<table>
<thead>
<tr>
<th>Centre name</th>
<th>Boyne View House</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000532</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Dublin Road, Drogheda, Louth</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>041 989 3288</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:seamus.mccaul@hse.ie">seamus.mccaul@hse.ie</a></td>
</tr>
<tr>
<td>Type of centre:</td>
<td>The Health Service Executive</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>Health Service Executive</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Maura Ward</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Una Fitzgerald</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>None</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Announced</td>
</tr>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>19</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>7</td>
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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 2 day(s).

The inspection took place over the following dates and times

From: 08 November 2017 08:30
To: 08 November 2017 17:00
09 November 2017 10:00
09 November 2017 14:00

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

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Our Judgment</th>
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</thead>
<tbody>
<tr>
<td>Outcome 02: Governance and Management</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 04: Suitable Person in Charge</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 07: Safeguarding and Safety</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 08: Health and Safety and Risk Management</td>
<td>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>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 12: Safe and Suitable Premises</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 16: Residents’ Rights, Dignity and Consultation</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 18: Suitable Staffing</td>
<td>Substantially Compliant</td>
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</table>

Summary of findings from this inspection

This report sets out the findings of an inspection carried out to inform a decision for the renewal of the centre's registration. The registration renewal application form is for 23 beds, which is a reduction in the overall capacity of three beds.

During the course of the inspection, the inspector met with residents and staff, the person in charge, the provider nominee and all members of the management team. The views of residents, relatives and staff were listened to, practices were observed and documentation was reviewed. Surveys completed by residents and their relatives or representatives were also reviewed.

The inspector found that care was delivered to a good standard by staff who knew the residents well and discharged their duties in a respectful and dignified way. The management team responsible for the governance, operational management and administration of services and resources demonstrated good knowledge and an ability to meet regulatory requirements. This inspection is the third inspection since the centre was last registered. The development of services within the region is under review and the authority was due to receive a time costed plan for the long
term plan for the future of the centre. On the days of inspection the inspector met with the estates manager who confirmed that no progress has been made and that all plans are back at stage one - design and allocation of budgetary phase.

The management and staff of the centre were striving to continuously improve residents’ outcomes. A person-centered approach to care was observed. Residents appeared well cared for and expressed satisfaction with the care they received. The inspector followed up on the action plan from the last inspection May 2017. In areas of direct clinical care delivery, the inspector was satisfied that actions were fully completed. However, the inspector found that the overall upkeep and maintenance of the building is in a poor state and requires further work to ensure that the environment is in line with regulatory requirements. This is discussed in detail under Outcome 12 Safe and Suitable Premises.

During this inspection moderate non compliance was found in three of the nine outcomes inspected. The findings are discussed in the body of the report and improvements are outlined in the Action Plan at the end for response.
Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

**Outcome 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:**

There were sufficient resources in place to ensure the effective delivery of care as described in the statement of purpose. There was a clearly defined management structure with explicit lines of authority and accountability. The provider nominee and Director of Nursing have responsibility for multiple centre's within the region. Within the centre, the person in charge works in partnership with the clinical nurse manager who then report directly to the Director of Nursing.

The centre was managed by a suitably qualified and experienced nurse. The person in charge was in position since the last registration inspection in the centre and held authority, accountability and responsibility for the provision of the service. During the inspection he demonstrated that he had sufficient knowledge of the regulations and standards pertaining to the care and welfare of residents in the centre. The centre is in the process of recruiting extra staffing into the nurse management team. The centre has recently appointed a new person in charge (Assistant Director of Nursing). Permission has also been granted to appoint one new clinical nurse manager.

Staff and residents were familiar with current management arrangements. Residents were complimentary of the management team, telling the inspector that staff were approachable and receptive to new ideas. Staff knew the residents well and discharged their duties in a respectful and dignified way.

A comprehensive auditing schedule and review system was in place to capture statistical information in relation to resident quality outcomes, operational matters and staffing arrangements. Policies and procedures were in place to guide practice and service provision. An annual review of the quality and safety of care delivered to residents was completed that informed the service plan being implemented in 2017.
Interviews with residents during the inspection and satisfaction surveys completed by or on behalf of residents in preparation for this announced inspection were positive in respect to staff and the provision of the care.

The inspector was informed by the estates manager that the future plan for the rebuild of the centre and a time costed plan will not be ready for submission to HIQA until February 2018. The submission of this time costed plan is a restated action carried over from the last two inspections carried out within this centre.

**Judgment:**
Substantially Compliant

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**Outcome 04: Suitable Person in Charge**  
The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.

**Theme:**  
Governance, Leadership and Management

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

**Findings:**  
The centre was managed by a suitably qualified and experienced nurse. The person in charge was in position since the last registration inspection in the centre and held authority, accountability and responsibility for the provision of the service. The management team in partnership with the person in charge had followed up on the action plan from the last inspection and there was clear evidence of the positive impact this was having on the centre.

The centre has informed HIQA that there is a new incoming person in charge who will take over the role on 20/11/2017. The handover and mentorship period for the new incoming person in charge has commenced.

The inspector met with the incoming person in charge. Through a one to one engagement she clearly demonstrated that she had sufficient knowledge of the regulations and standards pertaining to the care and welfare of residents in the centre.

**Judgment:**
Compliant

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**Outcome 07: Safeguarding and Safety**  
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.
Theme:
Safe care and support

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

Findings:
The inspector was satisfied that there were policies and procedures in place for the protection of residents from abuse. The policy on Safeguarding and Safety had last been reviewed August 2015 and reflected best practice guidelines. Staff spoken too were clear on their role and responsibilities in relation to reporting abuse. Staff were also knowledgeable in recognising the possible signs and symptoms, responding to and managing abuse. In conversations with residents, the inspector was informed by all residents spoken too that they felt safe and secure in the centre. The inspector reviewed the training records and found that there are five staff members due an update in their training. This is actioned under outcome 18 Suitable Staffing.

The centre has a policy dated February 2015 on procedures in place to support staff with working with residents who have responsive behaviours (how people with dementia and other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment). As follow up from the last inspection the centre management had carried out extra training for staff in the area of responsive behaviours. Staff spoken with adopted a positive, person centred approach towards the management of responsive behaviours. The person in charge informed the inspector that among the current residents there were no residents with a history of responsive behavioral issues.

There was a system in place for the safeguarding of residents' finances and property. The provider was acting as a pension agent for a small number of residents. The monies were held in a separate account and the system in place to manage these payments was transparent and clear.

The systems in place to promote a restraint free environment in line with the national policy was described and demonstrated. The restraint policy was last reviewed in May 2017. The centre had a record of all restraint currently in use which is updated on a weekly basis. Staff and records confirmed that in total 5 of the nineteen residents were using bedrails that restricted movement. The restraint policy clearly defined restraint and outlined the types of restraint, assessment, checks and review practices. In the two files reviewed, a consent form was signed by the next of kin. Care plans and evaluation records did not outline any alternatives tried. The inspector did see evidence that the continued use of the bedrails was discussed with the family and is kept under review at regular intervals. The centre is in the process of trialing a new type of electronic bed with the intention to replace some of the existing beds. Records of the duration of restraint and safety checks or releases were recorded and evidenced.

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

Theme:
Safe care and support

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

Findings:
The centre had policies and procedures relating to health and safety within the centre. There was a health and safety statement available for review dated 2017. The centre has a risk management policy last reviewed in May 2017 that includes the requirements set out in Regulation 26(1).

The centre had a current risk registrar that is kept under constant review by the management team. The risk register identified areas of risk within the centre and the control measures in place to minimise any negative impact on residents. The register also had identified additional control measures in place. The risk register has identified maintenance of equipment as a risk. The inspector found that some items of resident equipment had gone past the service due date. The centre management team had knowledge of this gap and are taking measures to have all equipment serviced.

Arrangements, consistent with the national guidelines and standards for the prevention and control of healthcare associated infections, were in place. Staff had access to personal protective equipment such as aprons and gloves. Hand sanitisers were placed at multiple locations along corridors. Staff were seen using these facilities between resident contact. Signs were on display to encourage visitors to use the hand sanitisers. Household staff spoken to were very knowledgeable on the system in place to ensure that the cleaning regime minimises the risk of cross infection. The cleaning schedule detailed the routine daily chores and also contained detail of a deep cleaning schedule. Relatives spoken too confirmed that the bedrooms are cleaned on a daily basis. The inspector noted multiple areas of wear and tear on surfaces and floor coverings throughout the building which is discussed under Outcome 12 Suitable Premises. Despite this, the inspector observed that the standard of cleanliness throughout the building was of a high standard.

Suitable arrangements were in place in relation to promoting fire safety. Fire safety and response equipment was provided. Daily checks are carried out on all escape routes and there is a comprehensive weekly fire safety checklist. The inspector was informed that the fire alarm is tested on a weekly basis. This detail is not currently captured within the current documentation. The PIC actioned the capturing of this detail with immediate effect. The fire alarm is serviced on a quarterly basis and the fire safety equipment is serviced on an annual basis. Fire exits were identifiable by obvious signage and exits were unobstructed to enable means of escape. Staff spoken to were knowledgeable about fire safety and evacuation procedures. A detailed fire simulation fire drill was carried out in March and September 2017. The training matrix identified that of the
current staffing compliment there was one staff member due to have their annual fire
training updated.

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

**Findings:**
There were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents. last reviewed in March 2017. Actions required from the last inspection had been completed. There were appropriate procedures for the delivery and collection by the pharmacy, and checking, storage, return and disposal of medicines by nurses.

Nursing staff were observed as they administered medications. Residents were unhurried and reminded of the purpose of the medicines administered. Prescription and administration records were maintained in accordance with the centre's policy and professional standards. The processes in place for the handling and checking of medicines received including controlled drugs were examined and found to be compliant.

The centre has a schedule of audits on medicines management. The inspector reviewed the audit findings for August and November 2017. There was two medication errors reported since the last inspection. The findings were reviewed and learning from incidents and reported errors informed improvements to protect residents. All registered nurses carry out additional training in medication management. In addition, an external provider carries out medicines management audits to ensure compliancy with the regulations.

A system was in place for a regular prescription review by the resident’s general practitioner (GP) and pharmacist. The reviews were clearly documented within the resident files.

Judgment:
Compliant

**Outcome 11: Health and Social Care Needs**
*Each resident’s wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident’s assessed needs are set out in an*
individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

**Theme:**
Effective care and support

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

**Findings:**
Residents’ health care needs were met through timely access to medical services and appropriate treatment and therapies. Access to a general practitioner and allied healthcare professionals including psychiatry of older life, occupational therapy, physiotherapy, dietetic, speech and language therapy, ophthalmology and specialist palliative care were made available when required. From the cases tracked it was evident that these services were available to residents on their admission and as required thereafter. There was good evidence within the files that advice from allied healthcare professionals was acted on in a timely manner. Arising out of the last action plan measures are now in place for residents to be reviewed by dentist either privately or through their medical cards. The centre management is actively ensuring that all residents will have a dental review.

There were processes in place to ensure that when residents were admitted, transferred or discharged to and from the centre, relevant and appropriate information about their care and treatment was maintained and shared between providers and services.

Each resident had a care plan developed with 48 hours of admission. The care plans were person centered and the detail contained within the care plans evidenced that the staff were knowledgeable on the specific care needs of residents under their care. There was evidence that care plan reviews occur at intervals not exceeding four months or more frequently in consultation with the family. The inspector saw evidence of the letter sent to each family informing them of the importance to be involved in the care plan review process. The centre is a dementia specific unit. Of the care plans reviewed and from conversations with the staff and families, the inspector concluded that the clinical team did not involve the residents in the care plan review meetings. Progress has been made and families are now all involved in the care plan reviews. However, this action is restated from the last inspection to meet the requirement to have residents where appropriate involved.

Assessments and clinical care accorded with evidence based practice. Residents had been assessed to identify their individual needs and choices. The assessment process used validated tools to assess each resident’s dependency level, risk of malnutrition, falls risk and their skin integrity. Clinical observations such as blood pressure, pulse and weight were assessed on admission and as required thereafter. The centre uses an electronic system to record and document resident care plans and all activities of daily living. The touch screen monitor has not been in working order since July 2017. The healthcare assistants now report to the registered nurse who has responsibility to input
this data into the system. The inspector spoke with the nursing management in relation to this as the findings relating to bowel management required review as key information that influence intervention management was not captured and had a negative impact on two of the resident files reviewed.

There was evidence that care plans are audited monthly by the clinical nurse manager. Each audit had an action plan with time specific targets to ensure full compliancy.

Staff provided end of life care to residents with the support of their general practitioner and have access to specialist community palliative care services if required. Each file reviewed had Priorities of care document filled in outlining future care preferences. This document plan is kept under review and updated in consultation with a family member. There was no resident receiving end of life care on the day of inspection. Staff outlined how religious and cultural practices were facilitated within the centre.

Residents were screened for nutritional risk on admission and reviewed regularly thereafter. Residents' weights were checked. There was a system in place to ensure that special dietary requirements are communicated between the clinical team and kitchen staff. The inspector sat with three residents during the lunchtime meal. There was good choice available. All three residents informed the inspector that the food was very tasty and second helpings were available.

Residents were assessed to identify their risk of developing pressure related skin injuries. Residents at risk had specific equipment in place to mitigate level of risk, such as repositioning regimes and pressure relieving mattresses and cushions. There was no resident with a wound on the day of inspection. The inspector reviewed the file of a discharged resident with a wound. A care plan was in place. Photographic evidence was also available. The centre has access to tissue viability specialist services to support staff with management of any residents' wounds.

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

**Findings:**
Deficiencies within the premises have been reported in previous reports since the last registration renewal which still apply. The registration renewal is for a reduction in bed numbers from 26 down to 23 residents. One room is now used for storage and the two remaining rooms will be converted into extra sitting room space for residents use. The centre’s management team are aware that HIQA require the design and layout of all changes to be reflected in an updated statement of purpose.

Not all aspects of the premises were inspected during this inspection. However, the inspector did follow up on the action plan from the last two inspection reports. The programme of refurbishment is ongoing and the original date for completion was January 2017. The inspector has noted the following deficiencies are recurring and are dependent on funding which to date has not been granted.
- Some of the bedrooms remain in a poor state of repair with furniture wood that have chipped and rough edges that can cause a risk of damage to residents with poor skin integrity.
- The flooring in some bedrooms is not suitable for mobile residents who are at risk of slips or falls.
- Bed tables in rooms were seen to have rust and so not receptive to cleaning.
- Some bedrooms are still awaiting TV points so residents can have their own TV in their room.
- Repainting of a number of rooms and areas within the centre
- Shelving in bedrooms too high and cannot be reached by residents

Overall bedroom sizes are small. The inspector noted, as per the statement of purpose, the centre only admits residents who can safely be cared for in a single room who can easily transfer from bed with minimal assistance. Residents with higher dependency levels are admitted to double rooms where there is more space to utilize manual handling equipment such as hoists.

The inspector reviewed the list of items that minor capital funding has been requested for by the centres management. All items have been risk rated as priority rating high as they relate to infrastructural risk. The items on this list include
- the need to replace flooring in the main dining hall and some of the resident rooms.
- Replacement of all bedroom sinks
- five sets of built-in wardrobes in bedrooms
The centres management team could not inform the inspector of when they will receive conformation from the registered provider of when this work will be granted funding to ensure that resident care is not compromised.

Within the resident rooms the inspector noted eight of the resident sinks were clinical hand hygiene sinks and not designed for the purpose of residents attending to personal hygiene within their own bedrooms. The water is warm in temperature and so residents do not have access to cold water for brushing their teeth within their own bedrooms. Staff spoken to clarify to the inspector that only fresh water brought into the bedrooms is used for the purpose of oral hygiene.

Despite the limitations, the provider nominee and staff have worked to maximise the living environment and ensure that it is welcoming and homely. The ongoing premises and maintenance issues that are carried over from each inspection are identified locally.
on their risk register.

**Judgment:**
Non Compliant - Moderate

### 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 consultation with resident's and their representatives in a range of areas on a daily basis and a formal resident meeting was held in July and October of 2017. While resident attendance numbers were low, there was evidence that issues raised by the residents were followed up and closed out to their satisfaction.

Resident's have access to an independent advocacy services. The centre is part of the local community and residents have access to radio, television, newspapers, information and frequent outings to events. The activity programme within the centre is varied and is changed as per resident’s requests. There was evidence of outings that had been organised and enjoyed by residents.

There was good evidence that residents have the opportunity to participate in activities that are meaningful and purposeful that suits their individual needs and interests. Each resident has a comprehensive form titled A ‘Key to me’ and a personal calendar highlighting significant events of importance to them. Each file reviewed had two entries made daily documenting their participation in an activity. The right to refuse was also respected.

The activities team have placed sensory tactile activity items at strategic locations throughout the corridors. There is a visitors room with a reminiscent corner. There is a relaxation/meditation room that was seen in use during the inspection. The residents also have access to a computer. However, internet access is not yet available but the inspector was informed by the management team that this is under review. Overall, the inspector found that there are adequate facilities for occupation and recreation including the opportunity to undertake personal activities in private.

Whilst staff did their utmost to support the rights and dignity of residents, aspects of the premises impacted on the rights and dignity of residents:
*No access to cold water in some rooms for residents to brush their teeth.  
*Shelving in bedrooms too high and cannot be reached by residents.  
*Damaged flooring, rusted bed tables and rooms in need of decorative repair did not provide a dignified environment for residents and also posed risk to their safety and welfare.

**Judgment:**  
Non Compliant - Moderate

**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:**  
Staffing levels and skill mix on the days of inspection were sufficient to meet the social and healthcare needs of the residents. Staff confirmed that they had sufficient time to carry out their duties and responsibilities, and the management team explained the systems in place to supervise and appraise staff. An annual appraisal is carried out with staff and the inspector saw evidence of this within three files. Staff were seen to be supportive of residents and responsive to their needs. Requests and residents’ alarm bells were promptly responded to by staff during the inspection. In discussions with the inspector, residents and families confirmed that staff were supportive and helpful. The use of agency staff is minimal and currently there are two members of staff within the care team who work within the centre on an ongoing basis, ensuring continuity of care.

A mandatory and relevant staff training programme was in place and a record of training for all staff was available. Mandatory training such as moving and handling, fire training and the prevention, detection and management of abuse had been provided. Additional training on CPR is provided to all care staff. The centre also provides training on areas of infection control, restraint management, nutritional and professional management of aggression and violence.

Manual handling practices observed were safe and appropriate, with assistive equipment available for use. Of the current staff, training records identified that there are currently five staff that are overdue to have their detection and management of abuse training updated. The inspector was informed that two training dates have been confirmed and
that all five staff will be prioritized.

Recruitment procedures were in place, and samples of staff files were reviewed against the requirements of schedule 2 records as per the regulations. All four files reviewed had Garda vetting disclosures in place. The management team confirmed that all staff have Garda vetting on their files. Evidence of professional registration for all registered nurses was made available and all nursing staff have evidence of current registration.

The provider nominee confirmed there are no volunteers working within the centre.

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:

Una Fitzgerald
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider’s response to inspection report

Centre name: Boyne View House
Centre ID: OSV-0000532
Date of inspection: 08/11/2017
Date of response: 22/12/2017

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:
The inspector was informed by the estates manager that the future plan for the rebuild of the centre and a time costed plan will not be ready for submission to HIQA until February 2018. The submission of this time costed plan is a restated action carried over from the last two inspections carried out within this centre.

1. Action Required:

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Under Regulation 23(a) you are required to: Ensure the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.

Please state the actions you have taken or are planning to take:
The Registered Provider acknowledges the need for a complete refurbishment of the centre. The refurbishment is being managed by the HSE Estates Department and a number of designs have been developed. The refurbishment is on the HSE Capital Plan and we are working with the Estates department and the Architect to finalise the details of the plan within the funding available. A meeting is scheduled for mid January 2018 with Mr Michael Fitzgerald, HSE Head of Operations and Service Improvement, Older Person Services to finalise the details and a plan will be submitted to HIQA by the 31st January 2018.

Proposed Timescale: 31/01/2018

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:
The risk register has identified maintenance of equipment as a risk. The inspector found that some items of resident equipment had gone past the service due date. The centre management team had knowledge of this gap and are taking measures to have all equipment serviced.

2. Action Required:
Under Regulation 26(1)(b) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the risks identified.

Please state the actions you have taken or are planning to take:
A service contract has been agreed and the outstanding equipment is scheduled for servicing, this will be completed by 31st January 2018. In order to prevent a reoccurrence, an asset register is being compiled for the centre and this will provide an alert system before servicing is due.

Proposed Timescale: 31/01/2018

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
Of the care plans reviewed and from conversations with the staff and families, the inspector concluded that the clinical team did not involve the residents in the care plan review meetings. Progress has been made and families are now all involved in the care plan reviews. However, this action is restated from the last inspection to meet the requirement to have residents where appropriate involved.

3. **Action Required:**
Under Regulation 05(5) you are required to: Make the care plan, or revised care plan, prepared under Regulation 5 available to the resident concerned and, with the consent of that resident or where the person-in-charge considers it appropriate, to his or her family.

**Please state the actions you have taken or are planning to take:**
All residents, where appropriate, are involved in the care planning process. For those residents who are unable or do not wish to participate, the Person in Charge, with the resident’s consent will ensure that his/her family are involved in the care plan development and reviews.

**Proposed Timescale:** 22/12/2017

**Theme:**
Effective care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The centre uses an electronic system to record and document resident care plans and all activities of daily living. The touch screen monitor has not been in working order since July 2017. The healthcare assistants now report to the registered nurse who has responsibility to input this data into the system. The inspector spoke with the nursing management in relation to this as key information that influence intervention management was not captured and had a negative impact on two of the residents whose files were reviewed.

4. **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:**
A replacement touch screen monitor for the electronic recording system has been installed and is in use for care staff to record all care delivered for each individual resident. This in turn alerts nursing staff to any necessary care interventions. The system also provides a separate alert which is reviewed each morning at handover. This will ensure that critical information is captured and will be monitored by the Clinical Nurse Manager on a daily basis and, in her absence, the registered nurse in charge.
Proposed Timescale: 22/12/2017

Outcome 12: Safe and Suitable Premises

Theme:
Effective care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The registration renewal is for a reduction in bed numbers from 26 down to 23 residents. One room is now used for storage and the two remaining rooms will be converted into extra sitting room space for residents use. The centre's management team are aware that HIQA require the design and layout of all changes to be reflected in an updated statement of purpose.

5. 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:
The Statement of Purpose has been reviewed and amended with the changes to the function of the rooms clearly stated. The floor plan has also been reviewed in conjunction with the Statement of Purpose to reflect these changes and has been forwarded to the authority.

Proposed Timescale: 22/12/2017

Theme:
Effective care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The inspector followed up on the action plan from the last two inspection reports. The programme of refurbishment is ongoing and the original date for completion was January 2017. The inspector has noted the following deficiencies are recurring and are dependent on funding which to date has not been granted.
- Some of the bedrooms remain in a poor state of repair with furniture wood that have chipped and rough edges that can cause a risk of damage to residents with poor skin integrity.
- The flooring in some bedrooms is not suitable for mobile residents who are at risk of slips or falls.
- Bed tables in rooms were seen to have rust and so not receptive to cleaning.
- Some bedrooms are still awaiting TV points so residents can have their own TV in their room.
- Repainting of a number of rooms and areas within the centre.
6. Action Required:
Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

Please state the actions you have taken or are planning to take:
A programme of refurbishment is ongoing in Boyne View House. This programme will include all works identified as follows:

1. Some of the bedrooms remain in a poor state of repair with furniture wood that have chipped and rough edges that can cause a risk of damage to residents with poor skin integrity.
   These units will all be replaced by the 31st March 2018.

2. The flooring in some bedrooms is not suitable for mobile residents who are at risk of slips or falls.
   Falls risk assessments are carried out on all residents on admission and on an ongoing basis. Those residents identified as being at risk of falls are supervised when mobilising. The rooms identified as requiring new flooring will be replaced by the 31st March 2018.

3. Bed tables in rooms were seen to have rust and so not receptive to cleaning.
   All defective bed tables have been replaced.

4. Some bedrooms are still awaiting TV points so residents can have their own TV in their room.
   Those rooms which are currently without TV points are scheduled for installation of TV points before the end of April 2018. Mobile TVs and DVDs are available for residents use in rooms where the TV points are not currently available.

5. Repainting of a number of rooms and areas within the centre.
   Many rooms within the centre have been recently repainted and the remainder will be complete by the 30th April 2018.

Proposed Timescale:
1. 31/03/2018
2. 31/03/2018
3. Complete
4. 30/04/2018
5. 30/04/2018

Proposed Timescale: 30/04/2018

Theme:
Effective care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The inspector reviewed the list of items that minor capital funding has been requested
for by the centers management. All items have been risk rated as priority rating high as they relate to infrastructural risk. The items on this list include:
- The need to replace flooring in the main dining hall and some of the resident rooms.
- Replacement of all bedroom sinks
- Five sets of built-in wardrobes in bedrooms
The centers management team could not inform the inspector of when they will receive conformation from the registered provider of when this work will be granted funding to ensure that resident care is not compromised.

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

**Please state the actions you have taken or are planning to take:**
The list identified was compiled following an environmental audit and will be used to inform quality improvement plan for 2018 in the centre. The high priority areas such as replacement flooring in the main dining hall and in some of the resident’s bedrooms will be replaced by the 31st March 2018. Where required, appropriate sinks will replace clinical sinks in residents bedrooms by the 31st March 2018. The other items on the list will be addressed through implementation of the quality improvement plan of the Centre.

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

<table>
<thead>
<tr>
<th><strong>Outcome 16: Residents' Rights, Dignity and Consultation</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theme:</strong> Person-centred care and support</td>
</tr>
<tr>
<td><strong>The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:</strong></td>
</tr>
<tr>
<td>Whilst staff did their utmost to support the rights and dignity of residents, aspects of the premises impacted on the rights and dignity of residents:</td>
</tr>
<tr>
<td>* No access to cold water in some rooms for residents to brush their teeth.</td>
</tr>
<tr>
<td>* Shelving in bedrooms too high and cannot be reached by residents.</td>
</tr>
<tr>
<td>* Damaged flooring, rusted bed tables and rooms in need of decorative repair did not provide a dignified environment for residents and also posed risk to their safety and welfare.</td>
</tr>
</tbody>
</table>

8. **Action Required:**
Under Regulation 09(3)(e) you are required to: Ensure that each resident can exercise their civil, political and religious rights.

**Please state the actions you have taken or are planning to take:**
A. Residents have always been provided with fresh drinking water to allow them to brush their teeth. Further, the replacement of sinks discussed above will ensure residents will have access to cold water to brush their teeth and will be completed by
31st March 2018.
B. Shelving will be repositioned for ease of access for the residents by 31st January 2018.
C. Flooring discussed above will be complete by 31st March 2018. All bed tables have been replaced and any outstanding decorative repairs will be complete by 30th April 2018.

Proposed Timescale: A: 31/03/2018
B: 31/01/2018
C: 30/04/2018

Proposed Timescale: 30/04/2018

Outcome 18: Suitable Staffing
Theme: Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The inspector reviewed the training records and found that there are five staff members due an update in their training. The inspector was informed that two training dates have been confirmed and that all five staff will be prioritized.

9. 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 has been provided to all staff.

Proposed Timescale: 22/12/2017