# Compliance Monitoring Inspection report

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

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Dargle Valley Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000031</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Cookstown Road, Enniskerry, Wicklow.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>01 286 1896</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:darglevalleynh@eircom.com">darglevalleynh@eircom.com</a></td>
</tr>
<tr>
<td>Type of centre:</td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
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<tr>
<td>Registered provider:</td>
<td>Bluebell Care Limited</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Sheila McKevitt</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>Helen Lindsey</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Announced</td>
</tr>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>26</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>4</td>
</tr>
</tbody>
</table>
About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

Please note the definition of the following term used in reports: responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).
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: 17 January 2018 09:30  
To: 17 January 2018 16:00

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

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Our Judgment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome 01: Statement of Purpose</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 02: Governance and Management</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 05: Documentation to be kept at a designated centre</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>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 09: Medication Management</td>
<td>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>Compliant</td>
</tr>
<tr>
<td>Outcome 16: Residents' Rights, Dignity and Consultation</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 18: Suitable Staffing</td>
<td>Compliant</td>
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**Summary of findings from this inspection**

The purpose of the inspection was to inform the decision of the Authority in relation to the application by the provider to renew the registration of the centre.

There was evidence of good governance. The provider, person in charge and assistant home manager worked closely together. They had addressed the non compliances identified on the last inspection in April 2017. Inspectors noted further improvements were required in relation to residents' documentation.

Residents health and social care needs were being met. Safeguarding practices in relation to vulnerable adults were found to be good. Residents independence and right to choice in relation to their care needs were promoted. There was evidence of continued commitment to train staff. Inspectors saw evidence of good practice in relation to medication management, risk management, fire safety procedures and the health and safety of residents.

Residents spoken with expressed their confidence in the staff and management, and
overall said they felt safe and felt well cared for.

The action plans outlined at the end of this report reflects the issues to be addressed.
**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.*

<table>
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<tr>
<th>Theme:</th>
<th>Governance, Leadership and Management</th>
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<tr>
<td><strong>Outstanding requirement(s) from previous inspection(s):</strong></td>
<td>No actions were required from the previous inspection.</td>
</tr>
<tr>
<td><strong>Findings:</strong></td>
<td>A statement of purpose was submitted as part of the application to renew registration. It had been reviewed in November 2017 and outlined the overall aim of the centre and other details as specified in Schedule 1 of the Regulations. A copy was on display in the centre.</td>
</tr>
<tr>
<td><strong>Judgment:</strong></td>
<td>Compliant</td>
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</table>

**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.*

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<tr>
<td><strong>Outstanding requirement(s) from previous inspection(s):</strong></td>
<td>The action(s) required from the previous inspection were satisfactorily implemented.</td>
</tr>
<tr>
<td><strong>Findings:</strong></td>
<td>There was a clearly defined management structure which was reflected in the statement of purpose. The provider nominee (PN), person in charge (PIC) and assistant home manager work full-time. They met daily and had a formal quality improvement meeting once every month to discuss management issues. Minutes of these meetings were available for review and provided assurance that the governance of the centre was strong.</td>
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The person in charge who commenced in November 2017 was supported in her clinical role by the provider who is a registered general nurse. She previously held the post of assistant director of nursing and has experience in caring for older persons in a residential setting.

The PIC was recording key performance indicators each month on areas of clinical practice such as the number of wounds, falls, medication errors and admission to hospital to mention a sample. A system had been established and implemented to audit areas of practice. The PIC had commenced auditing practices in November 2017. The use of bedrails, medicine management, nursing documentation and accident and incident and falls had all been recently audited. The results of these audits were available for review, they required further work to ensure the results of each audit were analysed and where necessary an action plan developed. Inspectors saw evidence that the results of all audits were being discussed at the monthly quality improvement meetings and communicated to staff at staff meetings.

An annual review of the quality and safety of care delivered to residents had been completed for 2017. The analysis included resident feedback on the service and a quality improvement plan for 2018 was outlined in the draft report.

Judgment: Substantially Compliant

**Outcome 05: Documentation to be kept at a designated centre**
The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

**Theme:** Governance, Leadership and Management

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

**Findings:**
Two action plans from a previous inspection were followed up on, both were found to be in compliance.

The policy in relation to the recruitment of staff had been reviewed in 2016 and was found to be fully implemented in practice. A sample of four staff files were reviewed and found to contain all the required documentation as outlined in Schedule 2.

Judgment:
### Outcome 07: Safeguarding and Safety

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

**Theme:**
Safe care and support

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

**Findings:**
Measures to protect residents being harmed or suffering abuse were in place.

Residents spoken with felt safe in the centre. The premises was safe and secure. There was a visitors sign in book at the front door. There was a policy and procedure in place for the prevention, detection and response to abuse. Staff demonstrated a good knowledge of what constituted abuse and they all had up-to-date refresher training in place. The person in charge confirmed all staff had a vetting disclosure in place in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012. Inspectors reviewed a random sample of four staff files which confirmed this.

The management team did not manage any money on behalf of the residents. They acted as pension agents on behalf of a small number of residents' systems in place in relation to this practice were found to be in compliance when reviewed in April 2017.

Residents displaying responsive had a corresponding behavioural support plan in place. These care plans identified residents triggers, responsive behaviours and diversion therapies all of which were specific to the resident in question. Incidents of behaviours that challenge were being recorded and reported to the residents general practitioner. Inspectors observed staff using diversion therapy with a resident during the course of the inspection.

There was a low use of restraint in the centre. Where bedrails were in use there was a record of alternatives trialled, tested and failed prior to bedrails being used. Residents with bedrails in use had a care plan in place to reflect their use. Inspectors saw that a small number of relatives had consented for the use of bedrails on behalf of the resident. The provider and person in charge committed to reviewing this practice and to moving towards a restraint free environment. There was no chemical restraint in use.

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

Findings:
The health and safety of residents, visitors and staff was promoted and protected.

The centre had a risk management policy, an emergency plan and an updated health and safety statement in place. The risk register was kept updated having been last done in October 2017. It identified risks and specific measures put in place to reduce the level of risk. However, the risks identified had not been rated before or after measures had been put in place to control the risk identified.

Records reviewed on inspection showed that the fire alarm was serviced on a quarterly basis and fire safety equipment was serviced on an annual basis. All emergency lighting was serviced on an annual basis. Staff spoken with were clear on what to do in the event of the fire alarm sounding. All staff had completed fire safety training within the past year. Records reviewed showed that fire drills were practiced at least twice each year. Records of these fire drills reflected those in attendance however the recording of times and any issues for improvement could lead to enhanced learning. The inspector saw that there was adequate means of escape and fire exits were unobstructed.

Accidents and incidents were all recorded in detail and were being followed up on by the management team at their monthly quality improvement meeting. There was also audits being completed on this aspect of care.

Manual handling practices observed were in line with best practice and records reviewed showed all staff had up-to-date training in place.

Infection control practices were good overall with hand washing and drying facilities and hand sanitizers were available throughout the centre.

Judgment:
Substantially Compliant

Outcome 09: Medication Management

Each resident is protected by the designated centre’s policies and procedures for medication management.

Theme:
**Safe care and support**

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

### Findings:
Medication management was safe. Inspectors reviewed the practices and documentation in place relating to medication management.

All medicines were stored securely. All controlled (MDA) medicines were stored in a secure cabinet, and a register of these medicines was maintained with the stock balances checked and signed by a staff nurse and health care assistant at the end of each shift. There were procedures in place for the handling and disposal of unused and out of date medicines.

Inspectors reviewed the processes in place for administration of medicines, and were satisfied that nurses were knowledgeable regarding residents individual medication requirements. Practice observed reflected the policies.

The pharmacist was facilitated to meet all necessary obligations to residents in accordance with guidance issued by the Pharmaceutical Society of Ireland, and visited the centre monthly. The management team with the general practitioner were conducting reviews of each resident's prescribed medications on a quarterly basis. Medication management audits were being carried out and there was evidence that areas identified for improvement in the June 2017 audit had been addressed in practice.

Medication incidents including medication errors were recorded. The person in charge was monitoring medication errors.

There were written policies in place relating to the ordering, prescribing, storing, administration and disposals of medicines. The content of these policies overall were reflected in practice. Inspectors noted the procedure to follow when administering medications covertly was not clearly outlined in the policy. This policy was updated and submitted to inspectors post the inspection, it clearly outlined the procedure to follow.

### Judgment:
Compliant

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

Findings:
The health care needs of residents were met being met and residents had opportunities to participate in meaningful activities, appropriate to their interests.

Residents had access to general practitioner (GP) services and a full range of other services was available on referral including a consultant geriatrician, speech and language therapy (SALT), dietetic services, physiotherapy and occupational therapy. Chiropody, dental and optical services were also provided. Inspectors saw evidence of prompt referral of resident when required: for example, residents who had a fall had been reviewed by the physiotherapist and residents with weight issues had been reviewed by the dietician.

Nursing assessments, care planning and additional clinical risk assessments were carried out for residents. Those with identified needs had care plans in place to reflect these needs. Some care plans were not detailed enough to reflect the care to be provided these included care plans for diabetes, end of life and wound care. There was evidence that residents and/or relatives were involved in the development of their care plans.

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

Findings:
The action plan from the previous inspection was followed up on.

Inspectors walked through the centre and found that the location, design and layout of the centre was suitable for its stated purpose and met the residents' individual needs. Its layout was reflected in the plans submitted with the application to renew registration. The location, design and layout were also clearly outlined in the statement of purpose submitted with the application to renew registration.
The storage of hoists was found to be safe. Inspectors observed one hoist stored in an open plan area, its storage posed no risk to residents and was not obstructing any exit doors.

**Judgment:**
Compliant

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**Outcome 16: Residents' Rights, Dignity and Consultation**

Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

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

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

**Findings:**
Residents were consulted with and actively participated in the organisation of the centre.

Residents were treated with dignity and respect. Inspectors observed staff treat residents with the utmost respect. Staff appeared to know the residents well, they took time to communicate with residents and did so in a kind and patient manner. Residents received personal care in their own bedroom or a bathroom which could be locked.

There were no restrictions on visitors, relatives informed inspectors that they visited during the day and late evening. There was not a specific private visitor's room, but residents could meet with people in private in their rooms, or communal areas of the home. The main dining room and lounge was seen to be used by lots of people visiting the home.

Residents had been registered to vote and they were given the choice at election time. A polling officer visited the centre to enable people to vote. Residents confirmed that their religious and civil rights were supported. Residents were able to watch Mass streamed to the television from a local church. The rosary was said at the request of residents.

Residents had access to meaningful activities and had choice in relation to how they lived their life. There was a programme of activities that residents could choose to take part in. This schedule was on display so residents could view. There was an allocated activity coordinator who spent time with individuals and also did group activities. Group activities included upper limb exercise class, arts and crafts, meditation and bingo. Music and movies were also popular with the residents. Residents spoken with said they
generally enjoyed the activities and chose which ones to join. Residents who were unable to attend activities in the communal room were provided with 1:1 activities in their bedroom.

Residents’ meetings were held on a quarterly basis. Minutes were available for review. They covered topics such as the change of person-in-charge, changes to the premises, and the plans for holidays. There were contact details available on the notice board about advocacy services, and residents could be supported to access them if they required.

The provider had carried out surveys of family members about the quality of the service provided in 2017 however the analysis of these had not been completed to date.

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):
No actions were required from the previous inspection.

Findings:
There were sufficient numbers of staff with the right skills, qualifications and experience to meet the assessed needs of the residents.

There was an actual and planned staff rota. Inspectors saw that there was a minimum of one staff nurse on duty at all times and the numbers of staff rostered during the day and night took into account the statement of purpose and size and layout of the building. Residents spoken with confirmed that staffing levels were good and their requested needs to be met.

Residents spoken with told inspectors that staff were kind, patient and they felt well looked after. The feedback received on questionnaires was extremely positive.

Records reviewed confirmed that all staff had mandatory manual handling, protection of vulnerable residents’ training in place and all had attended refresher fire training within the past year. Training planned for 2018 included a variety of topics, such as, dementia care and management of responsive behaviours. A sample of staff files reviewed
showed all the required documents had been obtained prior to the staff member commencing work in the centre.

All qualified staff were registered to practice in 2018 with Bord Altranais agus Cnáimhseachais na hÉireann.

**Judgment:**
Compliant

### Closing the Visit

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

**Acknowledgements**

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

**Report Compiled by:**

Sheila McKevitt  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority
Provider’s response to inspection report¹

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Dargle Valley Nursing Home</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000031</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>17/01/2018</td>
</tr>
<tr>
<td>Date of response:</td>
<td>21/03/2018</td>
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</tbody>
</table>

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 02: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
A number of clinical audits completed did not include an analysis of the results or an action plan.

1. 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

¹ The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Please state the actions you have taken or are planning to take:

We now operate a Quality Management System to facilitate improvement to the quality of service and the quality of care at the home. A Corrective, Preventative Action process is now in place in our home. The purpose of this is to:

(a) Identify the problem and provide an immediate solution to resolve the problem – Corrective Action

(b) Identify a long term solution to that particular problem which will have the effect of “preventing” the problem from reoccurring – Preventative Action.

(c) Continue this process on an ongoing basis, daily, weekly, monthly and annually which will result in Continuous Improvement.

The Corrective Action Request form (CAR) is used to record this process. During the Audit Process the CAR will be raised by the Auditor and presented as part of the results to the PIC/Provider and brought to monthly QIM meeting. The CAR will be used to identify trends and to drive an analysis of the problem at the Quality Meeting. The outcome of the analysis will be recorded on the CAR.

Proposed Timescale: 22/02/2018

Outcome 08: Health and Safety and Risk Management

Theme:
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Risks identified in October 2017 had not been risk rated in line with the risk management policy.

2. Action Required:
Under Regulation 26(1)(a) you are required to: Ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.

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

We will ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the home. We have employed the services of an external consultant to assist us to ensure we have an effective system in place to identify our risks and to rate them in line with the risk management policy. All documentation will be amended by March 30th 2018 to ensure all risks identified will be rated before measures have been put in place to control the risk identified and this risk escalation process will provide the ability to determine what is needed to be addressed immediately and how to prioritise other risks within the home. Our risk assessment will also name the person responsible and proposed timescale for completion.
**Proposed Timescale:** 31/03/2018

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

**Theme:**
Effective care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Some care plans required improvement to ensure they provided sufficient guidance to staff on how to meet resident's needs.

**3. 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:**
We will 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 Home. We will ensure our care plans provide sufficient guidance to staff on how to meet our resident’s needs. We are presently working on a detailed care plan template with an external consultant to guide our staff with the specific individual care for all residents. All residents shall have individual care plans based on their assessed needs. These care plans shall be implemented and care shall be provided for the resident to maximize their quality of life. The successful care of residents requires a comprehensive evaluation of their current condition and care needs. This assessment is required to provide the staff with ongoing information necessary to develop a care plan, to provide the appropriate care and services for each resident, and to modify the care plan and care/services based on the resident’s admissions status or change in condition.

**Proposed Timescale:** 31/03/2018