Health Information and Quality Authority
Social Services Inspectorate

Compliance Monitoring Inspection Report
Designated Centres under Health Act 2007

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

Centre name:	Donegal Community Hospital
Centre ID:	0617
Centre address:	Lifford Road Donegal Town County Donegal
Telephone number:	074 9740600
Email address:	susan.rose@hse.ie
Type of centre:	☐ **Private** ☐ **Voluntary** ☒ **Public**
Registered provider:	Health Service Executive
Person authorised to act on behalf of the provider:	Kieran Doherty
Person in charge:	Susan Rose
Date of inspection:	5 December 2012
Time inspection took place:	**Start:** 09:10 hrs **Completion:** 16:10 hrs
Lead inspector:	Sheila McKevitt
Support inspector(s):	Sonia McCague
Type of inspection	☐ **announced** ☒ **unannounced**
Number of residents on the date of inspection:	25
Number of vacancies on the date of inspection:	4

About monitoring of compliance

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

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

Regulation has two aspects:

- Registration: under section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of their 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
- 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. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.

Summary of compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

This inspection report sets out the findings of a monitoring inspection, in which 11 of the 18 outcomes were inspected against. The purpose of the inspection was:

- ☐ to inform a registration decision
- ☐ to inform a registration renewal decision
- ☒ to monitor ongoing compliance with Regulations and Standards
- ☐ following an application to vary registration conditions
- ☐ following a notification of a significant incident or event
- ☐ following a notification of a change in person in charge
- ☐ following information received in relation to a concern/complaint

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

Outcome 1: Statement of Purpose	☒
Outcome 2: Contract for the Provision of Services	☐
Outcome 3: Suitable Person in Charge	☒
Outcome 4: Records and documentation to be kept at a designated centres	☐
Outcome 5: Absence of the person in charge	☐
Outcome 6: Safeguarding and Safety	☒
Outcome 7: Health and Safety and Risk Management	☒
Outcome 8: Medication Management	☒
Outcome 9: Notification of Incidents	☒
Outcome 10: Reviewing and improving the quality and safety of care	☒
Outcome 11: Health and Social Care Needs	☒
Outcome 12: Safe and Suitable Premises	☒
Outcome 13: Complaints procedures	☒
Outcome 14: End of Life Care	☐
Outcome 15: Food and Nutrition	☐
Outcome 16: Residents' Rights, Dignity and Consultation	☐
Outcome 17: Residents' clothing and personal property and possessions	☐
Outcome 18: Suitable Staffing	☒

This monitoring inspection was unannounced and took place over one day. As part of the monitoring inspection, inspectors met with residents, relatives, and staff members. Inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files. Inspectors found that the four action plans outstanding from the last inspection report in March 2012 had been addressed.

Inspectors found that the management structure, which had changed since the last inspection, was not satisfactory. The named key senior manager on the registration certificate was not rostered to manage the centre in the absence of the person in charge. The statement of purpose required updating to include all the required information as outlined in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

Residents confirmed that they felt safe and secure in the centre. However, inspectors found that security in the centre was poor. The risk management policy had been updated since the last inspection. However, the approach to risk was not robust enough for the following reasons:

- risks identified in May 2012 had not been addressed
- the centre had been risk assessed just once in 2012
- a number of risks were identified on inspection

Residents' healthcare needs were cared for to a high standard. They received all care required without delay. However, nursing and medical records were poor. For example, resident care plans were not reflective of their assessed needs, not person centred and were not reviewed on a three-monthly basis. There was no record kept of influenza vaccine administration and entries in resident medical files were not signed. The system used to record nursing records was not always available on demand. This ongoing issue had not been addressed to a satisfactory level. Medication administration, storage, ordering and disposal were as per the medication management policy. The prescribing and transcribing practises did not however follow the centres policy and were not in line with professional best practise guidelines.

The premises did not have the cosy, homely appearance or comforts of a residence best suited to those living in the centre long-term. Some residents had to share a room with three others, had minimum private space and communal areas were open to the corridor. Fire doors and flooring had been upgraded since the last inspection.

The quality of care being delivered was not being audited satisfactorily and this was evident from the poor standard of documentation and medication management identified by inspectors rather than by management themselves. Accidents had been audited on a monthly basis; notifications of a serious accident had been reported to the Authority as per legislative requirements.

The complaints policy met the Regulations. There were no complaints. However, less serious issues were not recorded therefore trends could not be identified or managed prior to becoming a risk/complaint.

Staffing levels and the skill mix on paper appeared good. However, on review of the roster the person in charge or staff nurse in charge was covering for unexpected staff leave and therefore managers did not have time to carry out their management role. Staff rosters for the centre were not clear as staffing for other units were included and surnames of some staff were not recorded.

Section 41(1)(c) of the Health Act 2007

Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

Theme: Governance, Leadership and Management

Effective governance, leadership and management, in keeping with the size and complexity of the service, are fundamental prerequisites for the sustainable delivery of safe, effective person-centred care and support.

Outcome 1
There is a written statement of purpose that accurately describes the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

References:
Regulation 5: Statement of Purpose
Standard 28: Purpose and Function

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

The inspector found the statement of purpose reflected the care, services and facilities available to residents' living in the centre. The centre was issued with a registration certificate in June 2012 and an updated certificate in October 2012 to reflect a change in the management structure. An updated statement of purpose was submitted to the Authority post inspection. It reflected the change in management. However, it did not include all items listed in Schedule 1 of the Regulations, the registration number, date of registration, expiry date and conditions of registration were not included.

Outcome 3
The designated centre is managed by a suitably qualified and experienced nurse with authority, accountability and responsibility for the provision of the service.

References:
Regulation 15: Person in Charge
Standard 27: Operational Management

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

The management structure was not robust. The person in charge was off duty on the day of inspection. The key senior manager named on the registration certificate was not allocated to cover in her absence. A second key senior manager who had left in October 2012 had not been replaced. A staff nurse on the ward assumed the role of nurse in charge. However, she was involved in providing direct care to residents' as a staff nurse off sick was not replaced. Inspectors found that there was no key senior manager appointed to cover in the absence of the person in charge.

The key senior manager named on the registration certificate worked full-time in the day hospital. The inspector spoke with this member of staff who confirmed that she was not involved in managing the residential centre, although her name was on the registration certificate.

Theme: Safe care and support

Safe care and support recognises that the safety of service users is paramount. A service focused on safe care and support is continually looking for ways to be more reliable and to improve the quality and safety of the service it delivers.

In a safe service, a focus on quality and safety improvement becomes part of a service-wide culture and is embedded in the service's daily practices and processes rather than being viewed or undertaken as a separate activity.

To achieve a culture of quality and safety everyone in the service has a responsibility to identify and manage risk and use evidence-based decision-making to maximise the safety outcomes for service users.

Outcome 6
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.

References:
Regulation 6: General Welfare and Protection
Standard 8: Protection
Standard 9: The Resident's Finances

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

Residents spoken with felt safe in the centre. There were a number of information leaflets available to residents at the front desk including “Responding to Allegations of Elder Abuse” and “Open your Eyes”.

Staff spoken with were familiar with the centre’s policy on responding to suspicions, allegations and disclosures of abuse. There was a policy available which outlined the procedures in place for the prevention, detection and response to abuse. The inspector reviewed evidence that all staff working in the centre were in receipt of elder abuse training within the past two years, a small number were due to have refresher training. There had been no incidents of abuse reported to the Authority from this centre.

Systems in place to safeguard residents’ money were not reviewed during this inspection.

Outcome 7
The health and safety of residents, visitors and staff is promoted and protected.

References:
Regulation 30: Health and Safety
Regulation 31: Risk Management Procedures
Regulation 32: Fire Precautions and Records
Standard 26: Health and Safety
Standard 29: Management Systems

Action(s) required from previous inspection:

The actions required from the previous inspection were satisfactorily implemented.

Inspection findings

The policies and procedures in relation to risk management and health and safety had been implemented by staff working at the centre. The Safety Statement dated 2012 was available for review. The risk policy outlined how to undertake a risk assessment and identified that a risk management committee would be in place and included its membership and roles and responsibilities.

The person in charge had completed risk assessment forms in May 2012 identifying risks, including the management of the centre not being robust enough. Inspectors had concerns that this risk had not been addressed by the provider in December 2012, seven months post the risk being identified by the person in charge.

An emergency plan was in place and outlined clear procedures to follow in the event of loss of electric power, flood, gas leak or security concerns. Inspectors spoke to staff and found they were familiar with the contents of the emergency plan and reporting structures in case of an emergency.

Inspectors had concerns as there was no restrictive access to the centre. The reception desk inside the building's main entrance was manned. However, on entering inspectors walked directly past it into the registered centre and they were not asked for identification or to sign a visitor's book. On entering the centre inspectors observed the reception desk within the centre was not manned, there was no visitors' book available to sign and there were five entrance/exit doors into the centre with no restrictive access.

HSE infection prevention and control policies and procedures were found to be in place. Hand-washing and drying facilities and hand disinfectant gels were available at the reception and nurse's stations.

Inspectors had concerns about the exterior smoking area. Two male residents were seen accessing this smoking area in order to smoke. They remained outside in freezing temperatures sitting on cold metal chairs, wearing indoor clothing only for periods of up to 27 minutes. There was no evidence that this practise had been risk assessed to determine the risk to residents. There was no recorded evidence of either of the residents receiving/refusing or been offered the influenza vaccine.

Other risks identified included:

- both doors of the sluice room were open leaving it accessible residents; chemicals in use were not securely stored within the sluice
- manual handling equipment, including hoist slings and sliding board were stored in the sluice room
- no system in place to ensure battery operated call bells are checked on a regular basis
- residents' medical files and unsecure keys left on an open nurse's station
- Kitchen and cleaning staff carrying out both jobs on same day in the same uniform.

The fire alarm and fire fighting equipment was maintained, and all staff had attended fire safety and evacuation training. However, records reviewed showed the last fire drill practiced by staff was in April 2012. Inspectors observed that one of the means of escape was partially obstructed with black rubbish bags on a number of occasions during the inspection.

Outcome 8
Each resident is protected by the designated centres' policies and procedures for medication management.

References:
Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines
Standard 14: Medication Management

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

There was a policy in place for the management and administration of medications. Inspectors found that safe practices were in place for the ordering, storing and administration of medications. However, inspectors found the policy was not being adhered to in relation to prescribing and transcribing of medications and was therefore unsafe. For example, the policy stated that medical prescriptions should be legible, signed and dated by a registered medical practitioner. Inspectors found that a number of doctor's signatures were not legible and the signature bank available contained nurses' signatures only. Medical prescriptions were not individually signed by medical practitioners. Inspectors reviewed a number of resident prescription charts which were block signed.

The policy stated that each medical prescription should state the drugs from, strength, dosage, frequency, timing, duration and route of administration. However, a review of medication charts found this was not always practiced.

The policy stated that verbal orders taken should be recorded in the drug kardex/client's notes including the date, time of the order, the medical practitioner's name, and his/her confirmation of the order. It also states if nurses decide to transcribe they must follow the "Guidance to Nurses and Midwives on Medication Management 2007" (An bord Altranais). Inspectors observed that unsigned medications were been administered to residents. For example, unsigned valium 5mg had been administered to a resident. The medication chart stated the name of the drug, the dosage and three times were ticked. However, there was no medical or nurses' signatures on the medication prescription chart. It was not known who had prescribed the medication although nurses had signed to say they had administered the medication on two separate occasions.

Inspectors found that an influenza vaccine sticker was stuck in a small number of residents medical file. There was no narrative, date or signature written by the influenza vaccine sticker and no prescription for the influenza vaccine on the resident medication chart. Staff were unclear who had received, been offered or refused the vaccine and there were no records available to reflect same. This was not keeping in line with the HSE own Public Health Guidelines on the Prevention and Management of Influenza Outbreaks in Residential Care Facilities in Ireland 2012/2013.

Outcome 9
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

References:
Regulation 36: Notification of Incidents
Standard 29: Management Systems
Standard 30: Quality Assurance and Continuous Improvement
Standard 32: Register and Residents' Records

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

Accidents report forms were reviewed on inspection and cross referenced with notifications received by the Authority. The Authority had been notified of all accidents/incidents as per legislative requirements.

Theme: Effective care and support

The fundamental principle of effective care and support is that it consistently delivers the best achievable outcomes for people using a service within the context of that service and resources available to it. This is achieved by using best available national and international evidence and ongoing evaluation of service-user outcomes to determine the effectiveness of the design and delivery of care and support. How this care and support is designed and delivered should meet service users' assessed needs in a timely manner, while balancing the needs of other service users.

Outcome 10
The quality of care and experience of the residents are monitored and developed on an ongoing basis.

References:
Regulation 35: Review of Quality and Safety of Care and Quality of Life
Standard 30: Quality Assurance and Continuous Improvement

Action(s) required from previous inspection:

The action required from the previous inspection was satisfactorily implemented.

Inspection findings

There was evidence that consumer group meetings now took place on a quarterly basis. Members of the group included resident relatives, who the inspectors were informed, represented the residents'. Minutes of these meetings were available for review - minutes of the last meeting in October 2012 reflected an issue with providing activities to residents due to decreased staffing levels.

A consumer questionnaire was available at the nurses' station requesting members of the public to complete in order to assist in improving the services provided and requesting the completed form to be place in the secure suggestion box. There was no analysis of forms completed to date available for review on this inspection.

A monthly analysis of accident/incidents was completed and available for review. However, the analyses of audit results were not clear and did not indicate if there was any learning/change or review of practices as a result of the audit had been completed. The monthly completed audit forms were not signed or dated.

A restraint register was been kept on a weekly basis. This provided a clear record of restraint use in the centre and evidence that restraint use was been reviewed weekly.

There was no evidence that other aspects of residents care were being audited. For example, nursing documentation or medication management as mentioned under Outcome 8 above.

Outcome 11
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. 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.

References:
Regulation 6: General Welfare and Protection
Regulation 8: Assessment and Care Plan
Regulation 9: Health Care
Regulation 29: Temporary Absence and Discharge of Residents
Standard 3: Consent
Standard 10: Assessment
Standard 11: The Resident's Care Plan
Standard 12: Health Promotion
Standard 13: Healthcare
Standard 15: Medication Monitoring and Review
Standard 17: Autonomy and Independence
Standard 21: Responding to Behaviour that is Challenging

Action(s) required from previous inspection:

The action required from the previous inspection was satisfactorily implemented.

Inspection findings

The resident healthcare needs were being met. It was evident that residents were in receipt of a high standard of nursing, medical and allied healthcare team. Residents confirmed this to inspectors. They had only praise for the quality of care provided to them. From records reviewed access to all required allied health care professionals was sought and gained without delay.

However, record keeping was poor. A number of resident medical records had unsigned hand written entries and as mentioned under Outcome 8 above some contained influenza stickers with no date signature or narrative.

The computerised nursing documentation system was not adequate. The system continuously shut down while in use. Staff confirmed that this was an ongoing problem, which to date, had not been addressed satisfactorily.

Nursing documentation was reviewed for a number of residents met on inspection. The residents nursing assessments were not reflective of the resident and their assessed needs were not reflected in the resident care plans and they were not person centred in any way. For example, two male residents had the exact same hygiene care plan; the only difference was the residents' name. One frequent respite resident had his care plan last modified in November 2010. The evaluation of care given on a daily basis was poor, there was no link between the residents care plan and daily evaluation. For example, a number of residents who had bedrail check forms at the end of their bed had no care plan in place to reflect the use of said restraint.

An inpatient weekly bowel record chart for week ending 5 December 2012 indicated that 14 out of 32 residents had not had a bowel motion within the past week.

There was documented evidence that residents were involved in their care plan on admission but no evidence that they were involved in any review thereafter. Inspectors found that care plans were not routinely reviewed on a three monthly basis.

There were activities available for residents. A copy of the weekly schedule was posted in communal areas. Two members of staff were now responsible for coordinating and delivering the activities scheduled. Residents spoken with confirmed that they could choose whether to take part.

Outcome 12

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. There is appropriate equipment for use by residents or staff which is maintained in good working order.

References:

Regulation 19: Premises
Standard 25: Physical Environment

Action(s) required from previous inspection:

The actions required from the previous inspection were satisfactorily implemented.

Inspection findings

The premises were clean and tidy. Residents' continued to be cared for in four-bedded rooms which resulted in them having a minimum amount of personal space. Communal areas were open to the corridors and did not provide a cosy home like feeling best suited to those residents living in the centre long term. As mentioned under Outcome 7, there were a number of environmental risks identified.

The floor covering at the nurses' station and outside the treatment room had been replaced since the last inspection.

Theme: Person-centred care and support

Person-centred care and support has service users at the centre of all that the service does. It does this by advocating for the needs of service users, protecting their rights, respecting their values, preferences and diversity and actively involving them in the provision of care. Person-centred care and support promotes kindness, consideration and respect for service users' dignity, privacy and autonomy.

Outcome 13
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.

References:
Regulation 39: Complaints Procedures
Standard 6: Complaints

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

There was a complaints policy available for review and the procedure for making a complaint was displayed in the centre. There was no record of complaints and the nurse in charge on inspection confirmed that there were no complaints to date in 2012. This was also the case during the March 2012 inspection when the inspector discussed the benefit of logging less serious complaints to assist with the identification of any patterns which might be indicative of a larger problem that needed to be addressed. Less serious issues/complaints remained unlogged.

Outcome 18
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 has up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

References:
Regulation 16: Staffing
Regulation 17: Training and Staff Development
Regulation 18: Recruitment
Regulation 34: Volunteers
Standard 22: Recruitment
Standard 23: Staffing Levels and Qualifications
Standard 24: Training and Supervision

Action(s) required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

Staffing levels and skill mix appeared adequate to meet the nursing care needs of residents. However, as mentioned under Action 3 and evidenced by the non-compliances outlined under Outcome 8, 9, 10 and 11 above, the lack of a robust management structure was impacting on the ability of the management team to meet the legislative requirements. The evidence on inspection indicated that staff allocated to manage were actually covering sick leave and therefore did not have the time to fulfil their role and responsibilities as managers.

From the documented evidence submitted to the Authority post inspection and cross referenced off the An Bord Altranais website, all staff nurses were currently registered to work in Ireland. Staff had completed their mandatory training, a small number were due updates in training, these were been planned for the near future.

Rosters reviewed on inspection did not include the surname of all staff and inspectors observed a large number of staff on duty were not wearing name badges.

Staff files were not reviewed during this inspection.

Closing the visit

At the close of the inspection visit a feedback meeting was held with the nurse in charge and again with the nominated person on behalf of the provider and the service manager to report on the inspectors' findings, which highlighted both good practice and where improvements were needed.

Acknowledgements

The inspectors wish to acknowledge the cooperation and assistance of the residents, relatives, provider and staff during the inspection.

Report compiled by:

Sheila McKevitt
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

7 January 2013

Health Information and Quality Authority
Regulation Directorate

Action Plan

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

Provider's response to inspection report *

Centre Name:	Donegal Community Hospital
Centre ID:	0617
Date of inspection:	5 December 2012
Date of response:	25th January 2013.

Requirements

These requirements set out the actions that must be taken to meet the requirements of the Health Act 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

Theme: Governance, Leadership and Management

Outcome 1: Statement of purpose and quality management

The provider is failing to comply with a regulatory requirement in the following respect:

The statement of purpose did not include all matters listed in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

Action required:

Compile a statement of purpose that consists of all matters listed in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

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

Reference: Health Act, 2007 Regulation 5: Statement of Purpose Standard 28: Purpose and Function	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Acting Director of Nursing will review and update the Statement of Purpose to comply with legislation and submit to the Authority.	12/03/2013

Outcome 3: Suitable person in charge

The provider is failing to comply with a regulatory requirement in the following respect: The person in charge is not consistently engaged in the governance, operational management and administration of the centre due to the consistent shifts she is required to cover staff shortages. The key senior manager was not rostered to cover in her absence foe example on days off/annual leave/study leave.	
Action required: Ensure that the post of person in charge of the designated centre is full time and that the person in charge is a nurse with a minimum of three years experience in the area of geriatric nursing within the previous six years.	
Reference: Health Act, 2007 Regulation 15: Person in Charge Standard 27: Operational Management	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: CMM 2 commenced employment on 01/01/2013 CNM 2 moved from the Day Hospital on 14/01/2013 Staff Nurse increased from 0.5 WTE to 1 WTE Acting director to resume management role Rooster are being reviewed person in charge identified by a red dot.	January 2013

Theme: Safe care and support

Outcome 7: Health and safety and risk management

The provider is failing to comply with a regulatory requirement in the following respect:

Risks identified included:

- non restrictive access to centre, five unsecure entrance/exit points
- no record of visitors in or out of centre
- exterior smoking area for resident use
- staff were carrying out cleaning duties and serving food wearing the same uniform, no protective clothing was used by staff
- both doors of the sluice room were open leaving it accessible residents - chemicals in use were not secure within the sluice room
- manual handling equipment including hoist slings and sliding board were stored in the sluice room
- no system in place to ensure battery operated call bells are checked on a regular basis
- residents' medical files and unsecure keys left on open nurses' station.

Action required:

Take all reasonable measures to prevent accidents to any person in the designated centre and in the grounds of the designated centre.

Reference:

Health Act, 2007
Regulation 31: Risk Management Procedures
Standard 26: Health and Safety
Standard 29: Management Systems

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Estates have reviewed the access/exits to the centre and are currently developing a plan to secure these areas. An outline plan has been forwarded to the Authority. There is a visitor's book at the entrance to the unit. A large poster has been put in place requesting visitors to sign. The unit has been designated as non-smoking so residents have to go outside to smoke. There is a call bell in place and there is a canopy that acts as a roof. Currently there are two residents who smoke one is accompanied each time by a member of staff the other gentleman smokes one cigarette per day. As part of the security review estates have been requested to erect a fenced area with a secure gate at the smoking area.	April 2013 January 2013 April 2013

Every area of work is clearly identified on the off-duty All staff have been advised to keep Sluice doors closed at all times and the cupboard is to be locked at all times. The key is in a key box in the Nursing Office. Manual Handling equipment has been relocated. We have introduced a weekly call bell check. A new call bell system is being purchased. Three quotes have been sourced. Residents files are to be locked at all times unless in use and the unsecure keys have been removed to the Nursing office. All staff have been made aware of their responsibility regarding safe storage of medical nursing notes.	January 2013 February 2013 December 2012 January 2013 January 2013

Outcome 7: Health and safety and risk management

The provider is failing to comply with a regulatory requirement in the following respect: A fire exit was partially blocked by black rubbish bags during the inspection. Records reviewed showed that the only fire drill in 2012 took place in April 2012. There was no evidence available to show that a fire drill had been practiced for the second half of 2012.
Action required: Provide adequate means of escape in the event of fire.
Action required: Ensure, by means of fire drills and fire practices at suitable intervals, that the staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire, including the procedure for saving life.
Action required: Maintain, in a safe and accessible place, a record of all fire practices which take place at the designated centre.
Reference: Health Act, 2007 Regulation 32: Fire Precautions and Records Standard 26: Health and Safety

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

Provider's response: Maintenance operative has been informed that Fire exits are to be kept clear at all times. 37 Staff received Fire training in 2012 Monthly fire drills to be introduced. For this year the three dates for fire training are: 15 January, 23 April, 25 June. Full fire records are maintained.	 January 2013 February 2013

Outcome 8: Medication management

The provider is failing to comply with a regulatory requirement in the following respect: Medication management policies were not adhered by staff responsible for prescribing and transcribing medications. Prescribing and transcribing practises were not in accordance with current regulations or professional guidelines.	
Action required: Put in place appropriate and suitable practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents and ensure that staff are familiar with such policies and procedures.	
Reference: Health Act, 2007 Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines Standard 14: Medication Management	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: All Nursing staff completed An Bord Altranais medication management on-line in 2012 in order to update their knowledge. CNME have been contacted to provide onsite update on Medical Management for all nursing staff. This is being organised GPs have been personally asked and have been written to requesting that their scripts are legible as per policy.	 March, April, May 2012 March 2013 30/04/2013

Theme: Effective care and support

Outcome 10: Reviewing and improving the quality and safety of care

The provider is failing to comply with a regulatory requirement in the following respect:

There was no evidence that a system for reviewing the quality and safety of care and the quality of life for residents had been established or maintained.

Therefore there was no documented evidence that the quality of care provided to residents was improving.

Action required:

Establish and maintain a system for reviewing the quality and safety of care provided to, and the quality of life of, residents in the designated centre at appropriate intervals.

Action required:

Establish and maintain a system for improving the quality of care provided at, and the quality of life of residents in, the designated centre.

Reference:

Health Act, 2007
Regulation 35: Review of Quality and Safety of Care and Quality of Life
Standard 30: Quality Assurance and Continuous Improvement

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Care plan audits have been carried out in April 2012 and October 2012. Senior Staff are to attend a care plan training day on the 21 February to update them in the development of patient centred care plans. A three-monthly review case conferences to be established for residents in the unit longer than three months. The admission rate to this unit is approx. 300 per year	 February 2013 March 2013

Outcome 11: Health and social care needs

The person in charge is failing to comply with a regulatory requirement in the following respect:

The residents assessed needs were not reflected an individual person-centred care plan.

Care plans were not routinely reviewed on a three-monthly basis. There was no evidence that residents were notified of or consulted with regarding their care plan being updated.	
Action required: Set out each resident's needs in an individual care plan developed and agreed with the resident.	
Action required: Keep each resident's care plan under formal review as required by the resident's changing needs or circumstances, and no less frequent than at three-monthly intervals.	
Action required: Revise each resident's care plan, after consultation with him/her.	
Action required: Notify each resident of any review of his/her care plan.	
Reference: Health Act, 2007 Regulation 8: Assessment and Care Plan Standard 3: Consent Standard 10: Assessment Standard 11: The Resident's Care Plan Standard 17: Autonomy and Independence	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Nursing staff are receiving training in order to update their skills in developing person-centred care plans. A formal care plan review will take place for Long Term residents every three months. On admission, a care plan is discussed and agreed with the resident and the resident signs appropriate form and this is placed in the resident's notes.	February 2013

Outcome 12: Safe and suitable premises

The provider is failing to comply with a regulatory requirement in the following respect: Residents in four bedded rooms had minimum private space to undertake activities in private and a minimum amount of storage space for personal belongings.
Action required: Provide adequate private accommodation for residents.
Action required: Ensure the physical design and layout of the premises meets the needs of each resident, having regard to the number and needs of the residents.
Action required: Provide suitable storage facilities for the use of each resident.
Reference: Health Act, 2007 Regulation 19: Premises Standard 25: Physical Environment

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: HSE will submit plans for future of Donegal Hospital.	30/04/2013

Theme: Workforce

Outcome 18: Suitable staffing

The person in charge is failing to comply with a regulatory requirement in the following respect: It was not made clear from the roster who was in charge in the absence of the person in charge on day or night shift. It was not clear from the roster who was working in the centre or what area they were working in, for example, cleaning staff, kitchen staff or care staff. Staff did not wear name badges.

Action required: Ensure that an appropriately qualified registered nurse is on duty and in charge of the designated centre at all times, and maintain a record to this effect.	
Action required: Maintain a planned and actual staff rota, showing staff on duty at any time during the day and night.	
Reference: Health Act, 2007 Regulation 16: Staffing Standard 23: Staffing Levels and Qualifications	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Staff rosters have been reviewed. Person in charge is clearly indicated. All staff told to wear name badges at all times.	 January 2013 February 2013

Any comments the provider may wish to make[1]:

Provider's response:

A system of recording flu vaccine is now in place.

The Saturn system used to record the Nursing records is not always available on demand due to poor network service. This issue is being addressed but as yet we haven't reached a satisfactory outcome. The register provider is in the process of contacting the company involved.

As a result of high level of activity, approx 300 admissions per year, the atmosphere is more clinical. The long-term care aspects of this unit are being reviewed.

Provider's name: Kieran Doherty
Date: 7 February 2013

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