Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Office of the Chief Inspector

Report of an inspection of a Designated Centre for Older People

Name of designated centre:	Dungloe Community Hospital
Name of provider:	Health Service Executive
Address of centre:	Gweedore Road, Dungloe, Donegal
Type of inspection:	Unannounced
Date of inspection:	09 July 2019
Centre ID:	OSV-0000618
Fieldwork ID:	MON-0025043

About the designated centre

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

Dungloe Community Hospital is one of 11 community hospitals in Donegal. It is situated in the town of Dungloe in a region known as The Rosses. The centre is part of a one-storey building where a range of community services that include a day hospital, mental health services and out-patient clinics are located. Accommodation is provided for 33 residents. There are 16 places allocated for long-term care and the remaining places are allocated to residents who have rehabilitation, convalescence, respite or palliative care needs.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	22

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
09 July 2019	14:00hrs to 20:40hrs	Manuela Cristea	Lead
10 July 2019	08:45hrs to 16:00hrs	Manuela Cristea	Lead
10 July 2019	14:00hrs to 16:00hrs	Ann Wallace	Support

What residents told us and what inspectors observed

All residents and relatives who communicated with the inspector during the two-day inspection were highly complimentary of the support and assistance provided by staff and their commitment to ensure they enjoyed a good quality of life. They expressed satisfaction with the activities available to them, the choices they could make on a daily basis and the quality of food provided to them. Some relatives referred to the centre as a 'home from home' and described how they could come and go as they pleased, and they were always welcome by staff and felt like being part of a big family. A few mentioned that staffing levels were reduced, but they all emphasised that staff did their best, were always kind, attentive and respectful. Relatives told the inspector that they were confident and reassured that residents were well cared for and well looked after in the centre.

Capacity and capability

This was a two-day inspection for the purpose of monitoring ongoing compliance with the regulatory requirements and assessing progress with the compliance plan submitted to the Chief Inspector of Social Services in response to the findings of a previous inspection. Most of the action plans had been completed, however the projected refurbishment works to address the identified non-compliances in relation to regulations 17 and 12 had not started by the time of inspection. The inspectors were satisfied that the planned works were imminent and were due to start within the next three weeks.

An application to vary a condition of registration had been received by the Chief Inspector in a timely manner. This related to a request to extend the time-frame for the completion of refurbishment works in the centre to the end of 2020, due to delays at design stage.

The inspection findings showed that most of the matters arising from the previous inspection had been completed and despite the time delay, progress was being made in relation to the refurbishment plans. The inspector was satisfied that there was a realistic refurbishment plan in place, which considered both the impact of works and the mitigating measures for the residents currently living in the centre.

The registered provider is the Health Service Executive (HSE). The registered provider representative attended the feedback meeting on the second day of inspection. A second inspector also joined the feedback meeting. The registered provider representative and the person in charge provided both inspectors with comprehensive detail and updates in relation to the schedule of works for the

planned refurbishment required to achieve compliance with the regulations.

The registered provider representative communicated with the person in charge on a regular basis and was aware of key issues such as the accident and incidents, resources, including human resources and complaints.

Although some progress was evident in relation to refurbishment plans, this inspection further identified several areas for improvement. In particular, the staffing difficulties significantly impacted on the performance in other areas such as staff training, care planning, behaviours that challenge, governance and management.

The number of staff was not appropriate to meet the needs of all of the residents. A review of the rosters, solicited information from management, observation of practices, discussions with relatives, residents and staff on duty highlighted a shortage in staffing levels. The registered provider representative confirmed that they had more than eight staff vacancies at the time of inspection and an action plan to address some of these was awaiting approval. There were a number of reasons for the shortage in staffing, but primarily, these related to retirement, long-term sick leave and difficulties in recruitment.

For example, the person in charge had stepped up from the position of clinical nurse manager 2 (CNM2) while awaiting for the replacement of the position of director of nursing. She had been in this acting role for more than 2 and a half years. Although she was supported by the registered provider representative, the management structures in place to support her at operational level were not adequate. For example over a recent period of almost three months there was no deputy to assist her in the role due to unplanned absence.

Consequently the clinical governance was not sufficiently robust to ensure adequate oversight of care and services. As a result, there was a weakening in the quality control processes and auditing and monitoring of key performance indicators was conducted on a less frequent basis, with the last audit carried out in April 2019. In addition, the introduction of a new system of auditing the nursing metrics had been delayed and the implementation of a new electronic care planning system had not been carried out in a safe manner.

The person in charge had appropriately escalated the associated risks to the registered provider representative, who responded by introducing mitigating controls for the shortage of staff by reducing the number of beds to 28. This ensured that staffing levels remained safe for the residents.

In order to ensure that staffing levels were maintained the person in charge spent a large amount of time on the rosters, trying to maintain safe staffing levels, which in turn limited the time available for operational management. There was a cap on agency usage, which meant that not all staff could be replaced in the event of absence. Inspectors found that direct resident care was prioritised and staff were rotated accordingly. The core staff employed by the organisation worked additional hours and covered for each other to ensure residents were receiving the care required. In order to ensure consistency in the care for the residents, where agency

staff were used efforts were made to use the same staff from the agency.

Shortcomings were also identified in a number of areas such as: the review of policies and procedures, appropriate notification of incidents and the directory of residents. These will be discussed under their respective regulations.

The staff had access to a range of education courses appropriate to their roles and responsibilities. The majority of staff had completed the mandatory training with the exception of five staff members who did not complete the training in safeguarding vulnerable adults.

There was a clear organisational structure and reporting relationships in place, which staff fully understood and were able to describe to inspector. The staff were informed of the upcoming refurbishment plans and the inspector saw records of regular meetings at which operational and staffing issues were discussed. Staff told the inspector that the person in charge was dedicated to the provision of residential care and provided the staff team with good leadership. The planned refurbishment was widely advertised in the centre and relatives confirmed that they were aware of the plans. Staff confirmed that they were supported by management in carrying out their work. They were confident, well informed and knowledgeable about their roles and responsibilities.

Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration

The required application information and the associated fee were submitted in a timely manner. Additional information requested was also provided.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge had worked in the centre for several years in a management role. She was qualified and up to date with best practice in care of older people and had a very good knowledge of residents' needs. The staff, residents and relatives said she was approachable and available whenever they needed to talk to her or to relay information.

Judgment: Compliant

Regulation 15: Staffing

The numbers and skill mix of staff were not appropriate to meet the needs of the residents in the centre. There was a large number of staffing vacancies at the time of inspection, which impacted on staff's ability to deliver quality care. While the provider had mitigated this by reducing the number of beds in the centre, the current reliance on agency staff and high levels of overtime worked by the centre's own staff were not sustainable.

There was at least one staff nurse present at all times on the premises and all nurses had their registration up to date. There were no volunteers in the centre.

Judgment: Not compliant

Regulation 16: Training and staff development

The centre had a rolling training programme and the records showed that most staff had participated in a wide range of mandatory and relevant training such as: fire safety, moving and handling, dementia, doll therapy, frailty, restrictive practices, hand hygiene. However, a small number of staff did not complete their mandatory training in safeguarding vulnerable adults. The inspector was satisfied that residents were protected, as these staff had attended previous courses in the prevention of elder abuse.

Staff were appropriately supervised to perform their duties and were aware about their role and responsibilities.

From discussion with staff and the evidence available on the day, the inspector concluded that further up to date training in restrictive practices could also enhance the quality and safety of the care provided to the residents.

Copies of the regulations and standards were available.

Judgment: Substantially compliant

Regulation 19: Directory of residents

The directory of residents did not contain all information as required by Schedule 3 of regulations. The inspector was informed that a new system of recording residents' personal details, transfers, temporary absences and discharges had been created when the centre could no longer source the original directory book. The inspector reviewed the new system and found that it did not meet the regulatory requirements.

Judgment: Not compliant

Regulation 21: Records

Overall the records were well maintained as per regulations. They were accessible, easily available and stored securely.

Samples of documents required to be held in respect of the person in charge and each member of staff regarding the person's identity, vetting disclosure, relevant qualifications, registration details, employment history and references were available for inspection and were found to be satisfactory.

Judgment: Compliant

Regulation 23: Governance and management

There was a clearly defined management structure in place with established lines of responsibility and accountability. However, the identified staffing shortages impacted on the ability of the person in charge to maintain good oversight, appropriately manage the service and engage in quality improvement initiatives.

Contingency plans had been put into place to mitigate the current issues with staffing, quality assurance systems and lack of administrative support, however the inspector found that these measures were not sustainable and did not ensure that there was adequate oversight of the service.

The inspector saw evidence of a draft annual review for the previous year, which included comprehensive audits with reviews of incidents, medication management, care documentation, infection control practices, use of restraints and nutrition. Residents feedback and experience had been sought on a regular basis, both formally and informally, and was used to plan service delivery.

As discussed under Regulations 15 and 16, improvements were also required in ensuring the service was adequately resourced and all staff were trained in order to ensure a safe, appropriate and consistent service was provided.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose outlined the ethos and aims of the centre, the facilities

and services, provided details about the management and staffing and described how the residents' well-being and safety was being maintained. It contained all matters as per Schedule 1 of the regulations. The statement of purpose had been revised and reviewed within the last year.

Judgment: Compliant

Regulation 31: Notification of incidents

Most notifiable incidents had been brought to the attention of the Chief Inspector in a timely manner. However, the six-monthly reports and the quarterly notifications for the end of 2018 and beginning of 2019 had not been received.

The inspector also found that the notification of a serious incident had not been submitted, despite timely completion of the notification form. This oversight resulted from inadequate arrangements to cover for planned absences. However, the inspector was satisfied that the safeguarding process had been adequately followed and where a serious incident occurred, there were effective governance arrangements to ensure the safety and welfare of residents could be maintained.

Judgment: Not compliant

Regulation 32: Notification of absence

The registered provider representative was aware of the need to send in a notification if the person in charge was going to be absent from the centre for a period longer than 28 days.

Judgment: Compliant

Regulation 4: Written policies and procedures

All policies and procedures as per Schedule 5 were in place and available to staff. Most policies had been reviewed and had been locally adapted in the past three years as per regulatory requirements. However, a small number of policies required revision and review to ensure they continued to provide up-to-date evidence-based guidance to staff. The registered provider representative advised the inspectors that a policy group had recently been set up with the purpose to review and update local policies.

Judgment: Substantially compliant

Regulation 33: Notification of procedures and arrangements for periods when person in charge is absent from the designated centre

The registered provider representative was clear of the need to set out the arrangements in place when the person in charge was absent for more than 28 days.

Judgment: Compliant

Quality and safety

Overall the quality of care and support provided to residents was found to be of a good standard, and the care practices in place were person-centred. The inspector noted that there were good supervision arrangements for residents in the communal areas. Staff were familiar with residents' needs and despite being busy they ensured that residents always came first and provided appropriate responses to meet their needs. However, the individual assessment and care planning documentation required improvement.

The centre was in the process of transitioning to a new system of electronic records. At the time of inspection, thecentre was implementing a new electronic resident record system. This meant that there were two electronic systems running in parallel for the duration of the changeover as well as a paper-based system of recording assessments. The inspector found that while some of the nurses had training in the new care record system, most nurses used the system with difficulty and had challenges finding the information when requested by the inspector.

The inspector reviewed the information available from all three systems and found that overall, the care planning documentation was inconsistent. The inspector found evidence of really comprehensive, person-centred care plans that outlined the supports required to maximise residents' lives and reflected residents' changing needs. However, other care plans were generic and did not contain sufficient information to guide staff in how to care for the residents. In addition, the inspector identified a recently admitted resident who did not have any care plans in place in any of the electronic systems available. This was not in line with local policy and regulatory requirements to have a care plan initiated within 48 hours.

From the evidence available, the inspector was satisfied that the care plans were reviewed on a three-monthly basis, or sooner if needed. Residents and relatives, as required, were involved in the care planning process. The inspector saw evidence of this consultation process in the form of formal three-monthly reviews of care attended by resident, relatives, staff nurse and the general practitioner (GP). Some

of the relatives who spoke with the inspector reported that they found these meetings very valuable and provided them with an opportunity to discuss any issues arising.

There was evidence that pre-admission assessments were carried out to ensure that the centre could meet the needs of residents.

Residents' nutritional and hydration needs were met and residents confirmed that meals and meal times were an enjoyable experience. Residents' weights were recorded on a monthly basis and more regularly when clinical needs indicated. Nutritional assessments and care plans were in place that outlined the recommendations of dietitians and speech and language therapists where appropriate. Throughout the inspection residents were seen to be provided with regular snacks and drinks. Wounds were appropriately managed. Post-fall reviews were carried out with multi-disciplinary input.

The atmosphere in the centre was calm, friendly and welcoming. Residents said they felt safe in the centre and were well cared for. The inspector observed that staff had a positive attitude and spoke to residents in a kind and respectful way. Residents could exercise choice in relation to activities, food, and the time to get up or go to bed. This was also confirmed by the residents and relatives who spoke with the inspector.

Residents with responsive behaviours (how people with dementia may communicate physical and psychological discomfort) had appropriate and personalised plans in place to inform care delivery, which contained background personal information to assist communication. There was a policy and procedure in place to guide staff on meeting the needs of residents with responsive behaviours and staff were knowledgeable of residents' needs and provided positive behavioural interventions and supports. Staff were seen to reassure residents and divert attention appropriately to reduce residents' anxieties.

The restraints register was reviewed weekly and there were daily checks in place to ensure residents' safety was maintained. However, at the time of inspection, 11 residents were using bedrails on a regular basis. This amounted to half of the residents in the centre. Bedrails were only used following a risk assessment and had associated care plans in place. However in many instances, the risk assessment stated that alternatives to bedrails had not been trialled due to unavailability of resources such as low-low beds and sensor mats. This was not in line with local and national policy and was not in accordance with the inspector's findings on the day, whereby such resources were available. Staff's understanding on the use of restraints required review to ensure bedrails were only used as a last option and for the least amount of time.

Overall, the inspector was satisfied that risk was well managed, reported and appropriately escalated. The follow up from the previous inspection in relation to the location of the oxygen cylinders had been completed. The accident and incident logs showed that immediate action was taken in response to any identified risk. The inspector noted a low-low bed stored on a corridor, next to a residents' room. While

it did not obstruct movement or any exits, the inspector commented on the inappropriate location and storage of equipment. The person in charge confirmed that it was only used for training purposes and the bed was immediately removed. Appropriate assistive equipment to meet residents needs such as hoists, seating, specialised beds and mattresses was available.

The emergency plan and evacuation procedures were prominently displayed and staff were knowledgeable and had the mandatory training up to date. The fire register was regularly updated. Fire-fighting equipment was serviced annually and there were quarterly checks of fire alarms and emergency lighting. Routine checks were completed on unobstructed escape routes, automatic door close and that fire-fighting equipment was in place and intact. Fire drills occurred bi-annually as per local policy. There was evidence of simulated night-time fire drills and comprehensive information recorded on the performance of staff. Any improvements identified in the fire drills were followed up and acted on.

Regulation 11: Visits

Visitors were welcomed and encouraged to participate in residents' lives. A separate visitors room was available for the residents who wanted to meet their visitors in private.This had been an action from a previous inspection.

The inspector noted a sign at the entry in the designated centre indicating restrictions on visiting hours, however both residents and relatives confirmed that this was not enforced and they could come and go as they pleased. The person in charge informed the inspector that the notice had been left in place following an infection outbreak and it will be removed.

A directory of visitors was also available.

Judgment: Compliant

Regulation 20: Information for residents

Information was available for residents in the residents' guide as per regulatory requirements and opportunities for resident feedback were facilitated and confirmed. Residents' meetings occurred on a regular basis and issues arising from these meetings were followed up.

Judgment: Compliant

Regulation 25: Temporary absence or discharge of residents

There were processes in place to ensure that when residents were admitted, transferred or discharged, relevant and appropriate information about their care and treatment was shared between providers and services. Discharges were safe and planned at multi disciplinary case reviews.

Judgment: Compliant

Regulation 26: Risk management

There was a risk management policy in place and a range of procedures to guide and inform staff on how to manage varied risk situations. There was a risk register which was reviewed regularly and set out the control measures to mitigate most risks identified in the centre. An accident and incident log was maintained for residents, staff and visitors. The inspectors saw that the centre was free from trip hazards and that cleaning activities were undertaken safely. Moving and handling practices were noted to be safe and to meet good practice standards.

The hoists and assistive equipment were regularly serviced, in working order and stored safely in the centre. The centre had an up to date Health and Safety Statement.

Judgment: Compliant

Regulation 28: Fire precautions

All staff were knowledgeable and trained in fire safety. The fire procedures and evacuation plans were prominently displayed throughout the centre and the fire safety equipment including emergency lighting, smoke detectors and fire alarm were regularly serviced and tested. Residents had a personal emergency evacuation plan in place. Fire exit signage was available. Staff confirmed that they had taken part in fire drills and there was documentary evidence to support this.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

The inspector noted inconsistent practices in relation to care planning and care

planning documentation. The whole process required full review and increased oversight to ensure it met residents' needs, particularly at a time of transition in the record system used.

Some care plans were personalised and the documentation included appropriate assessment, treatment plans, reviews/reassessment and consultation with residents and their family. They reflected residents' changing needs and outlined the supports required to maximise the quality of their lives in accordance with their wishes.

Other care plans however, were generic and the assessment and review processes in place were insufficient to deliver good quality care.

There was also evidence of substandard practices in relation to care planning arrangements, which included a resident who did not have any care plans in place for more than four days.

Judgment: Not compliant

Regulation 6: Health care

Residents healthcare needs were met to a high standard. Residents had access to their own general practitioner and also a variety of allied health professionals such as physiotherapists, occupational therapists, dietitans, podiatrist, speech and language therapists and clinical nurse specialists in tissue viability, continence and dementia care. Out of hours GP services were also available.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Responsive behaviours associated with the care of residents with dementia were well-managed. Behaviour management plans were in place to guide staff on how to positively respond to such behaviours. Good practices were observed and correlated with the individual care plans. Throughout the two days, the inspector witnessed positive connections between staff and residents. De-escalation and diversional strategies were used in the least restrictive manner.

The use of bedrails however required review in relation to staff's knowledge, assessment and alternatives trialled prior to their use. This would ensure that the centre operated in line with national policy of working towards a restraint-free environment.

Judgment: Substantially compliant

Regulation 8: Protection

Residents felt safe and staff spoken with were clear of what actions to take if they observed, suspected or had abuse reported to them. Advocacy services were available when required. A record of all visitors was maintained at the entry in the centre to ensure the safety of the residents.

The inspector saw satisfactory evidence that incidents of alleged abuse were appropriately investigated and reported to the relevant authorities. The majority of staff had attended training in safeguarding vulnerable adults, and the person in charge was in the process of becoming a facilitator in the provision of this type of training.

The registered provider did not act as a pension-agent for any of the residents and did not handle any financial transactions.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Not compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 32: Notification of absence	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Regulation 33: Notification of procedures and arrangements for periods when person in charge is absent from the designated centre	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 20: Information for residents	Compliant
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 26: Risk management	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Dungloe Community Hospital OSV-0000618

Inspection ID: MON-0025043

Date of inspection: 09/07/2019

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: All vacant staffing positions are escalated to the Service Manager for approval to fill. Presently 3 staff nurse posts await approval at National level.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The Director of Nursing is co-facilitating a Safeguarding Training Day on 16/08/19, which will permit her to become an approved Safeguarding Facilitator (SGF). The identified staff not yet updated in Safeguarding are to attend this training session on 16/08/19 and all other future training will be done on site by the SGF. Updated training session on restrictive practice will be rolled out to all staff by Dec '19.	
Regulation 19: Directory of residents	Not Compliant
Outline how you are going to come into compliance with Regulation 19: Directory of residents:	

The Directory of Residents book has been purchased as is now utilised since July '19

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Hire B forms are forwarded to the Service Manager for approval when staff requires replacing. Risk Assessments are completed and escalated to the Service Manager when staff shortages arise. Beds closed when required and approved to ensure residents and staff safety, and admissions from Community & Acute Services postponed.

Presently 3 Staff Nurses posts forwarded to National level for approval.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
All outstanding notifications have now been forwarded to HIQA since July. In addition the Director of Nursing and Administrative Staff have been set up on the HIQA portal since 24/7/19, this will ensure timely submission of all future HIQA notifications.

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
A Policy Group has resumed for Social Care Services, a Staff Nurse from Dungloe Community Hospital has been nominated to sit on this Policy Group. Any out of date policies have now been identified and forwarded to the Committee for review and updating. Two policies have currently been updated since the inspection.

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
A new electronic record system had just been implemented at the time of the inspection, protected time is now allocated daily for Nursing Staff to complete their Care Plans and nursing documentation. Staff Nurses have also access to the two link nurses who received additional training in the new Carenotes System.

Clinical audits which include Care Plans are planned for 8/8/19, this will aid to identify shortfalls and an action plan will be drawn up. Audits now planned to be completed on a two monthly basis.

The resident identified at the time of the inspection has now a robust plan of care in place.

Regulation 7: Managing behaviour that is challenging	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
Updated sessions on restrictive practice and the restraint policy to be rolled out to all staff. These sessions to be completed by December 2019.

The number of bedrails in the centre have been re-assessed and removed since the inspection took place and this is an ongoing process.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	30/11/2019
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Yellow	16/08/2019
Regulation 19(1)	The registered provider shall establish and maintain a Directory of Residents in a designated centre.	Substantially Compliant	Yellow	31/12/2019
Regulation 19(3)	The directory shall include the information	Not Compliant	Orange	31/07/2019

	specified in paragraph (3) of Schedule 3.			
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	30/11/2019
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Substantially Compliant	Yellow	31/12/2019
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence.	Not Compliant	Orange	31/07/2019
Regulation 31(3)	The person in charge shall provide a written report to the Chief Inspector at the end of each quarter in relation to the occurrence of an incident set out in paragraphs	Not Compliant	Orange	31/07/2019

	7(2) (k) to (n) of Schedule 4.			
Regulation 31(4)	Where no report is required under paragraphs (1) or (3), the registered provider concerned shall report that to the Chief Inspector at the end of each 6 month period.	Not Compliant	Yellow	31/07/2019
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Not Compliant	Orange	31/12/2019
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.	Not Compliant	Orange	31/10/2019
Regulation 5(3)	The person in charge shall prepare a care plan, based on the	Not Compliant	Orange	31/07/2019

	assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.			
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.	Substantially Compliant	Yellow	31/12/2019