Health Information and Quality Authority
Regulation Directorate

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

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

Centre name:	Dalkey Community Unit for Older Persons
Centre ID:	OSV-0000510
Centre address:	Kilbegnet Close, Co. Dublin.
Telephone number:	01 235 3200
Email address:	annette.ohiggins@hse.ie
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	John O'Donovan
Lead inspector:	Helen Lindsey
Support inspector(s):	Shane Walsh
Type of inspection	Unannounced Dementia Care Thematic Inspections
Number of residents on the date of inspection:	49
Number of vacancies on the date of inspection:	1

About Dementia Care Thematic Inspections

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

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

Please note the definition of the following term used in reports:
responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor compliance with specific outcomes as part of a thematic inspection. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
23 May 2017 09:30	23 May 2017 17:30
24 May 2017 09:15	24 May 2017 13:00

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

Outcome	Provider's self assessment	Our Judgment
Outcome 01: Health and Social Care Needs	Compliance demonstrated	Non Compliant - Moderate
Outcome 02: Safeguarding and Safety	Compliance demonstrated	Compliant
Outcome 03: Residents' Rights, Dignity and Consultation	Substantially Compliant	Substantially Compliant
Outcome 04: Complaints procedures	Compliance demonstrated	Compliant
Outcome 05: Suitable Staffing	Compliance demonstrated	Non Compliant - Moderate
Outcome 06: Safe and Suitable Premises	Non Compliant - Major	Non Compliant - Major
Outcome 10: Suitable Person in Charge		Compliant

Summary of findings from this inspection

As part of the thematic inspection process, providers were invited to attend information seminars given by the Authority. In addition, evidence-based guidance was developed to guide the providers on best practice in dementia care and the inspection process.

Prior to the inspection, the person in charge completed the self-assessment and scored the service against the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Standards for Residential Care Settings for Older People in Ireland.

Inspector met with residents, relatives, and staff members during the inspection. The

journey of a number of residents with dementia was tracked. Care practices and interactions between staff and residents who had dementia were observed and scored using a validated observation tool. Documentation such as care plans, medical records and staff training records were also reviewed.

The centre provided a service for people requiring long term care and support and also a respite service. On the day of the inspection 49 residents were accommodated in the centre, and just under 50% of residents had a dementia diagnosis. There was no dementia specific unit and all residents shared the same environment.

Residents and relatives who spoke with inspectors were positive about the service provided in the centre. The staff team were seen to be responsive to residents individual needs, and had good access to training relevant to their role in the centre and so had relevant skills. While there were sufficient staff during the inspection, it was identified that at times there are lower staffing levels and this impacts routines in the centre, specifically around meal times.

There were systems in place to assess residents needs prior to admission, to carry out a comprehensive assessment when they arrived at the centre, and to put care plans in place. While documentation was found to be clear for long term residents, there were significant gaps in the care documentation for residents visiting on respite.

There was a range of activities available for residents in the centre, and they were seen to enjoy spending time taking part in different pastimes. However, records showed a small number of residents had not been engaged in activities of interest for a few weeks, and activities provided were not in line with their recorded interests.

Processes for managing complaints were clear and accessible to residents and their representatives. Where complaints were made they were dealt with following the expected procedure. There was also an effective process in place to safeguard residents from harm that included staff training and supervision, and clear local policies and procedures. The centre was working towards a restraint free environment with use of bed rails reducing over time.

The premises did not meet the needs of residents and did not provide sufficient storage. There were ongoing plans to develop parts of the centre to improve the experience of residents.

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

Outcome 01: Health and Social Care Needs

Theme:
Safe care and support

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

Findings:
Residents' wellbeing and welfare was seen to be maintained to a good standard and there was good access to healthcare services. However improvement was required in relation to assessing and documenting the needs of residents accessing the centre on a respite basis.

For long term residents there was a clear process in place for assessing their needs prior to admission, completed by the senior staff team. A comprehensive assessment was carried out by nursing staff when they arrived at the centre, and then care plans were developed to set out how individual needs were to be met.

There was a process in place to assess, record, and update resident's needs where they accessed the service on a respite basis. However inspectors were unable to identify resident's up to date needs due to assessment and care planning documentation being from previous stays, or not available. Through discussion inspectors judged that staff did know the residents well and were able to give a good overview of their health care and social care needs. However the absence of documentation resulted in a risk of needs not being met, especially where agency staff were being used on a regular basis.

There were care plans in place for long term residents. They were seen to be person centred and focused on the individual's preferences. Some care plans provided very clear detail of the care to be provided, for example residents preferred method of communication, advice on how to engage effectively, and clear instructions where there was a time element to residents needs. Staff were observed to be supporting residents in line with their care plans and knew the residents well.

There was a procedure for reviewing care plans, and records showed care plan were reviewed and updated as needs changed. For example where a residents needs changed in relation to a modified diet, or following a hospital stay. However, many examples were seen where reviews had been carried out on a six monthly basis, but the regulations require it is done at least four monthly. This issue was also identified at the

last inspection.

Where residents had dementia care needs these were detailed clearly. Care plans set out their resident's needs, the goal of the care and support to be offered and how to achieve the best outcomes for the resident. Where residents took medication in relation to their needs there were clear instructions to look out for any side effects or changes. There was also guidance to consider whether residents were exhibiting signs of delirium if their needs changed significantly. Documents about resident's life experiences to support staff in knowing them better and being able to talk about relevant topics with them were available.

A range of nursing assessment tools were being used to support staff to monitor residents needs. This supported staff in monitoring resident's ongoing healthcare needs and whether the care provided was effective. Where residents required medical assessment they were able to see a general practitioner (GP) who visited the centre regularly, or the out of hours doctor were made where required. Where urgent care was required residents were transferred to local hospitals.

The person in charge also monitored clinical care in the centre with a weekly review of the numbers and circumstances of incidents such as falls, pressure areas, psychotropic medication use, and restrictive practice use. These records showed that care practice was meeting resident's needs with low incidents reported.

Residents had the choice of GP, and a range of allied professionals were available to assess resident's needs. For example dietician, speech and language therapy, and physiotherapist. Where professionals made recommendations about how residents needs were to be met these were put in place, for example physiotherapy recommendations for mobility aids.

There was a policy in place to set out how residents were to be supported at end of life. This included respecting the decisions of residents in relation to the care and support they would want to receive, and their view of hospital admissions. Where residents were not able to express their views, meetings were held with families to identify what the previously expressed wishes of the resident were. Any decisions involved the resident, family and general GP.

Judgment:
Non Compliant - Moderate

Outcome 02: Safeguarding and Safety

Theme:
Safe care and support

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

Findings:
The centre had systems in place to protect residents from suffering abuse. The use of restraint in the centre was in line with the HSE national policy and reduction of restraint was promoted.

The centre had a policy in place on the protection of elderly people from abuse. The policy was in line with the HSE national 'safeguarding vulnerable persons at risk of abuse'. The centre had nominated the person in charge and a clinical nurse manager to act as the two safeguarding officers. Inspectors reviewed the processes in place for dealing with any allegations of abuse and found that a robust preliminary screening was carried out, which would then be assessed in conjunction with the HSE CHO6 adult safeguarding and protection team to determine if further actions were required.

The inspectors reviewed staff training and found that all staff in the centre had completed up to date training in safeguarding vulnerable adults. The inspectors spoke to a number of staff and management around their role if abuse was witnessed or reported and all seemed knowledgeable as what they would need to do if this occurred.

The inspectors reviewed the systems in place to safeguard residents' finances. The centre was managing finances for a number of residents. The systems in place to manage residents' finances seemed to be in line with the centre's policy and in line with the HSE's policy and social protection guidelines. A separate residents' account was in place for residents' finances.

The use of restraint in the centre was reviewed on an ongoing basis. Bed rail usage and the use of wander bracelets were continuously assessed by a multi-disciplinary team through trialling of alternatives. Audits evidenced alternatives were being trialled and thus the use of restraint was reducing in line with national policy. The inspectors reviewed six bed rail restraint assessments and found that three residents had alternatives tried. The three that did not have alternatives tried had the reason for this detailed in their individual care plan. For residents requiring a wander bracelet a standardised tool was used to continuously assess their risk of leaving the premises and records were kept of any attempt to do same.

The centre has a policy in place for managing resident with responsive behaviours. The inspectors reviewed care plans for residents with responsive behaviours and found that each had a behavioural support plan in place. A diary was kept for individual residents to track the behaviours and trend any triggers. Triggers and de-escalation techniques were detailed in the care plans. This was as per the centre's policy.

Judgment:
Compliant

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

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

Findings:
Residents were facilitated to feedback on the running of the centre. Residents' rights and dignity were respected in the centre, however the layout of the premises provided a challenge. Not all residents had opportunities to participate in activities based on their interests.

Residents in the centre were enabled to provide feedback on the running of the centre. Residents had been asked to complete feedback forms. A patient experience audit was completed using the feedback. Any issues identified in the audit had action plans associated to them. Residents also participated in residents' meetings which took place on a two to three monthly basis. Topics discussed at meetings included examples such as food, laundry services, HIQA visiting and the impact of noise in communal rooms. Management attended the meetings.

Residents spiritual and civil rights were met. Catholic mass was said in the centre and the rosary was recited daily for any residents wishing to take part. At the time of inspection there were no residents practicing another religion, but the inspectors were informed all religious spiritual needs would be respected and facilitated, for example Church of Ireland ministers had regularly visited the centre in the past.

The residents were registered to vote in the centre for local elections, general elections and referendums. A polling station was set up in the centre.

Some of the four person bedrooms did not promote residents privacy and dignity due to the limited personal space around each of the beds. There was insufficient space around each bed to access residents with a hoist if required. The action for this is made under outcome 6.

Residents were able to meet with their friends and relatives in the centre at times that suited them. There was a visitors room in the centre, but on the day of inspection was being used for storage. However there were other private areas in the centre that residents were seen to be using with their relatives including the outside spaces.

There centre had a part-time activity co-ordinator. When the co-ordinator was not working other staff would assist in carrying out activities. A weekly activities plan was displayed on the residents' information board in the main corridor. Inspectors were informed that most residents would participate in the activities. The inspectors observed a sing-a-long and found this to be the case. It was seen that an effort was being made by some of the staff to involve all residents in the activity, including those in need of additional stimulation due to cognitive impairment. A record was maintained of each resident's participation in various activities.

Inspectors carried out a formal observation for 30 minutes in one area of the centre and found the interactions between staff and residents were generally positive and indicated that care provided was going beyond task based care and focused in each individual's experience.

Some residents were identified to have not participated in any activity in over three weeks. It was explained by the staff that some residents do not wish to partake in activities, however none of the weekly activities planned for the centre were based on the interests listed in those residents' individual files.

Residents had access to various types of media including newspapers, television and radio. The centre had stated that there was a desire to access internet access for residents.

Judgment:
Substantially Compliant

Outcome 04: Complaints procedures

Theme:
Person-centred care and support

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

Findings:
The complaints of all residents of residents and representatives in the centre were listened to, recorded, and acted upon.

There was a clear policy in place that explained how complaints or concerns were managed in the centre. The policy outlined that all complaints, both formal and verbal, were to be recorded. The person in charge was named as the nominated person to manage complaints in the centre. There was a central function to oversee management of the complaints and there was a clearly explained process of appeal to use where people did not agree with the outcome reached.

There was supporting documents to assist staff in the centre with effective complaints management, including a guide for employees and '10 steps to handling complaints'.

There was clear signage in prominent positions in the centre using plain language and picture images to ensure it was accessible to people with different levels of communication skills. There were also 'your service your say' leaflets and posters in the centre.

Inspectors spoke with residents and relatives who were clear of who to complaint to if they had any issues. Records of the verbal and written complaints on each unit showed

that all feedback was taken seriously and acted on no matter who gave the feedback. Records showed that complaints were dealt with in timely way, and the complainant's satisfaction with the outcomes was stated. Improvements were seen where complaints raised a concern about the quality of care.

There was also an audit completed on the complaints made in the centre to check for any trends. This was available in the annual review of the performance of the centre against the national standards.

Judgment:
Compliant

Outcome 05: Suitable Staffing

Theme:
Workforce

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

Findings:
Staff in the centre had the appropriate skills to meet the needs of the residents, however staffing levels required review to ensure that resident's needs were consistently met.

On the day of the inspection there was a full staff compliment, which included the person in charge, CNMs, nursing staff, health care assistants, house hold staff and kitchen assistants. However inspectors were informed that on occasion when staffing levels were lower the routines in the centre were altered. For example when there was a full staff complement in the week there were two sittings for the lunch time meal and they made use of a dining room downstairs for tea. However if there were less staff available in the week and for every weekend meal, they were served in the dining room and in the library area. As described in outcome 6 this is a corridor area and fire exit. It was specifically reported that the number of catering assistants had an impact on the arrangements.

This issue had been recorded as a risk in the centre, and it was being monitored. However improvement was required to ensure residents, especially those for whom routine and consistency were important, needs were met.

Agency staff were used almost every day in the centre for a number of shifts. To ensure continuity for residents the same staff were requested to cover shifts in the centre.

The inspectors reviewed the training records of staff. They found that the all staff had received up to date mandatory training in fire safety, manual handling and safeguarding against elder abuse. Many of the staff had also received the updates safeguarding

training on the new HSE guidance. For any staff that were out of date in their mandatory training this had already been identified and training dates had been set. There was also a range of other training opportunities for staff including subjects such as falls training, end of life care, hand hygiene, manual handling, dementia training and supporting residents with responsive behaviour. There was also a plan in place to offer training on subjects such as wound management and nutritional requirements of people in residential settings.

Inspectors reviewed four recruitment files of staff. All four files were found to have the required documents as listed in schedule 2 of the regulations however there were gaps in the employment history noted for three of the four reviewed. The person in charge responded to this immediately asking staff to provide information on the missing periods. A review of nurses' registration documents and found that all were registered with the Nursing and Midwifery Board of Ireland.

For all volunteers working in the centre there was a policy in place that was seen to be put in to practice. There was an agreement in place for each individual and evidence of appropriate garda vetting.

Residents and relatives who spoke with inspectors provided positive feedback on the staff in the centre. They commended the person centred approach and responsiveness to any changes in health or social care needs.

Judgment:
Non Compliant - Moderate

Outcome 06: Safe and Suitable Premises

Theme:
Effective care and support

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

Findings:
The design and layout of the centre did not meet the needs of the residents. There was insufficient private, communal and storage space in the centre. Since the last inspection there had been no improvements made to the premises. The centre has plans in place to reconfigure and extend on the building.

The centre was laid out over two stories, with residents' bedrooms and communal areas on the first floor. There was a lift available for residents to use between floors. The first floor was divided into two units, Hillview and Castleview. The centre had eight four-bedded rooms, six two-bedded rooms and six single en-suite rooms.

Each resident had a lockable bedside locker, a wardrobe, and a chair. There was working call bell system in place for each resident's bed. The communal rooms had curtains in place to provide residents with some level of privacy, however the four bedded units were found to be unsuitable to meet the privacy and dignity of residents. The available personal space beside each bed was limited. The use of resident' equipment such as wheelchairs or hoists would prove difficult in these rooms due to the limited space.

While there was suitable assistive equipment for residents, there was insufficient storage space for the equipment. Equipment such as wheelchairs, hoists and commodes were found to be stored on corridors throughout the centre, in communal toilets and in the private visiting room.

Inspectors found that there was a suitable amount of communal toilets with seven communal toilets for the 44 residents without an en-suite in their rooms. It was noted that three communal toilets did not have grab rails installed beside the sink. There were only three communal showers available in the centre for same 44 residents (without an en-suite), meaning there was one shower for between 14 and 15 residents. As a result of the limited number of showers the inspectors were shown that a schedule of showering had been drawn up for the residents that outlined residents would only be offered a shower between once or twice a week.

There was not enough communal space available in the centre. There was a dining room and a day room in the centre. The day room was quite small so the majority of activities took place in an open area of the corridor called the 'library'. This area was the main passage between both units and the inspectors observed that during an activity the corridor became blocked by residents 'chairs. This area was also a main fire exit route.

The dining room could seat half the residents, and thus mealtimes were split into two sittings. However on occasions when staffing levels were low only one mealtime sitting would occur and some residents had to eat their meals in the same 'library' area which was not suitable for eating meals as it was part of the main corridor, and did not promote maintaining residents' dignity.

In general the centre was laid out in a manner that was easy for residents with dementia to navigate. Yellow and black signage had been installed throughout the centre to assist some resident to identify various areas throughout the centre. There had also been some attempts made to make the centre more homely. An old style dresser and a coat hanger holding hats, ties and scarves had been placed in the 'library area'. There had also been a faux fireplace installed into the day room. Residents had also personalised their bedrooms with their belongings.

Residents had suitable access to outdoor areas. There was a large garden on the bottom floor which residents could use if they wished. There were also two smaller gardened areas at the end of both the Hillview and Castleview areas, which residents could access independently. The centre was found to be well lit and suitable heated. It was visibly clean throughout the centre.

Judgment:
Non Compliant - Major

Outcome 10: Suitable Person in Charge

Theme:
Governance, Leadership and Management

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

Findings:
The person in charge was experienced, suitably qualified and demonstrated good knowledge of the regulations and standards.

They were clear of their role in the governance and operational management in the designated centre on a day to day basis.

There were arrangements in place to cover the role of person in charge when they were absent.

Judgment:
Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Helen Lindsey
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	Dalkey Community Unit for Older Persons
Centre ID:	OSV-0000510
Date of inspection:	23/05/2017 and 24/05/2017
Date of response:	28/06/2017

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 01: Health and Social Care Needs

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Examples were seen for residents on respite where there were no up to date care plans setting out how residents identified needs were to be met.

1. Action Required:
Under Regulation 05(3) you are required to: Prepare a care plan, based on the assessment referred to in Regulation 5(2), for a resident no later than 48 hours after

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

that resident's admission to the designated centre.

Please state the actions you have taken or are planning to take:
Respite care planning is being reviewed. All respite care plans will be revised on an ongoing base as residents are admitted. A section in the respite charts will be introduced for Allied Health Care Professionals to make entries. The respite resident's charts will be easier to navigate and show the sequence of events and the care delivered at the completion of our review.

Proposed Timescale: 30/07/2017

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Care plans were not consistently reviewed at four month intervals.

2. Action Required:
Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.

Please state the actions you have taken or are planning to take:
The PIC will ensure that Care Plans are systematically reviewed throughout the Centre in accordance with the Regulations. In offering this assurance the PIC will monitor this requirement within the Centre to ensure the proposed implementation date is achieved and that a renewed focus assures future compliance.

Proposed Timescale: 31/08/2017

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The activities plan did not reflect the interests of all residents.

3. Action Required:
Under Regulation 09(2)(b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests and capacities.

Please state the actions you have taken or are planning to take:
The Activities Co-ordinator shall review the residents 'key to me' in all care plans and

capture activities that could be incorporated into our monthly activity calendar.

Our dedicated Activities Co-ordinator is part time and in this context we will ensure that the activity programme developed is implemented throughout the Centre. In this regard, we have identified a member of staff who has the necessary qualifications to provide additional activities, both on an individual and group basis. A further 12 hours of activities is now being provided within the Unit which will be supported through this individual.

Proposed Timescale: 25/07/2017

Outcome 05: Suitable Staffing

Theme:
Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were times when the staffing levels and layout of the centre impacted on residents needs being consistently met.

Staffing levels also impacted on residents being engaged in meaningful activity.

4. Action Required:
Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

Please state the actions you have taken or are planning to take:
DCU strive to provide a full complement of Nursing and Care staff in accordance with our planned rosters during the working week. However, due to the lack of availability of Agency Nursing and Care staff, particularly during peak periods of leave, it is not always possible to provide full cover. During May 2014 the PIC instigated two meal sittings to meet our requirements under standard 26 at the time, with regard to our dining facilities. However, this interim plan (pending the redevelopment of our Unit) is contingent on having the appropriate number of staff to provide the service to residents as planned. The PIC and Provider are actively engaged in an ongoing recruitment process to secure additional staff to enable less reliance on agency provision thereby enhancing the opportunity for improvements through improved continuity of care. In securing agency staff currently, the PIC endeavours to achieve as much consistency as possible. The PIC is also engaged in securing appropriately qualified and experienced nursing and care staff through temporary employment mechanisms as interim to recruitment for permanent positions.

The proposed redevelopment of the Unit planned to commence in early 2018 will address the defeciencies identified in the dining space (referred to in a number of previous Inspections) and will ensure the necessity for multiple meal sittings is no longer required post completion planned works.

Proposed Timescale: 31/08/2017 (recruitment actions)

Proposed Timescale: 31/08/2017

Theme:
Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Recruitment records did not include a full employment history, together with a satisfactory history of any gaps in employment for all staff.

5. Action Required:
Under Regulation 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

Please state the actions you have taken or are planning to take:
The PIC is satisfied that identified gaps in recently recruited staff's files have been explained, as they were due to a range of life events, such as caring for elderly / sick family members, child care, or travelling. The PIC shall be mindful of this requirement if under taking recruitment initiatives in the future.

The files in respect of the individuals identified have been updated in this regard

Proposed Timescale: 30/06/2017

Outcome 06: Safe and Suitable Premises

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Deficits related to the premises were:
• No grab rails beside sinks in some communal toilets,
• Insufficient number of showers for the number of residents in the centre,
• Insufficient amount storage space for resident's assistive equipment,
• The communal areas were not large enough for the number of residents,
• The four bedded rooms in the centre provided minimal personal space and did not promote the privacy and dignity of residents.
• Though sufficient dining space was available in the centre there were times when other areas were used that were not designed for dining.

6. Action Required:

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

Please state the actions you have taken or are planning to take:
Grab rails are being installed in the identified areas at the time of writing this report.

The Provider has secured planning permission for a significant programme of refurbishment at Dalkey Community Nursing Unit.

The programme of work proposes the following,

• To reduce to 2, the number of rooms with planned occupancy for 4 persons to be utilised for accomodating short-stay patients (shoty-stay respite, 2 weeks max stay).
• To increase to 10, the number of single en-suite rooms at the Centre.
• To increase to 14, the number of rooms with maximum occupancy for 2 residents.
• To enhance the Dining Area to accomodate all residents at meal times.
• To enhance the Social Space (sitting room) to afford more opportunity for recreation/socialisation to the residents.
• To enable the provision of electronic hoisting in all resident rooms thereby necessitating less manual hoists and appliances.
• To enhance the bathing and washing facilities at the Unit through the provision of additional en-suite facilities and the provision of additional non-room based shower facilties.

The Provider has secured the resources to enable the re-configuration of Dalkey Community Nursing to commence. Plans for the commencement of these works are currently been discussed with residents and staff at the Unit. The proposed commencement date based on discussion to date with all stakeholders is the 1st Quarter of 2018. The programme of works is planned to be completed during the course of 2018.

The Provider will provide a regular update to the Authority in this regard

Proposed Timescale: 31/12/2018