Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	Aras Ghaoth Dobhair
Name of provider:	Bainistiocht Aras Gaoth Dobhair Cuideachta Faoi Theorainn Rathaiochta
Address of centre:	Meenaniller, Derrybeg, Letterkenny, Donegal
Type of inspection:	Unannounced
Date of inspection:	21 September 2023
Centre ID:	OSV-0000311
Fieldwork ID:	MON-0041395

About the designated centre

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

This centre is a purpose-built single-storey building located in Gweedore, a Gaeltacht area in Co. Donegal. The centre has been operating since 2004 providing continuing, convalescent and respite care to male and female residents primarily over 65 years with low-to-maximum dependency needs. The centre is registered for 41 residents to be accommodated. Communal day, dining and sanitary facilities were available in addition to 25 bedrooms with full en-suite facilities within two distinct units. The dementia unit can accommodate 20 residents and the general unit can accommodate 21 residents. Bedroom accommodation comprises of 17 single, four twin and four bedrooms with four beds in each. An aim of the service is to provide a caring environment where residents feel supported and valued, and where their primary needs can be met in a warm homelike atmosphere without undermining their dignity, privacy or choice. An objective of the service is to provide a high standard of care and treatment in keeping with best practice and current legislation, to dependent people who can no longer live at home.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	40

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
Thursday 21 September 2023	10:00hrs to 18:00hrs	Nikhil Sureshkumar	Lead
Friday 22 September 2023	09:00hrs to 17:00hrs	Nikhil Sureshkumar	Lead

What residents told us and what inspectors observed

Overall, the residents provided positive feedback regarding the care and service they received at the centre. The inspector observed that the staff, along with the newly appointed person in charge, were working to enhance the residents' quality of life. However, significant focus is now required to strengthen the leadership arrangements in the centre to ensure that the service provided to the residents is safe and effective.

Residents who spoke with the inspector expressed their positive experience in the centre. Some comments included, "this is a good centre," "staff are kind, and they help me at all times." One resident particularly enjoyed the activities in the dementia-specific unit and preferred to spend their time in the day room of the dementia-specific unit. The inspector also reviewed the recent residents' meeting minutes, where some residents had commented that they enjoyed the recent outdoor activities, the food served in the centre, and that they were happy about the staff.

The designated centre is situated in Derrybeg and is in a single-story building. It is divided into two units, namely the dementia-specific unit and the general unit, and offers outdoor and enclosed gardens to support the residents. Following an introductory meeting with the person in charge, the inspector went for a walk around the centre.

The centre's enclosed garden areas were accessible to residents without any restrictions, and this was an improvement since the previous inspection in the centre.

The inspector observed that the premises were generally clean and tidy; however, the storage of equipment in the corridors of the dementia-specific unit posed a trip hazard for residents in this area. This was a repeated finding from the previous inspection.

During the inspection, the inspector visited some of the bedrooms in both units and observed that the residents' bedrooms were personalised and had enough secure space to store their belongings. The residents' clothes were laundered externally, and they had easy access to their clothes.

The centre had a quiet atmosphere, and the ambience of the dementia-specific unit had hugely improved since the last inspection. However, the schedule of planned activities was kept in the office and was not made available for residents to see and let them know what activities were planned for the day. This was brought to the attention of the person in charge, and on the second day of inspection, an activity schedule was made available for the residents.

The inspector observed that the residents of the dementia-specific unit were

supported to take part in group activities. Furthermore, some residents from the other unit were also brought to the dementia-specific unit to engage in meaningful activities.

On the first day of inspection, a mass was scheduled, and a priest visited the residents. The inspector was informed that this was the first time a priest had visited the centre since the start of the COVID-19 pandemic, and it was a very important milestone in the centre's return to normal weekly contact with their community. The inspector was informed that the provider was making arrangements to regularise the visits by a priest.

The provider had coordinated with the local fire authority to conduct fire safety works at the centre during the week of the inspection. However, the residents and their families had not been informed about the planned building refurbishment plans, which were about to commence in the centre. This was discussed with the provider following the inspection, and written and verbal communications were issued to residents and/or their families.

The provider had recently conducted satisfaction surveys for both residents and their family members, and the inspector reviewed some completed questionnaires. The residents' comments in the surveys were overwhelmingly positive about the care provided in the centre. However, some family members expressed dissatisfaction with the care and with staff communication. Although the survey results had been reviewed by the management team, it was unclear how the provider planned to address these issues raised by the family members.

During the inspection, the inspector observed that some staff and some visitors in the centre were wearing face masks. This practice was inconsistent and did not reflect current guidance, as the centre was not experiencing an outbreak at the time of the inspection. While family visits were permitted, residents' family members were also required to wear face masks. The inspector observed that this restriction made it difficult for residents to communicate effectively with their family members, especially for those with hearing impairments.

There were sufficient numbers of staff on duty. Communal areas in the dementia-specific unit and the general unit were supervised at all times, and staff were observed to be respectful and kind in their interactions with the residents. Call bells were observed to be attended to in a timely manner. Staff practices in moving and handling residents were in line with good practice and ensured the safety and comfort of the residents.

Staff members who spoke with the inspector demonstrated good knowledge about the residents and their social care needs. However, it was observed that the dietary needs of several residents had not been effectively communicated to relevant staff members. As a result, some staff members were unaware of the dietary needs of newly admitted residents, which posed a potential risk to patient safety and continuity of care.

The inspector observed the residents' dining experience. There was a choice of meals available to the residents in both units, and residents had access to snacks

and drinks outside of their regular mealtimes. The inspector observed that there was adequate staff to support the residents during meal times.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impacted the quality and safety of the service being delivered.

Capacity and capability

Overall, significant focus and efforts were required from the provider to develop strong leadership and governance arrangements to ensure a good quality and safe service was being provided in the centre. At the time of the inspection, the centre was undergoing changes in leadership, and significant improvements were required in areas of governance and management, training and staff development and management of complaints in the centre.

This unannounced risk inspection was carried out over two days to follow up on the statutory notifications and a high volume of unsolicited information received in the Chief Inspector's office since the previous inspection in the centre. A number of these concerns were in relation to the provider's governance and management arrangements in the centre and were found to be validated on this inspection.

The provider of the centre is Bainistiocht Aras Gaoth Dobhair Cuideachta Faoi Theorainn Rathaiochta, which is a voluntary board consisting of seven members. The person in charge of the centre was recently appointed and had the required experience and a management qualification to meet the regulatory requirements. The person in charge reported to the provider representative, who also serves as the chairman of the board. There was a weekly reporting system in place, through which the person in charge kept the representative of the provider informed of day-to-day issues, complaints, staffing and key performance indicators such as incidents, including safeguarding incidents that occurred in the centre.

At the board level, the provider's management structure was clear; however, the roles and functions of the various sub-committees were less clear. These sub-committees had been created by the provider to support the board's functioning and decision-making; however, the communication structures between the board and the sub-committees were not clearly defined. Furthermore, they were not clearly set out in the centre's statement of purpose. During the inspection, the provider informed the inspector that the subcommittees included a finance subcommittee, a clinical governance subcommittee, a human resources (HR) subcommittee, and a community engagement sub-committee. However, some board members and the person in charge were not aware of the existence of the HR subcommittee and the community engagement sub-committee.

The inspector requested to review the records of the sub-committee meetings, and it was found that the sub-committee members did not meet regularly, and no

meeting records were kept. Consequently, it was unclear how these sub-committees functioned. Moreover, the inspector observed that the oversight arrangements to support the person in charge and residents' finances through the sub-committee structures were ad hoc in nature and were not effective in supporting the staff and the management team working in the centre. The provider had not also appointed a general manager in line with the assurances provided to the Chief Inspector in 2022. This was found to be a significant shortcoming in the provider's management structure.

There were oversight and audit processes in place; however, these were not being implemented, and as a result, the provider's current management systems did not ensure the quality and safety of the service being offered to the residents. This is further discussed under Regulation 23.

The inspector reviewed a record of incidents that occurred at the centre and found that the provider had failed to submit a statutory notification to the Chief Inspector regarding one safeguarding incident. The provider was required to submit a notification regarding this safeguarding incident, which they submitted following the inspection.

A schedule of staff training programmes was available in the centre. However, the training matrix indicated that not all staff were up to date with mandatory training, such as patient moving and handling and infection prevention and control training, in line with the provider's own policy.

Furthermore, the staff supervision in the centre required significant improvement to ensure continuity of care for the residents, and this is further discussed under Regulation 16: Training and Staff Development.

The provider had not developed a robust complaints procedure, and the complaint procedure that was available to residents did not meet the requirements of Regulation 34.

The inspector reviewed a sample of staff files, which showed that staff were Garda-vetted before they commenced their employment in the centre. Staff absences on the day of inspection were covered. The provider reported two staff vacancies, and the recruitment files indicated that recruitment was ongoing and these staff were awaiting Garda vetting. There was a rolling campaign available to address any potential staffing vacancies in the centre.

Regulation 14: Persons in charge

The person in charge met the requirements of the regulations. They worked full time in the designated centre and had responsibility for the day-to-day running of the designated centre.

Judgment: Compliant

Regulation 15: Staffing

The provider had kept the staffing resources of the centre under review, and the rosters reviewed on the day of inspection evidenced that there was a sufficient number of nurses, carers and ancillary staff on duty at all times in the centre.

Judgment: Compliant

Regulation 16: Training and staff development

A number of staff had not had appropriate training relevant to their respective roles in the centre. For example:

- Seven health care workers had not had up-to-date patient moving and handling training.
- 10 staff members had not attended Infection Prevention and Control training.
- Kitchen staff, care staff, and nurses had not been sufficiently trained regarding modified food. As a result, staff did not demonstrate knowledge about the specific risks associated with the use of high-risk consistency foods. As a result, residents who were on modified diet were not being offered appropriate food choices.

Staff supervision in the centre required additional improvement. For example:

- A number of residents' food preferences and recommendations from dietitians had not been sufficiently communicated to the kitchen staff. As a result, the kitchen staff did not have this important information about the recent admissions in the centre.
- Behavioural records for residents had not been completed following episodes of responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) in line with the recent instructions from the person in charge.

Judgment: Not compliant

Regulation 23: Governance and management

The management structure of the designated centre was not clear and insufficient.

For example:

- The provider's governance arrangements at the centre comprised a board of management, which was supported by a sub-committee structure. However, not all the members of the board were aware of the sub-committee structure and how these groups communicated with the board in order to make decisions in key areas such as finance, staff selection, recruitment and community engagement.
- The existence of two sub-committees was not clearly set out in the centre's statement of purpose.
- The provider had not appointed a general manager on a full-time basis for the governance and management of the centre in line with assurances provided to the Chief Inspector on 17 October 2022.

The provider failed to put appropriate management systems in place to ensure the service was safe and effectively monitored. For example:

- The oversight of safeguarding incidents was not robust and did not ensure that a recent safeguarding concern raised by a family of a resident was responded to in line with the requirements of the regulation and the centre's own safeguarding procedures.
- The oversight of the admission process was insufficient. For example, admission checklists that had been developed as a quality improvement measure following a recent safeguarding incident had not been consistently implemented in the centre.
- The provider did not have a coherent management plan in place to mitigate risks associated with the transmission of infections. For example, staff and visitors were observed using face masks on the days of the inspection, although there was no outbreak of COVID-19 in the centre. This arrangement was impacting on the residents' communication with their families. The provider explained that these precautions had been re-introduced because there was an increase in infections in the local community. However, the provider had not carried out an appropriate risk assessment prior to implementing these changes. Furthermore, the precautions were not being implemented consistently, as some staff and visitors did not wear face masks.
- The provider had not identified and made arrangements to manage the environmental risks the inspector identified on the day of inspection. For example:
    - Potential risks for Aspergillosis arising from the building work that was due to commence in the week following the inspection.
    - There was no plan in place to relocate residents to other bedrooms in the centre if they were impacted by the scheduled building works due to commence the following week.
- The current governance and management systems did not ensure that the person in charge was adequately supported by the provider. For example, the clinical governance committee and the financial subcommittees were established to support the person in charge in their respective roles. One of the committee members of the clinical sub-committee and the financial sub-committee acted as a point of contact for the person in charge. However,

these arrangements were ad hoc in nature, and the person in charge did not meet regularly with the appointed persons. As a result, some decisions were delayed, which impacted the quality and safety of care for residents. For example, the repair and replacement of equipment had not been carried out in a timely manner.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

The provider had not agreed in writing with each resident, on the admission of that resident to the designated centre concerned, the terms, including terms relating to the bedroom to be provided to a resident. For example, a number of short-stay residents did not have a contract in place.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The provider had not notified the Chief Inspector in writing about one safeguarding incident that had occurred in the centre.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The provider had not displayed a copy of an effective complaint procedure for dealing with complaints in a prominent position in the designated centre.

The provider had not updated the complaint procedure in the centre in line with the requirements of the regulation. For example, the provider's complaints procedure did not ensure the following:

- A written response to inform whether or not their complaint has been upheld and details of the review process.
- Identified a review officer to deal with the review of complaints in the centre.
- Established clear time frames to review complaints.

The provider had not ensured that all complaints in the designated centre were fully and properly recorded. For example, the provider's complaint procedure mentions that only written complaints will be treated as formal complaints and recorded in the

complaints folder. As a result, verbal complaints were not being recorded, and this information was not available for review and to identify trends or any issues that needed to be addressed through the centre's quality improvement plan.

The policy did not set out the provider's arrangements for ensuring that appropriate training would be provided for the nominated officer and the review officer to deal with the complaints.

The provider had not ensured that all staff were aware of how to identify a complaint. For example, a number of feedback questionnaires that were recently completed by the families regarding the quality and safety of service contained concerns regarding the service provided in the centre. This questionnaire received in the centre had not yet been analysed, and the concerns raised in the questionnaires had not been investigated, and actions had not been taken to address the issues.

Judgment: Not compliant

Quality and safety

The inspector noted that the care provided to the residents was generally of good quality; however, a series of actions were required by the provider to ensure the quality and safety of care and services for the residents, including improvements to the centre's premises, information available for residents, care planning, infection prevention and control, protection of residents and residents' rights.

The provider had identified a designated safeguarding officer and made arrangements to provide specialist training to ensure that any concerns or allegations of abuse that occurred in the centre were managed appropriately. Staff who spoke with the inspector were knowledgeable about how to report safeguarding concerns. The centre had a comprehensive safeguarding policy in place; however, this policy had not been implemented consistently. This is further discussed under Regulation 8: Protection.

The inspector reviewed a sample of care plans and noted that some residents' care plans were detailed and informative. However, some residents' food and nutrition care plans were not sufficiently developed to guide staff to provide safe and appropriate care.

Residents had timely access to general practitioners (GPs) from local practices, allied health professionals and specialist medical and nursing services.

Residents were found to have access to newspapers, radios, and televisions in the centre. Visits were happening in the centre, and two visitors spoke with the inspector and expressed high levels of satisfaction with the care and services their loved ones received. Residents' meetings were held regularly in the centre. However, the residents had not been informed about the building works that would

commence in the week following this inspection.

The provider had an information guide for residents, and this was placed in an accessible location for residents. However, the information guide had not been updated following recent changes in the regulations. This is discussed under Regulation 20: Information for residents.

Regulation 17: Premises

The premises of the centre did not currently conform to the matters set out in Schedule 6 of the Health Act (Care and Welfare Regulations 2013). For example, there was insufficient storage space to store clinical equipment in the centre. As a result, equipment such as hoists, transport wheelchairs, and zimmer frames were being stored inappropriately in a corridor in the dementia-specific unit, and this posed a trip hazard for residents who were able to access this area.

Judgment: Substantially compliant

Regulation 20: Information for residents

The provider had not updated the information guide for residents, and the guide did not contain the procedure in relation to complaints and the information regarding independent advocacy services, such as patient advocacy services.

Judgment: Substantially compliant

Regulation 27: Infection control

The provider had not ensured that procedures consistent with the standards for the prevention and control of healthcare-associated infections were fully implemented by staff. For example:

- The provider had some residents requiring full-body hoists for patient moving and handling. However, the slings used for full-body hoists were found to be shared between residents, and there were no systems in place to ensure that these slings were cleaned between each use. This posed a cross-contamination risk to residents.
- Several assistive chairs the residents used in the centre were visibly dirty and had not been sufficiently cleaned. This posed an infection risk to residents.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

The provider had not ensured that appropriate care plans were developed for residents following their admission to the designated centre. For example:

- Four resident's food likes and dislikes were not sufficiently detailed in their care plan.
- In addition, two residents' allergy information had not been included in their care plans or in their care files to prevent patient safety incidents from occurring.

Judgment: Substantially compliant

Regulation 8: Protection

The provider had not taken all reasonable precautions to protect the residents from abuse. For example:

- The inspector reviewed the record of incidents that occurred in the centre and found that the provider had not ensured that a safeguarding incident had been managed in line with the requirements of the regulation. For example, a preliminary investigation had not been completed within three days of the incident's occurrence, and the safeguarding team had not been notified about the incident within the required time frame.
- The provider did not take all reasonable measures to protect residents' finances in the centre. For example, a resident who was a ward of court did not have their pension monies directed towards the committee of the ward or to the resident's attorney before monies were taken out to provide for care and any other expenses that the resident incurred; instead, the monies were directed towards the centre's resident pension account that the provider was managing. This arrangement was not in line with the guidelines issued by the Department of Social Protection.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The residents and their families had not been consulted about and participated in the organisation of the designated centre. For instance, the provider had not

communicated with the residents and their families about the fire safety works that had been scheduled to begin in the week following the inspection.
Judgment: Substantially 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	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Substantially compliant
Regulation 31: Notification of incidents	Substantially compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 20: Information for residents	Substantially compliant
Regulation 27: Infection control	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Aras Ghaoth Dobhair OSV-0000311

Inspection ID: MON-0041395

Date of inspection: 22/09/2023

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Training is ongoing and updated as required for all staff. Manual handling and patient handling for the seven outstanding will be completed by 01/12/2023 Infection control training has been completed by all staff to include hand hygiene. Training for the IDDSI has been completed by all staff and staff are aware of all residents' dietary needs and preferences. A new procedure to communicate residents' food preferences and dietary needs has been implemented and is given to the kitchen staff every Monday along with any new respite residents that are admitted.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The previous plan to appoint a General Manager for administrative affairs proved unachievable. When the recruiter that we employed was not able to find a PIC, we reverted to the more traditional management structure. We recognise the need to devolve responsibility for non-clinical decisions from the PIC to other parties until she has accrued more experience of all clinical decisions and established her method of management effectively in Áras. The Clinical Management Sub-Committee will monitor the KPIs for the PIC and CNM1 which will be established by end Feb 2024.	

Other sub-committees, through the Chair, will provide additional support on non-clinical matters (where appropriate managing those matters in line with an overall agreed strategy for Áras) until responsibility for managing those affairs can be devolved to the Management Team. Enhanced administrative assistance (through the part-time deputy administrator) will provide logistical support for documentation and execution of non-clinical decisions and documentation reviews for accuracy and completeness to ensure that Standard Operating Procedures are being followed and that compliance can be demonstrated. It is intended that eventually the PIC and CNM1 will assume responsibility for all non-clinical matters but with a significant degree of devolution of authority to staff members best placed to drive forward progress in certain sectors. The length of time before that situation will be achieved has not been pre-determined and progress will be monitored by the Board. Reduction of support will occur over several years with no cliff-edge of support being withdrawn until all parties are satisfied that no further support is required.

We have enhanced the HR support being provided to the PIC and this now includes mentoring by a former PIC from another nursing home. HR support is provided by fortnightly (and sometimes weekly) reviews between the HR Consultant and PIC. The HR consultant will report progress at each Board meeting with a more comprehensive bi-annual report contributing to the review of the achievement of strategic goals which will have been identified by end Feb 2024.

The sub-committees are intended to be an aid to the Chair of the Board and to the Finance Sub-committee. They are not included in policies or the Statement of Purpose so as not to confuse a direct line of authority for staff, residents, or families - namely through the PIC to the Chair as the representative of the Board. Their role will be to report on visits to Aras and attendance at special functions and or any specific tasks allocated to them as required. They also report back on the community perception of Áras and the effectiveness of our actions to ensure families that their loved one are enjoying a happy and fulfilling experience with us. The sub committees, namely Finance, Clinical, Community Engagement and HR are advisory committees to the Board and Chair between board meetings, who may be called upon to consider issues relating to their terms of reference.
For all sub-committees:
• The Chair of the Board of Management shall be ex-officio a member of each sub-committee, but each sub-committee shall choose another member to act as chair during any meetings where the Chair of the Board is not in attendance.
• Term of office shall be three years or until the member leaves the board of Áras Gaoth Dobhair, whichever is sooner.
• Each sub-committee may co-opt external members should the need arise to provide specific skill sets, but such co-option must be ratified by the Board.
• Each sub-committee shall meet when required and report to the Board.
• Each sub-committee shall act as counsel to the Chair of the Board of Management in relation to the subject matter of their sub-committee.
• Each sub-committee shall give any advice to the Board as required.
• Each sub-committee shall undertake such duties as the Board may decide from time to time.
• Each sub-committee shall report on its activities to the Board at regular meetings and the Minutes of the Board meeting shall then constitute Minutes of the Sub-Committee.

The functioning of the Sub-Committees will be reviewed at least annually, or more often if any member of the Board seeks to place it on the agenda. Other specific matters where governance is indicated to be a contributory factor are dealt with under other headings in this response.

Regulation 24: Contract for the provision of services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 24: Contract for the provision of services: Contracts of care are being finalized, I received a template from NHI that I will incorporate into the current Aras contract of care then give it to residents and families.

Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents: Lessons learned from previous incident and the miscommunication with not notifying the chief inspector. We have a new auditing system that records complaints and incidents.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure: A new complaints policy is in place with the name of complaints officer added. A new auditing system is in place to record complaints either verbally or in writing. Clear time frames are in place to deal with complaints. Feedback forms have been analysed and issues have been addressed. Awaiting appropriate training for dealing with complaints on a formal basis.

Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: All wheelchairs and hoists have been stored away in a suitable space and no longer a trip hazard.	
Regulation 20: Information for residents	Substantially Compliant
Outline how you are going to come into compliance with Regulation 20: Information for residents: A new information booklet is being reviewed and compiled to incorporate recent changes in regulations and will be available to residents in the new year. We have the services of SAGE and National Advocacy Services who have been in to speak to the residents and given information to them.	
Regulation 27: Infection control	Substantially Compliant
Outline how you are going to come into compliance with Regulation 27: Infection control: Individual slings for each resident have been delivered. A cleaning checklist is in place for wheelchairs, comfort chairs and any other equipment in line with IPC protocol.	
Regulation 5: Individual assessment and care plan	Substantially Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan: All residents care plans have been audited and updated to include responsive behaviour, food preferences and allergies. They are evaluated and updated four monthly or sooner if there are any changes.	

Regulation 8: Protection	Substantially Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: The safeguarding incident had been notified by the previous person in charge to the provider and to HIQA within three days of receipt. All reasonable measures have been implemented to protect residents' monies and is in line with the Department of Social Protection	
Regulation 9: Residents' rights	Substantially Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: All residents and their families have been informed of the fire safety works that were due to commence on the 6th November both verbally on the phone or in person and in writing. They will continue to be updated as we progress to the second phase of the fire safety works.	

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 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	30/10/2023
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	01/12/2023
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	10/10/2023
Regulation 20(2)(e)	A guide prepared under paragraph (a) shall include information regarding independent advocacy services.	Substantially Compliant	Yellow	31/01/2024
Regulation 20(2)(c)	A guide prepared under paragraph (a) shall include	Substantially Compliant	Yellow	31/10/2023

	the procedure respecting complaints, including external complaints processes such as the Ombudsman.			
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Not Compliant	Orange	29/02/2024
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	29/02/2024
Regulation 24(1)	The registered provider shall agree in writing with each resident, on the admission of that resident to the designated centre concerned, the terms, including terms relating to the bedroom to be provided to the resident and the number of other occupants (if any)	Substantially Compliant	Yellow	31/01/2024

	of that bedroom, on which that resident shall reside in that centre.			
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Substantially Compliant	Yellow	30/10/2023
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.	Substantially Compliant	Yellow	31/10/2023
Regulation 34(1)(b)	The registered provider shall provide an accessible and effective procedure for dealing with complaints, which includes a review process, and shall display a copy of the complaints procedure in a prominent position in the designated centre, and where the provider has a website, on that	Substantially Compliant	Yellow	31/10/2023

	website.			
Regulation 34(2)(c)	The registered provider shall ensure that the complaints procedure provides for the provision of a written response informing the complainant whether or not their complaint has been upheld, the reasons for that decision, any improvements recommended and details of the review process.	Not Compliant	Orange	31/10/2023
Regulation 34(2)(d)	The registered provider shall ensure that the complaints procedure provides for the nomination of a review officer to review, at the request of a complainant, the decision referred to at paragraph (c).	Not Compliant	Orange	31/10/2023
Regulation 34(2)(e)	The registered provider shall ensure that the complaints procedure provides that a review is conducted and concluded, as soon as possible and no later than 20 working days after the receipt of the request for review.	Not Compliant	Orange	31/10/2023
Regulation 34(6)(a)	The registered provider shall ensure that all complaints	Not Compliant	Orange	31/10/2023

	received, the outcomes of any investigations into complaints, any actions taken on foot of a complaint, any reviews requested and the outcomes of any reviews are fully and properly recorded and that such records are in addition to and distinct from a resident's individual care plan.			
Regulation 34(7)(a)	The registered provider shall ensure that (a) nominated complaints officers and review officers receive suitable training to deal with complaints in accordance with the designated centre's complaints procedures.	Not Compliant	Orange	31/10/2023
Regulation 34(7)(b)	The registered provider shall ensure that all staff are aware of the designated centre's complaints procedures, including how to identify a complaint.	Not Compliant	Orange	17/11/2023
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later	Substantially Compliant	Yellow	31/10/2023

	than 48 hours after that resident's admission to the designated centre concerned.			
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Substantially Compliant	Yellow	31/10/2023
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned.	Substantially Compliant	Yellow	31/10/2023