

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	St David's Nursing Home
<b>Centre ID:</b>	OSV-0000391
<b>Centre address:</b>	Gentian Hill, Knocknacarra, Salthill, Galway.
<b>Telephone number:</b>	091 525 358
<b>Email address:</b>	davidsnursinghome@hotmail.com
<b>Type of centre:</b>	A Nursing Home as per Health (Nursing Homes) Act 1990
<b>Registered provider:</b>	Monica Browne
<b>Provider Nominee:</b>	Monica Browne
<b>Lead inspector:</b>	Marie Matthews
<b>Support inspector(s):</b>	Mary McCann
<b>Type of inspection</b>	Unannounced Dementia Care Thematic Inspections
<b>Number of residents on the date of inspection:</b>	14
<b>Number of vacancies on the date of inspection:</b>	1

## **About Dementia Care Thematic Inspections**

The purpose of regulation in relation to residential care of dependent Older Persons is to safeguard and ensure that the health, wellbeing and quality of life of residents is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer and more fulfilling lives. This provides assurances to the public, relatives and residents that a service meets the requirements of quality standards which are underpinned by regulations.

Thematic inspections were developed to drive quality improvement and focus on a specific aspect of care. The dementia care thematic inspection focuses on the quality of life of people with dementia and monitors the level of compliance with the regulations and standards in relation to residents with dementia. The aim of these inspections is to understand the lived experiences of people with dementia in designated centres and to promote best practice in relation to residents receiving meaningful, individualised, person centred care.

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

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

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

From: 14 June 2016 11:00 To: 14 June 2016 22:30

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

Outcome	Provider's self assessment	Our Judgment
Outcome 03: Information for residents		Substantially Compliant
Outcome 05: Documentation to be kept at a designated centre		Non Compliant - Moderate
Outcome 02: Governance and Management		Non Compliant - Moderate
Outcome 01: Health and Social Care Needs		Non Compliant - Moderate
Outcome 02: Safeguarding and Safety		Non Compliant - Moderate
Outcome 03: Residents' Rights, Dignity and Consultation		Compliant
Outcome 04: Complaints procedures		Non Compliant - Moderate
Outcome 05: Suitable Staffing		Substantially Compliant
Outcome 06: Safe and Suitable Premises		Non Compliant - Moderate
Outcome 07: Health and Safety and Risk Management		Substantially Compliant

**Summary of findings from this inspection**

This was an unannounced inspection which focused on the quality of life for residents with dementia. The centre did not have a dementia specific unit. At the time of this inspection, of the 14 residents accommodated, five had a formal diagnosis of dementia. No resident was under 65 years of age. Inspectors tracked the journey of four residents with dementia within the service. They observed care

practices and interactions between staff and residents with dementia using a validated observation tool. Inspectors also reviewed documentation such as care plans, medical records and staff files. Inspectors examined relevant policies including those submitted prior to inspection. The building was recently refurbished and was comfortable and well maintained. The provider outlined further plans to refurbish the centre to widen corridors which were not all widened as part of this refurbishment. Staff demonstrated good knowledge of each resident's likes and dislikes. There was a choice of a nutritious variety of food at mealtimes.

Management systems in place required review to ensure the service provided was safe, appropriate, consistent and effectively monitored to deliver a good quality of care. This was evident in relation to care documentation, auditing and policy development. Inspectors also identified that improvements were required in care planning to ensure they were comprehensive, linked to assessments and guided care. There was a relaxed atmosphere in the centre where residents had good input into how they spent their days. There was an emphasis on person centred care and the residents being at the core of the planning and delivery of care. Residents were encouraged to maintain their interests and independence and could access the garden from the centre independently.

Residents looked well cared for and told the Inspectors that they were well looked after here. Group and individual Sonas (a therapeutic activity for residents who are cognitively impaired) was available for residents. Pre admission assessments were conducted by the Person in Charge or his deputy which considered the health and social needs of the potential resident. Residents' healthcare needs were met and the general practitioners visited regularly. Staff demonstrated competency in managing behaviours associated with dementia however, there was an absence of behaviour support plans to direct care and ensure a consistent approach. Inspectors identified that improved signage and better use of visual cues was also required to help orientate residents with dementia.

Inspectors followed up on the actions from the previous registration inspection completed in September 2014. 10 of the actions had been fully completed, a further two were partially completed and 5 required further action to complete. These have been restated in the action plan to the report. The areas of non compliance were discussed in detail with the provider, the person in Charge, and the Assistant Director of Nursing at the end of the inspection. The action plan at the end of this report identifies in full all improvements required to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.

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

***Outcome 03: Information for residents***  
***A guide in respect of the centre is available to residents. Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.***

**Theme:**  
Governance, Leadership and Management

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

**Findings:**  
At the time of the last inspection inspectors found that the Residents' Guide did not comply with all the requirements of the Regulations as it did not include the terms and conditions relating to the residence in the centre. This had been addressed. The residents guide has been modified to include the terms and conditions relating to residence at the centre. The residents' contracts of care had also been reviewed to include information regarding the services to be provided and the fees to be charged. Further minor revision was required to include the approximate cost of additional services and to clarify the complete fees for services.

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

implemented.

**Findings:**

At the time of the last inspection inspectors found that some policies did not provide sufficient guidance for staff and that the complaint policy did not outline the independent appeals process.

This action was partially addressed. Some policies had not been reviewed since the last inspection. The policy on protection from abuse had been reviewed but required further revision to reflect the new Health Service Executive policy on Protection of Vulnerable adults. The complaints policy also required review to included details of an independent appeals process.

Schedule 2 information was available on all staff files reviewed. Further improvements were identified in relation to some care documentation. . Some records relating to aspects of residents' health care plans were duplicated or absent and some care plans were not linked to the assessments. A planned and actual staff roster was not available and codes were used on the roster without explanation. These are discussed further under outcomes 1 and 5.

**Judgment:**

Non Compliant - Moderate

***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:**

At the time of the last inspection inspectors found that the systems in place to monitor and develop the quality of care and experience of residents required improvement to ensure all areas of the service including complaints management and use of restraint, were adequately reviewed and that audits were effectively used to identify areas for improvement. These issues had been partially addressed. Inspectors observed improvements in the range of audits completed. However further improvements were required in the level of detail of the audits completed to ensure that audits were useful and effective and that areas highlighted for improvement were addressed. For example, accidents and incidents were audited and one of the criteria included in the audit was the completion of neurological observations for all unwitnessed falls, however during the

inspection inspectors identified that neurological observations were not recorded for some unwitnessed falls.

Issues were also identified in relation to overall supervision of clinical care. Gaps were evident in some care documentation and although there were management systems in place they were not effective for monitoring clinical care or ensuring policies and guidance documents were consistent with evidence based practice. An action plan has been included to address this.

**Judgment:**

Non Compliant - Moderate

***Outcome 01: Health and Social Care Needs***

**Theme:**

Safe care and support

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

No actions were required from the previous inspection.

**Findings:**

Inspectors found that each resident's wellbeing and welfare was maintained by a good standard of nursing care and appropriate medical and allied health care. However; improvements were identified in the accuracy and completeness of care plans to ensure that they reflected findings of the assessment completed for residents and provided sufficient guidance to staff to direct care.

There was evidence that pre admission assessments were completed and care plans were developed within 48 hours of admission. Inspectors saw that residents and their families, where appropriate, were involved in this process however, in the sample of care plans examined; there was poor evidence that residents or their families were involved in the four monthly reviews. Comprehensive assessments and a range of additional risk assessments had been carried out for all residents and care plans were developed based on the needs identified. A mental state assessment is completed on all residents on admission and repeated at regular intervals. This looked at memory or other mental abilities and helps to diagnose dementia and assess its progression and severity. It is also used to assess changes in a person who has already been diagnosed with dementia and can help to give an indication of how severe a person's symptoms are and how quickly their dementia is progressing.

Residents were screened on admission for a range of risks including nutritional risk, the risk of sustaining a fall, weight loss or skin integrity. However, inspectors identified a number of issues with quality of care plans which could impact on the delivery of care. Some care plans lacked sufficient detail and in some instances a care plan was not available even though a need was identified. For example, one resident was reviewed by dietician who made specific recommendations regarding the type of diet required but a

nutritional care plan was not available to reflect this advice and guide care. In addition, care plans were not always updated every four months as required in the regulations or when there was a change in the residents care needs. Other issues were identified in relation to care plans including duplicate care plans and care plans not linked to the assessments.

Residents had access to GP services and out-of-hours medical cover was provided. A full range of other services was available on referral including speech and language therapy (SALT), occupational therapy (OT) services and physiotherapy services. Chiropody, dental and optical services were also provided. There was evidence that residents had been referred to these services and results of appointments were written up in the residents' notes.

Residents' life stories were captured in their care plans however care plans for residents with dementia or cognitive impairment did not describe the residents' level of independence, what they could do for themselves, who they still recognised or the type of activities they enjoyed or where the resident was on their dementia journey. Further work is required to develop comprehensive care plans for all residents with dementia or cognitive impairment.

There were written policies and procedures in place to guide staff on the management of medications. Inspectors observed medication administration practices and found that they were in compliance with relevant professional guidance. Prescription and administration records contained appropriate identifying information including residents' photographs and were clear and legible. Appropriate procedures were in place for the return of unused /out of date medications. Controlled drugs were not reviewed during this inspection.

There were arrangements were in place to minimise risks to residents and inspectors saw that the person in charge reviewed any accidents and incidents that occurred. Residents at risk of falling were assessed and a falls prevention care plans was in place. As described above inspectors identified duplicate care plans in some instances which could cause confusion. Assistive equipment such as alarm/ sensor mats and walking aids were provided to reduce the risk of further falls for the resident. Evidence was available that post-fall observations were completed however neurological observations to monitor neurological function after a possible head injury as a result of a fall were not always recorded.

Inspectors observed the evening meal which was an unhurried social experience with appropriate numbers of staff available to support residents. Staff assisted residents who had difficulty in a discrete and respectful manner. The food provided was appropriately presented and provided in sufficient quantities. Drinking water and juices were provided for residents and snacks were available outside of meal times if required.

There were systems in place to ensure residents' nutritional needs were met. Residents' weights were checked on a monthly basis. Information was communicated to all staff outlining the residents who were on special diets including diabetic, high protein and fortified diets, and those who required a modified consistency diet or thickened fluids. Medication records showed that supplements were prescribed by a doctor and administered appropriately.

As discussed earlier however, nutritional care plans were not always developed to reflect the recommendations of dieticians or the speech and language therapists and additionally there was no evidence that nutritional intake records were completed where residents were identified as been at risk of weight loss.

Staff provided end of life care to residents with the support of their general practitioner and the palliative care team if required. Each resident had their end of life preferences recorded and an end of life care plan in place. These care plans addressed the resident's physical, emotional, social and spiritual needs. They reflected each resident's wishes and preferred pathway at end of life care.

**Judgment:**

Non Compliant - Moderate

***Outcome 02: Safeguarding and Safety***

**Theme:**

Safe care and support

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

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

**Findings:**

On the previous inspection areas for improvements were identified in the management of restraints to reflect national policy. Inspectors saw that restrain use had reduced since the last inspection. Two residents had bedrails in place and both were identified as enablers. The rationale for the use of the enabler was documented in their care notes. There were risk assessments completed for both residents. A policy on restraint use was available however this required review to reflect national policy.

The entrance to the centre was protected by keypad locks and a visitor's book was observed to be in use. Training on protection was provided to staff every two years. There was a policy in place in the centre on the prevention, detection and response to abuse. The inspectors noted that this policy had not been updated to reflect national policy and procedures as outlined in 'Safeguarding Vulnerable Persons at Risk of Abuse' (HSE 2014), as outlined under outcome 5. Staff spoken to were familiar with the policy and knowledgeable of abuse indicators and types and all staff spoken with knew what to do if they suspected abuse.

On the previous inspection, an allegation of abuse had been identified as incorrectly dealt with as a complaint. Inspectors identified a further incident during this inspection where a resident had complained that a staff member had shouted at her. This incident was again recorded in the centres complaint log by a staff member. The person in charge had investigated the incident and the staff member was no longer employed but there was no evidence on the staff members file of any increased supervision or of any disciplinary action and there was no evidence that that the residents family had been

notified or that HIQA had not been notified, as required by the regulations. Inspectors ascertained from speaking to residents that they felt safe. The person in charge was requested to submit a notification retrospectively to the Chief Inspector and to complete refresher training on Safeguarding.

There were no residents identified with expressive behaviours at the time of the inspection. There were policies in place to guide staff regarding the management of behavioural and psychological signs and symptoms of dementia (BPSD). Residents had access to the mental health of later life services, with onsite visits from the psychiatry of later life team.

**Judgment:**

Non Compliant - Moderate

***Outcome 03: Residents' Rights, Dignity and Consultation***

**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:**

On the previous inspection the use of CCTV in the centre was not appropriately managed. On this inspection inspectors observed that CCTV has ceased in communal areas. Cameras were still in place at the entrance to the centre however these had been deactivated and the provider confirmed that these were not in use at the time of the inspection.

As part of the inspection, inspectors spent a period of time observing staff interactions with residents with a dementia. Inspectors used a validated observational tool (the quality of interactions schedule, or QUIS) to rate and record at five minute intervals the quality of interactions between staff and residents in two communal areas. The scores for the quality of interactions are +2(positive connective care), +1 (task orientated care), 0 (neutral care), -1 (protective and controlling), -2 (institutional, controlling care). The observations took place at three different times for intervals of 30 minutes in sitting/dining area of the centre. Observations were undertaken both in the afternoon and evening.

Inspectors observed that the quality of interactions between residents and staff was very positive with evidence of good interactions between staff and residents. Staff were observed to take opportunities to chat with the residents and responded positively to residents when they initiated conversation.

There was evidence that residents were consulted with and participated in the organisation of the centre. There was minutes of resident meetings were held with monthly. Minutes of these meetings supported that residents were involved, in

discussing activities, the food and their views of the service provided and that they had an input into the organisation of trips and outings. Residents with dementia had access to advocacy services. A new advocate had been appointed to support residents and attend resident committee meetings.

Inspectors met with the activities coordinator. There was a range of activities available for residents. Several residents went for a walk every day with the support of the activities coordinator. Residents retained good links with the local community. There were regular visitors to the centre and some residents told inspectors they liked to visit local cafes. Inspectors saw that one resident had planned a return trip to Lourdes. Another resident visited a local day centre three days a week. Other activities included baking, gardening, exercise classes, live music sessions and bingo. Newspapers were delivered daily to the centre. Individual one to one therapies were provided to residents with cognitive impairment who could not attend the group passive exercise sessions arranged twice weekly. Residents were facilitated to exercise their civil, political and religious rights. Mass was celebrated monthly in the centre and a staff member said the rosary with residents in the afternoons. Two residents told inspectors that they voted in the recent elections. On the days of inspection visitors were observed spending time with residents in the sitting room. Residents told the inspectors that there were no restrictions on visitors and they could meet visitors in private.

**Judgment:**

Compliant

***Outcome 04: Complaints procedures***

**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:**

On the previous inspection inspectors found that the complaints procedure did not include an independent appeals process and incorrectly referenced the Authority as part of the centre complaints procedure. This action had been partially addressed. The procedure for making a complaint was displayed in the foyer of the centre and this had been updated to include details of the appeals procedure but the complaints policy which provided guidance to staff on the management of complaints had not been reviewed to reflect this information.

Residents who spoke with inspectors said that any issues of concern were responded to promptly by staff members and identified the person in charge as the person they would complain to if necessary. There was only complaint recorded in the complaints log. The person in charge stated that issues which could be addressed easily were not always

recorded in the log which might prevent patterns or trends from been identified by and responded to.

A review of complaint indicated that it was dealt with in a timely manner. The outcome of the complaint was recorded however the form did not prompt staff to record if the issue was resolved to the satisfaction of the complainant.

**Judgment:**

Non Compliant - Moderate

***Outcome 05: Suitable Staffing***

**Theme:**

Workforce

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

No actions were required from the previous inspection.

**Findings:**

Three staff files were reviewed by inspectors to ensure that all the requirements of Schedule 2 of the Regulations had been met including photographic identification, Garda Vetting and appropriate references. Confirmation of up to date registration with An Bord Altranais agus Cnáimhseachais Na hÉireann was available for all nursing staff.

Training records were reviewed. There was no training matrix in use or alternative system to help identify when staff attended mandatory or additional training or when refresher training was due. Subsequently it was not possible to determine if all staff had completed mandatory training. Inspectors reviewed a sample of three staff files and evidenced that they had attended training in fire safety, moving and handling and safeguarding vulnerable persons. An action has been included requiring the provider to review the training records and to confirm that all staff have completed mandatory training as required by the regulations. Other training completed by staff included first aid, cardio pulmonary resuscitation, dementia care and managing responsive behaviours.

Inspectors reviewed the planned / actual staff roster available which had some gaps evident. For example the hours the person in charge planned to work was not completed. Abbreviations were also used to denote working times without explanation. For example the N was used to denote the shift from 8pm until 8am and LD to denote the shift from 8am until 8pm. On the morning of the inspection there were appropriate staff numbers to meet the needs of residents. In addition to the person in charge, there was a clinical nurse manager (CNM) and three care assistants on duty in the morning. This reduced to one nurse and the person in charge and two care assistant until 6pm. A nurse and care assistant were on duty at night. The residents who spoke with inspectors spoke very favourably about the staff and described them as really helpful and caring. The staff had worked at the centre for several years and were very familiar with the residents in their care which contributed to the home like atmosphere.

**Judgment:**

Substantially Compliant

### ***Outcome 06: Safe and Suitable Premises***

**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:**

On the previous inspection, some areas of the physical environment did not comply with regulatory requirements. The corridors to the front of the centre were narrow and there was no emergency call bell in the dining room. The provider has recently completed an extension of the nursing home providing a new sitting room, dining room, one bedroom, storage space and a safe enclosed garden for residents. Residents confirmed they used this area when the weather was favourable. A call bell was provided in the dining room but had not yet been commissioned. The provider organised for this to be completed during the inspection. An action has been included in the action plan requiring this and this will be reviewed again on the next inspection.

The narrow corridors remained in the older part of the centre. Inspectors observed that special narrow width wheelchairs were in use and staff had completed training in people moving and handling to reduce the risk of injuries. The provider outlined further refurbishment plans to address this. The centre was clean and bright. There was adequate wardrobe space available to residents. Inspectors observed that a number of residents had personalised their rooms with personal items including photos. There was a functioning call bell system in place within the centre, and hoists and pressure relieving mattresses were available, with records available supporting that they were regularly serviced. Residents spoken with confirmed that they felt comfortable and safe in the centre. Some areas had personalised features to make them more easily identifiable to residents with dementia but consideration should be given to greater use of colour and visual cues to prompt recognition of key areas and promote independence.

**Judgment:**

Non Compliant - Moderate

### ***Outcome 07: Health and Safety and Risk Management***

**Theme:**

Safe care and support

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

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

**Findings:**

The actions from the previous inspection had been partially addressed. The emergency plan had been reviewed in response to the action plan from the previous inspection and transport arrangements had been included. Open waste bins were no longer in use in bedrooms and toilets. An enclosed colour coded laundry trolley was provided and this was stored in a bay off a bathroom.

All staff had received training in fire safety and fire drills were completed on a 6 monthly basis. However, the records of the fire drills gave no indication of the duration of the drill the number of people involved in the evacuation or the time of day the drill took place.

**Judgment:**

Substantially Compliant

**Closing the Visit**

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

**Acknowledgements**

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

***Report Compiled by:***

Marie Matthews  
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>	St David's Nursing Home
<b>Centre ID:</b>	OSV-0000391
<b>Date of inspection:</b>	14/06/2016
<b>Date of response:</b>	08/08/2016

### 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 03: Information for residents

#### Theme:

Governance, Leadership and Management

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

Further minor revision was required to include the approximate cost of additional services and to clarify the complete fees for services.

#### 1. Action Required:

Under Regulation 24(2)(b) you are required to: Ensure the agreement referred to in regulation 24 (1) relates to the care and welfare of the resident in the designated

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

centre and includes details of the fees, if any, to be charged for such services.

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

Estimated cost of additional services is now being specified in residents contract of care

**Proposed Timescale:** 08/09/2016

**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 policies required review to reflect new national policies. The complaints policy also required review to included details of an independent appeals process.

**2. Action Required:**

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

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

The complaints policy has been updated to include details of independent appeals process

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

**Theme:**

Governance, Leadership and Management

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

Some records relating to aspects of residents' health care plans were duplicated or absent and some care plans were not linked to the assessments.

A planned and actual staff roster was not available and codes were used on the roster without explanation.

**3. 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:**

Roster has been modified with explanation of codes and 24 hour clock . Care plans are

currently being reviewed.

**Proposed Timescale:** 08/12/2016

## **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:**

Management systems in place were not effective for monitoring clinical care or ensuring policies and guidance documents were consistent with evidence based practice.

### **4. 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:**

We are currently reviewing policies on abuse, incorporating HSE policy on safeguarding vulnerable persons at risk of abuse

**Proposed Timescale:** 08/09/2016

## **Outcome 01: Health and Social Care Needs**

### **Theme:**

Safe care and support

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

Some care plans lacked sufficient detail and in some instances a care plan was not available even though a need was identified. Duplicate care plans were found and care plans not linked to the assessments.

### **5. 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:**

Care plans are currently being reviewed to include all needs identified.

**Proposed Timescale:** 08/12/2016

**Theme:**

Safe care and support

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

Care plans were not always updated every four months as required in the regulations or when there was a change in the residents needs. Some care plans were not reviewed in consultation with the resident or where appropriate the resident's family

**6. 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:**

All care plans are currently being reviewed, 4 monthly, in consultation as appropriate with the resident or family member.

**Proposed Timescale:** 08/12/2016

**Outcome 02: Safeguarding and Safety****Theme:**

Safe care and support

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

Inspectors identified an allegation of abuse recorded in the complaints log which was not appropriately identified as abuse and was not investigated or responded to in line with evidence based practice.

**7. Action Required:**

Under Regulation 08(3) you are required to: Investigate any incident or allegation of abuse.

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

Incident was further investigated and forwarded to HIQA. In house refresher course on abuse being organised for September.

**Proposed Timescale:** 08/09/2016

**Outcome 04: Complaints procedures****Theme:**

Person-centred care and support

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

The complaints policy required review to comply with the regulations as it did not include an independent appeals process and incorrectly referenced the Authority as part of the centre complaints procedure.

**8. Action Required:**

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

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

The complaints policy has been updated to include details of an independent appeals process. Reference to HIOA has been removed from policy.

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

**Theme:**

Person-centred care and support

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

The outcome of the complaint was recorded but the form did not prompt staff to record if the issue was resolved to the satisfaction of the complainant.

**9. Action Required:**

Under Regulation 34(1)(g) you are required to: Inform the complainant promptly of the outcome of their complaint and details of the appeals process.

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

We have revised our complaint form and have included section/prompt to include outcome of complaint, and whether complainants are satisfied with resolution. If not satisfied, details are given on appeals process, as per policy.

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

**Outcome 05: Suitable Staffing**

**Theme:**

Workforce

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

There was no training matrix in use or alternative system to help identify when staff attended mandatory or additional training or when refresher training was due.

**10. Action Required:**

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

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

Training Matrix has been updated to include mandatory and refresher training. All staff have access to appropriate training. It is an ongoing process at St David's. Staff are facilitated to attend learning events at all times.

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

**Outcome 06: Safe and Suitable Premises****Theme:**

Effective care and support

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

The corridors to the front of the centre were narrow . There was no emergency call bell in the dining room. Better use of non verbal and visual cues were required to prompt recognition of key areas and promote independence.

**11. Action Required:**

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

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

Call bell is in place in the dining room. Additional non-verbal and visual cues will be displayed in key areas throughout the home. While the corridors at the front,an older part of the centre are narrow, staff have received training regarding best manner to support residents where necessary.

**Proposed Timescale:** 22/08/2016

**Outcome 07: Health and Safety and Risk Management****Theme:**

Safe care and support

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

The records of fire drills which took place gave no indication of the duration of the drill, the number of people involved in the evacuation or the time of day the drill took place.

**12. Action Required:**

Under Regulation 28(1)(e) you are required to: Ensure, by means of fire safety

management and fire drills at suitable intervals, that the persons working at the designated centre and residents are aware of the procedure to be followed in the case of fire.

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

Fire drills beginning on Monday 15/8/16, will record all in attendance, time involved in drill, and at what time they are taking place .

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