

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Glendale Nursing Home
<b>Centre ID:</b>	OSV-0000228
<b>Centre address:</b>	Shillelagh Road, Tullow, Carlow.
<b>Telephone number:</b>	059 918 1555 or 059 918 1500
<b>Email address:</b>	nursinghome@glendale.ie
<b>Type of centre:</b>	A Nursing Home as per Health (Nursing Homes) Act 1990
<b>Registered provider:</b>	Glendale Care Limited
<b>Provider Nominee:</b>	John Mangan
<b>Lead inspector:</b>	Catherine Rose Connolly Gargan
<b>Support inspector(s):</b>	Gemma OFlynn
<b>Type of inspection</b>	Announced
<b>Number of residents on the date of inspection:</b>	50
<b>Number of vacancies on the date of inspection:</b>	10

## About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

- Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- to carry out thematic inspections in respect of specific outcomes
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or wellbeing of residents.

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration decision. This monitoring inspection was announced and took place over 2 day(s).

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

From: 22 June 2016 09:30 To: 22 June 2016 17:30

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

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

**Summary of findings from this inspection**

This inspection took place in response to an application to change the entity of the centre. The current provider took over ownership of this centre in 2014. The provider is also changing the name of the centre from Glendale Nursing Home to Sonas Glendale Nursing Home. Inspectors also followed up on progress with completion of the action plans from the last inspection in the centre in January 2016. There were 11 actions from the last inspection, four actions were satisfactorily completed and

findings on this inspection did not support satisfactory completion of seven actions. These actions are restated in the action plan for this inspection.

The inspectors found that positive improvements had been made to the environment since the last inspection with creation of a comfortable sitting-room that opened out onto a new enclosed garden. This action, taken by the provider and staff team significantly enhanced the environment for all residents but especially for residents with dementia. In combination with reorganization of the layout of the large reception area and improved signage, the centre was found to provide a therapeutic and comfortable environment for residents. The collective feedback from residents was one of satisfaction with the service and care provided. Community and family involvement was encouraged with residents confirming their relatives/visitors felt welcome at all times. Staff were observed to be respectful and responsive to residents at all times during this inspection.

While improvements had been made since the last inspection in January 2016, the findings on this inspection confirmed that further substantial improvement is required in clinical governance and the management structure in the centre. Inspectors found that the systems in place to monitor the quality and safety of clinical care and the quality of life for residents were not adequate. The management of complains also required improvement. Key senior management roles were not fully embedded at the time of this inspection.

Residents had satisfactory access to healthcare, medical and allied health professionals and their care needs were met. However, improvement was required with documenting their care needs and the interventions necessary to address their identified needs. Consultation with residents regarding their end of life wishes and review of their care plans required improvement.

There was adequate staff numbers and skill mix to meet the needs of residents on the day of inspection and residents were supervised as appropriate with an increase in staffing resources in the evening time each day.

The Action Plan at the end of this report identifies improvements that must be made to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

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

***Outcome 01: Statement of Purpose***

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

**Theme:**

Governance, Leadership and Management

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

No actions were required from the previous inspection.

**Findings:**

There was a written statement of purpose available updated in January 2016 and a copy was forwarded to HIQA as required. However, this document required revision to reflect the changed entity and management structure regarding the name of the centre, reporting structure, details of the changed persons in management including the person in charge, deputy person in charge and the general manager as persons participating in management of the centre. Some other areas of the document also required review to ensure this document accurately the service provided to residents.

**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):**

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

**Findings:**

The governance and management structure changed in 2014 with a new provider and

management team. While improvement since the last inspection by HIQA in January 2016, the process of establishing governance structures and a full management team was still in progress and not fully embedded. The inspectors found that a clearly defined clinical management team needs to be fully implemented with clearly defined roles and lines of authority and accountability. The general manager role was found to be well established providing comprehensive administrative support in the day to day running of the centre. The person in charge was on planned leave on the day of inspection. Although the provider had put arrangements in place to ensure the needs of residents were met in the absence of the person in charge, deputising arrangements for the person in charge required review to ensure they met regulatory requirements. The centres' assistant director of nursing was deputising for the person in charge on the day of inspection with the support of an experienced nurse. The provider nominee was also on-site. The provider and management team expressed their commitment to achieving good standards in quality person-centred care through continuous improvement of the service they provided. The provider had completed a report detailing his review of the quality and safety of the service for 2015. While this quality review was comprehensive, improvements in relation to auditing processes were required to robustly inform priorities in future improvements in the service.

As found on the last inspection, inspectors found that audits were being done to monitor the quality and safety of care and the quality of life for residents. However, they did not consistently inform sustained improvement. This was demonstrated by inspectors' findings where some audits done in key clinical areas did identify areas for improvement, but this information was not analysed in some cases or action plans were not developed to address areas of deficit found. The inspectors also saw that some actions taken did not ensure the deficits were comprehensively addressed. For example, some deficits found by inspectors on this and the last inspection in January 2016 in medication management and care planning were not actioned although identified in audits done in these areas by the service. There was also evidence of recurrence of trip-risk posed by placement of walking frames identified in audits. These findings did not support a conclusion that there was learning from findings of audits done to review the quality and safety of care.

The provider attends the centre on average, twice weekly or more often if required and clearly demonstrated his commitment by work undertaken to date to provide a quality and safe service for residents in the centre. Dementia care was identified by the team as an area for development and refurbishment of the environment in that context was at an advanced stage. Improvements undertaken promoted the independence of residents with dementia and enhanced their comfort and quality of life.

**Judgment:**

Non Compliant - Moderate

***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
<p><b>Outstanding requirement(s) from previous inspection(s):</b> No actions were required from the previous inspection.</p> <p><b>Findings:</b> A sample of residents' contracts was reviewed and were found to be signed and dates. Some residents had signed their own contracts. However, details of additional fees were not clearly stated in some contracts reviewed. For example, the fee charged for activity provision was not stated.</p> <p>A residents' guide document was available to residents but required review to reflect the change in entity including title and personnel.</p>
<p><b>Judgment:</b> Non Compliant - Moderate</p>

<p><b><i>Outcome 04: Suitable Person in Charge</i></b> <b><i>The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.</i></b></p>
<p><b>Theme:</b> Governance, Leadership and Management</p>
<p><b>Outstanding requirement(s) from previous inspection(s):</b> No actions were required from the previous inspection.</p> <p><b>Findings:</b> An acting person in charge of the centre commenced in the role in February 2016 to replace the previous person in charge. The acting person in charge is a registered nurse and has many years experience of caring for dependent persons. While, the acting person in charge has completed numerous qualifications to deliver staff training and has the required experience in managing the centre, the acting person in charge has not completed a postgraduate management qualification in health or a related field as required by the regulations. The provider advised inspectors that a new person in charge was commencing in this role and forwarded the statutory notification to this effect to HIQA following this inspection.</p>
<p><b>Judgment:</b> Compliant</p>

<p><b><i>Outcome 05: Documentation to be kept at a designated centre</i></b> <b><i>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</i></b></p>
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***2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.***

**Theme:**

Governance, Leadership and Management

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

No actions were required from the previous inspection.

**Findings:**

The inspector found that records listed in Part 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) were maintained and available for review.

Written operational policies as required by Schedule 5 of the Regulations were available on inspection.

The directory of residents was maintained in an accessible format.

Some records as required by Schedule 3 and 4 of the regulations were inconsistently maintained and required improvement. For example, completeness of some statutory notifications to HIQA. and nursing care plan details.

Records to be maintained in respect of each resident as described by the regulations contained loose sheets of paper and as such posed a risk of loss of this documentation.

**Judgment:**

Non Compliant - Moderate

***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:**

There were arrangements in place for absence of the person in charge. The provider was in the process of reviewing the arrangements in place to ensure they were robust.

**Judgment:**



Compliant

***Outcome 07: Safeguarding and Safety***

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

**Theme:**

Safe care and support

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

No actions were required from the previous inspection.

**Findings:**

The training records viewed by the inspectors showed that staff received ongoing training in the prevention of abuse and safeguarding vulnerable residents. Staff spoken with confirmed to inspectors that they had received this training and were aware of what to do if they suspected or were informed of an allegation of abuse. The provider told the inspectors that he maintained a no-tolerance policy to any form of abuse in the centre. The inspectors observed notices to that effect in the reception area.

There were no allegations of abuse under investigation at the time of this inspection. The inspectors observed that no allegations of abuse were recorded or notified to the Authority since the new provider took ownership of the centre in 2014.

Some residents presented with episodes of psychological and behavioural symptoms of dementia. Inspectors observed that residents experiencing responsive behaviours were well supported with management of their symptoms by the care procedures in place. Care provided by staff to residents was respectful and gentle.

Evidenced based assessments and treatment plans were in place for residents with responsive behaviours. The majority of staff had attended training on dementia care and managing behaviours that challenge. Inspectors were advised that this training was ongoing to completion for all staff. There were no residents prescribed medications PRN (as required) as a chemical restraint. The inspectors saw that bedrails were currently being used for many residents, some of which were requested by residents to support their mobility and comfort while in bed. There was evidence of alternatives tried to ensure most bedrail use was appropriate. While bedrail assessments were completed for most residents with bedrails in use, this required improvement to ensure use of bedrails that restricted residents' mobility consistently reflected national restraint policy guidelines.

There was documentary evidence that residents were being checked while bedrails were in use. The staff team were working towards reducing the use of bedrails in the centre with low-low beds, additional equipment and further education for staff.

**Judgment:**  
Substantially Compliant

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

**Theme:**  
Safe care and support

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

**Findings:**  
Overall the health and safety of residents and others was promoted and protected. Fire safety policies and procedure were viewed by an inspector and were found to be centre-specific. The centre was compartmentalised for fire safety purposes and compartments were protected with fire doors. Fire safety management procedures were in place and included a daily check of the escape routes. The inspectors observed no fire doors were held open on this inspection by wedges. The inspectors were told that magnetic units fitted to hold doors open on corridors released to allow the doors to close on activation of the fire alarm. Inspectors also observed that most wooden fire doors to the outside of the building had been replaced with glass doors improving protection and visibility for residents.

Training records confirmed that fire training was provided to staff on various dates. Regular fire evacuation drills were undertaken which demonstrated effective evacuation and improvements for the future with the most recent fire drill completed on 25 May 2016. Each resident had an evacuation assessment and a plan completed to meet their emergency evacuation needs. Staff spoken with were aware of what to do in the event of fire making reference to the centre's established evacuation procedures.

The centre's health and safety statement was reviewed since the last inspection in January 2016. The risk management policy and risk registrar viewed by the inspectors referenced numerous safe working practice procedures and hazard identification sheets with control measures. Hazards to residents in the centre as observed by inspectors on this inspection were identified with appropriate controls in place to mitigate the level of risk they posed. Inspectors observed that supervision of residents had improved since the last inspection with rostering of an additional care staff member in the evenings. Hazards requiring risk assessment identified by inspectors on the last inspection in January 2016 were satisfactorily addressed. Since the last inspection;

- an area of corridor accessible to residents without handrails fitted on the last inspection were fitted with suitable handrails
- uneven areas of the floor surface on some corridors that posed a trip risk to residents were satisfactorily resurfaced,
- a door which was heavy to open for residents to an internal garden and smoking was

addressed.

Risk management procedures were in place and included risk of abuse, violence and aggression, self harm, unexplained absence of a resident, accidental injury to residents, visitors or staff as required by the regulations. The inspectors observed additional procedures were in place to address the risk of vulnerable residents leaving the centre unaccompanied. Exit doors were alarmed to alert staff of their inadvertent opening. Staff had completed a missing person drill and each resident had a missing person profile completed to assist the emergency services with their safe recovery if necessary. A checking procedure to ensure all residents were accounted for was completed and documented by a staff nurse at regular intervals.

The inspectors saw that numerous clinical risk assessments were completed for each resident including falls risk, pressure related skin damage, continence, moving and handling and risk assessments for individual residents who smoked. Controls were in place to protect residents who smoked including a staff call-bell installed in the external smoking hut. The provider utilised sensor alarms to support residents at risk of falls. The inspectors observed discreet use of these alarms when residents were in bed and also resting in chairs during the day in the sitting areas and at mealtimes. Accidents and incidents involving residents were recorded and were found to be responded to appropriately on an individual basis to prevent re-occurrence. Care plan documentation outlined strategies to mitigate clinical risks while also supporting residents' independence. Low-beds and crash mats were also used to prevent injury where appropriate.

The premises were visibly clean. Personal protective equipment such as gloves and aprons were readily available and hand sanitizers were located at the entrance to the centre and throughout resident and staff areas. The inspectors observed that staff took opportunities to cleanse their hands using the alcohol gels provided as appropriate on this inspection. The laundry room system was consistent with the recommendations of the prevention and control of healthcare associated infections standards with a separate entrance and exit door which were appropriately used by staff.

**Judgment:**  
Compliant

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

**Theme:**  
Safe care and support

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

**Findings:**  
Inspectors observed that medications were stored, and disposed of appropriately in line

with An Bord Altranais Guidance to Nurses and Midwives on Medication Management (2007). Residents' prescribed medications were being reviewed at least on a three-monthly basis. All medications prescriptions were completed in line with medication prescribing legislation including instruction some tablet preparations for residents with swallowing difficulties.

An inspector observed medication administration in the dining room. The nurse administering medications wore a red apron to inform others of her role and to avoid disturbance. The inspector observed that the nurse administered and recorded medications as prescribed in line with professional guidelines with the exception of signing administration records before administration of medications to residents. There were also some instances observed where medication for administration to residents was handled by staff involved in administration of medications. These findings are addressed and actioned under outcome 11.

A medicines information sheet was completed for each resident by the pharmacist that included the name and a photograph of each medicine prescribed for them, indications for use and possible side effects. Each resident's allergy status was clearly indicated. Prescriptions were transcribed by nurses and were in line with professional guidelines for this practice. The pharmacist was facilitated to meet their statutory obligations to residents.

A separate record was maintained for each resident that included details of courses of antibiotic, anti-psychotic, anti-depressant and anxiolytic medications administered.

**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:**

Incidents as described in the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 were reported in accordance with the requirements of the legislation with the exception of a notification of pressure related skin injury identified on this inspection as occurring in late 2015. This notification was subsequently forwarded by the provider to HIQA following this inspection. Quarterly notification requirements were forwarded to the Authority as required however, details of restraint use in the centre required review to ensure all restrictive measures used to protect residents were appropriately notified.

The provider and clinical management team were aware of their legal requirements regarding notifications to the Chief Inspector including serious injury to residents.

**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):**

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

**Findings:**

There were 50 residents accommodated in the centre. Two residents were in hospital on the day of this inspection and one resident was on holiday with family. 15 residents were assessed as having maximum dependency needs, 22 had high dependency needs, nine had medium and four had low dependency needs.

Residents had good access to a choice of GPs, allied health professionals, palliative care and psychiatry of older age services. Residents' documentation confirmed they had timely access to these specialist services as required. Residents spoken with expressed their satisfaction with the care they received. The inspectors found that the healthcare needs of residents including residents with a diagnosis of dementia were generally met, however as found on the last inspection in January 2016, some areas of clinical practice required further improvement to ensure residents' needs were comprehensively assessed and documented to guide care practices. A dietician attended the centre as necessary and assessed residents with or at risk of unintentional weight loss and set out recommendations to supplement their intake as appropriate. However, recommendations made were not consistently documented in some residents' care plans reviewed. Residents' weights were checked on a monthly basis or more often if necessary to facilitate identification and timely interventions. Reference sheets were available outlining residents' special diets including diabetic, modified consistency diets and thickened fluids.

The inspector found on this inspection that arrangements were in place to meet residents' assessed health and social care needs. Residents' care needs were assessed using validated risk assessment tools. While there were no deficits identified in the care residents were given, some residents' assessed care needs were not comprehensively documented in a care plan or needs identified lacked sufficient detail to inform

consistent, appropriate staff interventions. Daily progress notes were completed and were generally linked to care plans; however, the content required some improvement. Residents' care plan documentation was difficult to navigate posing a risk that relevant information to inform care practices would not be readily accessible. This finding was discussed with a senior member of staff deputising for the person in charge and communicated to the provider during a meeting at the end of the inspection. Residents and their relatives were involved in care plan development. However, many of the care plans were developed at the time of residents' admissions and needed updating to reflect current needs and care interventions required. Although staff documented their regular review of care plans, there was an absence of documentation supporting consultation with residents and/or their next of kin to ensure the care and support provided reflected the assessed needs and wishes of residents.

Staff training recorded confirmed that staff had attended training on safe moving and handling procedures. Inspectors saw that hoists were used as appropriate to support resident transfers. However, evidence of outdated moving and handling practices were seen throughout the course of the inspection. For example, some chairs in the sitting-room did not facilitate the hoist to be positioned within close proximity to residents, necessitating secondary manual positioning. The inspectors also observed outdated moving and handling techniques when assisting residents from a sitting to standing position.

As discussed in Outcome 9; pre-signing of some residents' medication administration records before administration of their medications was observed by inspectors. There were also some instances observed where medication for administration to residents was handled by staff involved in administration of medications. Findings regarding moving and handling procedures and some medication administration practices did not reflect professional standards or contemporary evidence based nursing care.

There was some evidence of a small number of residents developing pressure related skin ulcers in the centre. The inspectors reviewed pressure ulcer preventative procedures and wound care provided where pressure ulcers developed in the centre. Procedures to prevent pressure related skin ulcers were satisfactory. Assessment of risk of skin breakdown was completed with equipment such as pressure relieving mattresses and cushions in addition to care procedures including repositioning used appropriately. Wounds were assessed by staff using an appropriate measurement system which assessed size, type, and exudates and included a treatment plan. Photographic evidence was also obtained. However, a treatment plan was not documented for one resident reviewed. Tissue advisory specialists were consulted as necessary to support staff with management of wounds and a resident's seating was reviewed by an occupational therapist.

**Judgment:**

Non Compliant - Moderate

***Outcome 12: Safe and Suitable Premises***

***The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and***

*homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.*

**Theme:**

Effective care and support

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

No actions were required from the previous inspection.

**Findings:**

The design and layout of the centre meets its stated purpose. The centre is a single storey premises. Residents' accommodation in the centre consists of 60 single bedrooms with en-suite toilet/shower/washbasin, two dining rooms and three sitting rooms. An oratory is also available in the centre. The centre also has communal toilets and shower/bathrooms conveniently located throughout the centre. There is a spacious reception area where the receptionist, nurses station and person in charge's office is located therefore accessible to visitors and negating cause to access residents' accommodation to contact key staff.

One communal sitting room was recently refurbished to enhance the comfort of residents with dementia. This room opens out into a large enclosed garden, also recently created. This area provides a second safe enclosed area for residents. This communal sitting room facilitated residents with dementia to be in a quieter environment. The decor in the area was of a traditional style with items and furniture that was familiar to residents with dementia. The enclosed garden provided safe winding pathways through a varied and interesting environment. An enclosed pond populated by numerous ducks was created. Seating was placed at various points throughout. The provider advised inspectors that the outdoor seating was being upgraded and painted so resident could sit and relax in the garden. This area provided a comfortable and therapeutic environment for residents including residents with dementia.

The centre has adequate storage areas for residents' equipment. Residents also had adequate storage space in their bedrooms. The Laundry was located centre on-site and facilities and arrangements were observed to be of a satisfactory standard. The centre had a hair salon and clinical room.

The premises were brightly decorated, with natural light entering all resident areas. Work was ongoing with maintaining the internal fabric of the centre with painting and a floor carpet replacement programme. Handrails were located on all corridors, in showers and toilets. There was adequate assistive equipment to support residents' needs and service records were available and up to date. Bedrooms were equipped with a locker, chest of drawers, a wardrobe, a chair, a television and a bed for each resident. The inspector observed that many residents personalised their bedrooms with personal possessions and small items of furniture from their home. The provider told the inspectors that they encouraged residents to make the room 'their own' and to use items of their own furniture if they wished to enhance their comfort further in their new

environment.
<b>Judgment:</b> Compliant

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

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

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

**Findings:**  
There was a written operational policy and procedure for making, handling and investigation of complaints. The complaints procedure contained an appeals process. The complaints procedure was on display in the main foyer and at other locations in the centre.

The management team advised inspectors that most complaints were managed at a local level. Complaints that could not be resolved locally were escalated up to the provider. Inspectors reviewed the complaints log and found that the process for the management of complaints required improvement. The process for documenting complaints was inconsistent and the centre's complaint form wasn't always fully. This was noted on the last inspection in the centre in January 2016.

In a sample reviewed by inspectors, it was found that the outcome of the complaint was not always recorded. It was also not evident in the records reviewed whether the complainant was satisfied with the outcome of investigation of their complaint. There was also evidence that details of actions taken were not fully recorded and learning from complaints was not always clear due to inconsistent documentation procedures.

**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



<p><b>Outstanding requirement(s) from previous inspection(s):</b> Some action(s) required from the previous inspection were not satisfactorily implemented.</p> <p><b>Findings:</b> There was a policy available detailing end-of-life care procedures to guide staff. The policy in the centre is that all residents avail of advanced intervention including hospital admission unless documented otherwise. Inspectors observed that most care plans referenced the religious, social and spiritual needs of residents however, their wishes regarding place for receipt of this care was not consistently referenced. Individual religious and cultural practices were facilitated. There was a small non-denominational oratory available to residents for group or individual prayer and quiet reflection.</p> <p>There was evidence in medical records that end-of life care and decisions regarding resuscitation were documented by the GP. However, there was inconsistent evidence of discussion or input from residents or relatives in some residents' records or on a separate consent form to confirm this decision. Inspectors did not observe that these decisions were reviewed or updated regularly as residents' health improved to assess the validity of this clinical judgement on an ongoing basis.</p> <p>Palliative care services were available to support staff with management of residents' symptoms during end of life care including pain management.</p>
<p><b>Judgment:</b> Non Compliant - Moderate</p>

***Outcome 15: Food and Nutrition***  
***Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.***

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

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

**Findings:**  
The inspector found that residents were provided with a nutritious and varied diet to meet their nutritional needs in two dining room areas. The centre has policies in place to inform the management of residents' nutritional and hydration needs. The policies included evidence based practice and procedures to advise staff on nutrition assessment and hydration. An accredited nutritional risk assessment tool was used to assess

residents' needs. Residents' weights were regularly assessed, documented and closely monitored with corrective actions implemented where risk was identified. Staff were facilitated to attend training on food hygiene, and nutrition management. A dietician was available to residents on an as required basis.

Residents with swallowing difficulties were appropriately referred and assessed by the speech and language therapy (SALT) service.

However, there was inconsistent documenting of the dietician and SALT recommendations in residents' nutrition care plans. This finding is discussed in outcome 11. Details of recommendations made were copied to the kitchen for reference by the chef. Residents with swallowing difficulties who required assistance were assisted discretely and sensitively on a one to one basis by staff who maintained appropriate eye contact with the resident to ensure their safety with eating.

Inspectors saw that there was a choice of hot meal options offered on a daily basis to residents for their lunchtime meal. The menu was clearly displayed at residents' eye level on entering the dining room. Residents spoken with by the inspectors expressed their satisfaction with the food provided. The chef was observed to mingle among residents during mealtimes and residents confirmed that if they were not enjoying their meal or did not like the food on offer, the chef would always prepare an alternative for them. Residents had a choice of fluids to drink with their meals, jugs of fresh water in their bedrooms and were offered hot and cold beverages and snacks throughout the day.

**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):**

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

**Findings:**

There was evidence of significant improvement since the last inspection in January 2016 to ensure residents' rights were observed and met. There was an open visiting policy and residents told inspectors that contact with their family members was important to them. This was acknowledged by the provider and staff team who actively encouraged residents' visitors. Since the last inspection, the reception area in the centre was

rearranged to make the area inviting and conducive to small group gatherings. Comfortable seating was arranged in numerous clusters throughout the reception area. One area was themed in a café-style and a complimentary hot drinks dispenser was provided. This area also provided a comfortable and therapeutic environment for residents with dementia. Residents and relatives commended staff on how welcoming they were to all visitors. Residents could receive visitors in private if they wished and many were seen to visit in the reception area in the centre as well as in the communal sitting rooms and in some residents' bedrooms.

There was a suggestion box available in the reception area to gather any comments residents or their relatives wished to make. Residents' satisfaction surveys had been completed in late 2015 as a means of eliciting the views and satisfaction levels of residents. Inspectors were satisfied that staff treated residents with respect and ensured their privacy and dignity needs were met at all times. During discussions with the provider and management team, a strong emphasis was placed by them on these values. Staff were observed knocking on bedroom, toilet and bathroom doors and waiting for a response to enter. These findings were also confirmed by residents who spoke with inspectors. Inspectors observed staff interacting with residents in an appropriate and respectful manner. Many residents told inspectors of their satisfaction with the staff team caring for them and complimented their professionalism, kindness and gentleness in their approach to them.

There was an additional charge to the fee for activities in the centre. An activity assessment tool was used to ensure each resident had opportunity to participate in activities that met their interests and capabilities. A structured program of activities was in place and was clearly displayed. An activities coordinator was employed on a full-time basis and worked from Monday to Friday. Since the last inspection in January 2016, the provider had employed an additional carer to ensure residents were appropriately supervised and could enjoy recreational activities later into the evening and at weekends. The activity schedule provided for both cognitive and physical stimulation. Interactions with residents by staff generally reflected positive connective care. Inspectors found that staff knew residents well and connected with each resident on a personal level.

The centre had a minibus which is used to provide occasional day trips for residents to places of their choice. Links were being developed with the local community and volunteers assisted with providing entertainment for residents on a sessional basis.

A residents' committee met on a regular basis, this gave residents an opportunity to have an input in the running of the centre and express their views if they wished to do so. Minutes of the meetings were viewed by inspectors and referenced a good level of discussion including expressed satisfaction with their quality of life in the centre and the service they received. A quality of life committee had also been put in place which further enhanced communication between the provider, residents and their relatives.

Residents confirmed and inspectors observed that residents' religious and civil rights were supported. Religious ceremonies were celebrated which included weekly Mass. Inspectors observed some residents also spent some quiet time in the oratory. Inspectors saw that residents had access to televisions and radios. Newspapers were

available and the news topics were discussed each day if residents choose to join the group.

**Judgment:**  
Compliant

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

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

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

**Findings:**

The inspector observed that residents could maintain control over their personal possessions and clothing. Each resident had their own personal wardrobe which they could freely access and had sufficient space in their bedrooms to store their personal belongings. Residents could maintain control over their belongings and they had access to a lockable space to store valuables.

Residents clothing was discretely tagged to prevent loss of their clothing with a button-tagging system. The centre's laundry facility was located in the centre and arrangements and procedures were satisfactory to ensure residents' clothing was satisfactorily laundered. Designated laundry staff were responsible for this area. Residents spoken with by the inspector expressed satisfaction with the laundry service. The inspector observed that any incidents of lost or mislaid residents' clothing was adequately resolved, however, documentation required improvement to reference level of satisfaction with actions taken of the residents/relatives concerned. This finding is actioned in outcome 13.

The inspector observed that residents' clothing was clean and in good condition. Records were maintained of residents' property and were updated.

**Judgment:**  
Compliant

***Outcome 18: Suitable Staffing***  
***There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an***

*appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.*

**Theme:**  
Workforce

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

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

**Findings:**

The inspectors found that the numbers and skill mix of staff were appropriate to the assessed needs of residents. A minimum of two registered nurses were on duty at all times. Residents confirmed that there were staff available in sufficient numbers and with the appropriate skills and competencies to meet their personal and health needs. They spoke positively about staff and confirmed they were caring, responsive to their needs, and treated them with respect and dignity.

Staff observed and spoken with by inspectors demonstrated an understanding of their role and responsibilities in the delivery of person-centred care to residents. They demonstrated that they were knowledgeable about residents' individual needs, fire procedures and the process for reporting suspicions or allegations of abuse.

Staff told the inspector that they were well supported by the provider and that a good team spirit had been fostered among staff in the centre. The inspectors noted that there were staff meetings arranged and that a range of topics were discussed.

Supervision of staff was supported by a formal appraisal system since the last inspection in January 2016, to allow each staff member to be informed of their progress and strengths, and have opportunity to address their development needs. The provider advised that the staff appraisal system would inform staff training needs and the appointment of a new person in charge would ensure that areas already identified for improvement regarding care planning, safe moving and handling procedures and medication management practices would be addressed by enhanced staff guidance and supervision.

Staff were facilitated to attend professional development and mandatory training requirements as evidenced by the centre's training records given to inspectors.

There was a recruitment policy in place and inspectors were satisfied that staff recruitment was in line with the Regulations. The inspectors viewed a sample of staff files which contained full and satisfactory information and documents as specified in Schedule 2 of the Regulations including records of nurses' registration with An Bord Altranais agus Cnáimhseachais Na hÉireann.

**Judgment:**  
Compliant

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## 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:***

Catherine Rose Connolly Gargan  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority

## Health Information and Quality Authority Regulation Directorate

### Action Plan



### Provider's response to inspection report<sup>1</sup>

<b>Centre name:</b>	Glendale Nursing Home
<b>Centre ID:</b>	OSV-0000228
<b>Date of inspection:</b>	22/06/2016
<b>Date of response:</b>	26/07/2016

### Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non-compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

### Outcome 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 document required revision to reflect the changed entity and missing information as required by schedule 1 of the regulations.

#### **1. Action Required:**

Under Regulation 03(1) you are required to: Prepare a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Welfare of

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

Residents in Designated Centres for Older People) Regulations 2013.

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

Statement of purpose reviewed to reflected the changed entity and now contains all the information required by schedule 1 of the regulations

**Proposed Timescale:** 26/07/2016

**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:**

A clearly defined clinical management team needs to be fully implemented with clearly defined roles and lines of authority and accountability.

**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:**

A clearly defined clinical management team is being fully implemented  
New PIC has been appointed .All member of the management team have clearly defined roles and lines of authority and accountability

**Proposed Timescale:** 26/07/2016

**Theme:**

Governance, Leadership and Management

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

The system in place to monitor the quality and safety of care and the quality of life for residents required improvement to ensure that audits were comprehensive and areas of deficit identified, were addressed with a comprehensive action plan process.

**3. Action Required:**

Under Regulation 23(c) you are required to: Put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

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

An audit schedule is now in place for all areas .Information elicited for these audits will be analysed and action plans will be developed to ensure that deficits are



comprehensively addressed. We will also include a training programme for staff to ensure that there is learning from the findings of audits

**Proposed Timescale:** 26/07/2016

### **Outcome 03: Information for residents**

**Theme:**

Governance, Leadership and Management

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

A residents' guide document was available to residents but required review to reflect the change in entity including title and personnel

**4. Action Required:**

Under Regulation 20(1) you are required to: Prepare and make available to residents a guide in respect of the designated centre.

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

Residents' guide document updated which reflects change in entity including title and personnel

**Proposed Timescale:** 26/07/2016

**Theme:**

Governance, Leadership and Management

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

Details of additional fees were not clearly stated in some contracts reviewed. For example, the fee charged for activity provision was not stated.

**5. Action Required:**

Under Regulation 24(2)(d) you are required to: Ensure the agreement referred to in regulation 24 (1) includes details of any other service which the resident may choose to avail of but which is not included in the Nursing Homes Support Scheme or which the resident is not entitled to under any other health entitlement.

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

Details of additional fees are now clearly stated in all contracts

**Proposed Timescale:** 26/07/2016

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

**Theme:**

Governance, Leadership and Management

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

Some records as required by Schedule 3 and 4 of the regulations were inconsistently maintained and required improvement. For example, completeness of some statutory notifications to HIQA. and nursing care pan details.

**6. 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:**

Some records as required by Schedule 3 and 4 of the regulations were inconsistently maintained and required improvement. For example, completeness of some statutory notifications to HIQA.

HIQA notifications will now be completed as per regulations

Nursing care plans are now full completed with requisite details

**Proposed Timescale:** 26/07/2016

**Theme:**

Governance, Leadership and Management

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

Records to be maintained in respect of each resident as described by the regulations contained loose sheets of paper and as such posed a risk of loss of this documentation.

**7. Action Required:**

Under Regulation 21(6) you are required to: Maintain the records specified in paragraph (1) in such manner as to be safe and accessible.

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

All records are now filed in residents integrated folder

**Proposed Timescale:** 26/07/2016

**Outcome 07: Safeguarding and Safety****Theme:**

Safe care and support

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

Some bedrail assessments required improvement to ensure use of bedrails that restricted residents mobility consistently reflected national restraint policy guidelines.

**8. Action Required:**

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

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

New bedrails assessment will be introduced before the 10th august

**Proposed Timescale:** 10/08/2016

**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:**

Details of restraint use in the centre required review to ensure all restrictive measures used to protect residents were appropriately notified.

**9. Action Required:**

Under Regulation 31(3) you are required to: Provide a written report to the Chief Inspector at the end of each quarter in relation to the occurrence of any incident set out in paragraphs 7(2) (k) to (n) of Schedule 4.

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

All restrictive measures used to protect residents will be notified as per regulations.

**Proposed Timescale:** 26/07/2016

**Outcome 11: Health and Social Care Needs**

**Theme:**

Effective care and support

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

Some residents' assessed care needs were not comprehensively documented in a care plan or needs identified lacked sufficient detail to inform consistent, appropriate staff interventions.

A wound treatment plan was not documented for one resident reviewed.

Recommendations made by a dietician were not consistently documented in some

residents' care plans reviewed.

**10. 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:**

1. All residents assessed needs are now comprehensively documented.
- 2 Wound treatment plan in place for all residents with wound.
- 3 All recommendations by Healthcare specialists are consistently documented and will be audited regularly
- 4 All care plans are reviewed and changes made to reflect care needs

**Proposed Timescale:** 26/07/2016

**Theme:**

Effective care and support

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

Many care plans were developed at the time of residents' admissions and needed updating to reflect current needs and care interventions required.

There was an absence of documentation supporting consultation with residents and/or their next of kin to ensure the care and support provided reflected the assessed needs and wishes of residents.

**11. Action Required:**

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

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

Care plans are updated to reflect current needs and care interventions required. All care plans now clearly show who was consulted when compiling all care plans

**Proposed Timescale:** 26/07/2016

**Theme:**

Effective care and support

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

Moving and handling procedures observed as completed by staff with residents did not reflect contemporary evidence-based safe practices

Pre-signing of some residents' medication administration records before administration of their medications was observed and where medication for administration to residents was handled by staff involved in administration of medications.

**12. Action Required:**

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

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

All care workers will receive addition Moving and handling procedures Training before 1september.

All RNs will complete annual medication management update, Medication competency assessment completed for all RNs. Medication management audit completed 3 monthly

**Proposed Timescale:** 01/09/2016

**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 process for documenting complaints was inconsistent and the centre's complaint form wasn't always fully completed.

**13. Action Required:**

Under Regulation 34(2) you are required to: Fully and properly record all complaints and the results of any investigations into the matters complained of and any actions taken on foot of a complaint are and ensure such records are in addition to and distinct from a resident's individual care plan.

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

Staff will receive training in dealing with complaints.

Documenting of complaints is consistently and is audited weekly By PIC

**Proposed Timescale:** 01/10/2016

**Theme:**

Person-centred care and support

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

The outcome of complaints were not always recorded. It was also not evident in the records reviewed whether the complainant was satisfied with the outcome of investigation of their complaint. There was also evidence that details of actions taken

were not fully recorded and learning from complaints was not always clear due to inconsistent documentation procedures.

**14. Action Required:**

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

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

The outcome of complaints, actions taken and whether the complainant was satisfied with the outcome of investigation is now clearly recorded. Weekly audit of complaints will be completed by PIC. To ensure staff have an opportunity for learning, complaints will be discussed at staff meetings, handovers etc.

**Proposed Timescale:** 26/07/2016

**Outcome 14: End of Life Care**

**Theme:**

Person-centred care and support

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

Residents' wishes regarding place for receipt of end of life care was not consistently referenced in end of life care plans.

There was inconsistent evidence of discussion or input from residents or relatives in some residents' records regarding advanced decisions. These decisions were not reviewed or updated regularly as residents' health changed to assess the validity of this clinical judgement on an ongoing basis.

**15. Action Required:**

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

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

All end of life care plans are reviewed, Residents' wishes regarding place for receipt of end of life care are now consistently referenced in end of life care plans. Staff will receive training in advanced care planning. During the 4 monthly care plan review, end of life care plan will be reviewed with resident and/or Next of Kin, GP and clearly documented any change in resident end of life requests and conditions.

**Proposed Timescale:** 10/09/2016