked space in their bedroom if they wished to store their belongings.

There was a policy in place of residents’ property in line with the Regulations and a list of residents' valuable property and furniture was maintained where required.
**Outcome 18: Suitable Staffing**

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

**Theme:**

Workforce

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

No actions were required from the previous inspection.

**Findings:**

Suitable and sufficient direct care staffing and skill mix were found to be in place to meet the needs of the current resident profile. The staff rota was checked and found to be maintained with all staff that worked in the centre identified. Systems were in place to provide relief cover for planned and unplanned leave. Actual and planned rosters were in place. Cover for planned and unplanned leave was provided, primarily within the current staff complement. Agency staff were still used where necessary but the heavy reliance found on previous inspections had diminished. A clinical nurse manager was on duty both day and night, whom staff could contact to arrange to cover unplanned absences. Records reviewed showed that staff had been provided with opportunities to receive updated training in areas such as: safeguarding; moving and handling; fire safety: first aid: dementia care and food hygiene; pressure ulcer prevention; assessment and care planning. Samples of attendance records were also viewed. Appropriate and respectful interactions were observed throughout the day between residents and staff. Overall it was noted that resident's dignity and choice was respected during care interventions and in their daily lives. Good recruitment processes were in place including a Garda vetting process. Identity checks were also conducted for all overseas staff recruited. The inspectors verified that all nurses were registered with the Irish Nursing Board.

**Judgment:**

Compliant
Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Nuala Rafferty
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Outcome 02: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Evidence of involvement of residents families in the annual review of the safety and quality of care was limited.

1. Action Required:
Under Regulation 23(e) you are required to: Prepare the review referred to in regulation 23(1)(d) in consultation with residents and their families.

1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Please state the actions you have taken or are planning to take:
The 2017 annual review of the safety and quality of care will be completed before 31/07/17. The review will involve appropriate consultation with residents and their families. The level of consultation and consultation processes will be clearly documented in the review report.

A quality initiative entitled “Residents Voice” is currently taking place and this initiative will be used to encourage residents to actively participate in the annual review of the safety and quality of care.

Proposed Timescale: 31/07/2017

Outcome 05: Documentation to be kept at a designated centre
Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The delivery of care was not always recorded in a timely manner and was not sufficiently accurate to determine that the care plans in place were appropriately and fully implemented.

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:
Training on the importance of clear, accurate and contemporaneous records of residents’ care has been provided. The CNMs are monitoring the records on each shift to ensure delivery of care is accurately recorded in a timely manner.

It is planned to implement a revised clinical handover process. This will involve all carers and nurses and adopt a communication model, such as SBAR (situation, background, assessment, recommendation). This will support the appropriate and full implementation of care plans.

Proposed Timescale: 30/04/2017

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:
A clear rationale, for the use of bed rails was not always available. Evidence that prior alternatives were always tried, or that the bed rail was fully assessed and deemed suitable or safe was not available.

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:
The restraint policy has been updated based on the National Policy Towards a Restraint Free Environment and all staff are receiving refresher training on the policy.

A full review of the use of bed rails has been completed. The review was carried out by a team of carers, nurses and CNMs and involved a critical review of each incidence of use of bed rails to determine compliance with policy. The review process was used as an educational opportunity. A robust review system of bed rails is now in place and will be supported by 3 monthly audits. The supporting policy and MDT clinical decision process have been revised to ensure compliance with national policy and that the following are adequately provided for - safety checks when bed rails are in use, commitment to least restrictive practice for shortest length of time, authorisation process, special precautions, risk of entrapment, consent, monitoring, review, audit, emergency use and duty of care.

Proposed Timescale: Completed

Proposed Timescale: 11/01/2017

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:
Personal emergency egress plans in place did not fully guide staff on the management of the potential risks associated with impaired cognitive ability, requirement for supervision and the extent or level of compliance staff could expect from each resident.

4. Action Required:
Under Regulation 28(2)(iv) you are required to: Make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and safe placement of residents.

Please state the actions you have taken or are planning to take:
The PEEP plans will be revised and updated to ensure that they can act as a meaningful
guide to staff in an emergency. Specifically, a summary overview paragraph of the “must know” about each resident is being put in place.

**Proposed Timescale:** 28/02/2017

### 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:**
Medicine omissions and management of refusals of medication by residents did not ensure that all medicines were administered as directed by the prescriber.

5. **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:**
Documentation related the reasons for refusal or omission of medications is now not limited to the medication administration sheet, but linked to the care plan and progress notes to ensure maximum multi-disciplinary team communication.

Three monthly audit programme of care plans and medication administration to include management of medication refusals and individual care plan changes will be carried out.

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 an Electronic MAR system is being implemented.

**Proposed Timescale:** 31/03/2017

### Outcome 11: Health and Social Care Needs

**Theme:**
Effective care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Assessment and care planning were not specific enough to direct the care to be delivered or guide staff on the appropriate use of interventions to consistently manage the identified need.
6. **Action Required:**
Under Regulation 05(2) you are required to: Arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person’s admission to the designated centre.

**Please state the actions you have taken or are planning to take:**
To ensure comprehensive assessments are completed, a quality review of care documentation will be undertaken to ensure assessment and care planning are specific enough to guide staff on the appropriate use of interventions to consistently manage identified needs.

Education and training will be provided on holistic assessments to include the health, personal and social care needs of a resident linked to development of meaningful care plans. This will be achieved by participation of nursing staff in professional development programmes.

**Proposed Timescale:** 30/06/2017

**Theme:**
Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Reviews of care plans did not include a determination of the effectiveness of the plans to manage the needs identified.

7. **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:**
Arrangements are in place to ensure that reviews of care plans take place no less frequently than at four monthly intervals in consultation with the resident concerned and where appropriate the resident’s family. These reviews will also include a determination of the effectiveness of the plans to manage the needs identified and will be revised if necessary where residents needs have changed. The review and effectiveness of care plans will be monitored by the Director of Nursing.

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

**Theme:**
Effective care and support

Page 27 of 30
The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The documentation of care was not sufficiently accurate or appropriately linked to evidence the continuous delivery of a high standard of evidence based nursing care or give a clear and accurate picture of residents’ overall health management.

8. Action Required:
Under Regulation 06(1) you are required to: Having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care for a resident, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnámhseachais.

Please state the actions you have taken or are planning to take:
Training on the importance of clear, accurate and contemporaneous records of residents’ care has been provided. The CNMs are monitoring the records on each shift to ensure delivery of care is accurately recorded in a timely manner and that a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnámhseachais is being provided.

The Director of Nursing monitors care plans to ensure the continuous delivery of a high standard of evidence based nursing care.

Proposed Timescale: Completed

Outcome 12: Safe and Suitable Premises

Theme:
Effective care and support

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

The design and layout of the centre was broadly in line with the statement of purpose although there were few areas of diversion and interest for residents, overnight facilities for families were not available and designated visitors rooms were not identified.

9. Action Required:
Under Regulation 17(1) you are required to: Ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.

Please state the actions you have taken or are planning to take:
Arrangements will be made to identify a designated visitors room which can also be used by families to remain in the Nursing Home overnight.

Additional areas of diversion and interest for residents will also be identified.
<table>
<thead>
<tr>
<th>Proposed Timescale: 30/04/2017</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outcome 13: Complaints procedures</strong></td>
</tr>
</tbody>
</table>
| **Theme:**
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The complaints record did not include the satisfaction of the complainant further to issues being resolved.

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

Please state the actions you have taken or are planning to take:
The complaints policy will be reviewed to ensure that it makes provision for to record the satisfaction of the complainant further to issues being resolved. In future the outcome of a scheduled follow up with the complainant will be recorded in the complaints log.

---

<table>
<thead>
<tr>
<th>Proposed Timescale: 28/02/2017</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outcome 14: End of Life Care</strong></td>
</tr>
</tbody>
</table>
| **Theme:**
Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Arrangements to capture the will and preference of residents in relation to emotional, social and spiritual needs, place of death, or funeral arrangements was not always found.

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

Please state the actions you have taken or are planning to take:
All residents will be given the opportunity to discuss their preferred options for their ‘end of life’ care. This will be offered in a supportive manner so as to provide appropriate care and comfort to residents approaching end of life, which addresses their physical, emotional, social, psychological and spiritual needs. This engagement with residents will be clearly documented in the residents’ records.
Where advanced directives are in place the signatures of all members of the multi-disciplinary team involved in the decision making process will be clearly documented.

The local Hospice Service will be consulted to provide information and training for staff.

SAGE Advocacy Service will be consulted to see what support it can provide if required.

Focussed in-house awareness training for staff on quality improvement initiatives in relation to End of Life care will be provided.

The Think Ahead Speak for Yourself Program will be made available to residents in Talbot Lodge.

**Proposed Timescale:** 30/06/2017