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:	Boyne View House
Centre ID:	OSV-0000532
Centre address:	Dublin Road, Drogheda, Louth.
Telephone number:	041 989 3288
Email address:	seamus.mccaul@hse.ie
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Maura Ward
Lead inspector:	Sonia McCague
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	22
Number of vacancies on the date of inspection:	4

About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

▪ Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
▪ Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

▪ to monitor compliance with regulations and standards
▪ to carry out thematic inspections in respect of specific outcomes
▪ following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
▪ arising from a number of events including information affecting the safety or wellbeing of residents.

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
23 May 2017 09:30	23 May 2017 17:00

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

Outcome	Our Judgment
Outcome 01: Statement of Purpose	Substantially Compliant
Outcome 02: Governance and Management	Non Compliant - Moderate
Outcome 07: Safeguarding and Safety	Non Compliant - Major
Outcome 08: Health and Safety and Risk Management	Compliant
Outcome 09: Medication Management	Substantially Compliant
Outcome 10: Notification of Incidents	Substantially Compliant
Outcome 11: Health and Social Care Needs	Non Compliant - Moderate
Outcome 12: Safe and Suitable Premises	Non Compliant - Moderate
Outcome 16: Residents' Rights, Dignity and Consultation	Non Compliant - Moderate
Outcome 18: Suitable Staffing	Non Compliant - Moderate

Summary of findings from this inspection

This report sets out the findings of an unannounced monitoring inspection, that may inform a decision regarding the centre's registration.

During the course of the inspection, the inspector met with residents and staff, the person in charge as Assistant Director of Nursing and the Director of Nursing. The views of residents and staff were listened to, practices were observed and documentation was reviewed.

Overall, the inspector found that staff knew the residents well and discharged their duties in a respectful and dignified way.

The management and staff of the centre were striving to improve residents' outcomes. A person-centred approach to care was noted. Residents healthcare was promoted with timely access to medical and relevant services. Relatives spoke positively about the staff that cared for residents and residents expressed satisfaction with staff and care delivered.

Governance and management arrangements were in place and described; however, improvement was required to ensure high quality care and the delivery of an appropriate and effective service. Seven out of the 10 action plan responses to the last inspection in November 2016 had not been fully addressed or completed as described within the specified timeframes stated.

As previously reported, aspects of the design and layout of the premises do not sufficiently meet the needs and the number accommodated. A proposed development plan was available for new residential care facilities for Older people in Louth that was aligned to national and corporate strategies, and based on an alternative model of care ' The Teaghlach Project'. However, the Health Information and Quality Authority (HIQA) has not formally received an approved costed plan with definitive time frames for its completion or for the improvement and refurbishment of the existing premises, as previously reported.

Based on the overall findings, the inspector was not assured that the designated centre had sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose and function.

The overall findings are outlined within the body of the report and the actions required are outlined at the end for response by the provider and person in charge.

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: Statement of Purpose
There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:
Governance, Leadership and Management

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

Findings:
The statement of purpose detailed the aims, objectives and ethos of the centre, outlined the facilities and services provided for residents and contained information in relation to the matters listed in schedule 1 of the regulations.

The person in charge informed the inspector that it was under review and changes made which would affect the purpose or function of the centre would be notified to the Chief Inspector within a revised copy. For example, the purpose and function of rooms was subject to change.

Judgment:
Substantially Compliant

Outcome 02: Governance and Management
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.

Theme:
Governance, Leadership and Management

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

Findings:

There was a defined management structure that identifies the lines of authority and accountability, specifies roles and responsibilities for the areas of care provision. Staff and residents were familiar with current management arrangements.

Governance and management arrangements were in place and described; however, further improvement was required to ensure high quality care and the delivery of an appropriate and effective service. Seven out of the 10 action plan responses to the last inspection in November 2016 had not been fully addressed or completed as described within the specified timeframes stated. Based on the overall findings, the inspector was not assured that the designated centre had sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose and function.

The person in charge had responsibility for two designated centres and was actively involved in an on-going training programme for staff working in three centres operated by the provider. The inspector was not assured that the person in charge had sufficient time to be fully engaged in the effective governance, operational management and administration of this centre due to the demand of their involvement and responsibilities across three sites and based on the overall findings and recurrent major non-compliance in Outcome 7.

As reported in a previous inspection March 2015, it remains unclear to ascertain whether there are sufficient resources to ensure the effective and safe delivery of care of this dementia specific unit. Aspects of the design and layout of the premises do not sufficiently meet the needs and the number accommodated. To date, HIQA has not formally received an approved costed plan with definitive time frames for completion of improvement and refurbishment of the premises, as previously reported and discussed in Outcome 12.

Auditing and management systems were in place to capture statistical information in relation to resident outcomes, operational matters and staffing arrangements. Clinical audits were carried out that analysed accidents, complaints, medicine management issues/errors, skin integrity, care plans, the use of restraint, nutritional risk and dependency levels. This information was available for inspection; however, not all incidents were reported to inform management and auditing arrangements.

The inspector was informed that there were no complaints since the previous inspection and that a low level of incidents were reported. However, the management arrangements and systems in place did not sufficiently ensure issues identified were escalated sufficiently or managed to ensure corrective and appropriate action was taken in a timely manner. In a review of one resident's records the inspector read that concerns had been raised by the resident's relatives via allied health care professionals in March 2017. In addition, the inspector noted that up to eight incidents had occurred within the past five weeks that negatively impacted on other residents, visitors and staff, with only two recorded and reported as an incident.

A comprehensive annual review of the quality and safety of care delivered to residents for 2016 was completed that informed the service plan being implemented in 2017.

Judgment:

Non Compliant - Moderate

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

Theme:
Safe care and support

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

Findings:
The centre had policies in place to protect residents from suffering abuse and to respond to allegations, disclosures and suspicions of abuse. The person in charge is a dedicated safeguarding officer who completed Health Service Executive (HSE) safeguarding training in accordance with the national policy and is certified to deliver this training to staff.

The national policy on safeguarding vulnerable persons at risk of abuse was available to guide practice. Staff had received safeguarding training on identifying and responding to elder abuse. The person in charge and staff spoken to displayed sufficient knowledge of the policy and were clear on reporting procedures required.

The centre has a policy on and procedures in place to support staff in working with residents who have behavioural and psychological symptoms of dementia (BPSD). This policy was informed by evidence-based practice. Some residents had responsive behaviours, also known as behavioural and psychological signs of dementia (BPSD). Staff on duty at the time of the inspection demonstrated a positive, person centred approach towards the management of responsive behaviours. The inspector reviewed a file of a resident who had BPSD. Staff spoken with were knowledgeable on the resident's triggers and knew the appropriate intervention management. However, the measures in place were insufficient or not consistently available or implemented in practice. As a result, episodes of responsive behaviour that negatively impacted on other residents, visitors and staff had occurred regularly. While a dedicated care plan and supplementary document was available, there was insufficient evidence that the detailed interventions were applied or available in practice. A daily support plan, allocation of suitable skilled staff or a pre-planned weekly programme at times identified to trigger responsive behaviour was not consistently in place.

The management of and response to resident's responsive behaviours were not suitably sufficient to minimise the risk posed to the resident, other residents, visitors and staff that was required following the previous inspection.

Staff were trained to work with residents who had dementia and had attended training such as prevention and management of aggression and violence (PMAV) to equip them to work with residents with responsive behaviours. Residents had access to consultant led mental health and psychology services. The inspector saw that assessments had been completed and used to inform interventions in residents' care plans, which were reviewed on an ongoing basis. There was evidence of interdisciplinary collaboration to promote person centred approaches for residents who had responsive behaviours. However, from an examination of resident records and discussions with staff, the inspector was not satisfied that re-referrals for allied health assessments were made as required or that recommended interventions and treatment plans by specialised healthcare professionals were consistently implemented in practice. This is included in the action plan of Outcome 11 for address.

A restraint register was maintained that was subject to regular reviews. A recent audit and review of bedrail usage and restraint had been undertaken aimed at reducing the use and staff training was planned for within the coming weeks. The inspector reviewed the use of restraint and found that 11 of the 22 residents used bedrails, six residents used position seating lap belts within a specialised chair and three used an electronic alarm anklet/bracelet. The inspector noted that a risk assessment was undertaken to inform this decision. Staff spoken with confirmed the various alternatives that had been tried prior to the use of bedrails. Additional equipment such as a grab rail, low beds and sensor alarms were available to reduce the need for bedrails. Safety checks for residents with bedrails were in place and recorded.

Judgment:
Non Compliant - Major

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

Theme:
Safe care and support

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

Findings:
The centre had policies and procedures relating to health and safety that included a health and safety statement and risk management procedures to include items set out in Regulation 26(1). An infection control policy with supporting protocols was in place.

Arrangements were in place for investigating and learning from audits, serious incidents and adverse events involving residents. Some actions taken to minimise incidents included increased supervision. However, as referenced in outcome 2, some incidents had not been adequately recorded or reported to inform corrective action and

management or additional control measures.

Reasonable measures were in place to prevent accidents to persons in the centre and in the grounds. The management and staff team had completed a review of reported incidents and accidents involving residents to identify the key cause or likely factors in order to inform control measures. A low number and frequency of resident incidents and accidents was reported. Emergency response procedures were in place and tested to support staff to react in an emergency situation such as a fire or missing person.

Satisfactory arrangements, consistent with the national guidelines and standards for the prevention and control of healthcare associated infections, were in place. Staff had access to hand washing facilities and hand sanitisers on corridors and were seen using these facilities between resident contact. The standard of cleanliness throughout was good.

Suitable arrangements were in place in relation to promoting fire safety. The fire alarm system was serviced on a quarterly basis and fire safety equipment was serviced on an annual basis.

Fire safety and response equipment was provided. Fire exits were identifiable by obvious signage and exits were unobstructed to enable means of escape. Fire evacuation procedures were prominently displayed throughout the building. Staff were trained in fire safety and those who spoke with the inspector confirmed this. A personal emergency evacuation plan (PEEP) for each resident that identified the resident's mobility levels, likely response due to dementia and requirements for assistance in the event of an emergency evacuation. Staff had completed a simulated fire drill.

The weekly fire alarm test was carried out during the inspection. Staff spoken with and records reviewed confirmed the fire safety checks had occurred and were completed accordingly.

Judgment:
Compliant

Outcome 09: Medication Management
Each resident is protected by the designated centre's policies and procedures for medication management.

Theme:
Safe care and support

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

Findings:
Residents had access to a pharmacist and general practitioner (GP) of their choice. These arrangements were determined prior to each resident admission.

There were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents. The processes in place for the handling of medicines, including controlled drugs, were safe and in accordance with current guidelines and legislation. The inspector saw that controlled drugs were stored safely in a double locked cupboard and stock levels were recorded at the beginning and end of each shift in a register in keeping with legislative requirements.

Nursing staff demonstrated safe practices in medication administration and management. The inspector observed the staff nurse consulting with residents during the administration of medicines and performing good hand hygiene.

Systems were in place for ordering, supply and dispensing methods. There were appropriate procedures for the handling, checking, return and disposal of medicines. However, some improvement was required in relation to the transcribing of medicine records by nurses following the admission of residents. In a sample of medicine kardexs reviewed incomplete evidence of double checking was found and the transcribed kardex completed by a nurse did not accurately reflect the prescription received on admission. Therefore it was unclear if medicines were administered in accordance with the most recent prescription.

A system was in place for reviewing and monitoring safe medication management practices. A review system that included a member of staff from the nursing team, the resident's general practitioner (GP) and the pharmacist was in place to improve the overall management and review of medication management.

Judgment:
Substantially Compliant

Outcome 10: Notification of Incidents
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:
Safe care and support

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

Findings:
Notification in relation to quarterly reports, unexpected deaths and occupancy levels were provided, where relevant, as prescribed in the regulations.

An arrangement for the recording of accidents and incidents occurring in the designated centre was in place. However, from a review of incident and resident records available, the inspector found that all incidents had not been recorded appropriately or reported in accordance with the provider's policies or notified to the Chief Inspector, as required.

An incident alleging theft of money (financial abuse) February 2017 was recorded in the incident records reviewed that had not been notified to HIQA, as required.

A change in persons named on the registration certificate as persons participating in the management of the centre had occurred. While this was apparent following an inspection in 2017 of another centre operated nearby by the provider, HIQA had not been formally notified.

Judgment:
Substantially Compliant

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

Theme:
Effective care and support

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

Findings:
Arrangements were in place to meet the health and nursing needs of residents within this dementia specific unit. Comprehensive assessments were carried out prior to and following the admission of residents to the centre. Care plans had been developed based on the identified and assessed needs of residents and were reviewed accordingly. Residents and relatives were involved in the assessment and planning of care. For example, the information identified in the communication record entitled "My Preferred Priorities for Care" was detailed and informed the respective care plans including end of life. A system was in place whereby residents' relatives were formally invited to participate in the review of care plans and to attend general forums on a quarterly basis that facilitated open discussions.

In the main, the care plans examined reflected the interventions required to achieve the desired goals. Systems were in place to prevent unnecessary hospital admissions.

Timely access to medical and allied health care services was in place. Residents could retain the services of their own general practitioner (GP) and they had good access to community and acute medical services. They had access to allied healthcare professionals including occupational therapy (OT), dietetic, speech and language, ophthalmology and chiropody services on a referral basis. The inspector reviewed residents' records and found that some residents had been referred to these services

and results of appointments were written up in the residents' notes and care plans. A recommendation to re-refer a resident to OT for occupational assessment was made by the inspector to support meaningful activity and occupation.

Residents of the centre had access to the community mental health team and palliative care services. None of the current residents were actively dying or approaching the end of life.

Residents had access to dental services on a referral basis and this service had been provided to a resident since the last inspection. A requirement from the previous inspection in relation to routine check-ups for all residents with natural teeth had not been completed, however, the waiting time and accessibility of dental services when required had been addressed. The person in charge told the inspector he was co-ordinating a list of private dental services that may provide this routine service. The response to the action arising from the previous inspection relating to accessibility to routine dental services is therefore restated.
There were processes in place to ensure that when residents were admitted, transferred or discharged to and from the centre, relevant and appropriate information about their care and treatment was available and maintained, and shared between providers and services.

A selection of care records and plans were reviewed. A pre-assessment by staff prior to resident admission for long term care formed part of the centre's admission policy and practice. The Common Summary Assessment Form (CSARS) that held comprehensive information of assessed needs was used to support residents admitted to the centre for long term care and respite.

Residents' records were mainly electronically held with some such as repositioning charts and fluid intake and output records maintained in hard copy formats. An assessment of all activities of daily living, including communication, personal hygiene, continence, eating and drinking, mobility, spirituality and sleep was undertaken on admission. There was evidence of a range of assessment tools being used to monitor areas such as the risk of falls and malnutrition, cognition, mood, mobility status and skin integrity. The person in charge told the inspector that none of the residents had pressures ulcers or wounds. Residents identified at risk of developing pressure ulcer had appropriate equipment such as pressure relieving mattresses and cushions and repositioning regimes in place and recorded to mitigate this assessed risk.

The development and review of care plans was described as being carried out by a key worker in consultation with residents or their representative/s. The assessment of resident's views and wishes for the end of life were recorded in 'My Preferred Priorities for Care' and outlined in a related care plan and subject to regular reviews. Some improvement was required in relation to recording or demonstrating the on-going involvement of residents and representatives in the care plan and decision making processes. A care plan reviewed include details and information known by staff regarding religious, spiritual and cultural practices or named persons to assist residents in decisions to be made was noted in the records reviewed. Active treatment including resuscitation status was recorded in sample of residents medical notes reviewed.

The management and review of falls and reported incidents was guided by policies. 'Post falls assessments were carried out and recorded to minimise risks. Mobility and daily exercises was seen to be encouraged. Physiotherapy and occupational therapy (OT) services were available on a referral basis. Residents had suitable mobility aids and modified chairs following seating assessments by an occupational therapist and or a physiotherapist. Hand rails on corridors and grab rails were seen in facilities used by residents which promoted their independence.

Many residents were seen enjoying various activities during the inspection. Staff told the inspector they encouraged residents to participate in group or individual activities daily. The weekly activity programme included exercises, bingo, music, floor and board games tailored for the resident group. Each resident's likes and preferences were assessed, known by staff and recorded. Relevant information was reflected in a care plan to plan the daily activity programme.

Resident's care plans were subject to a formal review no less frequently than at four-monthly intervals. However, a social and recreational plan for one resident seen displayed in the staff office was held separate to the electronic care plan for behavioural support subject to review. A number of staff had signed and dated the record from 2016 indicating they had read the three page plan. However, there was little evidence that this specific plan and specified interventions within were implemented in practice or been included in the overall review of care plans to inform an evaluation. It was unclear what elements of the plan worked well to achieve the desired goal or that re-referrals for allied health assessments were made as discussed in Outcome 7.

Assessments carried out included and clinical assessment in relation to monitoring and recording of weights, nutritional intake and risk of malnutrition. Staff were knowledgeable and described practices and communication systems in place to monitor residents that included regular weight monitoring, recommended food and fluid consistency and arrangements for intake recording, if required. The recording of fluid intake records had improved since the previous inspection, as required. However, the recording of contemporaneous records in antecedent behavioural and consequence (ABC) records required review and improvement. The inspector saw late entries recorded that were made up to two days after the actual event.

Access to dietician and speech and language therapists was available and provided on a referral basis based on an assessment of need or change in resident condition. Residents were provided with food and drink at times and in quantities adequate for their needs. The meal observed was properly served and presented in an appetising manner. A water dispenser stocked with water and disposable cups was freely available to residents in the communal day room.

Menus showed a variety of choices at mealtimes and snacks and drinks were available between meal times. There was sufficient staff on duty to offer assistance to residents in a discreet and sensitive manner. The family member of resident told the inspector he assisted his loved one at mealtimes during his visit. This arrangement was seen to be facilitated in a separate room identified as the resident and relative's room.

Judgment:

Non Compliant - Moderate

Outcome 12: Safe and Suitable Premises
The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:
Effective care and support

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

Findings:
Interim measures were put in place to manage the previously reported deficits of the accommodation such as the small size and layout of bedrooms with limited space and storage for personal possessions, adaptations and support equipment. An admission criterion to specific bedrooms was for mobile residents and was subject to dependency level and care needs. The admission process included informing residents and their representative of the accommodation available to them at the time of the pre-admission stage such as likelihood of a single, twin or communal bedroom. This enabled them to exercise choice and control.

Criteria for the admission of residents to specific bedrooms are to be included in the centre's revised statement of purpose.

As reported in a previous inspection March 2015, it remains unclear to ascertain whether there are sufficient resources to ensure the effective and safe delivery of care of a dementia specific unit. Aspects of the design and layout of the premises do not sufficiently meet the needs of all residents and the number accommodated. The centre functioned as a combined short and long stay unit which created a high level of activity, stimuli and turnover of new residents with dementia and their visitors to the environment on a regular or ongoing basis.

The provider's action plan response to the inspection March 2015, that informed the renewal of the centre's current registration due to expire June 2018, in relation to the governance and management of the premises included:
• a design team is currently being appointed to develop a phased solution which will include a mixture of refurbished and new accommodation on site
• a projected construction commencement date of January 2017 subject to no delays to planning or approvals processes.
However, to date, HIQA has not formally received confirmation of planning permission and an approved costed proposal of the action to be taken with a definitive time frame

for completion of improvement and refurbishment. On the day of inspection the Director of Nursing showed the inspector a copy of proposed floor plans for a new building. Her understanding was that the project was to be completed by 2020 but the timelines for this development was not known.

The centre was registered for 26 residents and the maximum occupancy level was reported as 23 residents. This high number of occupants in a dementia specific unit is not in accordance with national averages (19) reported or in line with international averages of 12 residents in small scale domestic style units. This arrangement requires ongoing review.

Previous inspections had found that the dining space was too limited to accommodate 26 resident and some residents had to take their meals in their bedrooms. There were now two sittings for meals and the inspector found that the arrangement in place met the needs of all the residents.

Previous inspections identified that 15 single bedrooms, with floor areas ranging from 7.5m² to 9m² could not safely accommodate residents who required the assistance of 2 staff or a hoist for transfers. The provider allocated these rooms to mobile residents who did not require the assistance of two staff or a hoist for transfers. Residents with higher dependency needs were accommodated in twin bedrooms or more spacious single rooms. The inspector found that the bedrooms were adequate to meet the privacy and dignity of residents on the day of inspection. However, the refurbishment plans of painting and maintenance and repair of the call bells was ongoing. The inspector noted that a programme of refurbishment was ongoing but would not be completed by the timeline identified in the previous action plan.

Some rooms and equipment had been refurbished but others were in need of repair and required redecoration. The installation of shelving for personal possessions and replacement of floor covering in parts, furniture and bed tables was described as on-going.
Despite its limitations, the provider and staff had worked to maximise the potential of the existing building and to create an environment which suited residents with dementia. A mural was painted near the entrance and furniture had been sourced to create a homely environment for residents. A vintage radio and telephone were displayed on the table in the foyer and in the resident and visitors room. Furnishings in were homely and colourful in parts. There were wall clocks in all the bedrooms and some rooms had names or photographs on the door to help residents to identify their bedroom. Further consideration was to be given to the use of colour and signage to support way-finding for residents, as previously reported.

The design and layout of the centre meant that circulation through the building required walking through the living or dining spaces to access resident's bedrooms and the visitors' facilities. This did not impact on the dining experience observed for residents, however the space available in the day room did not allow for seating to be arranged in clusters to support social interaction between residents and chairs were placed around the perimeter of the room. Residents did not have access to side tables in the main communal sitting room to support them with magazines, papers, tea cups, snacks and drinks and to promote optimal functioning and independence.

The inspector observed that there was a suitable, well maintained courtyard which provided a secure outdoor space for residents. As previously reported, access to the courtyard was via two fire doors which were noisy when opened and was difficult for residents to open. The action plan to address this matter was not achieved within the timeframe specified in response to the last inspection. The person in charge stated that the work to complete this matter had been delayed but would be completed shortly. The inspector pointed out loose wiring to be addressed along the top and side of these doors to the person in charge.

Judgment:
Non Compliant - Moderate

Outcome 16: Residents' Rights, Dignity and Consultation
Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

Theme:
Person-centred care and support

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

Findings:
The inspector saw that residents' privacy and dignity was respected as residents could receive visitors in private and personal care was provided in their bedrooms. The overall structure and layout of the building remained the same therefore previously reported areas for improvement remained outstanding. For example, some twin rooms shared a centrally located toilet facility. As this was accessible from both of the twin rooms, and circulation through the building continued to require walking through residents living or dining rooms to access residents' bedrooms and the visitors' facilities. Conditions such as this remained unchanged as previously reported following the inspection 9 March 2015 that informed the renewal of this period of registration.

Arrangements to minimise the risk of compromising resident privacy and dignity and manage the available space such as reducing the number of residents accommodated to 23 and limiting the number of maximum dependent residents to 10 was described. The person in charge also told the inspector that residents requiring additional equipment, modified or mobility aids were allocated to the larger single bedrooms or twin rooms. In addition, the spacious rooms previously held vacant for end of life care were to be incorporated into the overall use to meet the dependency needs of residents.

The design and layout of the centre meant that opportunities for residents to be consulted with and to participate in the organisation of the centre were described by staff. A resident's forum was facilitated on a regular basis and family or representative involvement was central to care and services provided.

Access to and information in relation to independent advocacy services was available to residents. Residents' independence and autonomy was promoted. For example, the inspector saw residents being able to access all parts of the centre and internal courtyard area independently or with support at a time of their choosing.

Residents were able to make decisions about their care and had choices about how and where they spent their day, when and where they ate meals. However, visiting and group activities for residents took place in the main communal day room that served multiple purposes. This arrangement was not optimal to support meaningful positive engagement or for those sensitive to high levels of noise, crowded areas and stimuli. This required review.

Residents had options to meet visitors in a private or communal areas based on their assessed needs. Visitors were unrestricted except in circumstances such as an outbreak of infection. A record of visitors was maintained. Arrangements were provided for residents to attend external appointments or family occasions.

Notice boards, televisions, radios, magazines and news papers were available. Communication aids such as personal ipads or ipods for use by residents were not available and to be explored and provided where appropriate.

Residents were seen to be well groomed and dressed in an appropriate manner with clothes and personal effects of their choosing. Residents were seen being supported to attend the hairdresser onsite during this inspection for personal grooming. Residents and relatives who spoke with the inspector expressed satisfaction with this service provided.

Judgment:
Non Compliant - Moderate

Outcome 18: Suitable Staffing
There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

Theme:
Workforce

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

Findings:
There was a sufficient number of staff and skill mix on duty during the inspection to meet the needs of residents. However, improvements were required in relation to the deployment of staff with the appropriate skills, qualifications and experience.

There was an actual and planned roster in place, with changes indicated. However, the full names of some staff working was not recorded on the actual roster reviewed. The roster showed there was a nurse rostered on duty at all times. The daily staffing compliment of nurses, carers and cleaning personnel was often supported by agency staff. On the morning of the inspection one of the three nurses, one of the five care attendants and one of the two cleaning personnel were contracted from a recruitment agency. The staffing compliment also included two catering staff members and a work experience student. The activity co-ordinator was off duty and the clinical nurse manager was attending study day. A general operative staff member worked between two centres on this site and was involved in the fire alarm test carried out during this inspection. The inspector was informed by the person in charge that a minimum of two nurses was rostered at all times (day and night) and that an additional nurse was rostered daily when resident activity levels were greater. The previous day's roster showed two of the three nurses on day duty were agency staff and one of the two night nurses was from an agency and rostered to cover each night this week.
From a review of the staff rosters over a two week period and discussions with staff, the inspector found that the recommended and required one to one staffing provisions were not consistently available or assigned appropriately. This was evidenced from a review of incident and care records, and by staff reports.

A review of staff allocation patterns was required to ensure staff with the appropriate skills, qualifications and experience supported residents with specific needs such as responsive behaviours. For example, agency staff were allocated for the specific role and responsibility of one to one support for a resident daily. However, the agency person, their actual training and experience levels was unknown in advance. It was also unknown who would be covering this shift on the days (Wednesday to Sunday) following this inspection. This arrangement did not support person-centred care. In addition inconsistency and poor planning did not sufficiently ensure if staff with the appropriate skills, qualifications and experience were available to support residents with specific needs such as responsive behaviours.

Policies were in place for the recruitment, training and development of staff. A sample of staff files were reviewed by the inspector, and these were found to contain the information required by Schedule 2 of the regulations.

All rostered nursing staff employed by the provider had up-to-date professional registration in the general nursing division issued by An Bord Altranais agus Cnáimhseachais.

Annual appraisals were to be developed to ensure adequate supervision, monitoring and

support was in place for staff.

A range of staff training opportunities included dementia specific training courses were provided. A training programme was in place for staff which included mandatory training in fire safety, moving and handling practices, safeguarding (the prevention, detection and response to abuse) and CPR for nurses. The person in charge said that many staff members had completed training in dementia care and the management of responsive behaviours (PMAV) was mandatory for staff working in this centre. A training date on the use of restraint was planned for all staff to attend in the coming weeks.

According to the person in charge and training records available, the majority of staff had completed up to date mandatory training in line with the regulations. However, it was unclear if contracted agency and relief staff from another centre onsite rostered for day and night duty had completed relevant training appropriate for residents of this specific unit. Electronically held training records were not available on the day of the inspection due to measures taken that limited computer networks following a recent cyber risk. The person in charge was to review the records of rostered staff when available to identify that all (including relief workers) had completed the required training to work in this dementia specific centre.

The inspector was informed by the person in charge that there were no volunteers operating in the centre at the time of the inspection, but a number of applicants to volunteer had been received but these had not been processed.

Judgment:
Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Sonia McCague
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:	Boyne View House
Centre ID:	OSV-0000532
Date of inspection:	23/05/2017
Date of response:	26/06/2017

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: Statement of Purpose

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The person in charge informed the inspector that it was under review and changes made would be notified to the Chief Inspector within a revised copy. For example, the purpose and function of rooms was subject to change.

1. Action Required:
Under Regulation 03(2) you are required to: Review and revise the statement of

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

purpose at intervals of not less than one year.

Please state the actions you have taken or are planning to take:
The Person in Charge has notified the Registration Section of the Health Information and Quality Authority of changes to Person's Participating in Management of the Centre as a previous person participating in management had retired. While the name had been changed within the Statement of Purpose and notified to the Authority, the name of this person was present on the Certificate of Registration.
Any changes being planned for room changes will be notified to the Authority using a variance form.
Any changes that affect the management or function of the service will continue to be notified to the Authority.

Proposed Timescale: 30/09/2017

Outcome 02: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The inspector was not assured that the designated centre has sufficient resources to ensure the effective delivery of care, as discussed throughout the report.

Actions outlined in the action plan responses to the previous inspection findings had not been completed in a timely manner or within the specified timeframes.

Aspects of the design and layout of the premises do not sufficiently meet the needs and the number accommodated. To date, HIQA has not formally received an approved costed plan with definitive time frames for completion of improvement and refurbishment of the premises, as previously reported and discussed in Outcome 12.

2. Action Required:
Under Regulation 23(a) you are required to: Ensure the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.

Please state the actions you have taken or are planning to take:
The governance and management of the Centre has been reviewed and the following changes are being actioned:

The Person in Charge of the Centre is onsite and will be responsible for fulfilling the PIC functions for this centre only with a requirement to provide support to the Director of Nursing within the overall service. In the interim, an acting Assistant Director of Nursing will provide management and governance for the service.

The Person in Charge has now access to all care plans and progress notes on a daily

basis. These will be monitored daily and any issue that may arise or is written in a progress note that does not have a follow up incident plan will be acted upon immediately.

The Person in Charge will no longer undertake training thus freeing more time to concentrate on the designated centre concerned.

The Clinical Nurse Manager will now deputise for the Person in Charge thus allowing for a consistent governance structure within the Centre.

There is a plan in place to backfill a vacant Clinical Nurse Manager 1 post to provide extra support to the staff within the Centre.

Only designated centre staff who have received dementia care training will now deliver care to individuals who present with behavioural and psychological issues associated with dementia.

Funding has been approved for the installation of doors going into the courtyard and these will be installed by end of June 2017.

Funding has been approved for the painting of the entire centre and quotations have been invited from potential contractors.

The timeframe for submission of planning permission to the County Council is on or before 30th August 2017, and the Authority will receive a fully costed plan at this time.
Funding for a new building has been approved by the Department of Health under Capital Development Programme for new building and refurbishments.
The Project planning is now at the detailed design phase and budgetary costings will be provided to the Health Information and Quality Authority by 30/08/2017

Proposed Timescale: 30/08/2017

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The inspector was not satisfied that the person in charge had sufficient time to be fully engaged in the effective governance, operational management and administration of this centre based on their responsibilities across three centres, the overall findings and recurrent major non-compliance in Outcome 7.

The management arrangements and systems in place did not sufficiently ensure issues identified were escalated sufficiently or managed to ensure corrective and appropriate action was taken in a timely manner.

3. Action Required:
Under Regulation 23(c) you are required to: Put in place management systems to

ensure that the service provided is safe, appropriate, consistent and effectively monitored.

Please state the actions you have taken or are planning to take:
As detailed above, the governance and management of the Centre has been reviewed and the following changes are being actioned:

The Person in Charge of the Centre is based onsite and will be responsible for fulfilling the PIC functions for this centre only with a requirement to provide support to the Director of Nursing within the overall service.

The Person in Charge has now access to all care plans and progress notes on a daily basis. These will be monitored daily and any issue that may arise or is written in a progress note that does not have a follow up incident plan will be acted upon immediately

The Person in Charge will no longer undertake training thus freeing more time to concentrate on the designated centre concerned.

The Clinical Nurse Manager will now deputise for the Person in Charge thus allowing for a consistent governance structure within the Centre and will be reflected in the Statement of Purpose as outlined in Outcome 1.

There is a plan in place to backfill a vacant Clinical Nurse Manager 1 post to provide extra supervision and governance within the Centre.

This enhanced governance and management structure will ensure issues identified are escalated and managed appropriately and correctively in a timely manner.

Proposed Timescale: 31/07/2017

Outcome 07: Safeguarding and Safety

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The management of and response to resident's responsive behaviours were not suitably sufficient to minimise the risk posed to the resident, other residents, visitors and staff that was required following the previous inspection.

4. Action Required:
Under Regulation 07(2) you are required to: Manage and respond to behaviour that is challenging or poses a risk to the resident concerned or to other persons, in so far as possible, in a manner that is not restrictive.

Please state the actions you have taken or are planning to take:

The PIC had been monitoring closely the incidents relating to the resident's responsive behaviour, however, a review of these incidents following inspection identified that staff training and education in relation to the triggers precipitating behavioural and psychological issues associated with dementia was not sufficient and a proactive, comprehensive plan has been implemented as follows:

Supervision, assessment and reporting of residents' behaviour as appropriate is provided by identified staff on a daily basis within the Centre. This is reviewed by the PIC or CNM on an ongoing basis.

Referrals to Occupational Therapy and other professionals are completed and any recommendations are incorporated into care plans.

Occupational and recreational interventions are planned in line with the residents' personal interests as detailed within the care plan and are monitored on an ongoing basis and amended as appropriate to the resident's care needs.

Any behavioural issues that cause concern are documented with ABC charts as well as incorporated into care plans and incident forms.

The Centre has a direct referral system to Psychiatry of Old Age Services and Palliative Care Services as required by residents.

The new falls monitoring system has been reviewed and a new system installed which provides a staff alert to resident movement and provides for minimal restrictions to residents and noise intrusion to other residents.

Proposed Timescale: 20/06/2017

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The measures in place were insufficient or not consistently available in practice resulting in episodes of responsive behaviour that negatively impacted on other residents, visitors and staff.

While a dedicated care plan and supplementary document was available, there was insufficient evidence that the detailed interventions were applied or available in practice.

A daily support plan, allocation of suitable skilled staff or a pre-planned weekly programme at times identified to trigger responsive behaviour was not consistently in place.

5. Action Required:
Under Regulation 07(1) you are required to: Ensure that staff have up to date

knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.

Please state the actions you have taken or are planning to take:
A full detailed care plan is activated on a daily basis with a dedicated named person/persons to facilitate occupation, recreation and activities.

This is evaluated on a weekly basis to ascertain what works and doesn't work and is changed accordingly

Occupational Therapy referrals have been made to assist in ascertaining abilities and interests of residents with behavioural and psychological issues.

Staff support residents and families/visitors to avail of alternative quiet spaces within the Centre, particularly where the resident is known to respond adversely to environmental noise.

Supervision, assessment and reporting of residents' behaviour as appropriate is provided by identified staff on a daily basis within the Centre. This is reviewed by the PIC or CNM on an ongoing basis.

Proposed Timescale: 20/06/2017

Outcome 09: Medication Management

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Improvement was required in relation to the transcribing of medicine records by nurses following the admission of residents to ensure double checking was complete to ensure medicines were administered in accordance with the most recent prescription.

6. Action Required:
Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.

Please state the actions you have taken or are planning to take:
The PIC and CNM will ensure that residents admitted to the Centre receive their medications as prescribed on their actual medical prescription.

No drugs will be administered from any other prescription such as transcribed medication chart until signed by a Doctor.

Nursing staff will only use the prescription as issued by the respite residents' G/P.

The prescription that the resident brings with them on admission will be used, and any transcribing will reflect exactly the order of prescribing on the original prescription

No alterations will be made to any prescription except for alphabetical coding. This will only be for the purpose of recording.

The PIC and CNM will closely monitor to ensure compliance with regulatory/NMBI requirements for medication management.

Administration guidelines and Centre policies will be updated to reflect these changes in the prescribing, transcribing and administration of medicines.

Proposed Timescale: 20/06/2017

Outcome 10: Notification of Incidents

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
All incidents and events had not been notified to HIQA, as required.

7. Action Required:
Under Regulation 31(1) you are required to: Give notice to the chief inspector in writing of the occurrence of any incident set out in paragraphs 7(1)(a) to (j) of Schedule 4 within 3 working days of its occurrence.

Please state the actions you have taken or are planning to take:
The Person in Charge will assure the Authority that any incident set out in paragraphs 7(1)(a) to (j) of Schedule 4 will be notified to the Authority within 3 working days of its occurrence. The PIC omitted to inform the Authority of missing money as financial abuse, as there was no evidence of abuse occurring, and read the regulations as recurring pattern of theft. The PIC will inform the Health Information and Quality Authority in future where there is money missing within three working days as well as on the quarterly notifications.

Proposed Timescale: 20/06/2017

Outcome 11: Health and Social Care Needs

Theme:
Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Some improvement was required in relation to recording or demonstrating the on-going involvement of residents and representatives in the care plan and decision making processes.

8. 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 and CNM will retain evidence that all residents and/or their representatives are facilitated to be involved in the care planning process and in the decision making process. The PIC, CNM and all staff will continue to work closely with the resident and or any representative, including an advocate in the absence of any family involvement to ensure that their decisions no matter how small, at any particular time are respected and implemented.
A letter of invitation goes to all relatives on admission and again on a three monthly interval when each care plan is due for review.

Proposed Timescale: 20/06/2017

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A social and recreational plan for one resident seen displayed in the staff office was held separate to the electronic care plan for behavioural support subject to review. A number of staff had signed and dated the record from 2016 indicating they had read the plan. However, there was little evidence that this specific plan and specified interventions were implemented in practice or been included in the overall review of care plans to inform an evaluation. It was unclear what elements of the plan worked well to achieve the desired goal.

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9. Action Required:
Under Regulation 05(1) you are required to: Arrange to meet the needs of each resident when these have been assessed in accordance with Regulation 5(2).

Please state the actions you have taken or are planning to take:
The PIC has had a meeting with the Clinical Nurse Manager and the Activities Coordinator. A full assessment of each resident's ability is undertaken, and a plan of care is provided on a daily basis based on those abilities. Each activity is also facilitated and recorded based on residents' abilities. The specific care plan as outlined during the inspection has now been revised and is planned for the day before and is undertaken by staff familiar with the resident from 08.00 am until 10.00 pm.

Proposed Timescale: 20/06/2017

Theme:
Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
From an examination of resident records and discussions with staff, the inspector was not satisfied that recommended interventions and treatment plans by specialised healthcare professionals were consistently implemented in practice.

10. 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 that resident's admission to the designated centre.

Please state the actions you have taken or are planning to take:
The Person in Charge along with the Clinical Nurse Manager and all staff will ensure that any prescribed interventions or recommendations from other disciplines are acted upon and are incorporated into daily care plans in a timely manner.

Proposed Timescale: 20/06/2017

Theme:
Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A requirement from the previous inspection in relation to routine check-ups for all residents with natural teeth had not been completed

11. Action Required:
Under Regulation 06(2)(c) you are required to: Provide access to treatment for a resident where the care referred to in Regulation 6(1) or other health care service requires additional professional expertise.

Please state the actions you have taken or are planning to take:
The Person in Charge has now made available a list for all dental services within the area. This will now be brought to the attention of all residents/and/or their representatives. We will continue to undertake oral health assessments ongoing and on admission. We will work with each resident in facilitating dental services and advise each resident/and/or their representatives of the need for routine dental services. We will continue to ensure that emergency dental care is undertaken by HSE personnel. We will work on this action through a quality improvement initiative with residents and relatives, and actively promote oral health as a health promotion initiative.

Proposed Timescale: 30/09/2017

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The recording of contemporaneous records in antecedent behavioural and consequence (ABC) records required review and improvement. The inspector saw late entries recorded that were made up to two days after the actual event.

The inspector was not satisfied that re-referrals for allied health assessments were made as required or that recommended interventions and treatment plans by specialised healthcare professionals were consistently implemented in practice.

12. Action Required:
Under Regulation 06(1) you are required to: Having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care for a resident, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais.

Please state the actions you have taken or are planning to take:
The Person in Charge along with the Clinical Nurse Manager monitor the care plan to ensure that the entries are recorded contemporaneously. The addition of touch screen recording of interventions is greatly assisting in this matter. However, in the event of failure of the online system, the PIC will ensure that contemporaneous records are monitored consistently. The Centre did go through a period where online recording was challenged due to cyber threats, and was then recorded as late entry. This will now be risk assessed and a plan put in place to respond to such an eventuality.
The PIC will continue to ensure that the recommendations of all specialised healthcare professionals are consistently implemented in practice.

Proposed Timescale: 30/07/2017

Outcome 12: Safe and Suitable Premises

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
As reported in a previous inspection March 2015, it remains unclear to ascertain whether there are sufficient resources to ensure the effective and safe delivery of care of a dementia specific unit.

Aspects of the design and layout of the premises do not sufficiently meet the needs of all residents and the number accommodated.

The centre functioned as a combined short and long stay unit which created a high level of activity, stimuli and turnover of new residents with dementia and their visitors to the environment on a regular or ongoing basis.

The provider's action plan response to the inspection March 2015, that informed the renewal of the centre's current registration due to expire June 2018, in relation to the governance and management of the premises included:
• a design team is currently being appointed to develop a phased solution which will include a mixture of refurbished and new accommodation on site
• a projected construction commencement date of January 2017 subject to no delays to planning or approvals processes.

However, to date, HIQA has not formally received confirmation of planning permission and an approved costed proposal of the action to be taken with a definitive time frame for completion of improvement and refurbishment.

On the day of inspection the Director of Nursing showed the inspector a copy of proposed floor plans for a new building. Her understanding was that the project was to be completed by 2020 but the timelines for this development was not known.

This high number of occupants in this dementia specific unit is not in accordance with national averages (19) reported or in line with international averages of 12 residents in small scale domestic style units. This arrangement requires on-going review.

The refurbishment plans of painting and maintenance and repair of the call bells was on-going. The programme of refurbishment was not completed by the timeline identified in the previous action plan response.

Further consideration was to be given to the use of colour and signage to support way-finding for residents, as previously reported.

Space available in the day room did not allow for seating to be arranged in clusters to support social interaction between residents and chairs were placed around the perimeter of the room.

Residents in the main communal sitting room did not have access to side table to support them with magazines, papers, tea cups, snacks and drinks and to promote independence.

As previously reported, access to the courtyard was via two fire doors which were noisy when opened and was difficult for residents to open. The action plan to address this matter was not achieved within the timeframe specified in response to the last inspection.

Loose wiring along the top and side of the doors where residents accessed the courtyard needed to be addressed.

13. 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:
We have communicated with the Project Office with responsibility for the planning of the new build. The submission of plans to the County Council is aimed for the 30th of August 2017. Copies of plans and associated costings will be submitted to the Health Information and Quality Authority by 30/08/2017. Funding has been allocated by the Department of Health for Capital expenditure for new build construction.

The provider recognises that the number of people within the Centre is high. The provider recently reduced the number of residents at any one time from 26 to 23, 18 long stay and 5 respite. The Provider through the PIC aims to ensure that all admissions are admitted based on need and what the service is able to provide to meet all needs on a weekly basis. The Centre does not admit any more than 2 maximum dependency residents on any period of time for Respite Care. The Centre also ensures that no resident is admitted to a single room where their needs cannot be met in a safe or dignified way. The Provider will continue to monitor and review all admissions to the Centre to ensure that the needs of residents can be appropriately met.

The Centre has now received funding for painting and redecoration of the Centre. Extra shelving for personalisation of rooms has now commenced.

Call bell system has now been approved and is in the process at time of report writing of being installed.

The colour scheme and way finding is being incorporated as part of the painting schedule

A second sitting room and relaxation room is now available and will be utilised on a daily basis more than previous.

Families and visitors will now be facilitated to use alternative rooms other than the main sitting room during visitations.

Side tables are now being purchased for individual resident usage.

The two doors going into the Courtyard area will be in place by the end of June

Loose wiring into the courtyard has now been tidied.

Proposed Timescale: 30/08/2017

Outcome 16: 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 overall structure and layout of the building remained the same therefore previously reported areas for improvement remained outstanding. For example, some twin rooms shared a centrally located toilet facility. As this was accessible from both of the twin rooms, and circulation through the building continued to require walking through residents living or dining rooms to access residents' bedrooms and the visitors' facilities.

Conditions such as this remained unchanged as previously reported following the inspection 9 March 2015 that informed the renewal of this period of registration.

14. Action Required:
Under Regulation 09(3)(b) you are required to: Ensure that each resident may undertake personal activities in private.

Please state the actions you have taken or are planning to take:
The PIC, CNM and staff will ensure that residents continue to use the facilities provided with as little disruption from visitors as possible. The placing of intermittent screens in both rooms to ensure dignity and privacy for residents will be re-evaluated to ensure it is providing dignity and privacy at all times. The PIC, CNM and staff will ensure that visitors are respectful of other residents and ensure that mealtimes are uninterrupted by visitors except on the request of the resident in question with due regards to dignity of other residents at mealtimes.
We will again ensure that signage is placed on these doors when occupied, and that the door on either side can be locked to ensure dignity for the resident. Staff will continue to be extra vigilant on behalf of residents to ensure that this is monitored closely and is being effective.

Proposed Timescale: 30/06/2017

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Visiting and group activities for residents took place in the main communal day room that served multiple purposes. This arrangement was not optimal to support meaningful positive engagement or for those sensitive to high levels of noise, crowded areas and stimuli. This required review.

15. Action Required:
Under Regulation 09(3)(a) you are required to: Ensure that each resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.

Please state the actions you have taken or are planning to take:
Alternative private visiting areas are now available and the PIC and CNM will continuously encourage the use of these rooms on an ongoing basis, so as to keep the

day room free from a build up of visitors. The PIC and CNM will raise this through the resident's relatives forum so as to plan this for going forward.

Proposed Timescale: 30/07/2017

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Communication aids such as personal ipads or ipods for use by residents were not available and to be explored and provided where appropriate.

16. Action Required:
Under Regulation 10(1) you are required to: Ensure that each resident, who has communication difficulties may communicate freely, having regard to his or her wellbeing, safety and health and that of other residents in the designated centre.

Please state the actions you have taken or are planning to take:
The Person in Charge will now explore the usage of computers and tablets and other electronic devices for individual residents. The PIC will explore a number of different communication aids appropriate for people with dementia and ensure that these are utilised.

Proposed Timescale: 30/10/2017

Outcome 18: Suitable Staffing

Theme:
Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Improvements were required in relation to the deployment of staff with the appropriate skills, qualifications and experience.

One to one staffing provisions were not consistently available or assigned appropriately. This was evidenced from a review of incident and care records, and by staff reports.

A review of staff allocation patterns was required to ensure staff with the appropriate skills, qualifications and experience supported residents with specific needs such as responsive behaviours.

17. 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:
The PIC will ensure the deployment of appropriate staff to the area. Only staff who are familiar with people with dementia will now work with a person who may experience behavioural and psychological issues associated with dementia. The PIC undertook a review of the arrangements in place for one to one immediately post inspection to ensure that only centre staff were involved in these activities and that those from the recruitment agency if required were allocated to other duties.
The centre has been able to recruit a number of staff in recent months and the Director of Nursing and PIC undertake to place staff within the Centre based on their experience and wish to work with people with dementia.
The position of a full time activities, recreation and occupation personnel has been approved and the position has been offered to one of the current staff with a key skill in this area.

Proposed Timescale: 30/07/2017

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Annual appraisals were to be developed to ensure adequate supervision, monitoring and support was in place for staff.

18. Action Required:
Under Regulation 16(1)(b) you are required to: Ensure that staff are appropriately supervised.

Please state the actions you have taken or are planning to take:
These have been developed and will now commence. Nursing staff will be first to undertake annual appraisals

Proposed Timescale: 30/09/2017

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
It was unclear if contracted agency and relief staff from another centre onsite rostered for day and night duty had completed relevant training appropriate for residents of this specific unit.

19. Action Required:
Under Regulation 16(1)(a) you are required to: Ensure that staff have access to appropriate training.

Please state the actions you have taken or are planning to take:
We will now review all staff who are redeployed from another site to ensure that they have the appropriate training to work within this Centre. All relief staff have completed FETAC or QQI training in which there is a dementia module. We will now review with agency contractors that, as far as possible, staff have undertaken training relevant to their role in Dementia Specific Units. Only those staff who are part of the staffing complement of the Centre or who regularly work within the Centre from the agency will undertake one to one duties with residents who have behavioural issues associated with dementia.

Proposed Timescale: 30/08/2017