Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People

Name of designated centre:	Aras Gaoth 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:	06 November 2018
Centre ID:	OSV-0000311
Fieldwork ID:	MON-0025159

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. A regular turnover of two respite persons formed part of the service provision. 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. A previously dedicated palliative care bedroom with an adjoining sitting room was currently occupied by a long term care resident. 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:	38

How we inspect

To prepare for this inspection the inspector or 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
06 November 2018	08:45hrs to 16:30hrs	Sonia McCague	Lead

Views of people who use the service

Residents who could communicate with the inspector were satisfied with the care and support provided. Residents felt safe in the centre and were satisfied with their accommodation, food, arrangements for visitors, the choices they could make, activities and staffing. They were able to identify a person who they would speak with if they were unhappy with something in the centre.

Relatives met and visitors spoken with during the course of the inspection were complimentary of the care and service provision.

Capacity and capability

This centre required improvement to demonstrate its capacity and capability to comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended).

While the leadership, governance and management personnel in place remained the same, the arrangements which contribute to residents experiencing a safe and good quality service required improvement and development. A defined management structure was in place and reporting relationships were described, however, some improvement was required to ensure the lines of authority and accountability in the centre were clearly defined, understood and effectively implemented.

Much information was gathered in relation to clinical audits and in feedback sought from residents and or their family as required from the previous inspection; however, a conclusive analysis or final report had not been completed based on the information collected and on-going monitoring to inform learning or a quality improvement plan. The management of meetings and communications in relation to decisions affecting a resident's care and future plan required improvement to ensure the resident and the person in charge or a member of staff is included or involved, and a record of any decision and outcomes are available in the centre.

Schedule 5 policies and procedures made available to the inspector had not been approved by those with responsibility and were not signed off as having been read and understood by all staff. Many policies were not implemented in full in the practices found or observed.

The recruitment process was not robust or in accordance with the centre's policy.

Gaps within recruitment process were found as staff employed had worked in the centre prior to a record of Garda clearance and with incomplete employment history. An absence of Garda clearance records and an agreed contract for volunteers was also evident. The audit and programme of training, professional development and appraisal of staff was incomplete and did not demonstrate a proactive approach to ensure all staff had completed mandatory and relevant training when and as required.

While the numbers of staff on duty during the inspection was sufficient, confirmation to demonstrate staff were sufficiently experienced and suitably trained was not available or demonstrated for all staff working. As a result of non-compliance's found, the inspector was not assured that the registered provider and the person in charge were sufficiently engaged in the governance, operational management and administration of the centre on a regular and consistent basis or that the management systems in place were robust to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

Records maintained (hard and soft copies) were stored securely and most were accessible to the inspector when required. But some records and correspondence in relation staff members and residents care were not complete, up-to-date and available.

Residents had information and means of communicating available to them. Contracts of care were easy to understand with the general terms of the stay and fees to be paid referenced and agreed. However, the number of residents occupying the resident's bedroom was not explicit in a sample examined.

Unsolicited information received by the Office of the Chief Inspector since the previous inspection related to poor communication arrangements regarding resident care. This was considered during this inspection and was partially substantiated.

Regulation 15: Staffing

Staffing levels at the time of the inspection were sufficient to meet the health and social care needs of residents. Staff confirmed that they had sufficient time to carry out their duties and responsibilities, and were knowledgeable of residents' abilities and needs.

Judgment: Compliant

Regulation 16: Training and staff development

Access to a range of mandatory and relevant training was outlined in the training programme for staff with roles and responsibilities for the delivery of care to

residents. However, an analysis of all staff members training had not been sufficiently completed or updated since the previous inspection. Gaps within staff training were identified and a complete record of training was not known or available for all rostered staff.

A comprehensive recruitment policy was available that included best practice standards. Staff induction and appraisal formed part of this recruitment policy, however, a record of each staff member's commencement date, induction, probation and appraisal was not available on all files examined.

Judgment: Not compliant

Regulation 19: Directory of residents

An established directory of residents had been maintained as required.

Judgment: Compliant

Regulation 21: Records

Records were held and maintained in both hard and soft copy formats. Many records to be maintained in respect of each resident and otherwise as described by Schedules 3 and 4 of the Regulations were available and were stored securely. Residents' files held relevant information such as transfer and discharge letters from hospital or multi-disciplinary professionals they had been assessed by. However, a record of all correspondences in relation to each residents care was not available or held in the centre, as required. This was discussed at length with the person in charge who agreed to follow up on the matter.

A sample of staff files were reviewed against the requirements of schedule 2, while some contained the information required others did not. Gaps within the employment history of staff recruited and an absence of correspondence detailing the actual commencement date of staff members existed. The inspector also noted that a staff member was rostered and had worked in the centre prior to a declaration of Garda clearance.

Information on display in the reception area included emergency fire procedures along with the complaints procedure and the registration certificate.

Judgment: Not compliant

Regulation 22: Insurance

A current certification of insurance was available in the centre.

Judgment: Compliant

Regulation 23: Governance and management

While a clearly defined internal management structure was in place, the arrangements for the governance and administration oversight for the centre required improvement.

Formal and minuted meetings with staff and between management were described as infrequent but occurring occasionally. This did not assure the inspector that robust governance and management arrangements were in place.

Adequate resources were not provided to ensure the effective delivery of care in accordance with the statement of purpose and to implement the centre's policies.Gaps were found within staff recruitment, appraisal and training, and in the arrangements to manage risk, maintain records, agree and implement policies and in the communication systems.

The lines of authority and accountability required review and improvement to ensure residents' safety and welfare. For example staff and volunteers worked in the delivery of direct care and support to residents in the absence of a record of Garda Clearance and without confirmation of appropriate training.

Internal reporting mechanisms were understood by staff. Members of the team were aware of their roles, responsibilities and reporting procedures to the person in charge. There were systems in place to audit clinical outcomes involving residents, however an improvement plan as a result of all audits was not evident to ensure adequate resources were provided for an effective service in line with the centre's policies and statement of purpose.

An annual review completed prior to the previous inspection August 2017 had not been prepared in consultation with residents. This was highlighted in the previous inspection report. However, the response outlined by the provider had not been fully implemented within the specified time frame.

In April 2018 the person in charge had sought feedback and established the satisfaction levels of residents or their relatives within a survey. However, there was no analysis, action or quality improvement plan described or developed as a result. The inspector was informed that the annual review for 2018 was due to be

completed by December 2018 that would include these findings.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

A written contract of care was agreed with or on behalf of each resident following admission that set out the general terms on which that resident resided in that centre. However, the contracts of care for residents in shared bedrooms did not identify the bedroom occupancy of residents.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The statement of purpose had been recently reviewed 18 October 2018 and outlined the facilities and services to be provided. Some improvements were to be made to ensure only services available were to be included and that relevant information was provided in accordance with Schedule 1.

Judgment: Substantially compliant

Regulation 30: Volunteers

Volunteers were involved in the centre. A sample file reviewed contained a job description and letter from an external party confirming Garda clearance but a suitable written agreement and official Garda vetting clearance document was not in place.

Judgment: Not compliant

Regulation 4: Written policies and procedures

Schedule 5 policies were available, but were not signed off as read by staff or approved by the person in charge and provider. Policies were not consistently implemented in practice. For example, policies on end of life, use of restraint,

recruitment of staff and volunteers, and staff training and development were not implemented in full.

Judgment: Not compliant

Quality and safety

Overall the quality and safety of the care and support provided to residents was of a reasonable standard but some areas were in need of improvement to achieve the aims and objectives of the centre's statement of purpose.

The atmosphere was relaxed, and staff were respectful to and friendly with residents, and were welcoming to visitors.

Residents' health care needs were being met through good access to health care services as previously found. There was evidence that residents' health care was promoted and many had recently availed of the flu vaccine. There were two residents with low grade pressure ulcers that were being treated and monitored closely by staff, and a low rate of falls and accidents was reported. Care plans for a range of identified needs were developed to support residents' needs but some plans had not been developed as required and care plans developed had not been sufficiently updated as changes occurred.

Suitable support for residents with dementia and responsive behaviours was provided. There was evidence that residents and their representatives were facilitated to make informed decisions about treatment plans and civil affairs. However, these decisions were not reflected in an appropriate care plan that was subject to regular reviews.

Residents' nutritional and hydration needs were monitored and there were systems in place to access a dietician and to ensure residents do not experience poor nutrition and hydration. But improvement in relation to residents' meal time and dining experience was required to ensure it was an enjoyable, informed, person centred, organised and pleasurable part of each resident's day.

Residents said they felt safe in the centre and well cared for by staff they knew well. Policies were in place and procedures were described to protect residents from harm or suffering abuse and to respond to allegations, disclosures and suspicions of abuse which included the requirement for all staff to receive safeguarding training. However, the training records available did not demonstrate or confirm this. The inspector was told by management they did not have any responsibilities associated with being a pension agent for any of the existing residents.

The previous inspection of August 2017 highlighted a high level of restraint usage (over 50%). The provider's action plan response stated that the management team support the principle of a restraint free environment. However, there was little

evidence of much progress in this regard as bedrail usage remained high and the alternative less restrictive equipment outlined in the centre's policy that were to be trialled prior to the use of bedrails were not available.

Residents were offered opportunities to exercise their choice which was respected and they felt consulted with in relation to their daily routines. But opportunities for residents to meet to evaluate the service were not regularly held. There was no information available about quality improvements brought about as a result of resident feedback.

Prayer and religious services were an important aspect of some residents' routine. A weekly mass service held by the local priest was complimented by residents and they were satisfied with the activities made available to them.

Opportunities for residents to engage in activities was encouraged and facilitated. Residents were able to develop and maintain personal relationships with family and friends in accordance with their wishes and were able to link with the wider community. Some continued to attend day centres they were involved with prior to being resident. Visitors were welcomed and participated in supporting residents'. Residents, relatives and visitors were in the main satisfied with the access to information about service provision in the centre while others highlighted areas within the communication arrangements that were in need of improvement, which was substantiated during this inspection.

Residents had had been facilitated with an opportunity to vote in the recent presidential election and there choices in this regard was respected. Access to an independent advocacy service and other supportive agencies was advertised and available to support the rights of residents.

Measures were in place for infection prevention and control. A comprehensive risk management policy was available, but hazards previously highlighted on inspection such as equipment used by staff left along corridors and obstructing hand rails had not been adequately assessed or controlled to mitigate associated risks.

The premises were clean and suitably decorated. It included supportive equipment and a variety of communal areas within three distinct areas, referred to as the dementia side, the general side and the reception area. A review of the dining arrangements and temperature in all areas occupied by residents was needed as parts of the centre occupied by residents felt cold at times.

While fire safety precautions and arrangements were in place, written confirmation that all necessary works had been completed to the satisfaction of the Fire authority was not available and gaps seen in staff training records did not assure the inspector that all staff had completed training in fire safety. The person in charge agreed to submit a copy of the current floor plan and written assurance from a competent fire engineer that fire safety works have been completed to the satisfaction of Fire Safety Authority following a recent review.

Regulation 10: Communication difficulties

Residents had access to newspapers, radio and television. Some residents had a personal mobile phone while others had use of the centres phone to make or receive calls and communications.

Vision and hearing devices to aid residents' independence and promote communication were maintained and serviced. A television and or radio was available in all rooms occupied by residents and a number of information and notice boards were available with informative leaflets and notices.

There were systems in place for communications between the resident/families, the acute hospital or public health providers and the centre. However the records and information in relation to communications and a meeting held between external professionals and parties with a resident's representatives were not available. The resident or a staff member involved in the residents care planning had not attended case review meeting/s and the rationale for this was unclear.

Judgment: Not compliant

Regulation 11: Visits

Residents could receive visitors in private outside of the bedrooms and main living areas.

Judgment: Compliant

Regulation 13: End of life

Family members' involvement in residents care and welfare was promoted and records of communication with family members was seen in some of the resident files reviewed.

Assessments in relation to activities of living, personal and social care, preferences and previous routines were determined and recorded from admission.
However, those with advance care directives did not have an end of life care plan, and a care plan for all had not been developed within three months of a residents admission in accordance with the centre's policy. The location preferences for all residents had not been explored or assessed and reflected in a relevant care

plan. For example, a resident's preference for a single bedroom when approaching end of life was not assessed or determined with 24 residents (58.5%) accommodated in shared bedrooms.

Judgment: Not compliant

Regulation 17: Premises

The matters arising from the previous inspection were followed up.

The premises is a single storey purpose built centre, aimed at supporting residents' privacy and dignity in that all bedrooms had full en-suite facilities, storage provisions, support equipment such as bed tables, lockers, individual screening, hoists and call bells. A privacy lock was noted in bathroom facilities examined.

The centre was clean, suitably decorated and in the main warm.Some parts of the centre felt cold at times and when communicated to staff it was addressed by closing windows opened for ventilation purposes. A review and audit of the temperature levels through out would be beneficial to evaluate the suitability of temperatures in rooms and reception areas occupied by residents.

Residents occupying twin and four bedded rooms had dependency ratings that ranged from low to maximum levels. Residents occupying bedrooms with four beds had their privacy and dignity maintained in the practices observed and by the facilities available addressing the finding on the previous inspection. However, the adequacy of the dining spaces layout and arrangements required significant improvement, as discussed under food and nutrition.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Residents who spoke with the inspector reported they were provided with food and drink at times and in quantities adequate for their needs.

Residents' nutritional and care needs were known by staff supporting residents to eat and drink and to those serving food. Procedures were in place to guide practice and clinical assessment in relation to monitoring and recording of weights, nutritional intake when required and risk of malnutrition were maintained. Access to dietetic and a speech and language therapists was available and provided on a referral basis based on an assessment of need or change in resident condition. The inspector reviewed residents' records and found that some residents had been referred to and received these services.

The inspector observed the lunchtime experience in dining rooms and within the centre, the approach and arrangements varied between units. One dining room demonstrated a reasonably positive experience while the other primarily represented institutional and neutral care and support. The inspector observed the set-up, serving, support and assistance to be primarily task orientated with little quality interaction, meaningful conversation or social engagement. Attributable factors were poor planning and layout of tables, haphazard positioning of the small resident group (35%) at and between dining tables or at bed tables. The presence of the hot trolley within the dining room was not appropriate as an accessible adjoining kitchenette for this was available that was accessed from outside of the dining room. The meals being provided from the dining room to other residents (65%) that dined in other parts of the unit resulted in staff entering and leaving the main dining room numerous times.

More than 50% of residents in the centre dined in areas other than in the dining rooms, and the inspector was not assured that all of these arrangements were person-centred or appropriate. For example, a small number of residents dined in their bedroom by choice, but other residents observed dined along open planned corridors and in day rooms using bed tables required review. A complete review of the dining experience through out the centre was required.

In addition, residents were not aware of the lunch menu options in advance and although the options were written on a white board within each dining room for those attending, it was difficult to read and understand. For example, the writing was unclear it did not specify the type of 'mince' that was available. The inspector concluded that the dining experience for all residents required much improvement as a social occasion with adequate systems, planning and means of communication to offer residents opportunities to interact, socialise and engage.

Judgment: Not compliant

Regulation 26: Risk management

The matters arising from the previous inspection were followed up.

A risk management policy to identify, assess, monitor and control risks was in place.

Control measures were put in place to address the hazards identified the inspector on the previous inspection in relation to the accessibility of personal protective equipment within the dementia unit. However, a recurrent hazard related to the storage of items in corridors had not been adequately considered or controlled. The Inspector observed the hand rails obstructed in many areas by portable equipment used by staff in the course of their work such as mop buckets, a hoover, waste bins and a linen trolley. These items were left unattended along the corridors while not in use or needed. These practices required review to ensure the risk management

policy available was implemented and effective in practice.

Judgment: Substantially compliant

Regulation 27: Infection control

Suitable provisions for the prevention and control of health care associated infections were observed.

Judgment: Compliant

Regulation 28: Fire precautions

In follow up to the actions required from the previous inspection, the inspector was informed that the fire safety precautions and arrangements that required improvement had been addressed to the satisfaction of the local Fire Authority. However, a record demonstrating that the fire safety works were complete to the satisfaction of the fire Authority was not available following a recent review.

The person in charge undertook to acquire this assurance in writing and agreed to submit the outcome of the review undertaken along with an up-to-date copy of the centre's floor plan following an additional compartment of double fire rated doors within the footprint of the dementia unit.

The inspector was informed that fire safety training for staff and a number of simulated evacuation exercises had occurred throughout the year. However, gaps within fire safety training were found in the staff training matrix record.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

The assessment, care planning and provision of health care had come into compliance on the previous inspection. The inspector was informed that the transition from maintaining records in hard to soft copy had occurred last year.

This inspection focused on resident assessments and care plans associated with the specific regulations examined such as end of life, food and nutrition, use of restraint and responsive behaviours. The assessment and management of wounds and

pressure ulcers were also reviewed.

Overall, there was evidence of effective assessments prompting the planning and evaluation of care. But some improvement was needed in relation to the level of detail within care plans following assessments, changes in conditions and recommendations by allied health care professionals. The dates of assessment outcomes and the specifics of the interventions or measures agreed or decided were not consistently reflected or updated. For example, changes in a diabetic medicine regime and diet, and decisions regarding active or comfort measures agreed were not adequately reflected in the sample of residents care plans reviewed.

Judgment: Not compliant

Regulation 6: Health care

Residents had good access to nursing, medical and allied health care.

Residents' health care needs were appropriately referred to their GP and to community health care professionals in order to promote residents' health and well-being.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

There were policies and procedures in place to inform restraint in accordance with best practice standards. The policy stated the use of 'ultra-low beds, body positioning devices and crash mats' were to be used before the use of bedrails. However, the inspector confirmed the provision of alternative equipment such as ultra-low or low-low beds was limited to 15% of beds available in one unit which likely attributed to the continued high level of bedrail usage by 60% of residents. A review of the resources available was required to implement the centre's policy. Staff had not recently participated in training to update their knowledge and skills appropriate to the use of restraint.

Some residents had responsive behaviours which staff were observing, monitoring and trending in behavioural records. GP and community psychiatry services were involved and available to the residents and staff supporting residents.

Judgment: Not compliant

Regulation 8: Protection

Policies and procedures were in place to protect residents from harm or suffering abuse and to respond to allegations, disclosures and suspicions of abuse. Some staff had a record confirming they had received safeguarding training to enable them to identify and respond to elder abuse, however, there was insufficient evidence to confirm that all staff had received training in relation to the detection and prevention of and responses to abuse.

Judgment: Not compliant

Regulation 9: Residents' rights

There was evidence that residents were consulted with on a daily basis by staff supporting and assisting them and they had choices in how to spend their day. However, improvement was needed to ensure adequate arrangements were in place to facilitate resident involvement in the running of the centre.

While a resident's forum was described, the last reported meeting was in April 2018 and there no known actions arising from it. The satisfaction levels of residents or their relatives had been surveyed since the previous inspection carried out in August 2017; however, there was no action or quality improvement plan developed. The person in charge described a plan to adopt and modified a user friendly survey template that was to be used to establish satisfaction levels going forward but this was not yet implemented.

Residents had access to an independent advocacy service which had been accessed by a resident earlier this year. Information and contact details of these services were strategically placed throughout the centre.

The inspector was informed by staff that each resident had the option to exercise their right to vote but none chose to do so which was respected. Religious services were provided for. A weekly mass service occurred in the centre and access to religious ministers was available, as desired.

Facilities for occupation and recreation were available. The inspector was informed that residents were offered group and individual activities that were meaningful to them by the dedicated activity staff member that worked three days each week.

Coordinated outings were described and entertainers coming to the centre were facilitated in addition to a variety of games, arts and crafts and recreational activities. Volunteers had supported residents to complete works of art and craft that were exhibited in the local art gallery. Portraits of some residents and a summary of their life story had been illustrated that included meaningful art facts

and symbols.
Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Not compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Substantially compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 30: Volunteers	Not compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 10: Communication difficulties	Not compliant
Regulation 11: Visits	Compliant
Regulation 13: End of life	Not compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Not compliant
Regulation 26: Risk management	Substantially compliant
Regulation 27: Infection control	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Aras Gaoth Dobhair OSV-0000311

Inspection ID: MON-0025159

Date of inspection: 06/11/2018

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 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: We took action immediately and reviewed our training matrix which had not been kept up to date. We identified where the training was lacking and prioritised Elder Abuse Manual Handling Fire Safety and Basic Life Support. There is an on-going programme in place and I expect these topics to be covered by at least 90% staff by 31st December 2018 at which time we will look at another range of topics for training. A specific member of staff has been given the responsibility to keep the training records up to date. All new staff will have a complete record of their induction probation and appraisal included in their personal file.	
Regulation 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: The documentation regarding a family meeting has been obtained and is on file. All staff files will be audited during December and January. Any deficits will be addressed and corrected by the end of January 2019.	

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Management meetings and staff meetings will be held regularly and will be fully minuted and actioned.
We have already had a management meeting and a staff nurse meeting with follow-ups planned and a further meeting with care staff and support staff is scheduled.

Resources have to be prioritized and in 2019 we will give special consideration to increasing the number of low height beds which should have a positive impact on the level bedrail usage.

An annual review will be completed, as required.

Regulation 24: Contract for the provision of services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 24: Contract for the provision of services:
The existing contract does identify the room that the resident will occupy. For all new admissions we will include how many beds are in the room.
The contract has been amended.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
The statement of Purpose has been amended to accurately describe services available.

Regulation 30: Volunteers	Not Compliant
Outline how you are going to come into compliance with Regulation 30: Volunteers: The Garda Vetting process has been commenced for this volunteer. It should be completed within 4 weeks.	
Regulation 4: Written policies and procedures	Not Compliant
Outline how you are going to come into compliance with Regulation 4: Written policies and procedures: All 20 schedule 5 policies are under review and being condensed where it is appropriate to do so. This should make them more user friendly and accurate to the practice in Aras Ghaoth Dobhair. This exercise will be completed by the end of February 2019 and all staff will have an education session on the policies relevant to their role.	
Regulation 10: Communication difficulties	Not Compliant
Outline how you are going to come into compliance with Regulation 10: Communication difficulties: Minutes of this meeting have been put into the resident`s file. Improvements in the communication arrangements have been implemented.	
Regulation 13: End of life	Not Compliant
Outline how you are going to come into compliance with Regulation 13: End of life: All residents with an advance care directive will have an end of life care plan within 4 weeks	

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Since our inspection we have changed how the meals are served. This has allowed more space in the dining room and minimal disruption to residents eating their meal. Please See regulation 18

Regulation 18: Food and nutrition	Not Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
Since our inspection we have changed how the meals are served.

• Information on the menu board is clearer.
• The ban Marie is taken into the kitchenette.
• There is more space in the dining room.
• Meals are served through the hatch from the kitchenette.
• Residents eating in the dining room are no longer disturbed by staff coming in to get meals for other residents who chose to eat in their rooms.
• When mince is on the menu it is described as beef mince or whatever kind of meat it is.
• We will look into different styles of table which may be more suitable for residents in wheelchairs
• There is a folder with photographs of all the meals that we serve this can be shown to some residents with communication difficulties to assist them to make a choice, alternatively we plate both dishes and bring it to the resident to choose which one they would prefer.

Regulation 26: Risk management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management:
Cleaning staff have been instructed to put their equipment away from the main thoroughfare when not specifically in use.
The linen trolley has been relocated to an area where it does not interfere with the handrail.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
I am waiting for the Fire Safety Authority to provide documentation that all works that were required to upgrade the fire safety in Aras Ghaoth Dobhair have been carried out. This information has been requested but not yet supplied.

Fire training has been carried out throughout the year unfortunately the training matrix was not up to date. There are 8 staff members without up to date fire training and this will be provided before the end of December 2018

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
A nurses meeting took place on the 3rd December, all residents care plans were reallocated to a different staff nurse and each full time nurse will have 6 or 7 care plans to be responsible for.
All residents will have full reassessment and care plans by the end of February 2019. The care plans will be audited every 3 months thereafter.

Regulation 7: Managing behaviour that is challenging	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
30 of our staff attended training in Managing responsive behavior on 12th February 2018 carried out.
The remaining relevant staff will receive training by the end of January 2019
The number of residents assessed as requiring bedrails is not a due to challenging behavior but to the risk of receiving an injury from a fall from the bed. We will endeavor to increase the number of low height beds as our budget will allow over the next 12

months. We will aim to have another 3 beds by the end of March 2019	
Regulation 8: Protection	Not Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: All staff have had training in detecting and responding to Elder Abuse. An update to that training will be given to all staff by the end of December 2018.	
Regulation 9: Residents' rights	Substantially Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: We will hold a residents forum every 2 months from the beginning of 2019.	

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 10(1)	The registered provider shall ensure that a resident, who has communication difficulties may, having regard to his or her wellbeing, safety and health and that of other residents in the designated centre concerned, communicate freely.	Not Compliant	Orange	06/12/2018
Regulation 10(2)	The person in charge shall ensure that where a resident has specialist communication requirements, such requirements are recorded in the resident's care plan prepared under Regulation 5.	Not Compliant	Orange	06/12/2018
Regulation 13(1)(a)	Where a resident is approaching the	Not Compliant	Orange	31/01/2019

	end of his or her life, the person in charge shall ensure that appropriate care and comfort, which addresses the physical, emotional, social, psychological and spiritual needs of the resident concerned are provided.			
Regulation 13(1)(d)	Where a resident is approaching the end of his or her life, the person in charge shall ensure that where the resident indicates a preference as to his or her location (for example a preference to return home or for a private room), such preference shall be facilitated in so far as is reasonably practicable.	Substantially Compliant	Yellow	31/01/2019
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	31/12/2018
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	31/12/2018
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a	Substantially Compliant	Yellow	06/12/2018

	particular designated centre, provide premises which conform to the matters set out in Schedule 6.			
Regulation 18(1)(b)	The person in charge shall ensure that each resident is offered choice at mealtimes.	Substantially Compliant	Yellow	06/12/2018
Regulation 18(1)(c)(i)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which are properly and safely prepared, cooked and served.	Not Compliant	Orange	06/12/2018
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Not Compliant	Orange	31/01/2019
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	31/01/2019
Regulation 23(b)	The registered provider shall	Not Compliant	Orange	31/01/2019

	ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.			
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	31/01/2019
Regulation 23(e)	The registered provider shall ensure that the review referred to in subparagraph (d) is prepared in consultation with residents and their families.	Substantially Compliant	Yellow	31/01/2019
Regulation 24(1)	The registered provider shall agree in writing with each resident, on the admission of that resident to the designated centre concerned, the terms, including terms relating to the bedroom to be provided to the resident and the number of other occupants (if any)	Substantially Compliant	Yellow	06/12/2018

	of that bedroom, on which that resident shall reside in that centre.			
Regulation 26(1)(a)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.	Substantially Compliant	Yellow	06/12/2018
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	31/12/2018
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	Not Compliant	Orange	31/12/2018

	resident catch fire.			
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose relating to the designated centre concerned and containing the information set out in Schedule 1.	Substantially Compliant	Yellow	06/12/2018
Regulation 30(a)	The person in charge shall ensure that people involved on a voluntary basis with the designated centre have their roles and responsibilities set out in writing.	Substantially Compliant	Yellow	06/12/2018
Regulation 30(c)	The person in charge shall ensure that people involved on a voluntary basis with the designated centre provide a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012.	Not Compliant	Orange	31/12/2018
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.	Not Compliant		31/03/2019
Regulation 04(2)	The registered provider shall make the written policies and procedures	Not Compliant	Orange	31/03/2019

	referred to in paragraph (1) available to staff.			
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Not Compliant	Orange	28/02/2019
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.	Not Compliant	Orange	28/02/2019
Regulation 8(2)	The measures referred to in paragraph (1) shall include staff training in relation to the detection and prevention of and responses to abuse.	Not Compliant	Orange	31/12/2018
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre	Substantially Compliant	Yellow	31/01/2019

	concerned.			