Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	Aras Ghaoth Dobhair
Name of provider:	Bainistiocht Aras Gaoth Dobhair Cuideachta Faoi Theorainn Rathaiochta
Address of centre:	Meenaniller, Derrybeg, Letterkenny, Donegal
Type of inspection:	Unannounced
Date of inspection:	29 June 2022
Centre ID:	OSV-0000311
Fieldwork ID:	MON-0033952

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

This centre is a purpose-built single-storey building located in Gweedore, a Gaeltacht area in Co. Donegal. The centre has been operating since 2004 providing continuing, convalescent and respite care to male and female residents primarily over 65 years with low-to-maximum dependency needs. The centre is registered for 41 residents to be accommodated. Communal day, dining and sanitary facilities were available in addition to 25 bedrooms with full en-suite facilities within two distinct units. The dementia unit can accommodate 20 residents and the general unit can accommodate 21 residents. Bedroom accommodation comprises of 17 single, four twin and four bedrooms with four beds in each. An aim of the service is to provide a caring environment where residents feel supported and valued, and where their primary needs can be met in a warm homelike atmosphere without undermining their dignity, privacy or choice. An objective of the service is to provide a high standard of care and treatment in keeping with best practice and current legislation, to dependent people who can no longer live at home.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	32

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 29 June 2022	10:00hrs to 17:50hrs	Nikhil Sureshkumar	Lead

What residents told us and what inspectors observed

The inspector met with a number of residents on the day of the inspection. Those residents who spoke with the inspector praised the staff and the service provided in the centre. From what the residents told the inspectors and from what the inspectors observed, the designated centre was a pleasant and comfortable place to live. However, improvements were required in the governance and management of the centre and in fire precautions to ensure that the service provided to the residents was safe and effective.

The designated centre is located in Derrybeg, a Gaeltacht village in the West of Donegal. The residents accommodated in the centre were predominantly Irish speakers. The inspector observed some staff and residents communicating in Irish on the day of inspection.

Residents reported that the staff were kind and caring. Some residents told the inspector that they were well looked after and were happy that they could stay near to their homes and that their friends and families could visit them regularly. Residents told the inspector that they felt safe in the centre and that they could talk to someone if they were concerned about anything.

The reception area was bright, airy and welcoming, with a seating area with comfortable seating and access to toilets. The centre is divided into two units, and one of the units is a specialist dementia-specific unit. The inspector observed that the premises was clean, and the centre's housekeeping arrangements were sufficient to ensure cleaning and disinfection in the centre. This was an improvement from the previous inspection.

The centre's day rooms were spacious, and activities rooms were available in both units. One of the activities rooms of the centre is a sensory room, and the room appeared welcoming and was decorated with soothing decor and lighting. The room was well equipped with multi-colour sensory lights, facilities for aroma therapy and some sensory tactile objects to provide appropriate stimulation for residents living with dementia.

The inspector observed that there was an activity programme on display, and staff were allocated to carry out activities in the centre. The inspector observed the interactions between residents and staff during the inspection, and they were found to be respectful and friendly. Staff were found to be offering assistance to residents in a discrete manner when required.

The inspector noted that the residents have access to television and newspaper in the centre. The inspector saw some residents watching television in a day room. The residents told the inspector that the centre was quiet and they were able to watch their chosen programmes in peace. Other residents were found enjoying the views of the outdoors through large glass windows, whilst a number of residents

were observed walking around the centre with staff assistance. The inspector noted that the centre has wide and unobstructed corridors with handrails to support residents in moving around the centre. Overall the inspector noted that the atmosphere of the centre was relaxed and calm.

There was adequate storage space in the centre. Larger items of equipment such as hoists were securely stored in their allocated storage spaces so that they did not obstruct corridors where residents might be walking. The inspector observed that staff practices in moving and handling residents were in line with good practice and ensured the safety and comfort of the residents.

The inspector visited some of the bedrooms in both units and saw that the bedrooms were personalised with items such as family photographs. There was sufficient secure space to store the personal belongings of the residents. The residents' personal clothes were laundered in the centre, and clothes were stored neatly in the wardrobes and were accessible to the residents.

The inspector noted that the multi-occupancy rooms in the centre had privacy curtains in place, and staff respected the residents' privacy when entering and leaving their bedrooms. Call bells were located at appropriate locations in the bedroom and were accessible to residents to call for assistance when they needed to.

The inspector observed the residents' dining experience. There was a choice of main course and dessert. The food served was of high quality and was attractively presented. Residents in all areas had access to snacks and drinks outside of their regular mealtimes. The inspector noted that the snacks and refreshments provided were nicely presented and appetising and supported those residents who were at risk of malnutrition. The staff were found to be knowledgeable about the dietary needs of the residents. The inspector observed that there was adequate staff to support the residents during meal times, and this observation was confirmed by residents who chatted with the inspector. Feedback from residents was very positive in relation to their menus and their mealtime experience. This was an improvement on the previous inspection.

The centre has two internal courtyards, and one of the courtyards is a garden. The inspector noted that the layout of the internal courtyard in the dementia-specific unit has improved since the last inspection. The paths were paved, which provided a safe surface for the residents to walk around. There were seating areas around the garden, and a shed was provided for residents to sit in, however, staff were using the garden shed on the day of inspection to relax during their break times. In addition, residents were not facilitated to access the garden courtyards independently and required staff assistance to go out into the garden.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impacted the quality and safety of the service being delivered.

Capacity and capability

The inspector found that the governance and management systems in place have improved since the previous inspection. Regular management meetings were held, and a record of those meetings was available for the inspector on the day of inspection. However, the management systems required strengthening to improve the quality of service in the centre. This is further discussed under Regulation 23.

This risk-based one-day unannounced inspection was carried out to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). The inspector reviewed the actions from the compliance plans of the last inspection, the information submitted by the provider and the person in charge, and other information received by the Chief Inspector in relation to the designated centre. The person in charge and three of the members of the voluntary board represented the provider during this inspection.

The provider of the centre is Bainistiocht Aras Gaoth Dobhair and is a voluntary body made up of local voluntary organisations, each of whom has appointed a director to the provider entity. The provider informed the inspector during the inspection that the arrangements for the lease of the building were under review to ensure that responsibility for the maintenance and upkeep of the premises was clarified. However, the lease agreement was not finalised at the time of inspection.

The person in charge (PIC) was an experienced, qualified nurse who held a management qualification as required by the regulations. The person in charge was supported by one clinical nurse manager and a team of staff in the centre. This was a reduction in the management capacity as there were two clinical managers at the time of the previous inspection. The person in charge informed the inspector that the provider intended to recruit an additional nurse manager to ensure continuous oversight of the service in two units but was awaiting funding to be available to support the recruitment. However, the inspector was not assured that the succession planning arrangements were sufficient to sustain the clinical leadership in the centre when the PIC returned to their substantive post in 2023. Further assurances were received from the provider following the inspection in relation to the clinical leadership team in the centre going forward.

There was a nurse at all times in the centre, and the rosters indicated that where several staff vacancies existed, these were covered using agency staff. The provider assured the inspector that the centre was actively recruiting staff to fill the current vacancies. However, the inspector noted that some care staff were also assigned to carry out laundry duties in the absence of dedicated laundry staff. This reduced the time that these staff were available to provide personal care for the residents. This is further discussed under Regulation 15.

A training programme was available for staff working in the centre. The person in charge had oversight of the training programme, and there were systems in place to

indicate where staff were due for training updates. However, the training matrix showed that not all staff were up to date with their mandatory fire safety training, and there were no dates scheduled for this training to take place. Assurances were provided following the inspection that the staff had completed the required fire safety training. In addition, some staff who spoke with the inspector were not knowledgeable about the residents' care plans to prevent pressure ulcers and informed the inspector that they relied on pressure-relieving devices to prevent residents from developing pressure ulcers.
The inspector noted that a summary of the complaints procedure was available at the centre's reception. Even though complaints received in the centre were fully recorded and investigated, the provider had not nominated a person other than the complaints officer to oversee the complaints processes.

Regulation 14: Persons in charge

The person in charge of the designated centre has the appropriate experience and a management qualification as required by the regulations.

Judgment: Compliant

Regulation 15: Staffing

The number and skill mix of staff available was not sufficient having regard to the needs of residents and the size and layout of the designated centre. For example:

- The care staff were allocated to carry out laundry duties in addition to their caring duties in the centre. As a result, the staff had to shift their focus from providing direct care to the residents to laundering their clothes in the centre.
- The centre reported vacancies for seven nurses, and the vacancies were not filled at the time of inspection. The nursing vacancies were being covered by agency staff, however, this did not provide continuity of clinical care for the residents.
- The second clinical nurse manager (CNM) post was vacant in one of the units at the time of the inspection, and the person in charge was responsible for carrying out the CNM's duties on this unit as well as carrying out her own role and responsibilities as the person in charge. This was not sustainable and meant that the oversight of clinical care was not robust, as evidenced by the findings in relation to pressure sore management in the designated centre. In addition, a number of clinical audits had not been completed on this unit.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Not all staff had access to appropriate training as some staff were not up to date with their mandatory fire training training requirements.

The supervision of staff practices in caring for those residents who were at risk of pressure ulcers was not adequate. This was evidenced by the lack of appropriate interventions that were in place for some residents who were identified as being at risk of developing pressure ulcers. This is discussed further under Regulation 6.

Judgment: Substantially compliant

Regulation 21: Records

The inspector noted that the records required under Schedule 2 and Schedule 3 of the Regulations were generally well maintained in the centre.

Judgment: Compliant

Regulation 23: Governance and management

The provider had not ensured that the service provided in the centre was safe, consistent and effectively monitored. For example:

- The centre had not ensured that the care staff were provided access to care plans in the centre to ensure effective and continuous delivery of care to the residents.
- Falls audits were not carried out for 2022. As a result, the inspector was not assured that appropriate measures were carried out to manage falls in the centre. The provider carried out a falls analysis in the centre following the inspection.

The person in charge's secondment from their substantive post was due to finish in 2023. While deputising arrangements were in place for any temporary absence of the person in charge, there were no clear succession plans in place made to sustain leadership in the centre once the current person in charge had left their post.

Judgment: Not compliant

Regulation 31: Notification of incidents

A record of accidents and incidents involving residents that occurred in the centre was maintained. Notifications and quarterly reports were submitted within the specified time frames.

Judgment: Compliant

Regulation 34: Complaints procedure

The provider had not nominated a person to oversee the complaints management process so as to ensure that the complaints were responded to appropriately and in accordance with the regulatory requirement.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

Policies and procedures on the matters set out in Schedule 5 were reviewed at appropriate intervals and were made available to staff in the centre.

Judgment: Compliant

Quality and safety

The inspector noted that the care provided to the residents was generally of good quality, with residents reporting that they felt safe and well cared for by the staff in the centre. However, some improvements were required to ensure that the service provided in the centre was safe and robust.

Furthermore, at the time of the inspection, the provider was in the process of re-arranging the tenancy agreement with the current owner of the building. As part of the process, the provider has arranged for the owner to complete a pre-lease survey of the building. Following this survey, the competent engineers had recommended that a fire safety risk assessment be carried out. However, at the time of the inspection, there were no arrangements in place to have the fire safety assessment completed.

Records showed that the provider was a pension agent for a number of residents. There was a clear record of each resident's account and any monies that were lodged on their behalf. Measures were in place to ensure that the accounts were audited by an accounting firm. However, some improvements were required to ensure that the pension agent arrangements were brought in line with the guidelines issued by the department of social protection in managing the residents' financial affairs. This is further discussed under Regulation 8.

The inspector reviewed a sample of care plans and noted that the care plans for those residents who were at risk of developing pressure sores did not have sufficient up-to-date information to guide staff to provide safe and appropriate care for these residents. This had not been identified through the centre's clinical governance systems.

Although residents were seen mobilising around the internal areas of the designated centre, the inspector observed that residents could not access the indoor garden in the centre. As a result, the residents could not sit and relax in the indoor garden when they wished to without having to seek staff assistance.

Regulation 11: Visits

There were procedures in place to protect residents and visitors unfamiliar with public health guidelines on safe visiting. Alternative areas to residents' bedrooms were available and used to facilitate residents to meet with their visitors.

Judgment: Compliant

Regulation 12: Personal possessions

Residents were supported to maintain control of their clothing and personal belongings. Residents had adequate storage space in their bedrooms, including a lockable space for their valuables if they wished.

Judgment: Compliant

Regulation 17: Premises

On the day of inspection, the inspector noted that the premises and layout of the designated centre were appropriate to the number and needs of the residents.

Judgment: Compliant

Regulation 26: Risk management

A centre-specific risk management policy and procedures were in place. This information included a risk register which included assessment and review processes. Control measures to mitigate the levels of risks identified were described.

Judgment: Compliant

Regulation 27: Infection control

Centre's arrangements to support the infection prevention and control in the centre were satisfactory on the day of inspection.

Judgment: Compliant

Regulation 28: Fire precautions

The registered provider had not taken adequate precautions against the risk of fire in the centre. For example:

- The provider informed the inspector that they are negotiating with the owner of the building to clarify the fire compartmentation arrangement in the centre.
- The floor plan displayed near the fire alarm panel did not reflect the compartmentation arrangements of the centre. As a result, the staff were not clear about the compartmentation of the centre.
- The provider did not engage with a competent person following the recent building survey, which had identified that a full fire safety risk assessment of the building has to be completed.

The fire evacuation drills were not effective as they did not identify the issues with the centre's fire compartmentation and building layout. The provider has to make staff aware of the centre's fire emergency procedures through suitable training, which includes evacuation procedures, building layout and escape routes.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

The inspector found that the care plans of some residents did not reflect the residents' current needs. For example, two residents who were at risk of pressure ulcers did not have an appropriate skin integrity care plan to prevent pressure ulcers from developing and to ensure continuity of care to the residents.

Judgment: Substantially compliant

Regulation 6: Health care

Residents' nursing care and health care needs were met to a good standard and pressure sores were well managed. Residents were supported to safely attend outpatient and other appointments in line with public health guidance. Residents had timely access to general practitioners (GPs) from local practices, allied health professionals and specialist medical and nursing services.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Staff spoken with the inspector had up-to-date knowledge appropriate to their roles to positively react to responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment). Records showed that where restraints were used, these were implemented following risk assessments, and alternatives were trialled prior to use.

Judgment: Compliant

Regulation 8: Protection

The current financial arrangements in the designated centre did not provide adequate protection for residents from financial abuse as the current processes for those residents whose pension monies or social welfare payments were being managed by the provider did not ensure that these monies were lodged into a separate resident's account in line with department of social protection guidance.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The provider had not ensured that the residents could exercise their choice in independently accessing the safe indoor courtyard and garden in the centre. The courtyards were locked and the arrangements in the centre meant that the residents could only access the courtyard area with the assistance of a staff.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Aras Ghaoth Dobhair OSV-0000311

Inspection ID: MON-0033952

Date of inspection: 29/06/2022

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant 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 document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:

• DON is specifically allocating designated staff from the Cleaning Department panel, to maintain laundry duties being carried out which will not negatively impact on Direct Patient care.

• DON has actively engaged with a Nurse Recruitment Agency over the past 12 months and has interviewed and successfully gained seven International Nurses through this process. This process has been regularly updated in monthly reports provided to the Regional HIQA Inspector.

• Two nurses are now in the Designated Centre, and the DON has one nurse due to sit their RCSI Exam coming in September, two further nurses in late October /November and two further nurses in December 2022.The deficit of seven nurses will then be addressed.

• DON will then be able to assign training and roles and responsibilities to senior staff with maintaining regular Clinical Audits, as newly recruited staff nurses become established in the Designated Centre.

• To address the deficit at present the DON has engaged with three Nursing Agencies and has offered short term contracts for three nurses, to provide sustained continuity of care.

• The Board of Management has noted the Inspector's comment that it is not sustainable having "the Person in Charge responsible for carrying out CNM and Nurse duties as well as carrying out her role and responsibilities as a Person-in-Charge"

• We propose to restructure the administrative/ management roles between now and August 2023 when the current DON's secondment from HSE ends.

• We have established a Clinical Oversight Sub-committee of the Board – consisting of

the local doctor and two pharmacists who are on the board, along with the Chair.

• We propose to hire a part-time Manager who will assume responsibility for financial, HR and administrative tasks.

• This will leave clinical matters as the responsibility of a CNM2, who will be the Person-in-Charge with a CNM1 to act as her/ his deputy and substitute during absence. Both of those roles will count towards our cohort of nurses.

• Further training of the current CNM1 will commence in September and recruitment of a manager will commence by October, when a job specification has been defined.

• The CNM1 will assume more responsibilities ad interim while this new structure is being put in place.

Regulation 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:

• Fire Safety Training had been identified in April 2022 for the remaining staff but had to be postponed due to a COVID Outbreak situation in the Designated centre. This was discussed with the HIQA Inspector on the day of Inspection.

• This training had been rescheduled in July and all staff due to attend did so.

• The Training spreadsheet had been updated to reflect this on the day of the Inspection and the Training folder with all staff attendances and training completed had been presented him.

• A Training matrix as discussed by the Inspector with the DON was completed in July 2022

• DON will request all healthcare staff to access training/modules on HSELand, in the Identification of Risk Factors in the Prevention of Pressure Ulcers.

• DON will endeavor to access training in Tissue Viability and Wound Management for all Nursing staff and establish a Link Nurse to monitor through Clinical Audits and provide additional inhouse training, as required.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• With the introduction of new nurses coming to the Designated centre, the DON will ensure that a named Team Nursing approach for all healthcare staff will be provided.

• The DON and CNM will also ensure a comprehensive handover and discussion of residents` care needs will be put in place, and that all Healthcare Staff will have access to care plans to ensure effective and continuous delivery of care to the residents.

• A Falls Analysis (for the period of January 2022 to June 2022) was conducted and sent to the HIQA Inspector, per his request, in July 2022.

• Regular Medication reviews, allocation of appropriate resources and updating of the Risk Register are in place and continually being monitored and reviewed.

• DON is organising access to a QQI Level 6 Leadership and Management course for CNM to commence September /October and to be completed by December 2022/January 2023

• The Board of Management will put in place the new management structure detailed in response to Regulation 15 above.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
• Complaints Policy has been revised and amended and a clear line of nominated person(s) has been identified.

• Complaints Folder was up to date and Complaints closed. This was discussed, and folder shown to the Inspector on the Day of Inspection.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:

• The DON had engaged with a competent person following the HSE Building Survey in November 2021, who would have been able to conduct a comprehensive Fire Safety Risk Assessment.

• However, due to the ongoing negotiations with the Designated Centre and the HSE, of which the responsibility of Fire Safety and Training was to be undertaken by the HSE, this Fire Safety Assessment was not conducted.

• DON and the Registered Provider have since highlighted the urgency of this assessment to be conducted. The HSE Fire Officer for Sligo/ Leitrim visited Aras on 01/09/22 and conducted a walkaround of Aras and a thorough examination at floor level and attic level with our General Maintenance Operative. to conduct the Assessment and update the Fire Plan in relation to compartmentalization of the Designated Centre throughout. He was given further documentation that he sought for review with the Chief Fire Officer with a view to coming back in two to six weeks to discuss the identification of works to be carried out, and the Plan of Action and dates to commence works.

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
• Care Plan Training is to be sourced by the DON and provided to all nurses working in the Designated Centre.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• The current financial arrangements were discussed with the HIQA Inspector on the Day of Inspection and pertinent clarifications addressed.

• We are engaging with the Department of Social Protection for guidance on how to have the pensions of the two relevant dementia patients paid in to their own (or guardians') accounts from which the money will be transferred automatically to Aras.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• The DON discussed with Inspector on the Day of Inspection that inclement weather conditions had prohibited regular access to the Dementia Garden for residents.

• However, Healthcare staff have introduced regular access to the Dementia Garden as noted in each resident's Activity Log, and documented residents right to refuse to access the garden.

• This Daily Log is maintained by the Activities Coordinator and a Communication Template reflecting same has been established also.
• To enable residents to avail of the facility of the Dementia Garden and fresh air, a risk assessment will be conducted for each relevant resident as to whether they need supervision and assistance to access the Garden.
• They will be informed of the availability of the garden and note will be taken of their preference to access or not access the Garden with appropriate measure being taken to facilitate those who so wish.
• Preferences and participation in visits to the Garden will be noted in the Daily Activities log.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Substantially Compliant	Yellow	31/12/2022
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	31/10/2022
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/07/2022
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the	Substantially Compliant	Yellow	31/12/2022

	effective delivery of care in accordance with the statement of purpose.			
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	30/09/2023
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	30/09/2022
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a	Substantially Compliant	Yellow	31/07/2022

	resident catch fire.			
Regulation 34(3)(a)	The registered provider shall nominate a person, other than the person nominated in paragraph (1)(c), to be available in a designated centre to ensure that all complaints are appropriately responded to.	Not Compliant	Orange	31/08/2022
Regulation 34(3)(b)	The registered provider shall nominate a person, other than the person nominated in paragraph (1)(c), to be available in a designated centre to ensure that the person nominated under paragraph (1)(c) maintains the records specified under in paragraph (1)(f).	Not Compliant	Orange	30/09/2023
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Substantially Compliant	Yellow	31/12/2022
Regulation 8(1)	The registered provider shall take	Substantially Compliant	Yellow	31/08/2022

	all reasonable measures to protect residents from abuse.			
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Substantially Compliant	Yellow	31/07/2022