<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Glencarrig Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000043</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Glencarrig Court, Firhouse Road, Dublin 24.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>01 451 2620</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:info@glencarrignursinghome.com">info@glencarrignursinghome.com</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>Nucare Company Limited</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Siobhan Launders</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Leone Ewings</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>Sonia McCague</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Announced</td>
</tr>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>21</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>4</td>
</tr>
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</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).
Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration renewal decision. This monitoring inspection was announced and took place over 1 day(s).

The inspection took place over the following dates and times
From: 19 September 2017 09:30  
To: 19 September 2017 19:30

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

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Our Judgment</th>
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</thead>
<tbody>
<tr>
<td>Outcome 01: Statement of Purpose</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 02: Governance and Management</td>
<td>Non Compliant - Major</td>
</tr>
<tr>
<td>Outcome 03: Information for residents</td>
<td>Compliant</td>
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<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>Non Compliant - Moderate</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>Compliant</td>
</tr>
<tr>
<td>Outcome 08: Health and Safety and Risk Management</td>
<td>Non Compliant - Major</td>
</tr>
<tr>
<td>Outcome 09: Medication Management</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 10: Notification of Incidents</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 11: Health and Social Care Needs</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 12: Safe and Suitable Premises</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 13: Complaints procedures</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 14: End of Life Care</td>
<td>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>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 17: Residents’ clothing and personal property and possessions</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 18: Suitable Staffing</td>
<td>Substantially Compliant</td>
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</table>

Summary of findings from this inspection
This was the tenth inspection of this centre by HIQA. This report sets out the findings of a one day, announced inspection, the purpose of which was to inform a decision for the renewal of the centre’s registration. As part of this inspection notifications and unsolicited information received were also reviewed. Information received included the governance and management of the centre, personal information on display, management of residents property and staffing.
Following the last inspection which took place on 15 September 2016, a provider meeting was held to discuss regulatory non-compliances and actions taken to address these. In addition, an action plan update was requested by the inspector and submitted to HIQA in April 2017. Deficiencies in the premises had been identified on previous inspection. The provider gave the inspectors detailed information at the time of the last registration renewal in terms of plans to renovate the centre, and the work was due to be complete by the end of June 2015. All rooms in the centre would be either single or twin. Planning was in place to make the required improvements, but to date works had not commenced within the time frames outlined by the provider. Inspectors found that some refurbishments to the premises had taken place. The building plans as submitted to HIQA, and detailed planning to reduce multi-occupancy rooms, improve communal space and laundry had not been actioned.

During the course of the inspection, the inspectors met with residents, relatives, staff and the management team in the centre. The inspectors spoke with the provider and person in charge at the start of the inspection. The views of all were listened to, staff practices were observed and documentation maintained was reviewed. Surveys completed by residents and/or their relatives were also reviewed.

Overall, the inspectors found that the care was delivered to a good standard by staff who knew the residents well, and were familiar with the residents assessed needs. The management and staff of the centre were working to improve residents’ outcomes. A person-centered approach to care was noted. Residents were well cared for, had good access to health and social care services and expressed satisfaction with the assistance and support they received in the centre. Relatives spoken to were complimentary of the care.

Management systems are in place within the centre that defines the lines of responsibility and accountability. The provider and person in charge were responsible for the governance, operational management and administration of services. Improvements were identified on this inspection relating to fire safety, including the evacuation strategy and record-keeping of fire drills. An immediate action was issued to the provider to undertake a fire safety risk assessment of the premises as the present layout of the centre meant that up to 18 residents could be located in one of two fire zones. In the event of fire, or any other reason no simulations had been practiced, to demonstrate how those residents located in zone two could be re-located and evacuated safely.

The Authority had received unsolicited information pertaining to safeguarding, personal information, resident’s property and governance of the centre. This was followed up during the day of inspection. The management team had been requested to carry out a detailed investigation. Inspectors confirmed that appropriate actions were taken to protect all residents. Nonetheless, the provider had failed to complete statutory notifications relating to aforementioned report. Overall, current systems in place for notifying HIQA were not robust and required review.

The provider confirmed that all staff have completed Garda vetting disclosures. There were sufficient resources in place to ensure the effective delivery of care as
described in the statement of purpose. The person in charge had been re-appointed on 15 May 2017, as she had left her role in July 2016 and had now returned. There had been no change in any other persons participating in management of the centre since the last inspection. Management and staff had good knowledge of residents’ care and identified healthcare needs.

Management had governance systems and arrangements in place to ensure that the service provided met identified needs. Nonetheless some improvements were required relating to record-keeping, complaints management, statement of purpose, health and safety and risk management, staff training and health and social care. A major non-compliance relating to fire safety evacuation procedures was identified by inspectors and an immediate action issued to the provider.

Actions required following the last inspection had been satisfactorily addressed, apart from the final layout of one multi-occupancy bedroom which did not ensure privacy and dignity. The findings are discussed throughout the report and areas for improvement are outlined in the action plan at the end of the report.
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):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
There was a written statement of purpose that described the service and facilities that are provided in the centre. The statement of purpose consists of a statement of the aims and objectives of the designated centre. The management have kept the statement of purpose under review and revised the content at intervals of not less than one year.

The statement of purpose contained most of the information required by Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People). However, further information about the layout of the bedrooms, and multi-occupancy rooms was required. In addition, the complaints procedure was not fully outlined and references to the National Standards for Residential Care Settings for Older People in Ireland (2016) were not updated.

Judgment:
Substantially 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:
A clearly defined management structure was in place that identified who is in charge, who is accountable and what the reporting structure is. However, inspectors had identified some gaps in the management systems, fire safety procedures and the provider had failed to address the plans as agreed to make required improvements to the premises.

The provider is Nucare company limited, and HIQA was notified in July 2017, that the provider nominee is now appointed as one of the two directors of this company. She works full-time in the centre as the systems manager, and all staff report to her. She is supported by the other director of the company, and the person in charge. The admissions process was managed by the person in charge who assessed suitability for any proposed admission to the centre.

The systems in place to review and monitor quality and safety of care were in place. A detailed annual review of quality and safety of care delivered to residents had taken place, and a quality improvement plan was in progress. Some examples had been implemented including - changes to the environment, mealtime experience and renovation of the family room. This had taken place following consultation and inputs from residents and relatives.

The provider had not commenced the proposed building works to improve premises, as submitted to HIQA at the time of the last registration renewal.

As outlined within this report, some improvements were required in terms of complaints management. Management and oversight of notifications and record-keeping to meet the requirements of the regulations. Weekly governance meetings took place.

Inspectors identified that adequate resources such as pressure relieving equipment, was not readily available to meet the assessed and changing needs, or following an acute hospital stay. One resident's family had purchased their own specialised equipment including a bed that would be maintained by the provider. The governance and oversight of these systems was not reflected in policies reviewed, or records maintained by the provider or person in charge.

Judgment:
Non Compliant - Major

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 guide to the centre for residents included a summary of the centre's services and facilities, the terms and conditions of residence, the complaints procedure and visiting arrangements for residents.

The inspectors were told that the contract of care terms and conditions had been recently revised and a process of issuing, renewing and agreement of the new contracts was to be completed for all residents. The inspectors reviewed a sample of residents' contracts of care, which were found to set out the services to be provided, fees and charges. There was an anomaly between charges agreed and items included in one of the revised and proposed contracts. This was highlighted to the provider representative and attributed to a gap in communication between both about service provision, personal property and resources available which is discussed Outcomes 2, 16 and 17.

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:
The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service. The person in charge had changed since the time of the last inspection, and the previous person in charge had left on 8 May 2017.

The inspectors met with the person in charge, who is a registered general nurse and she works full-time in the centre. She has more than three years in six years experience required as person in charge in this centre, in the care of older people. HIQA was notified that she returned to the role of person in charge of the centre on 15 May 2017, within the required legislative timeframes. She completed an interview with inspectors separately on 7 June 2017 following this notification of change of person in charge.

The person in charge had good knowledge of the Health Act 2007 (Care and Welfare of
Residents in Designated Centres for Older People) Regulations 2013 in relation to her role as the person in charge.

Deputising arrangements were in place with two senior staff nurses designated by the provider. She clearly demonstrated a person-centered approach.

The person in charge had maintained her continuous professional development and had completed courses in supervisory management, nursing older people, nutrition, and fire warden duties. All documentation requested by the inspectors was readily available. Although the person in charge was clear about her responsibilities in terms of notifications, she confirmed that all were submitted by the provider nominee. This is discussed in Outcomes 2 and 10 of this report.

**Judgment:**
Compliant

<table>
<thead>
<tr>
<th>Outcome 05: Documentation to be kept at a designated centre</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>

| Theme: |
| Governance, Leadership and Management |

<table>
<thead>
<tr>
<th>Outstanding requirement(s) from previous inspection(s):</th>
</tr>
</thead>
<tbody>
<tr>
<td>The action(s) required from the previous inspection were satisfactorily implemented.</td>
</tr>
</tbody>
</table>

| Findings: |
| The records as listed in Part 6 of the Regulations were maintained in a manner so as to ensure completeness and accuracy. Overall, a satisfactory standard of record-keeping could be evidenced throughout the inspection, and records requested were accessible. Improvements were found to be required in schedule 3 and 4 records records reviewed including: |
| -records residents' property |
| -additional charges in place |
| -pre-admission assessments |
| -fire drills. |

A sample of staff files were reviewed and found to contain all the requirements of schedule 2 of the regulations, inclusive of Garda Síochána vetting dislosures.

The centre was adequately insured against accidents or injury to residents', staff and
visitors, as well as loss or damage to a resident’s property.

A directory of residents was maintained which contained all of the matters as set out under regulation 19.

The designated centre had all of the written operational policies which had been kept under review as required by schedule 5 of the regulations. Inspectors reviewed a sample of policies, overall found most were evidence-based and guided staff practices. Improvements were required in policies on continence, mealtime’s policy, and residents' property and possessions.

**Judgment:**  
Non Compliant - Moderate

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**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 persons participating in management included two senior nurses who undertook the duties of the person in charge in her absence. Both nurses were found to be fit to undertake this role during previous inspections of this centre, and full and complete information was made available to HIQA by the provider.

**Judgment:**  
Compliant

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

**Findings:**
The provider had made improvements since the time of the last inspection. Staff training had been completed and awareness relating to the use of restraint at the centre.

Measures were in place to protect residents from being harmed or suffering abuse. There was a policy which provided guidance for staff to identify and manage incidents of elder abuse. This included information on the various types of abuse, assessment, reporting and investigation of incidences and necessary referrals to external agencies.

The training records identified that staff had opportunities to participate in training in the protection of residents from abuse. Staff spoken with were knowledgeable regarding the signs of abuse, reporting procedures and what to do in the event of a disclosure about actual, alleged, or suspected abuse.

Emphasis was placed on residents’ safety. The 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, call-bell facilities, modified mobility aids, hand rails in circulating areas and support arrangements were available for residents.

In questionnaires completed and during discussions with inspectors, residents confirmed that they felt safe in the centre due to the measures taken, such as the secured entrance and due to the support and care provided by the staff team.

Systems and arrangements were in place for the management of resident's finances and property. At the time of the inspection the provider and person in charge informed inspectors that currently they did not hold any residents cash or valuables in safekeeping. Fees and charges for services provided were invoiced and generally set up by a standing order or direct debit arrangement. A record of these transactions was maintained and receipts provided to payees accordingly. In relation to resident personal property such as a TV, furniture, bed and pressure relieving mattresses, improvements were required in relation to the detailing and documenting of these property items as outlined in outcome 5.

The policy, practice and assessment forms reviewed reflected practice in line with national policy, as outlined in Towards a Restraint Free Environment in Nursing Homes (2011). Improvements were noted and now a low rate of restraint and/or bedrail use by residents was reported. None of the 21 residents were reported to be using both bedrails or other means of restraint. Two residents used one bedrail and some had enablers to support movement in and out of bed. Detailed risk assessments had been completed regarding the use of bedrails and records of decisions were available to show the decision was made in consultation with the resident or representative, staff nurse and general practitioner (GP). Decisions were also reflected in the resident's care plan and subject to review.

The inspectors were informed that various alternative equipment such as, pillows, enablers and floor mats were tried prior to the use of bedrails. This formed part of the
Due to their medical conditions, some residents displayed behaviours that challenged them or those around and responding to them. During the inspection, staff approached residents in a sensitive and appropriate manner, and the residents responded positively to techniques used by staff. Support and distraction techniques were used at times for those with responsive behaviours. Minimal use of PRN (as required) psychotropic medicines prescribed for some residents was used as a last resort according to staff spoken with. The PRN medicine administration records within the past month confirmed this.

Records to capture the antecedents, behaviour and consequences (ABC) formed part of the assessment process. However, staff required further education and training in this area to ensure every effort was made to identify antecedents and/or triggers of behaviours in order to minimise the consequences for all other residents sharing the communal area. This requirement is included in the action plan of outcome 18.

Support from the community psychiatry team was available on a referral or follow-up basis. Staff spoken with were familiar with the interventions used to respond to residents with responsive behaviour. However, improvement was required to ensure a structured and personalised daily programme was put in place for individuals that included activities specific to their likes and interests to promote positive behavioural support. This requirement is included in the action plan for outcome 11.

Judgment:
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:
This outcome was reviewed by inspectors and overall the health and safety of residents, visitors and staff was seen to be promoted in the centre. The garden was accessible from the sun room, with a new outdoor smoking area now in place. Following a review of this area, which was located in a wooden shed, a fire blanket and suitable ashtrays were in place. However, the soft furnishings on the seating frame did not contain evidence of flame retardancy.

There were risk management policies and procedures in place. The policy contained the procedures required by regulation 26 and schedule 5 to guide staff. Staff were familiar with the contents of the emergency plan. The risk register in place was well maintained.
and updated on a monthly basis, this was overseen by the provider. Each risk assessment set out the identified risk, the level of risk identified, the steps taken to mitigate the risk and the person responsible for taking the action. The documents were thorough and covered a wide range of areas. Incident and accident reporting provided information to support the reduction of identified risks. There was also an up-to-date health and safety statement available signed and dated by the director of the entity.

The records of fire safety maintenance and checks confirmed that there were routine checks to ensure fire exits were unobstructed, automatic door closer were operational and fire fighting equipment was in place. Annual checks were carried out on the fire safety equipment, and the fire alarm was serviced on a quarterly basis. Clear signage was in place throughout the centre guiding residents, visitors and staff to the nearest exit. The layout of the centre was zoned and this was outlined in a sign with narrative, there was no visual map displayed to clearly outline this to residents, staff and visitors to the centre.

The procedure to follow in the event of a fire was posted in different parts of the centre, and staff were able to describe their role in evacuation when the inspectors spoke with them. Records confirmed that all staff had completed refresher training in fire safety procedures. A record of fire drills showed that seven individual drills had been carried out in the last year. Although night staff had completed fire safety training all the drills had been completed in daylight hours, and all night staff had not been involved in a drill when there was minimum or reduced staffing in place.

The centre was separated for fire safety purposes into two compartments or zones. Zone one consisted of communal day space and one bedroom for three people. Zone two was identified to inspectors as having the remaining 13 bedrooms in two corridors within the building. This zone was set out and can accommodate up to 22 residents but there were 18 on the day of the inspection. Residents dependencies varied and a number of residents were identified who would need the assistance of one or two staff in the event of an emergency or fire. This was clearly recorded on individual evacuation plans kept up-to-date by the person in charge. However, this had not been tested by staff completing a fire drill. Some simulated fire evacuation drills from all parts of the building had been maintained. One record identified the need to involve night staff, but did not appear to have been acted on to date, with an updated record to inform learning or improve fire safety arrangements. The provider was given an immediate action to review fire safety and evacuation arrangements in the centre. The provider confirmed she would request an immediate review and undertake a fire safety risk assessment and update HIQA accordingly.

Identified clinical risks were well documented and addressed in a timely manner, with the involvement of the person in charge and senior staff. For example, the follow-up on any falls and incidents included referral and review by the physiotherapist. Moving and handling assessments were up-to-date and the use of any assistive equipment monitored closely to ensure adherence to best practice including servicing and staff training.

There were safe procedures in place for the prevention and control of infection and the centre was clean, hygienic and well presented. Personal protective equipment was
available in the centre, and there were hand gel sanitizers available throughout the
centre. Staff were observed practicing hand hygiene.

**Judgment:**
Non Compliant - Major

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**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.
The processes in place for the handling of medicines, including controlled drugs, were safe and in accordance with current guidelines and legislation.

Systems were in place for ordering, supply and dispensing methods. There were appropriate procedures for the handling, checking, reporting errors, return and disposal of medicines. An inspector saw that controlled drugs were stored safely in a double locked cupboard and stock levels were recorded at the beginning and end of each shift in a register in keeping with legislative requirements.

Nursing staff demonstrated safe practices in medicine administration and management. The inspector observed the staff nurse consulting with residents during the administration of medicines and performing good hand hygiene.

A system was in place for reviewing, reconciliation and monitoring of medicine management practices was in place. The use of psychotropic and sedative medicines on a PRN basis was subject to audit and reviews. The records showed low levels used or administered.

An arrangement for the review of prescribed medicines by the GP on a three monthly basis was in place, and records were available to demonstrate this arrangement was implemented in practice.

The pharmacist was available to residents if required and involved in the management and delivery of prescribed medicines to residents in the centre. Staff and residents were satisfied with the pharmacy service provided.

**Judgment:**
Compliant
### 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. The person in charge was aware of the legal requirement to notify the Chief Inspector regarding incidents and accidents.

HIQA was in receipt of unsolicited information that was followed up with the provider on this inspection. The detail of the complaint had been followed up by the provider, and the centre had carried out a comprehensive investigation as per their policy. Nonetheless, a formal notification of the allegation had not been made by the provider or person in charge at the time. Appropriate measures were actioned and there was clear evidence on learning. All accidents and incidents were recorded. However, a review of the process was required to ensure that all notifiable incidents are notified to the Chief Inspector within the three-day timeframe.

**Judgment:**
Substantially Compliant

### Outcome 11: Health and Social Care Needs

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

**Theme:**
Effective care and support

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

**Findings:**
Arrangements were in place to provide nursing, medical care and allied healthcare for residents.

A selection of resident records and plans were reviewed. A pre-admission assessment
was completed prior to resident admission and formed part of the centre's admission policy and routine practice. However, some gaps in the completion of this document were found and to be actioned under outcome 5.

There was a documented assessment of all activities of daily living, including communication, personal hygiene, continence, eating and drinking, mobility, spirituality and sleep. Social and recreational plans such as 'a key to me' were also completed in a sample reviewed. There was evidence of a range of assessment tools being used to monitor areas such as the risk of falls and malnutrition, mobility status, cognition, skin integrity and risk of developing pressure ulcers.

The development and review of care plans was done by a key worker in consultation with a resident or their representative. Each resident’s care plan was subject to a formal review at least every four months or as changes occurred. Feedback received from residents and relatives also confirmed this.

Inspectors were told there were no residents at the end of life. An assessment of resident’s views and wishes for the end of life were seen recorded and outlined in a related care plan and subject to regular reviews. A care plan to include details and information made known to staff regarding religious, spiritual and cultural practices or named persons to assist residents in decisions and arrangements made was noted in the records reviewed. A collaborative decision regarding active treatments such as cardio pulmonary resuscitation formed part of the assessment and care planning process. Decisions between the resident and or representative, their GP and a nurse was seen recorded for some residents; however, gaps in assessments that informed decisions regarding active treatment plans was found. A recorded decision for one resident was partially completed and did not reflect the resident's decision or specify the assessed decision. The person in charge agreed to follow up on this matter at the inspection.

Inspectors reviewed the management of clinical issues including wound care and falls management and found they were subject to regular assessment and reviews of planned care. However, it was established that a pressure relieving mattress put in place to meet the assessed needs of a resident had been removed due to the lack of pressure relieving mattresses in the centre and to meet the changed needs of another resident. Both were assessed as maximum dependency, at high risk of developing pressure ulcers and in need of pressure relieving device to mitigate the risk. However, suitable and sufficient resources or arrangements were not in place to meet the assessed needs of all residents due to a lack of available resources. This is an improvement also referenced in outcome 2.

Physiotherapy and occupational therapy (OT) services were available to residents on a referral basis. Residents had suitable mobility aids and modified chairs following seating assessments by an occupational therapist or a physiotherapist. Hand rails on corridors and grab rails were seen in parts of the facilities used by residents. However, in order to influence a model of support and promote resident independence, an audit of the suitability of the existing furniture available including beds, headrests, grab rails in two toilets, armchairs and sofas was required in association with the resident profile and their assessed dependency. This action is outlined in outcome 13. As observed on inspection, some of the beds were static/divan beds without an attached head rest or
height adjustment option, and some of the seats and furniture in bedrooms and communal areas was low and or deep rendering it difficult to stand/get up from.

Residents were satisfied with the healthcare service provided and good access to general practitioner (GP) services was reported. Four GPs were providing a service to the resident group and out-of-hours medical cover was available. A range of other services was available on a referral basis including chiropody, speech and language therapy (SALT), and dietician and tissue viability advice services. An inspector reviewed residents’ records and found that some residents had been referred to these services and results of appointments were written up in the residents’ notes and care plans.

Communication systems were in place to ensure that residents’ nutritional and care needs were known by staff supporting residents to eat and drink and to those preparing and serving food. Procedures were 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’ clinical observations that included regular monitoring of weight, desire for recommended food and fluid consistency and intake. A dietician was assessing and reviewing a number of residents in the centre during this inspection.

Residents were seen enjoying various activities at times during the inspection. Each resident’s likes and preferences were assessed, known by staff and daily activities undertaken were recorded and seen in logs made by the activity coordinator/manager that worked from 10:30 to 12:30 three or four mornings weekly. Music and singing songs coordinated by a volunteer was seen to be enjoyed by a group of residents on the afternoon of the inspection. A morning group activity was seen to be a positive experience for 12 residents. However, all group activities took place in the main day/dining area due to the limitations of communal space elsewhere. The noise, stimuli and activity levels in this area for all residents including those not partaking in a group appeared to challenge some residents present. The role of the physical environment in understanding and working proactively to support residents and or manage residents’ arousal required review. This is discussed further in outcome 13.

Emphasis was placed on family engagement. Residents were encouraged and facilitated to access external functions deemed appropriate and family events. Two residents attended a day care centre three days weekly. One had decided to remain in the centre on the day of inspection and this was facilitated.

Religious ceremonies were celebrated, and a monthly mass service in the centre was available to residents. A visit by a minister of another faith was by arrangement via family. Overall, most residents had opportunities to participate in meaningful activities that were purposeful to them and which suited their needs, interests and capacities. However, as outlined in outcome 7, some improvement was required for those with responsive behaviours and or an inability to communicate verbally or actively engage in a larger group.

**Judgment:**
Substantially Compliant
**Outcome 12: Safe and Suitable Premises**
The location, design and layout of the centre is suitable for its stated purpose and meets residents’ individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

**Theme:**
Effective care and support

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

**Findings:**
This is a small centre which is family owned and operated and this provider has been involved and operated the centre since 1997. This centre is located in a suburb of Dublin in a ground floor single-storey bungalow, which has been extended over the years provides accommodation for older people.

The provider had partially addressed the non-compliances relating to the premises and facilities in the centre. The provider had outlined a programme where flooring, decorating, and the premises had been reviewed over the last year. Improvements were visible to inspectors with suitable flooring, décor in communal spaces and bedrooms and provision of an outdoor smoking area.

The general maintenance of the premises had improved, and external pathways and gutters were clear, and the secure private garden well maintained. The visitors room had been repurposed and was now used for activities, private dining and family meetings. Signage had also improved and an additional shower is now in place for residents use. However, not all aspects of the Schedule 6 requirements were addressed including:

- some bedside lockers and furniture were marked and damaged requiring replacement
- inadequate storage arrangements for food in freezers in the boiler room
- unsuitable storage of prescribed food supplements in an external building
- storage of three wheeled commode/shower chairs in a shower room
- absence of wall-mounted drying rack for sluice room
- grab rails in two toilets not fitted in place to promote independence
- flooring in two bedrooms (7 & 3) heavily marked and worn, and not securely fitted
- laundry room is by an external route and the doorway is partially blocked by a large washing machine which is a hazard for staff working in this area

Progress to review the use of three multi-occupancy rooms was reviewed. The centres' accommodation is all on the ground floor with 14 bedrooms in total. Six single rooms (one with toilet en-suite), five twin rooms (one with toilet en-suite) and three three-
bedded rooms. The smaller of the multi-occupancy three bedded bedroom had been re-configured since the last inspection. The built-in wardrobes had been removed, and a new sink put in place. However, the outcome of this review of the layout did not ensure that each resident had suitable and sufficient space around their beds, screening and wardrobe space and seating in place. The provider was informed that further review of this bedroom in terms of occupancy was required at the time of feedback.

On the day of the inspection the centre was a comfortable temperature, with adequate lighting and ventilation in place. The layout had not changed since the last inspection other than how one room was organised. Plans to extend the centre and upgrade the premises had not progressed.

Three communal shower rooms were now in place for use at the centre, there was no bath available for use. Five toilets were available for residents located throughout the centre. Staff changing and toilet were also in place. The kitchen was well organised, visibly clean and well equipped to meet the needs of the residents. An office/clinical room was located near the front reception where private meetings could taken place and the provider and person in charge were based.

Overall, although improvements were noted, the premises did not meet the requirements of the National Standards for Residential Care Settings for Older People in Ireland (2016). Particularly relating to provision of day space and availability of shower/baths to meet the dependencies of the residents and the numbers applied for. For example, the noise, stimuli and activity levels in the main sitting area, for all residents including those not partaking in a group appeared to challenge some residents present.

Judgment:
Non Compliant - Moderate

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

Findings:
The updated complaints policy was displayed in the reception area. The inspectors noted that it did not fully meet the requirements of the Regulations. Arrangements outlined to inspectors that the provider was the complaints person, and the person in charge oversaw the complaints process. However, there was no evidence of any review of the outcome of complaint by the person in charge. Details of the appeals process should a complainant be dissatisfied with the outcome were not clear. The right to access the services of the Ombudsman was clearly outlined within the policy.
The provider has also designed an easy-read colour poster which was displayed on the notice-board in the reception area, to promote feedback to improve service provision. The complaints policy was also provided to each resident within their written residents guide. Residents, relatives and staff spoken with were aware of the procedure if they wished to make a complaint.

Complaints and feedback from residents were viewed positively by the provider and the person in charge and used to inform service improvements. The inspectors read the complaints records relating to any complaints which were logged over the previous 12 months. As outlined in outcome 5 the records required improvement and the outcomes were not clear, nor were the satisfaction of the complainant recorded. The appeals process as was in place at the time of the last inspection had now changed and both the provider and person in charge were not found to be clear about their individual in terms of the updated complaints policy and legislative requirements.

**Judgment:**
Non Compliant - Moderate

### 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:**
There were no residents receiving end-of-life care in the centre at the time of the inspection. There was access to specialist community palliative care services, when appropriate or through acute services.

A person-centred approach was evidenced by the detail provided within individual assessments and end-of-life care plans. The end-of-life care plans in place for residents clearly documented residents' preferences.

A number of residents were accommodated in twin and triple shared rooms. However, for those residents who were considered to be approaching end-of-life, a single room was considered if available, in recognition of maintaining the dignity and privacy of both parties previously sharing, respecting the privacy and dignity of either party.

The policy on end-of-life care addressed all physical, emotional, spiritual and social needs of residents at end of life and promotes respect and dignity for dying residents. The person in charge had recently updated this policy.
An annual remembrance service was hosted each year acknowledging the lives of all those who passed away within the previous year.

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

**Findings:**
Inspectors saw that there had been improvements around the provision of sufficient staff to assist and supervise mealtimes. This enhanced residents’ mealtime experience to ensure that all residents’ needs are met in a timely manner. Medicines are now given after mealtimes so that residents can enjoy their meal without interruptions. Nurses and care staff were available to assist and provide clinical supervision in both the dining and day rooms during meals. One resident exercised a choice and preferred to dine in their room and was served first. Residents confirmed to inspectors their satisfaction with the meals, choice and quality of the food, drinks and snacks available to them. Each resident is provided with food and drink at times and in quantities adequate for his/her needs.

Suitable furniture including seating and tables were now in place to promote independence while eating snacks or meals. The layout of the day space had been reorganised to meet the dining needs of all residents at the centre. Residents’ mealtime experiences are monitored by the person in charge as well as feedback from residents. This is reviewed on a monthly basis by the management team, incorporating feedback from resident meetings.

Suggestions for improvement regarding the food, choices, presentation, assistance given, seating arrangements, ambiance or facilities was actively sought from both the Residents and staff. The records of the meetings reviewed by inspectors confirmed the actions taken following each meeting.

The recommendations of dietetic reviews, including any special dietary requirements were implemented by staff.

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

**Findings:**
There was evidence that residents were consulted with and had opportunities to participate in their daily routine and comment on the organisation of the centre. A resident’s committee was operational that discussed important items such as the food, staff, laundry service and activities. This was chaired by the activity coordinator who was contracted to fulfil this role. Residents had opportunity to meet on a daily and regular basis with staff and management that worked in the centre.

Family members’ had opportunities for involvement in resident care and welfare, and decisions. The inspectors established from speaking with residents, relatives and staff that opportunities to maintain personal relationships with family and friends in the wider community was encouraged. Visitors were unrestricted except in circumstances such as an outbreak of infection. A record of visitors to the centre was maintained.

Access to and information in relation to the events, the complaints process and independent advocacy services was available to residents. Residents’ independence, choice and autonomy were promoted. Voting arrangements for residents were facilitated internally and externally to enable residents exercise their rights. Residents who spoke with inspectors and those who completed questionnaires said they were able to make decisions about their care and had choices about how they spent their day, when and where they ate meals, and when they rise from and return to bed. Residents had options to meet visitors in a private, or communal areas based on their assessed needs which addressed the action from the previous inspection.

Clocks, communication aids and telephones were available to residents. A daily newspaper was available and notice boards. Wi-Fi and computer access was not available but to be explored if requested by a resident.

The inspectors saw that residents' personal privacy and dignity was respected during this inspection as personal care was provided for residents in their bedrooms. Staff knocked on doors and awaited permission before they entered and call bell facilities were available. Communal bathrooms and toilets were available and are discussed in Outcome 13.

Residents were seen to be well groomed and dressed in their own clothes with personal
effects of their choosing. Nonetheless, screening between two beds, had not been fully addressed and required further review. Residents who spoke with inspectors and those who completed questionnaires said they were respected, consulted with and cared for by kind staff.

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 were systems in place to safeguard residents’ personal property possessions. Unsolicited information relating to access to personal monies had been received. The inspectors confirmed that the provider was not a pension agent for any resident at the centre. The inspector reviewed the policy and procedures in place, and found that there were records of personal property, and of property held for safe keeping. As outlined in Outcome 5 some of the sample of records required improvement, and the policy was not fully reflective of the findings of this inspection relating to residents' property and possessions.

There was a small laundry room on-site where residents' personal laundry was completed. Arrangements for regular laundering and of clothing, and safe return were discussed with the provider. The person in charge confirmed that each resident had their clothing labelled for safe return of all items. All sheets and towels are now laundered off-site by an external provider. An external laundry services collected soiled lined and returned clean linen to the centre three times a week.

Each resident had access to a lockable drawer beside their bed to store their belongings. One of the multi-occupancy bedroom layout did not allow for a resident to store their belongings beside their bed space. Some residents also preferred to keep their bedrooms locked and had a keylock or key made available to them to ensure privacy.

Judgment:
Substantially 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
**Theme:**
Workforce

**Outstanding requirement(s) from previous inspection(s):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
Since the last inspection the skill-mix and management hours available for the person in charge had improved. Inspectors reviewed actual and planned rosters for staff, and found that staffing levels and skill-mix was sufficient to meet the needs of residents. Ongoing review of resident dependency and staffing levels were monitored monthly to inform staffing levels and skill-mix. Staff spoken to confirmed that they had sufficient time to carry out their duties and responsibilities, and nursing staff explained the systems in place to supervise staff. The centre had a process of staff appraisals in place. Staff spoken with felt supported by the management team.

Evidence of current professional registration for all registered nurses working in the centre was seen by inspectors. Training records showed that extensive training had been undertaken and staff spoken with confirmed this. This included in house mandatory training on safeguarding and safety, patient moving and handling, fire safety and infection control. All staff nurses had additional requirements such as medication management and cardio pulmonary resuscitation. The training matrix records were completed for all staff training. Recruitment and induction procedures were in place. All documents as required by Schedule 2 of the regulations for staff were maintained, and staff did not commence in employment until their Garda Vetting disclosures were available. The activities staff member had a part-time role, and had been vetted in line with legislation. There were no volunteers working at the centre.

There were appropriate staff numbers and skill-mix on duty to meet the assessed needs of the residents on the day of the inspection. The provider and person in charge confirmed that staffing numbers were increased to facilitate the inspection. Nonetheless, the resident and relative feedback confirmed staff availability and staffing provision was adequate.

Staff were observed to have a gentle approach and knew residents and their care needs well. All had attended mandatory the training programme. However, as discussed in Outcome 8 further training in dementia care and managing responsive behaviours was required to up skill some staff in this area.

**Judgment:**
Substantially 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:

Leone Ewings
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
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 01: Statement of Purpose

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The statement of purpose was not fully in line with Schedule 1; information about the layout of the bedrooms and multi-occupancy rooms was required. In addition, the complaints procedure was not fully outlined and references to our Standards were not updated.

1. Action Required:

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Under Regulation 03(2) you are required to: Review and revise the statement of purpose at intervals of not less than one year.

**Please state the actions you have taken or are planning to take:**
The Statement of Purpose has been updated to provide more information about the layout of the bedrooms and multi-occupancy rooms, details of our appeals process as per the complaints procedure and correctly reference the current HIQA Standards. A copy of this has been given to our inspector for review.

**Proposed Timescale:** 26/10/2017

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### Outcome 02: Governance and Management

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The management team did not demonstrate a full understanding and accountability of their roles and responsibilities in terms of complaints, notifications in terms of regulatory responsibilities and specific roles.

**2. Action Required:**
Under Regulation 23(b) you are required to: Put in place a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

**Please state the actions you have taken or are planning to take:**
The Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) was fully reviewed by both the PIC and Provider-nominee together to clarify all of the above and to ensure improved effectiveness in the management and control of operations within our nursing home.

The PIC & Provider-nominee meet weekly to discuss Residents’ health, staffing, equipment, training, complaints, restraints, risk register, safety, notifications, staff meetings, recent / upcoming changes, etc. and to set goals, set time frames, agree work plans and allocate roles & responsibilities to ensure effective delivery of care and plan for any areas where improvements or additional resources are required.

Residents health and experiences are discussed to ensure that their needs assessments are informing their individual care plans, staffing levels and training needs.

Risk management is prioritised and the risk register is reviewed and evaluated to inform best practice and continuous improvement.

Audit outcomes are discussed and learning from same is used to agree actions required to improve our quality of service for our Residents.
Key Performance Indicators monitored on a daily basis are analysed weekly and used to inform and evaluate how we manage our services. Areas addressed include falls, pressure ulcers, restraints, incidents, infections, complaints, etc.

Additionally we have set up monthly review and evaluation meetings to monitor outcomes and benchmark them against our Statement of Purpose, our Annual Review Plan and inspection findings. Part of this is to identify and address any gaps to ensure robust management and governance systems. In this past month we have done work to reinforce our communications, resource allocation and planning, and safety systems and to discuss and improve the use of meaningful activities for Residents with reduced physical, cognitive or communication abilities or responsive behaviours. We have also reviewed our premises with a view towards ongoing improvements and both our notifications and management of complaints systems to identify and learn from previous gaps in these areas.

Further elements of our governance leadership will be evaluated and reviewed on a continuous basis in order to strengthen ourselves in this important aspect of running our nursing home and progress our compliance in this area.

**Proposed Timescale:** 07/10/2017

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The provider had not completed the proposed works to improve premises as outlined to HIQA at the time of the last registration renewal. Some clinical equipment including pressure relieving equipment, was not readily available to meet the changing healthcare needs of residents.

**3. Action Required:**
Under Regulation 23(a) you are required to: Ensure the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.

**Please state the actions you have taken or are planning to take:**
The providers and our management team are fully committed to improve our compliance level and our staff are as committed as we are to creating the best possible home for our residents.

As previously stated in earlier reports, Glencarrig Nursing Home has been operating as a nursing home for over 27 years. It is a non-purpose built premises. To bring it into full compliance with all the requirements of Regulation 17(2) is challenging but as we previously committed on this subject we worked tirelessly with our architect to come up with a cost-effective design which would satisfy all the required criteria. We lodged our plans for improvements and extension to the nursing home in December 2013 and received full planning permission in February 2014, followed by Fire Certification & DAC.
Following this we engaged with a full team of professionals & consultants including Architect, QS, PDSP, Structural Engineer and Services Engineer to work through all of the necessary stages such as various site investigations and building surveys, cost estimation and analysis and phasing plans (to reduce the impact on our residents). It was at that time hoped that the planned building work would be undertaken and completed in 2015. However we received a major set-back regarding financing for these works and worked tirelessly in an attempt to secure the finances needed throughout all of 2015 and 2016.

We will continue pursuing financing options so that we can continue back on track to finalise the tendering stage and commence (and complete) the building work at the earliest opportunity. In the interim, we will attempt to progress our plans on an incremental basis prioritising improvements to our communal and bedroom spaces.

Two additional pressure relieving mattresses were made available for use 21/09/17.

**Proposed Timescale:** 21/09/2017

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**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 following policies were found to require review and did not fully reflect practices in the centre or were fully evidence-based:
- Residents’ property and possessions policy
- Continence policy
- Mealtimes policy

**4. 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:**
Residents’ property, Continence and Mealtimes polices are all being reviewed and updated in accordance with best practice and to reflect our up-to-date procedures. Associated documentation will also be reviewed and updated accordingly. Designated staff teams will be involved in both the review and implementation of identified improvements in each of these areas and will also audit their effectiveness at one-month, three-month, six-month and then annual intervals. Audit outcomes will be monitored and discussed by the management team and further improvements actioned as needed.
**Proposed Timescale:** 30/11/2017  
**Theme:** Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
Schedule 3 and 4 records were not fully maintained relating to pre-admission assessments, fire drills, additional charges and resident property lists.

**5. 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:  
Pre-admission assessment document was updated to ensure all sections would be fully completed in the future. Resident property list for one item which had not been dated was updated, all other resident property lists were reviewed to ensure personal property was fully listed, signed and dated and found to be correct. Additional charges for one resident were expanded on appropriately for clarification. Additional charges for all other residents were reviewed to ensure any charges were fully explained and found to be correct.

Our Fire drills records have been reviewed and expanded to include a comprehensive Fire Drill Evaluation record sheet which includes a description of the simulated conditions, time taken to evacuate and any further actions required to improve our practices and procedures. It includes a scored rating system in relation to the Initial Response, Evacuation Response, Staff Knowledge and Fire Alarm Equipment. It will identify any deficiencies in staff knowledge or skills, fire prevention and evacuation equipment as well as modifications needed to improve our fire safety or evacuation procedures. This will be used to evaluate and inform our fire response and evacuation procedures, equipment and training. We will review both our drills and the evaluation sheet on a monthly basis over the next three months in terms of effectiveness and as part of our current review and evaluation of our fire safety and evacuation procedures.

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**Proposed Timescale:** 12/10/2017  
**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:**  
Up to 18 residents could be located in their bedrooms within zone 2, as identified to inspectors in terms of containing any potential fire in this large space.
This was part of an immediate action plan given to the provider on the day of the inspection.

6. Action Required:
Under Regulation 28(2)(i) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

Please state the actions you have taken or are planning to take:
As advised to on the day of the inspection, we immediately engaged the services of a competent professional to undertake a fire safety risk assessment of our premises which is due for completion 03/11/17. A preliminary review of fire safety for our premises 20/09/17 and is of the opinion that the management of Glencarrig Nursing Home is complying so far as is reasonably practical with the specific requirements of the applicable legislation relating to fire safety and especially Section 28 of the Health Act 2007 (Care & Welfare of Residents in Designated Centres for Older People) Regulations 2013 (S.I.415 of 2013). As part of the forthcoming Fire Safety Risk Assessment to review in detail our overall fire safety measures including the issues of emergency evacuation and compartmentation layout in line with best standards.

We have a valid Fire Safety Certificate, written confirmation from a properly and suitably qualified person with experience in fire safety design and management, that we complied with all statutory requirements relating to fire safety and building control as well as all requirements of the statutory fire authority in 2014.

To further address the queries raised, we are also reviewing our fire safety and evacuation arrangements in-house.

Resulting improvements to date include:
Simulated day-time and night-time fire drills / evacuations were carried out (with reduced staffing for the night-time drills) 10/10/17
Fire drill evaluation sheet developed to improve recording, assessment, review and better inform the effectiveness and suitability of our fire safety and evacuation procedures, fire prevention and evacuation equipment, and staff knowledge and skills. 20/10/17
Ski-sheets for immobile Residents will be sourced 03/11/17
2 additional fire doors will be installed in the bedroom corridors to compartmentalise that area 30/11/17

Our Fire Safety policy and evacuation procedures will be updated to reflect any recommendations or learning from both our internal and external reviews and any measures that may arise will be actioned immediately.

On completion of the above, our Fire Safety practices and evacuation procedures will be audited in relation to effectiveness and compliancy and any further measures required actioned immediately.

Proposed Timescale:
Theme: Safe care and support
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The arrangements including simulated drills for evacuating where necessary in the event of fire of all persons in the designated centre, and safe placement of residents were not fully practiced as part of the overall drill procedures.

This was part of an immediate action plan given to the provider on the day of the inspection.

7. 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:
We have had 4 fire-drills in the first half of this year, 2 of which simulated evacuation of residents from different bedrooms to the other fire compartment in January and March. Additionally we had refresher fire training in May, June, and July.

Additional fire drills were carried out on 10/10/17 and included both day-time and night-time (with reduced staffing) evacuation scenarios.

Our Fire drills have been reviewed to extend the range of simulation scenarios practiced. We have also developed a comprehensive Fire Drill Evaluation record sheet which includes a description of the simulated conditions, actions taken during the drill, the number of staff involved, the number of people evacuated, evacuation equipment used, the time taken to evacuate and any deficiencies / learning / further actions required 12/10/17. This will be used to evaluate and inform our fire response and evacuation procedures, equipment needs, and frequency and type of fire drills needed.

It is planned to carry out additional Fire drills on a monthly basis over the next 3 months. We will review our simulation scenarios, drills and the evaluation sheet each time in terms of effectiveness and as part of our current review and evaluation of our fire safety and evacuation procedures.

Proposed Timescale: 30/10/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Soft furnishings in the external wooden smoking lodge were not fire retardant.

8. Action Required:
Under Regulation 28(1)(a) you are required to: Take adequate precautions against the risk of fire, and provide suitable fire fighting equipment, suitable building services, and
suitable bedding and furnishings.

**Please state the actions you have taken or are planning to take:**
The soft furnishing was removed from the Garden Lodge.

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**Proposed Timescale:** 19/09/2017

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Evacuation procedures in place at night time when minimum staffing levels of two are in place were not evidenced in the records reviewed. This was part an immediate action plan given to the provider on the day of the inspection.

**9. Action Required:**
Under Regulation 28(1)(d) you are required to: Make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.

**Please state the actions you have taken or are planning to take:**
2 of our fire-drills this year, in January and March, simulated evacuation of residents from different bedrooms to the other fire compartment. Night-time evacuations with reduced staffing were discussed both times although this was not specifically practiced fully or timed. We had night-staff fire training in July which focussed on night-time fire precautions, placement and use of assistive evacuation equipment at night-time as well as responding to and managing a fire situation and evacuating Residents from their bedrooms with reduced staffing.

To improve our fire practices, simulated night-time fire drills / evacuations were carried out with reduced staffing to reflect our night-time staffing levels 10/10/17.

Our Fire drills have also been reviewed and expanded and now include a comprehensive Fire Drill Evaluation record sheet which includes a description of the simulated conditions, time taken to evacuate and any deficiencies / learning / improvements required. It includes number of staff involved, number of people evacuated and evacuation equipment used 12/10/17.

It is planned to carry out additional Fire drills, including night simulation drills, on a monthly basis over the next 3 months as part of our current review and evaluation of our fire safety and evacuation procedures.
Proposed Timescale: 30/10/2017

Theme: Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The two zones or compartments in use at the centre were not clearly illustrated on the fire alarm safety plan.

10.   Action Required:
Under Regulation 28(3) you are required to: Display the procedures to be followed in the event of fire in a prominent place in the designated centre.

Please state the actions you have taken or are planning to take:
A plan of the building clearly indicating each room and the two zones / compartments has now been put at the fire panel and the fire alarm safety plan.

Proposed Timescale: 29/09/2017

Outcome 10: Notification of Incidents

Theme: Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Robust systems were not in place by the person in charge in terms of recognising when something was notifiable to HIQA in line with regulatory requirements.

11.   Action Required:
Under Regulation 31(1) you are required to: Give notice to the chief inspector in writing of the occurrence of any incident set out in paragraphs 7(1)(a) to (j) of Schedule 4 within 3 working days of its occurrence.

Please state the actions you have taken or are planning to take:
As part of our auditing, evaluation and review processes we will ensure that we meet the requirements regarding submission of 3-day notifications.

Proposed Timescale: 20/10/2017

Outcome 11: Health and Social Care Needs

Theme: Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Recording gaps in assessments that informed decisions regarding active treatment plans was found.

A measure put in place to meet the assessed needs of a resident had been removed due to the lack of pressure relieving mattresses in the centre despite both residents assessed as a high risk of developing pressure ulcers.

In order to influence a model of support and promote resident independence, an audit of the suitability of the existing furniture available including beds, headrests, grab rails, armchairs and sofas was required in association with residents assessed dependency.

Some improvement in individual activity provision was required for residents with responsive behaviours and or an inability to communicate verbally or actively engage in a larger group.

12. **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:**
Two additional pressure relieving mattress were provided immediately on the 21/09/17, one to meet the assessed needs of one of our residents plus a spare to provide for future sudden changes in our residents needs.

An audit of existing furniture and supports is in process and all items identified as requiring replacement / improvement are being attended to immediately. Proposed completion by 30/11/17 or before.

We will continue working with our individual Residents and our activities team looking at and adapting our activities program taking each resident’s likes, dislikes, level of engagement, enjoyment, reaction, environmental factors and responsive behaviours into account. Additional to this an Activities care plan is under development for Resident’s with responsive behaviours which will be evaluated and adapted on an ongoing basis to reflect any improvements or changes in the Resident’s needs or responses. 15/11/17

**Proposed Timescale:**

**Theme:**
Effective care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Improvement was required to ensure a structured and personalised daily programme or care plan was put in place for individuals that included activities specific to their likes and interests to promote positive behavioural support.

13. **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:**

Compilation of personalised daily & activity programs for residents whose behaviours and needs suddenly change can take time in some cases. Positive behavioural support is a long-term approach which requires drawing on a resident’s remaining skills, capabilities and interests within their newly reduced cognitive and / or physical status. It involves getting a clear picture of the resident as they are now, how they cope with their environment and how their newly changed needs can be met while continuing to maximise their independent functioning and promote their own control over their daily activities. Identification of both the predisposing and precipitating factors is required as well as observation of the resident’s engagement, enjoyment and / or reaction to a range of both supported and independent activities.

Regular updating of individual Resident’s ADL assessments and social / recreational plans, physiotherapy, OT, SALT, dietician and GP referrals, documenting behavioural charts, working with our activities team to trial and observe different environments and activities to improve each Resident’s level of both engagement and enjoyment and regular discussion at staff / clinical meetings and during the daily handover of same form part of our ongoing approach to meet the unique and changing behaviours and needs of each of our Residents.

These assessments and observations are integrated into each Resident’s care plan where both triggers that can result in increased anxiety or agitation and approaches / activities that can result in positive responses are documented. Care plans are updated and reviewed each time there is a change in a Resident’s responsive behaviour and to record successes as they are achieved to improve the Resident’s day-to-day quality and enjoyment of life.

Additional to this, an Activities Care Plan is under development for Resident’s with responsive behaviours to highlight suitable activities that are of interest to them which minimise their levels of anxiety or agitation. This will be integrated with the existing care plans and both evaluated and adapted on an ongoing basis to reflect any improvements or changes in the Resident’s needs or responses. Daily activity sheets will record the activities the Resident engaged with / participated in each day and their responses to same, environmental factors will also be noted. These sheets will be reviewed and evaluated in conjunction with behavioural charts to explore patterns and discern which activities positively support the Resident the most. 15/11/17

The cornerstone of success in reducing responsive behaviours is not to accept that how things are currently for the Resident is the best that can be achieved but to continue striving to find more successes to improve the quality of their day.

We will continue looking at each resident’s changed / changing behaviours and needs from every possible angle and working with our multi-disciplinary and activities teams to promote each Resident’s functioning and positive engagement throughout each day.
Proposed Timescale: 15/11/2017

Outcome 12: Safe and Suitable Premises

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The premises does not meet the needs and requirements of all residents in the centre and required improvement:
- day space was limited for 25 residents and was under the minimum required spatial standard
- three showers for 25 people was under the minimum recommended numbers and not meeting the numbers based on dependency of residents accommodated in centre
- some bedside lockers and furniture were marked and damaged requiring replacement
- inadequate storage arrangements for food in freezers in the boiler room
- unsuitable storage of prescribed food supplements in an external building
- storage of three wheeled commode/shower chairs in a shower room
- absence of wall-mounted drying rack for sluice room
- grab rails in two toilets not fitted in place to promote independence
- flooring in two bedrooms (7 & 3) heavily marked and worn, and not securely fitted
- laundry room is by an external route and the doorway is partially blocked by a large washing machine

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

Please state the actions you have taken or are planning to take:
Day space may indeed be limited and slightly under the recommended spatial standard but there is ample seating and dining room for 25 residents as well as ample room for Residents to move freely about and to undertake a range of activities either on their own, with their visitors, in groups or all together. We understand that a suitable environment is important for maintaining independence and promoting quality-of-life as is the importance of ‘places and spaces’ for living. Ease of moving about the home is important, especially for those with limited mobility, and as older people may prefer to spend a lot of time indoors it is important to provide a variety of interesting, accessible environments for their stimulation and comfort.

We have 4 main communal rooms plus several seated lounge areas plus our outdoor garden lodge all of which are used daily by our Residents and their visitors. Residents can sit or dine anywhere of their choosing and receive guests in private or in any communal area. Diverse activities such as music, TV or group activities, for example, could be facilitated in 3 of our rooms while the 4th room is still available as a quiet space for reading, chatting or crafting activities. Each room has many alternative uses and can accommodate individuals or small or large groups together as per our
Residents choosing or to meet their individual or collective interests and needs. After extensive renovations to all of our communal areas last winter, a series of alternative room layouts were trialled in consultation with the Residents to increase the spaciousness in each room and to see how best we could use those spaces to better meet our Residents’ needs. All feedback from Residents, families & visitors has been extremely positive, with repeated comments on how bright, airy and spacious our communal areas have become. None of our residents or families feel that there are spatial constraints or a lack of room to meet their interests or needs.

Some of our Residents have a preferred sitting area and spend much of their day in their desired spot but many more of our Residents enjoy the diversity of ambling around or sitting in different areas at different times of the day and freely do so or are assisted to do so if needed. We have sufficient space in our living room for all 25 Residents to gather together for celebrations and popular activities. We have sufficient space in both our lounge and our living room to bring numerous tables and chairs together to facilitate group activities such as arts, crafts, baking, potting plants or flower arranging or communal dining for increased socialisation and special occasions. We have sufficient space for our tables and chairs to be spread out or clustered in small groups so that Residents can choose whether to sit, read, relax or dine alone, with a friend or in a group together in different configurations at different times of the day / week to suit their individual personal preferences and needs. We may have limited space but we have enormous flexibility and diversity and make excellent use of our environment as is evidenced by the positive feedback from our Residents and visitors on this topic.

Our décor throughout was conceived during a 6-month comprehensive consultation and creative process with our Residents and their families aimed at providing a range of stimulating environments to match their interests and needs. There is a mix of visual and tactile themed decorations either hand-made by our Residents or personally selected by our Residents relating to favourite outdoor themes ranging from forests, beaches, gardens, flowers and trees and other personal interests ranging from movie stars, music, memorabilia and spiritual themes. Many Residents who wouldn’t have had any interest in doing so in the past now enjoy strolling along the corridors reminiscing about places they’ve been, activities they used to enjoy and times gone past.

We have continued making further improvements with the residents’ input throughout this year including the addition of our refreshment station, music wall, garden wall, memorabilia corner, arts, crafts & private dining room and garden lodge and will continue looking for ways to improve even more on an ongoing basis, especially as our residents’ needs or interests change. A review of all space within our building is ongoing on a continuous basis as is our schedule of daily activities to maximise the use and effectiveness of all of our space taking into account the diverse and changing needs of our Residents. Completed and ongoing.

With the addition of a 3rd shower early this year, we find that we have ample showering facilities for 25 Residents. Residents choose when and how often they would like to shower, no Resident is ever waiting for a shower to be free and in fact it is a rare occurrence that all 3 showers would be in use at the same time. This will be reviewed on an ongoing basis as our Residents’ choices or needs change and additional showers
will be installed if the assessed need for same arises. Completed and ongoing.

Two items of furniture have been removed and an audit of the remaining furniture is being carried out with all items identified as requiring replacement / improvement being attended to immediately. Proposed completion by 30/11/17 or before. This will be reviewed on an ongoing basis so that all furniture can be replaced as needed on a planned phased basis.

Food is not normally stored in the freezers in the boiler room as could be noticed by my complete surprise at any being there. It is usually brought directly into the kitchen storage area. All kitchen and delivery staff have been reminded never to store food items there and notices have been placed in the boiler room as well. Completed 20/09/17.

Prescribed food supplements arrive in bulk once a month and are usually brought directly into the office while they are being sorted. As our monthly order was scheduled to arrive on the morning of the inspection, and in order to facilitate ease of the inspection, we had decided to store them temporarily in sturdy boxes in closed storage cupboards in a locked external building which has a separate key to ensure they were secure and safe from unauthorised access for the day. We had taken recent temperature recordings to ensure they would not be exposed to excessive heat or humidity while there. They were brought into the office that evening. We will revert to and continue our usual practice of bringing them directly into the office upon delivery. Completed 19/09/17.

The use of and storage of commodes was immediately reviewed and alternative arrangements put in place. This will be reviewed on an ongoing basis as the needs of our Residents’ change. Completed 21/09/17 and ongoing.

Drying rack in sluice room and additional grab rails in toilets were installed, completed 10/10/17.

Flooring in rooms 3 & 7 immediately fixed 20/09/17. Flooring in all other bedrooms reviewed and found to be in safe condition. An audit of bedroom flooring is being carried out so that a replacement program for flooring identified can be planned on a phased basis over the next year.

Proposed Timescale: 30/11/2017

Outcome 13: Complaints procedures

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The records of the outcome of complaints were not fully maintained in the centre by provider.
15. **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:**
Our complaints records have been updated to ensure the outcome of each complaint will be recorded.

**Proposed Timescale:** 10/10/2017

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

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A record informing a complainant of the outcome of the complaint reviewed by inspectors did not contain details of the appeals process.

16. **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:**
Our complaints records have been updated to ensure that details of the appeals process will be given to complainants.

**Proposed Timescale:** 10/10/2017

**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:
The layout of three beds in one three bedded room did not allow for adequate levels of privacy and dignity or screening in place between two bed spaces.

17. **Action Required:**
Under Regulation 09(3)(b) you are required to: Ensure that each resident may undertake personal activities in private.

**Please state the actions you have taken or are planning to take:**
This room was completely reconfigured less than a year ago. Various room layouts and furniture options were discussed with the Residents in the room. They chose the existing layout (as well as the décor and furniture) as they feel it matches their own
personal preferences as well as meeting their own needs the best.

In light of the concerns raised this room layout has been re-evaluated again to maximise privacy and personal space for each Resident and improve screening between bed spaces taking into account each Resident’s personal and dependency needs. A copy of proposed plans has been submitted to our inspector.

**Proposed Timescale:** 25/10/2017

### Outcome 17: Residents' clothing and personal property and possessions

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

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
One of the residents in a three bedded room did not have adequate space to store personal possessions beside their own bed space.

18. **Action Required:**
Under Regulation 12(c) you are required to: Provide adequate space for each resident to store and maintain his or her clothes and other personal possessions.

Please state the actions you have taken or are planning to take:
This room layout has been re-evaluated to maximise personal space for each Resident and to enable each Resident store their personal possessions within their own bed space. A copy of proposed plans has been submitted to our inspector.

**Proposed Timescale:** 25/10/2017

### Outcome 18: Suitable Staffing

**Theme:**
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff development and training in dementia care and managing responsive behaviours was required to upskill staff in this area.

19. **Action Required:**
Under Regulation 16(1)(a) you are required to: Ensure that staff have access to appropriate training.

Please state the actions you have taken or are planning to take:
Staff training linking into activities to support and minimise responsive behaviours is being sourced. It is envisaged that 2 staff will be trained and they will then embed this learning with our other staff in order to integrate this area to a greater extent into our Residents care plans and to ensure that each Resident engages in meaningful activities.
Residents’ patterns of responsive behaviour in conjunction with daily activities records will be analysed to evaluate the positive or negative impact of participating in each activity, taking into consideration the changes which may occur in tandem due to progression of their conditions.

This will be audited in conjunction with our existing audits on dementia and responsive / challenging behaviours.

**Proposed Timescale:** 15/12/2017