

# eDeposit Ireland

**Gahan House, High Street, Graiguenamanagh, Kilkenny**

Item Type	report
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**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Gahan House
<b>Centre ID:</b>	OSV-0000545
<b>Centre address:</b>	High Street, Graiguenamanagh, Kilkenny.
<b>Telephone number:</b>	059 972 4404
<b>Email address:</b>	mmulligangahanhouse@eircom.net
<b>Type of centre:</b>	Health Act 2004 Section 38 Arrangement
<b>Registered provider:</b>	Graiguenamanagh Elderly Association Limited
<b>Provider Nominee:</b>	Val Lonergan
<b>Lead inspector:</b>	Ide Cronin
<b>Support inspector(s):</b>	None
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	12
<b>Number of vacancies on the date of inspection:</b>	0

## 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: 14 March 2017 09:45 To: 14 March 2017 15:45

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

<b>Outcome</b>	<b>Our Judgment</b>
Outcome 02: Governance and Management	Non Compliant - Major
Outcome 03: Information for residents	Compliant
Outcome 05: Documentation to be kept at a designated centre	Non Compliant - Moderate
Outcome 07: Safeguarding and Safety	Compliant
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 11: Health and Social Care Needs	Compliant
Outcome 12: Safe and Suitable Premises	Compliant
Outcome 13: Complaints procedures	Compliant
Outcome 18: Suitable Staffing	Non Compliant - Moderate

**Summary of findings from this inspection**

This monitoring inspection was unannounced and took place over one day. The purpose of this inspection was to monitor on going compliance with the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and the National Standards for Residential Care Settings for Older People in Ireland (2016).

The inspector also followed up on areas of non-compliance identified at the previous inspection which took place in August 2016. As part of the inspection, the inspectors met with residents, and staff members observed practices and reviewed documentation such as policies and procedures, staff rosters, care plans, medical records and risk management processes. The provider nominee and person in charge were both on leave on the day of inspection and the inspection was facilitated by the assistant manager and the nurse on duty. It was found that some progress was made by the provider in implementing the required improvements identified in the last inspection but some of the failures found at that time were again evident on this inspection particularly relating to the effective governance of the centre.

Non-compliances associated with governance and management, risk management,

and inadequate recruitment procedures were found. This did not support the provision of a quality and safe service which was sufficiently robust to meet the needs of individual residents. The findings of this inspection were discussed at length with the assistant manager, nurse on duty and a representative of the board who acknowledged the inspection findings.

The Action Plan at the end of this report identifies areas where improvements are required to comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Standards for Residential Care Settings for Older People in Ireland(2016)

**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 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):**

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

**Findings:**

On the previous inspection it was found that there were no audit reports available. There was no annual review of the service. There was no system in place for clearance from the Garda Vetting Bureau for volunteers. These actions remain outstanding at the time of this inspection.

On this inspection it was found that the management structure was adequately resourced. However, it was not defined in terms of roles, responsibility and clear lines of authority and accountability. It was not clear to the inspector that the governance systems in place demonstrated that the management team working within the service were aware of their responsibilities under the legislation. These findings are supported by the repeated non compliances identified in some outcomes and it was not demonstrated that there was a clear commitment by the management team to promote and strengthen a culture of quality and safety.

The inspector found that the current governance structure did not set out the lines of authority and accountability or stipulate individual accountability and specify details of roles and responsibility. The person in charge was not present on the day of inspection and the assistant manager was unable to retrieve some documents requested by the inspector. She was unaware that timescales had elapsed for some action plans particularly in relation to Garda vetting of volunteers. She informed the inspector that she was unclear of her role and her responsibilities as she did not have individual accountability for certain aspects of the service. Therefore, the inspector formed the judgement that key information pertinent to the operation of the centre was not shared among the relevant people participating in the management of the centre. Staff were unaware of the content of the last inspection report and it was not available either to residents or staff.

There were three volunteers working in the centre. Following the inspection of 8 August 2016, HIQA issued two action plans to source Garda vetting for all volunteers and agree and set out roles and responsibilities of volunteers in writing. The provider in their response to the action plan outlined that this would be completed by 30 November 2016. This action plan had not been progressed within the agreed timelines. The inspector saw that Garda vetting for one volunteer had been received on 19 January 2017 and there was no evidence in the files in relation to Garda vetting being submitted or processed for the other volunteers. One volunteer had their role and responsibilities set out. However, it had not been agreed or signed off by the provider or the volunteer. The inspector was informed that the volunteers had not been working in the centre since Christmas. This is actioned under outcome 18: Staffing.

The provider had engaged an external consultant to develop a quality management system including policies and procedures and audit templates. While audits were being completed on a monthly basis the inspector found that some audits were not specific to the client profile of residents living in the centre. Audits were not sufficiently detailed or broad enough to identify trends and current or future risks or where these may occur. Some of the audits viewed included some learning and actions required to improve practice. However, they did not always include the actions taken to address the problem identified, when the action was implemented or checked to determine effectiveness.

There was no annual review of the service available for 2016. The assistant manager was unsure whether or not it had been completed or if a copy of the review had been made available to residents.

On previous inspections the inspector has requested minutes of board meetings to be made available. To date, minutes have not been made available to the inspector therefore it was not possible to ascertain how leadership was demonstrated and the internal governance structure functions in relation to strategic and operational planning in relation to the delivery of a safe, effective person-centered service for residents. This is actioned under Outcome 5.

The inspector saw that weekly meetings took place between the person in charge and senior team. There had been one staff meeting held since the last inspection. Documentary evidence of consultation with residents and/or their representatives was limited. The most recent residents' meeting had been held in December 2016 and residents told the inspector that they were very happy in the centre.

The inspector observed that appraisals were carried out. However, records viewed were not signed by the manager or staff member and some did not identify ongoing training or development opportunities which would maintain staff competence in all relevant areas.

**Judgment:**  
Non Compliant - Major

***Outcome 03: Information for residents***

***A guide in respect of the centre is available to residents. Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.***

**Theme:**

Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**

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

**Findings:**

Only the component of the Residents' Guide was considered as part of this inspection. A Residents' Guide and information brochure was available which included a summary of the services and facilities provided. The Residents' Guide included useful information about the local community. The inspector observed that copies were available in the reception area. On the previous inspection it was found that the Residents' Guide did not contain the following information::

- Procedure respecting complaints
- arrangements for visits
- terms and conditions relating to residence in the centre.

The inspector reviewed the Residents' Guide on this inspection and found that the Registered Provider had amended the document to include the information that was required since the previous inspection.

**Judgment:**

Compliant

***Outcome 05: Documentation to be kept at a designated centre  
The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.***

**Theme:**

Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**

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

**Findings:**

Information governance still required improvement. The inspector found that either

some records were not available on site for inspection purposes or records that were requested by the inspector were not retrievable. All of the policies as listed in Schedule 5 of the regulations were in place.

Improvements were still required in Schedule 2 records – the documents to be held in respect of staff employed, were available but in the sample of files examined some information needed reorganisation to ensure ease of retrieval of the required information. In a sample of four staff files reviewed by the inspector there was no photographic identification in a file and in another file there were no references present as required by the regulations. These actions remain outstanding since the previous inspection. The assistant manager assured the inspector that all staff were Garda vetted.

**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):**

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

**Findings:**

The inspector found that measures were now in place to protect residents from harm or suffering abuse and to respond to allegations, disclosures and suspicions of abuse.

There was a policy in place covering the prevention, detection, reporting and investigation of allegations or suspicion of abuse. It incorporated the national policy on safeguarding vulnerable persons at risk of abuse. For the most part training records confirmed that staff attended the mandatory training in safeguarding. Seven staff were still outstanding and had been scheduled for training in April 2017. Staff spoken to by inspectors confirmed that they had received training on recognising abuse and were familiar with the reporting structures in place. There was a nominated person to manage any incidents, allegations or suspicions of abuse.

The assistant manager informed the inspector that there were no residents who displayed responsive behaviours. There was a policy on dementia care which incorporated aspects of responsive behaviours. The inspector saw that there was good access to mental health services within the area. Training in the management of responsive behaviours had been provided for 15 staff since the last inspection.

There was a policy now available on restraint but the practice in the centre was one of a restraint free environment. The inspector saw that restraint was not common place in the centre and none were in use on this inspection and no restraint use were notified in the last quarter of 2016.

The financial controls in place to ensure the safeguarding of residents' finances were not assessed on this inspection as this line of enquiry was compliant on the previous inspection. Residents continue to manage their own finances. Each resident had their own personal lockable storage in their bedroom.

**Judgment:**

Compliant

***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:**

On the previous inspection it was found that there was a risk management policy and a risk register in place. However, it did not meet regulatory requirements as it did not have the measures in place to control the following specified risks:

- accidental injury to residents, visitors or staff
- self-harm

On this inspection it was found that the risk management policy was in accordance with the regulations. However, the inspector saw that the policy was not implemented in practice. Due to the lack of a hazard identification process, hazards were not being identified nor was there evidence of sufficient formal processes in place to address any risks arising. This highlights a culture within the centre where staff were not proactively engaged in hazard identification and mitigation of risks. Accidents and incidents were recorded. However, the inspector did not observe an effective system in place for investigating and learning from incidents.

There was an emergency plan formulated in relation to fire, all emergency situations and where residents could be relocated to in the event of being unable to return to the centre. Clinical risk assessments were undertaken, including falls risk assessment, assessments for dependency, continence, nutrition, moving and handling. There was a safety statement in place dated August 2015.

Fire safety measures were in place. A staff member had responsibility for ensuring that fire safety management was up-to-date. A procedure for the safe evacuation of

residents in the event of fire was displayed and all fire detecting equipment had been serviced. Training records viewed confirmed that staff had received formal fire safety training and there was an on going training plan in place. There was an effective programme in place for the servicing fire fighting equipment and checking of all fire doors.

The inspector saw that fire drills took place at least every six months and all staff were facilitated to attend. Residents also participated in the unannounced fire drills the last one took place in October 2016. Records of daily, weekly and monthly fire checks were made available to the inspector. These checks included inspection of the fire doors, fire extinguishers, escape routes, fire panel and emergency lighting.

A personal emergency evacuation plan (PEEP) was seen to have been developed for all residents. The PEEPs were detailed and outlined any mobility, visual, cognitive and auditory impairments of each resident and the supports required for evacuation. The PEEPs were updated by the nurse to reflect any changes in a resident's condition. A summary of the PEEPs had also been developed to serve as a quick reference guide for staff.

Training in moving and handling of residents remains outstanding for some staff. The assistant manager told the inspector that this training had been scheduled. Residents were promoted to maintain their independence when mobilising. The inspector observed that residents did not have routine manual handling requirements. The centre was found to be visibly clean and clutter free.

**Judgment:**

Non Compliant - Moderate

***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):**

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

**Findings:**

On the previous inspection it was found that there was no documentary evidence of consultation with residents in the development and review of care plans. This action plan had been completed. In the sample of care plans reviewed by the inspector it was evident that there was consultation with residents/relatives in the development and

review of care plans.

Residents had been assessed as not requiring full time nursing care. A nurse was employed who attends the centre for 10 hours per week over two days. Additional care hours could be made available as required, for example if a resident was receiving palliative care.

A number of GPs attended residents in the centre and an "out of hours" GP service was available if required. The records confirmed that residents were assisted to achieve and maintain the best possible health through quarterly medication review, blood profiling if required and annual administration of the influenza vaccine. Residents were referred as necessary to the acute hospital services and there was evidence of the exchange of comprehensive information on admission and discharge from hospital. In line with their needs, residents had on going access to allied healthcare professionals including dietetics, speech and language therapy, diabetic clinic, chiropody and physiotherapy.

The inspector reviewed a sample of care plans which included end of life and dementia care. There was evidence of a pre-assessment undertaken by the nurse and a member of care staff prior to admission for residents. Following admission, there was a documented comprehensive assessment of all activities of daily living, including communication, social care needs, mobility, elimination, personal hygiene, nutrition and sleep. This assessment was reviewed and updated at least every four months or in line with a resident's changing condition.

Residents' social care needs were met and residents had opportunities to participate in meaningful activities, appropriate to their interests and preferences. A social care plan was developed for each resident on admission and updated on a monthly basis. The social care plan outlines residents' social contacts and the hobbies and activities they enjoy.

There were activities offered including gentle exercise, arts and crafts, matinée afternoon, gardening and live music. Healthcare staff had responsibility for directing activities. Residents were facilitated to attend activities external to the centre if they wished. Day trips out were organised such as trips to the local garden centre or shopping. Some residents enjoyed going for drives when the weather was good.

**Judgment:**

Compliant

***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

<p><b>Outstanding requirement(s) from previous inspection(s):</b> The action(s) required from the previous inspection were satisfactorily implemented.</p> <p><b>Findings:</b> Only the components of the previous inspection were considered as part of this inspection. On the previous inspection it was found that the sluice room was not finished as equipment had not been installed nor had the floor covering been replaced.</p> <p>Prior to this inspection the provider had submitted photographic evidence to indicate that this action had been completed. The inspector saw that the sluicing equipment was fully operational and floor covering had been replaced in some areas in the centre.</p>
<p><b>Judgment:</b> Compliant</p>

<p><b><i>Outcome 13: Complaints procedures</i></b> <b><i>The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.</i></b></p>
<p><b>Theme:</b> Person-centred care and support</p>
<p><b>Outstanding requirement(s) from previous inspection(s):</b> No actions were required from the previous inspection.</p> <p><b>Findings:</b> The inspector viewed the policy and procedure for making, investigating and handling complaints. The complaints process was displayed in an accessible position in the centre. There was a nominated person to deal with complaints in the centre.</p> <p>The inspector reviewed the complaints log and found that there were no complaints logged. However, the assistant manager outlined how complaints were generally responded too.</p>
<p><b>Judgment:</b> Compliant</p>

<p><b><i>Outcome 18: Suitable Staffing</i></b> <b><i>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</i></b></p>
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***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):**

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

**Findings:**

There was a planned and actual staff roster in place which showed the staff on duty during the day and night. Based on observations, a review of the roster and these inspection findings, the inspector was satisfied that the staff numbers, qualifications and skill-mix were appropriate to meeting the number and assessed needs of the residents. A record of resident dependency levels, the staffing levels and training programmes were maintained.

Staff training records demonstrated some commitment to the on going maintenance and development of staff knowledge and competencies. Further education and training completed by staff this year to date included responsive behaviours and first aid. As outlined under Outcome 7 and 8 mandatory training in relation to elder abuse and manual handling was not up-to-date. Staff appraisals had been completed but were not in-line with best practice as outlined under Outcome 1.

Residents spoke positively about staff and indicated that staff was caring, responsive to their needs, and treated them with respect and dignity. Good interactions were observed between staff and residents who chatted with each other in a relaxed manner. Staff spoken with were knowledgeable of residents' individual needs. There were adequate staff supervising the dining room during lunch. There was evidence of communication meetings between senior staff in the centre. There has been one staff meeting since the previous inspection. Staff told the inspector that they did not have access to relevant guidance from Government or statutory agencies in relation to older people for example the staff member with responsibility for fire was not aware of the fire safety guidance issued by HIQA.

There were no volunteers in the centre on the day of inspection. However, the assistant manager, nurse and provider representative were informed again of the vetting procedures that need to be in place should volunteers become part of the team

**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:***

Ide Cronin  
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<sup>1</sup>

<b>Centre name:</b>	Gahan House
<b>Centre ID:</b>	OSV-0000545
<b>Date of inspection:</b>	14/03/2017
<b>Date of response:</b>	03/04/2017

### 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 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 found that the current governance structure did not set out parameters of authority and accountability or stipulate individual accountability and specify roles and accountability.

#### **1. Action Required:**

Under Regulation 23(b) you are required to: Put in place a clearly defined management

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

structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

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

A review of the current governance arrangements will be carried out to clearly define the management structure and identify lines of authority and accountability across all areas of service provision.

**Proposed Timescale:** 30/04/2017

**Theme:**

Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Audits were not sufficiently detailed or broad enough to identify trends and current or future risks or where these may occur

**2. 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:**

The current system for auditing will be revised to reflect a more centre specific approach to quality management.

**Proposed Timescale:** 31/03/2017

**Theme:**

Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The annual review for 2016 was not available in the centre.

**3. Action Required:**

Under Regulation 23(d) you are required to: Ensure there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.

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

The annual review for 2016 has been completed and submitted to the Health Information and Quality Authority. This has been made available for residents, staff and visitors.

**Proposed Timescale: 27/03/2017**

**Theme:**

Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The inspector observed that the annual review for 2015 was not available to residents.

**4. Action Required:**

Under Regulation 23(f) you are required to: Make available a copy of the review referred to in regulation 23(d) to residents and, if requested, to the chief inspector.

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

The annual review for 2015 has been made available for residents, staff and visitors.

**Proposed Timescale: 24/03/2017**

**Outcome 05: Documentation to be kept at a designated centre**

**Theme:**

Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

In a sample of four staff files reviewed by the inspector there was no photographic identification in a file and in another file there were no references present as required by the regulations.

**5. Action Required:**

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

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

A review of the staff files will be completed to ensure that all documentation required is in place.

**Proposed Timescale: 30/04/2017**

**Theme:**

Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Ensure that all records such as minutes of board meetings are available for inspection.

**6. Action Required:**

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

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

The Minutes of Board of Management meetings will be held on site for future inspection purposes.

**Proposed Timescale:** 30/04/2017

**Outcome 08: Health and Safety and Risk Management**

**Theme:**

Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Staff were not proactively engaged in hazard identification and risk assessment.

**7. Action Required:**

Under Regulation 26(1)(b) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the risks identified.

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

A full review of the risk management system will be carried out to address these issues.

**Proposed Timescale:** 31/05/2017

**Theme:**

Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The inspector did not observe an effective system in place for investigating and learning from incidents.

**8. Action Required:**

Under Regulation 26(1)(d) you are required to: Ensure that the risk management policy set out in Schedule 5 includes arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents.

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

The current system will be reviewed to identify aspects which need to be addressed.

**Proposed Timescale:** 31/05/2017

**Outcome 18: Suitable Staffing**

**Theme:**  
Workforce

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

Ensure that all staff have up-to-date mandatory training as required by the regulations.

**9. 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:**

Staff training is ongoing over each 12 month period and will continue to be addressed across the year. Mandatory training will be prioritised for all staff during the next six months to achieve compliance.

**Proposed Timescale:** 31/10/2017

**Theme:**  
Workforce

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

Staff told the inspector that they did not have access to relevant guidance from Government or statutory agencies in relation to older people.

**10. Action Required:**

Under Regulation 16(2)(c) you are required to: Make copies available to staff of relevant guidance published from time to time by Government or statutory agencies in relation to designated centres for older people.

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

Relevant guidance documentation has been made available to the staff.

**Proposed Timescale:** 31/03/2017

**Theme:**  
Workforce

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

Ensure that all volunteers have their roles and responsibilities set out and agreed in

writing.

**11. Action Required:**

Under Regulation 30(a) you are required to: Set out in writing the roles and responsibilities of people involved on a voluntary basis with the designated centre.

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

All three volunteers who come on a weekly basis to play bingo with the residents have their roles and responsibilities set out and agreed in writing.

**Proposed Timescale:** 31/03/2017

**Theme:**

Workforce

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

Garda vetting disclosures had not been provided for all volunteers.

**12. Action Required:**

Under Regulation 30(c) you are required to: Provide a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 for people involved on a voluntary basis with the designated centre.

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

All three volunteers who come on a weekly basis to play bingo with the residents have completed the vetting process.

**Proposed Timescale:** 31/03/2017