Health Information and Quality Authority
Regulation Directorate

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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	Áras Mhic Dara Community Nursing Unit
Centre ID:	OSV-0000626
Centre address:	An Cheathrú Rua, Co na Gaillimhe, Galway.
Telephone number:	091 595 204
Email address:	eileen.costello@hse.ie
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Lead inspector:	Una Fitzgerald
Support inspector(s):	Catherine Sweeney
Type of inspection	Announced Dementia Care Thematic Inspections
Number of residents on the date of inspection:	37
Number of vacancies on the date of inspection:	0

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.

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 following receipt of unsolicited information. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
21 March 2019 09:00	21 March 2019 16:00
22 March 2019 10:00	22 March 2019 15:00

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

Outcome	Provider's self assessment	Our Judgment
Outcome 01: Health and Social Care Needs	Compliance demonstrated	Compliant
Outcome 02: Safeguarding and Safety	Compliance demonstrated	Compliant
Outcome 03: Residents' Rights, Dignity and Consultation	Compliance demonstrated	Compliant
Outcome 04: Complaints procedures	Compliance demonstrated	Compliant
Outcome 05: Suitable Staffing	Compliance demonstrated	Non Compliant - Major
Outcome 06: Safe and Suitable Premises	Compliance demonstrated	Substantially Compliant
Outcome 08: Governance and Management	Not applicable	Non Compliant - Major
Outcome 09: Statement of Purpose	Not applicable	Non Compliant - Moderate

Summary of findings from this inspection

This dementia thematic inspection focused on the care and welfare of residents who had dementia. The centre completed the provider's self-assessment and compared the service with the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013 and the National Standards for Residential Care Settings for Older People in Ireland (2016). As a result of findings of this inspection Outcome 8 Governance and Management and Outcome 9 Statement of Purpose were added to the report.

The Governance and management systems in place for this designated centre were

not acceptable and required significant improvement to ensure that the centre operated in accordance with the Health Act 2007 as amended. Findings from this inspection were that the registered provider (Health Service Executive) had breached their conditions of registration by failing to adhere to Conditions 5 and 7 of registration for a three month period of time as evidenced by the monthly occupancy numbers reported to the Health Services Executive management team.

Condition 7 of the registration sets out that the centre is registered to accommodate 34 residents. On day one, inspectors found 37 residents living in the centre which was an additional three residents over and above the number permitted. Furthermore the HSE was not adhering to its own statement of purpose (SOP) by using rooms which were not included in their SOP when applying for registration in 2015. In addition, three of the bedrooms that were registered for single occupancy (as set out in their SOP) had two residents accommodated in them.

Further evidence of unacceptable governance was found when inspectors reviewed staff files. The HSE had failed to ensure that all staff working in the centre had a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 available for inspection. In the absence of the required documentary proof of vetting the provider was issued with an urgent compliance plan. The management system in place prevented the person in charge having oversight of Schedule 2 regulatory requirements. The person in charge had an envelope in the office that contained the Garda Vetting disclosures which she had been instructed not to open and to be given to inspectors when requested. Inspectors found that three registered nurses on duty did not have a vetting disclosure on file. On day two of the inspection, two of the missing vetting disclosures had been sent out from a central office. However, one newly appointed member of staff did not have a Garda vetting disclosure on file.

On the days of inspection there was a total of 11 residents with a formal diagnosis of dementia and a further three residents who have symptoms of dementia. Inspectors tracked the care pathways of residents with dementia and spent periods of time observing staff interactions with residents. A validated observational tool, the quality of interactions schedule -QUIS was used to rate and record the quality of interactions between staff and residents. Specific emphasis focused on residents who had dementia. Documentation such as care plans, clinical records, policies and procedures, and staff records were reviewed.

Inspectors found that the direct care was delivered to a good standard by staff who knew the residents well. Resident and staff interactions observed were kind and patient. Staff discharged their duties in a respectful and dignified way. The person in charge had proactively engaged with all stakeholders to ensure that the culture within the centre was open and transparent. A person-centered approach to care was observed. Residents appeared well cared for. There was good evidence that independence was promoted and residents had autonomy and freedom of choice. Residents spoke positively about the staff. Inspectors met with residents, some of whom had dementia. Their feedback was very positive.

Inspectors observed numerous examples of good practice in areas examined which

resulted in positive outcomes for residents. The results from the formal and informal observations were positive. The living environment was a hub of activity throughout the two days of inspection. All staff were engaged in activities and valued the importance of social interactions with residents. The atmosphere within the centre was open, welcoming and friendly. Residents had access to outdoor gardens that were well maintained.

Inspectors followed up on the action plan from the previous inspection in January 2018, and findings indicated that three of the actions were not implemented. Namely, the statement of purpose did not meet with regulatory requirements, the annual review for 2018 was not available and the management had failed to ensure that robust auditing systems were in place to ensure that the service is safe and effectively monitored. During this inspection, of the eight outcomes assessed, there was two major non compliances, one moderate non compliance and one substantial compliance found. 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 01: Health and Social Care Needs

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 inspectors found that there were systems in place to assess the health and personal care needs of residents including residents with dementia. Inspectors focused on the assessment, care planning, and implementation of the care delivered to residents with a diagnosis of dementia within the centre. A sample of residents files were reviewed with a focus on aspects of care such as assessment and care planning, access to healthcare, End of life care, nutrition, and medication management.

Inspectors spoke to a number of residents over the two days of inspection. All residents spoken to stated that they were very satisfied with the care they received in the centre. Residents reported that they felt safe, adding that they were treated very well. The residents told inspectors that they regularly engaged in the activities scheduled within the centre. Inspectors noted that staff interaction with residents was very positive, with the majority of staff communicating with Irish-speaking residents through Irish.

Inspectors noted that residents had appropriate and timely access to health and social care services which reflected their individual care needs. Residents had good access to GP services and access to allied health professionals such as physiotherapy, occupational therapy and dietetic services. A comprehensive assessment was completed on each resident on admission and as required thereafter. Validated assessment tools were used to assess each resident's dependency levels, nutritional status, skin integrity, falls risk, social care and end of life needs. This comprehensive assessment process informed the development of a person-centered care plan. A system was in place to ensure that care plans were reviewed and updated appropriately. Inspectors found good evidence that care was delivered in the centre in line with the resident's documented care plan. The care plans for residents with a diagnosis of dementia provided clear guidance to the care staff in relation to the care required when residents are exhibiting behaviour symptoms of dementia. Resident and family involvement in the development of the care plan was well documented. An end of life care plan was developed for residents approaching end of life. The end of life care plan included the assessed physical, emotional, psychological and spiritual needs of the residents.

The centre has a comprehensive policy in place to monitor and record the nutritional intake of residents with dementia. Inspectors observed residents with dementia being facilitated with meals and to eat independently, where possible, in a respectful and dignified manner. Residents who required assistance were attended to by staff who delivered care in a person-centered way. A choice of drinks were available and accessible to residents throughout the centre. Residents who required a modified diet were offered a choice from the daily menu. Inspectors noted good communication between the catering staff and the care staff in relation to resident's needs. There was a system in place to ensure that catering staff had access to the residents' nutritional assessments and care plan. The inspectors observed the dining experience to be a positive and sociable event. Tables were set appropriately and meals were served in an attractive and appetizing manner. Residents confirmed that the food was of a very high standard and that their choices, likes and dislikes were facilitated. Residents who did not wish to attend the dining room were facilitated to eat in a place of their choosing. Residents were weighed monthly and more often if required. All residents had a risk assessment for malnutrition completed on admission and as required thereafter. Appropriate measures were taken for residents who were found to be at risk, for example, fluid and food intake charts and referral to dietitian were in place.

The inspectors reviewed the medication administration system within the centre. The clinical room was well organized and there was a robust system in place to ensure safe administration of medications. Medication administration was documented in line with relevant professional guidelines. Inspectors observed that the management of controlled drugs within the centre was in line with professional guidelines. Nurses were observed administrating medicines to residents. They were seen to use this task as a means of engagement and took the opportunity to ask the resident how they were feeling and if they had any concerns.

Inspectors noted that a resident's right to refuse an intervention treatment was recorded. For example: one resident had refused the annual flu injection. The potential negative impact of this decision had been explained to the resident. Their choice to refuse was respected.

Judgment:
Compliant

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:
Measures to protect residents from being harmed or suffering abuse were in place. A

policy on, and procedures for the prevention, detection and response to allegations of abuse was in place. Staff who communicated with the inspectors confirmed that they had received training on safeguarding vulnerable adults and were familiar with the reporting structures in place. In addition, staff confirmed that there were no barriers to raising issues of concern.

There were systems in place to ensure allegations of abuse were fully investigated, and that pending such investigations measures were in place to ensure the safety of residents. Inspectors followed up on unsolicited information pertaining to an allegation of abuse that had occurred outside of the centre. A full investigation had been carried out and safeguarding plans were implemented. Inspectors found that the person in charge had taken all reasonable measures to protect the resident. This matter was satisfactorily addressed.

A review of training records indicated that staff were provided with up-to-date knowledge and skills, appropriate to their role to enable them to manage responsive behaviours. The staff were observed to be knowledgeable regarding residents' behaviours. The dementia care plans reviewed included a description of the types of behaviours which the resident sometimes demonstrated and provided guidance on strategies to prevent the behaviours and to calm the resident if the behaviour escalated. There was good access to allied healthcare professionals and advice received from the psychiatry of later life team (POLL) was taken on board which had a positive outcome for residents.

The centre had a policy on the use of restraint. The centre actively promotes a restraint free environment. Staff were clear that restraint measures were a last resort and only considered when less restrictive interventions had not achieved the desired outcome to keep a resident safe. There was no chemical restraint in use within the centre. There was no resident with bedrails in use.

There were systems in place to safeguard residents' money. The centre acts as a pension agent for seventeen residents. The administrator confirmed that the centre is in compliance with the department of social welfare guidelines. The money is held in a resident's account separate to the centre's account. In addition small amounts of money are kept in the centre for resident personal use. The staff member responsible for residents' money explained the systems regarding documenting transactions. There were clear systems in place to ensure that residents could access their money in a timely manner. Records reviewed evidenced two signatures against all transactions.

Judgment:
Compliant

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:
Person-centred care and support

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

Findings:
Inspectors observed that the residents in the centre received care in a dignified way that respected the residents' privacy. Residents were observed to be facilitated to exercise choice and were observed to come and go freely around the communal areas of the home. Residents were facilitated to spend time alone, if requested. Inspectors observed that bedroom and bathroom doors were closed when personal care was being delivered. Staff were observed to knock and wait before entering bedrooms. Adequate space and screening curtains were provided in shared bedrooms.

Activities were seen to be well organised and residents were facilitated to participate. On the day of inspection activities observed included a sing song and story telling, individual art therapy, individual hand massage, and religious services. Local musicians are scheduled to facilitate music sessions weekly. Participants of a day care service, which operates within the centre, join the residents for group activities, meals and religious services. Residents informed the inspectors that they enjoyed this interaction as it enhances their connection to the local community.

The centre is situated in the Gealtacht area of Connemara. The majority of residents spoke Irish as their first language. Most of the communication in the communal areas was made through Irish. Residents' communication needs were assessed and included in the resident care plans. Newspapers and a large television was available to residents in the communal areas and each bedroom had a television which was accessible to the residents. The centre is well connected with the local community. There was no restriction on visitors to the centre. There were private areas throughout the centre for residents to receive visitors.

Staff spoken to were knowledgeable about residents' preferences. This was reflected in the social assessment and care plan developed for the residents. As part of the inspection, communication between staff and residents was monitored using a validated observation tool QUIS (Quality of interaction schedule) to rate and record the quality of interaction. During these observation periods, inspectors noted that care was delivered in a respectful and person-centred manner that respected the resident's right to choose and facilitated their independence.

Judgment:
Compliant

Outcome 04: Complaints procedures

Theme:
Person-centred care and support

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

Findings:
There were policies and procedures for the management of complaints. The complaints process was displayed in a prominent place at the entrance to the centre and also at the nurses station. The person in charge was involved in the management of complaints. Inspectors reviewed the complaints log. Records indicated that complaints were minimal. There had been no complaints made to date in 2019.

Inspectors reviewed the documentation in place for the last two complaints received. The management had comprehensive and detailed documentation in place that evidenced that the complaints were investigated promptly, a record of the outcome was documented and there was detail if the complainant was satisfied with the outcome.

Residents were informed on admission of the complaints procedure. Residents spoken with on the days of inspection told inspectors that they would not hesitate to make a complaint if they had one. In addition, residents voiced satisfaction with the care and were aware of who they could complain to if they needed.

Judgment:
Compliant

Outcome 05: Suitable Staffing

Theme:
Workforce

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

Findings:
A number of staff files were viewed. As previously stated, the registered provider had failed to ensure that all staff had a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 and 2016 was available for inspection. On day one of the inspection there were three staff on duty that did not have Garda vetting disclosures available for inspection. The system in place did not ensure that the documentation in place to meet with the requirements of Schedule 2

regulation could be met. The person in charge had been given a sealed envelope and was instructed that this envelope was for the attention of the inspector. The person in charge was very clear that she had been instructed not to open this envelope. This list of names did not align to the contents of the envelope. As a result the provider was issued with an urgent compliance plan.

Inspectors reviewed actual and planned rosters for staff, and found that staffing levels and skill mix were sufficient to meet the needs of residents. Staff spoken to confirmed that they had sufficient time to carry out their duties and responsibilities when caring for the resident direct care needs. Inspectors found that there was a good ratio of nurses and care support staff on duty. The centre management had multi task attendants (MTA) employed who cross covered roles. For example, the MTA carry out the role of healthcare assistant and cleaning duties. The staff were assigned what role they were on in advance and did not cover two roles on the same day.

The education and training available to staff enabled them to provide care that reflects up-to-date, evidenced based practice. All staff had completed training in safeguarding and safety. All staff had completed annual fire training. Evidence of current professional registration for registered nurses was seen by inspectors. Recruitment and induction procedures were in place. These required improvement as one nurse had commenced employment without the GV being in place.

There were no volunteers working in the centre.

Judgment:
Non Compliant - Major

Outcome 06: Safe and Suitable Premises

Theme:
Effective care and support

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

Findings:
The centre is purpose built and is designed to meet the needs of the residents. Aras Mhic Dara Community Nursing unit is registered to accommodate 34 residents. The centre did not have a dementia specific unit and residents with dementia integrated with the other residents in the centre. The centre accommodates a day care service.

The centre was seen to be clean and in a good state of repair. It was suitably decorated in a comfortable, familiar and homely manner. For example, the day room contained a mural of the inside of an old stone cottage. Bedrooms were observed to be decorated with residents' personal belongings, pictures and furniture. The floor covering throughout the centre was safe and well maintained. This facilitated ambulant residents

to move independently and unimpeded around the centre. The lighting, heat and ventilation in the centre adequately met the needs of the residents. The temperature of the centre was comfortable.

There are a number of private and communal areas throughout the centre. Inspectors observed these areas being used by residents during the course of the 2 day inspection. The central communal area of the centre contains a large day room which was well supervised. There is a number of smaller communal rooms, a conservatory and an oratory freely accessible to the residents. There is a large dining area with ample space for safe, unimpeded movement. The communal living areas are well furnished with comfortable and functional furniture. There is a clock on the wall of the dayroom to assist residents with dementia to orientate to day and night time.

The centre has a safe, outdoor internal garden which is accessible to residents at all times. The garden areas are well maintained. Residents informed the inspectors that they enjoy sitting out in the courtyard having ice-cream during the summer months.

There is a sufficient number of toilets, bathrooms and showers to meet the residents' needs. Assisted toilets contained grab rails in the bath, shower and toilet areas. Toilets have non-slip floors and are step-free and spacious enough to accommodate residents and assistants.

There was a lack of signage to direct residents around the centre. Inspectors discussed the use of additional signage to meet the needs of ambulant residents with a diagnosis of dementia. The addition of directional signage throughout the centre would support residents to navigate the centre and locate their bedrooms, indoor and outdoor communal areas and bathroom facilities.

Judgment:
Substantially Compliant

Outcome 08: Governance and Management

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:
Inspectors found that there were sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose. Areas of good practice were found in relation to the direct provision of care that impacted positively on resident outcomes.

Inspectors were not satisfied that the governance and management systems in place

were sufficient to ensure that the service provided was safe, appropriate, consistent and effectively monitored. The findings on this inspection relate to:

• The system in place to ensure compliance with Schedule 2 documentation had not identified that multiple staff members did not have a Garda vetting disclosure on file in the centre.
• Recruitment procedures required review as a newly hired staff member had been recruited prior to completion of garda vetting process
• Inspectors reviewed the clinical audits in place that give the management an oversight of the whole service. The audits reviewed were of poor quality. For example; the last falls audit conducted was in June 2016. This audit was a list of residents that had a fall. From the audits reviewed there was no evidence that the information was analysed, or that any quality improvements were identified as a result of information gathered to improve residents outcomes. This action is restated from the last inspection.
• Over a period of months the management had admitted residents above the capacity registered for under Condition 7 of the registration. Management had poor understanding of the requirements of the Health Act.
• There was no annual review of the service for 2018 available for review. This was a restated action from the last inspection.

Judgment:
Non Compliant - Major

Outcome 09: Statement of Purpose

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:
Following on from the last inspection in January 2018 the management were requested to review the Statement of Purpose in line with regulatory requirements. Inspectors acknowledge that the detail on the premises had been updated.

The Statement of Purpose reviewed by the inspectors on the day of inspection requires further review. The management team had amended the wording of Condition 7. The additional wording is not aligned to the information set out in the certificate of registration. In addition, the registration details had not been updated to reflect the current registration details. For example: the Registration expiry date was inaccurate.

As per the statement of purpose the centre had allocated open bedrooms for residents.

As previously stated the centre had 37 residents in the centre. Unregistered beds were occupied. For example, three of the double bedrooms that were registered for single occupancy use had two residents accommodated in them.

Judgment:
Non Compliant - Moderate

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

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	Áras Mhic Dara Community Nursing Unit
Centre ID:	OSV-0000626
Date of inspection:	21/03/2019
Date of response:	23/05/2019

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 05: Suitable Staffing

Theme:
Workforce

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
A number of staff files were viewed. The registered provider had failed to ensure that all staff had a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 and 2016 that was available for inspection

1. Action Required:
Under Regulation 21(1) you are required to: Ensure that the records set out in

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

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:
* The General Manager (GM) has completed an audit of every Gardaí Vetting and reviewed all issues such as illegible/ poor quality stamps. These have now been corrected
* Staffs whose file did not meet schedule 2 were put off duty, until full compliance with Schedule 2, which has now been achieved
* Management team now fully aware of legal responsibility to provide file with full compliance of schedule 2
* This action, now completed, means a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 and 2016 is on site for all staff
* The Head of Service and General Manager have met with Human Resources and a standard operating process re Gardaí Vetting has been developed. SOP cover all recruitment, temporary and permanent, and transfers. All Directors of Nursing (DONs) and Persons in Charge (PICs) have received it for review and implementation.
* No start date can be agreed with new staff until the DON/PIC has Garda Vetting declaration on site.

Proposed Timescale: 23/05/2019

Outcome 06: 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:
There was a lack of signage to direct residents around the centre. Inspectors discussed the use of additional signage to meet the needs of ambulant residents with a diagnosis of dementia . The addition of directional signage throughout the centre would support residents to navigate the centre and locate their bedrooms, indoor and outdoor communal areas and bathroom facilities.

2. 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:
* Review of current signage: completed by Registered Provider and CNM 2 on 20/5/19. List completed of additional signage required.
* Identify signage needs :Literature reviewed re best practice in enabling persons with dementia to be supported through enabling signage.
* Design signage: Meeting scheduled with Registered Provider Representative (RPR, CNM 2 and signage company for Thursday 23rd May to discuss design for signage. CNM

2 to involve residents by advising them of proposed new signage and discussing individual signage for each bedroom in line with residents preferences.
* Print Signage :Signage is to be printed and supplied by external supplier and display all signage in both Irish, English and picture format
* Display signage :Signage to be hung by maintenance team on receipt of same.
* Occupational Therapist is to complete an environmental assessment in relation to dementia friendly home

Proposed Timescale: 31/07/2019

Outcome 08: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Inspectors were not satisfied that the governance and management systems in place were sufficient to ensure that the service provided was safe, appropriate, consistent and effectively monitored.

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

Please state the actions you have taken or are planning to take:
* In the reviews with DONs there is a structured template going to be used covering Quality Safety and Capacity and Capability
* The RPR and PIC will initially meet monthly to ensure action plan from dementia thematic inspection is implemented and utilise this structured meeting to discuss the implementation of the annual quality review
* Schedule 2 requirements including vetting disclosures are now in place.
* Recruitment process now reviewed for all staff including staff that transfer into service from other HSE services. Director of Nursing and HR now aware of requirement to review staff transfer files. Standard operating process developed.
* The falls audit tool will be revised in line with the HSE (2018) Service User Falls Practical Guide for Review
* Audit schedule for the unit has been scheduled for next six months, with responsibility for audit plan with PIC/RPR. Outcome of audits will be reviewed and action plan put in place if required to improve quality of life for the residents.
* The Quality Patient Safety (QPS) advisor produces a 6 monthly report on incidents which includes Slip trips and falls for the Social Care QPS Committee – this report and the learnings will be discussed at the monthly DONs/PICs meetings with the Older People Services Managers.
* The Head of Service and General Manager have set up DON governance meetings with set Terms reference and agenda to support PIC in meeting regulations.
* The RPR has completed a number of visits to the unit, in conjunction with GM will

schedule monthly visits to unit to complete a review of services, and will complete unannounced visits to ensure compliance with regulation 23.
* The number of residents is now 34, and will not exceed again past registered number of 34 residents. All residents now live in bedrooms, which are registered, and beds not registered will not be used again.

Proposed Timescale: 30/06/2019

Theme:
Governance, Leadership and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
There was no annual review of the service for 2018 available for review.

4. Action Required:
Under Regulation 23(d) you are required to: Ensure there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.

Please state the actions you have taken or are planning to take:
* The Annual Review (2018) of the quality and safety of care delivered is proposed. This has to be shared with residents and their families for their input.
* Following it a schedule will be agreed for the improvement plan which will be the responsibility of DON/CNM2/RPR and will be discussed at monthly meetings with Registered Provider. Support for implementation will be discussed with Head of Service/General Manager.
* The Quality Patient Safety (QPS) advisor will support to Annual Review process

Proposed Timescale: 30/06/2019

Outcome 09: Statement of Purpose

Theme:
Governance, Leadership and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The Statement of Purpose reviewed by the inspectors on the day of inspection requires further review to ensure that the document meets with all requirements of the regulations.

5. Action Required:
Under Regulation 03(1) you are required to: Prepare a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Please state the actions you have taken or are planning to take:
* The Statement of Purpose has been updated in the new HIQA provided format and amended to contain all information as set out in Schedule 1 of the Health Act 2007(Care and Welfare of residents in Designated Centres of Older People) Regulations 2013.

* Bedrooms, which are not registered for use, are clearly identified as per Schedule 1 point 4, and these rooms will not be used at this time.

Proposed Timescale: 23/05/2019