

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Killarney Community Hospitals (Fuschia, Hawthorn and Heather Wards)
Centre ID:	OSV-0000568
Centre address:	St Margaret's Road, Killarney, Kerry.
Telephone number:	064 663 1018
Email address:	killarney.hospitals@hse.ie
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Ber Power
Lead inspector:	Caroline Connelly
Support inspector(s):	Michelle O'Connor
Type of inspection	Unannounced
Number of residents on the date of inspection:	91
Number of vacancies on the date of inspection:	5

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
28 March 2017 10:30	28 March 2017 19:00
29 March 2017 09:00	29 March 2017 18:10

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

Outcome	Our Judgment
Outcome 02: Governance and Management	Compliant
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Non Compliant - Moderate
Outcome 06: Absence of the Person in charge	Compliant
Outcome 07: Safeguarding and Safety	Non Compliant - Moderate
Outcome 08: Health and Safety and Risk Management	Non Compliant - Major
Outcome 09: Medication Management	Non Compliant - Moderate
Outcome 11: Health and Social Care Needs	Substantially Compliant
Outcome 12: Safe and Suitable Premises	Non Compliant - Major
Outcome 13: Complaints procedures	Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Non Compliant - Major
Outcome 17: Residents' clothing and personal property and possessions	Non Compliant - Moderate
Outcome 18: Suitable Staffing	Non Compliant - Major

Summary of findings from this inspection

This inspection of Killarney Community Hospital, by the Health Information and Quality Authority (HIQA), was unannounced and took place over two days. The centre was registered to accommodate the needs of 96 residents and there were 91 residents residing there on the days of the inspection. The centre is operated by the Health Service Executive (HSE) and is located on the outskirts of Killarney town. It comprises three separate units named Fuschia, Hawthorn and Heather. This inspection report sets out the findings of a monitoring inspection. As part of the inspection inspectors met with residents, relatives, the provider, the person in charge, two Assistant Director of Nursing (ADON), Clinical Nurse Managers (CNM), nurses, activity staff, practice development facilitator and numerous staff members. Inspectors observed care practices and reviewed all governance, clinical and

operational documentation including nursing and medical records, accident and incidents, complaints and staff related records. Inspectors also followed up on the actions required from the previous inspection.

Since the previous inspection in June 2015 there have been a number of changes to the governance and management of the centre which included changes to the person in charge. The person in charge had been working in the centre as an ADON and was appointed as acting director of nursing and person in charge in September 2016. There were also two newly appointed ADONs working in the centre as persons participating in management. An interview was conducted with the new person in charge and ADONs during this inspection. The management team displayed good knowledge of the regulatory requirements and they were found to be committed to providing evidence-based care for the residents. They were proactive in response to a number of actions required from previous inspections however inspectors viewed a number of actions that remained non-compliant and further actions were required on this inspection including an immediate action in relation to fire training and lack of fire drills. The combination of incomplete staff fire training and no fire drills caused inspectors to issue an immediate action plan to address the risk to residents in the event of a fire. A comprehensive plan was returned to HIQA by the provider, within the required time-frame, detailing immediate actions taken to counteract this risk.

Inspectors found that residents' healthcare and nursing needs were met to a good standard. Residents had easy access to medical, allied health and psychiatry of later life services. A number of the allied health staff were on site or in close proximity to the centre. Staff interacted with residents in a kind and respectful manner and inspectors found that residents appeared to be very well cared for. Residents and relatives were spoken with throughout the inspection. The feedback received from them was generally positive and indicated that they were satisfied with the staff and care provided. However, a number of residents did tell the inspectors that they found residing in the multi-occupancy rooms difficult. This was due to the lack of privacy and increased noise levels disturbing them during the day and the night.

Resident accommodation consisted mainly of large multi-occupancy rooms and similar to findings on previous inspections the premises did not meet the individual and collective needs of residents in terms of their privacy, personal space, access to communal space and adequate and accessible sanitary facilities. This had a significant negative impact on the quality of life of residents who resided in the centre. On the first day of the inspection, inspectors saw that in the three units a large number of the residents spent the day in their bedrooms, either in bed or on a chair at their bedside. Some did attend the dining rooms for meals or activities but returned to their bedrooms immediately following same. In Fuschia ward there were more residents in the sitting and dining room than in the other two units. The inspectors concluded that as a consequence of the prevalence of mainly large multi-occupancy rooms, and the fact that residents spent most of the day by their beds, the centre appeared institutionalized and hospital-like. On the second day of inspection with encouragement from staff there were a lot more residents up and about and enjoying the communal space.

Inspectors saw that a few of the actions required from the previous inspection had

been addressed however the large majority of actions remained ongoing. Improvements were seen in the provision of activities. The inspectors spoke to the staff providing activities and saw group and one-to-one activities taking place throughout the two day inspection. Premises issues, care planning, medication management, staff files all required action. These areas and other actions required are detailed in the body of the report, which should be read in conjunction with the action plan at the end of this report. The action plan at the end of the report identifies improvements necessary to ensure compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Standards for Residential Care Settings for Older People in Ireland 2016.

Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

Outcome 02: Governance and Management

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

Theme:

Governance, Leadership and Management

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

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

Findings:

The centre was operated by the Health Service Executive (HSE) who was the registered provider. The provider nominee who had responsibility for a number of other centres had an office based in this centre and was available to the management team. Since the previous inspection in June 2015 there have been a number of changes to the governance and management of the centre which included changes to the person in charge. The person in charge had been working in the centre as an ADON and was appointed as acting director of nursing and person in charge in September 2016. There were also two newly appointed ADONs working in the centre as persons participating in management. There was now a clearly defined management structure, the centre was managed by a full time person in charge who was supported by two assistant directors of nursing and each of the three units was managed by a full time clinical nurse manager. The lines of accountability and authority were clear and all staff were aware of the management structure and were facilitated to communicate regularly with management.

The management team displayed knowledge of the regulatory requirements. They were proactive in response to a number of actions required during the inspection. However, inspectors viewed a number of actions that remained non-compliant from previous inspections and further actions were required on this inspection including an immediate action which is discussed under outcome 8 Health and Safety. Issues in relation to the premises were ongoing. The provider had given assurances that a new build premises will replace the existing building to ensure compliance with the standards and the regulations, and to meet the privacy and dignity needs of the residents. The inspector met the chief assistant technical services officer who outlined the process for the new build and assured the inspector plans are in place and a design team will be appointed within the next month.

Inspectors saw evidence of the collection of key clinical quality indicator data including pressure ulcers, falls, and the use of psychotropic medications, bed rails, medication management and administration, the assessment of risk, and health and safety. Inspectors saw that there were systems in place for monitoring the quality and safety of care provided to residents. These included internal audits and reviews such as falls audits, nursing documentation audit, infection control audit, oral hygiene audit, food and nutrition audit, and end of life audit, social and recreational audit. These audits had taken place in 2016 and the centre had commenced the use of a computerised system of auditing to monitor all of the units in accordance with evidenced based practice. Audit outcomes and any corrective actions were documented and had resulted in changes to practices particularly around falls and food and nutrition.

There was evidence of consultation with residents and relatives through residents meetings chaired by activity staff, and relative meetings chaired by the person in charge. Inspectors noted that issues raised by residents were brought to the attention of the person in charge and items were followed up on subsequent meetings. The person in charge told the inspectors that a comprehensive survey had been undertaken in 2016. Results of same showed residents satisfaction with the care and service they received. Inspectors also saw the results from the quality of life audit completed by eight residents where they identified they would like more trips out and these had been facilitated. A number of residents stated that the lack of a garden for Heather and Hawthorn units was a quality of life issue, which management said they were looking into.

The inspectors saw that a comprehensive annual review of the quality and safety of care and support in the designated centre had been undertaken by the management team in accordance with the standards. This review was made available to the inspectors and there were a number of recommendations and actions from this review that are currently being actioned.

Judgment:

Compliant

Outcome 04: Suitable Person in Charge

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The person in charge was new to her role since the previous inspection and displayed good knowledge of the standards and regulatory requirements.

The inspectors interacted with the person in charge throughout the inspection process.

There was evidence that the person in charge was engaged in the governance, operational management and administration of the centre on a day-to-day basis. Inspectors were satisfied that she was a registered nurse, was suitably qualified and had a minimum of three years experience in nursing of the older person within the previous six years, as required by the regulations. She had extensive managerial experience and had been acting person in charge in another centre in the past. She demonstrated a commitment to her own professional development and held numerous post registration qualifications including a BA in Healthcare management, an MA in nursing and post graduate diploma's in Advancing Practice and Health Protection.

Staff, residents and relatives all identified her as the person who had responsibility and accountability for the service and said she was very approachable and were confident that all issues raised would be managed effectively.

Judgment:

Compliant

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

Theme:

Governance, Leadership and Management

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

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

Findings:

This outcome was not generally inspected with the exception of staff files. A sample of staff files were reviewed by the inspectors and a number of gaps were identified. For example, one staff file did not contain a full employment history; others did not include details and documentary evidence of any relevant qualifications or accredited training of the person. The centre had in place HSE Garda Vetting Liaison Officers Garda vetting report confirmation forms for a number of staff. However, this is not a disclosure in accordance with the National Vetting Bureau Act 2012 as required by schedule 2 of the 2013 care and welfare regulations.

Judgment:

Non Compliant - Moderate

***Outcome 06: Absence of the Person in charge
The Chief Inspector is notified of the proposed absence of the person in***

charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

There had been a number of changes with respect to the person in charge over the last number of years and the provider had notified HIQA in relation to same. This demonstrated their awareness of the responsibility to notify HIQA of any absence or proposed absence for 28 days or more.

Deputising arrangements were in place to cover for the person in charge when she was on leave. There are two new ADONs in post since the last inspection. Both of the ADON's had worked in the centre in managerial roles prior to their promotion, and one of the ADON's will act as person in charge when the person in charge is on leave. The inspectors met and interviewed the ADONs during the inspection and they demonstrated an awareness of the legislative requirements and their responsibilities. They were found to be suitably qualified and experienced in residential care of the older adult. The CNMs and senior staff nurses also took responsibility for the centre at weekends, evenings and night time with the backup of the ADONs and person in charge on call if required.

Judgment:

Compliant

Outcome 07: Safeguarding and Safety

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

Theme:

Safe care and support

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

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

Findings:

The policy on elder abuse was up to date and referenced the most recent Health Service Executive policy 'Safeguarding Vulnerable Persons at Risk of Abuse'. Residents with whom inspectors spoke said that they felt safe in the centre. Relatives spoken with had no concerns regarding the quality of care delivered in the centre. Staff spoken with,

were familiar with the policy, with different types of abuse, and with what action to take in the event of an allegation or incident of abuse. However, not all staff had up-to-date training in the detection and management of elder abuse. The action required for this is under outcome 18 Staffing.

The systems to manage residents' finances were reviewed by inspectors. The centre was a pension agent for a number of residents, but this was all managed through the HSE national accounts in Tullamore where robust records were maintained of all transactions. An inspector met the person responsible for residents finances and she explained the system used. The centre had recently changed payment arrangements for chiropody and hairdressing. This is now all managed and invoiced through the finance office, following countersigned receipts by staff, confirming the service had been supplied to each individual resident. There were a number of residents who handed money in for safekeeping on the units for the purchase of cigarettes, sweets and personal items. Inspectors viewed the system used and saw money was kept in a locked safe. Each resident had an individual envelope and a book was maintained where each lodgement or withdrawal was recorded. All transactions were signed by two staff members and by the resident or relative if appropriate. Receipts were maintained for all purchases. This system was found to be sufficiently robust to protect both the resident and the staff members.

The centre had an up-to-date policy on the management of responsive behaviours. However, not all staff had up-to-date training in this area to guide them in day-to-day practice. The action for this is also covered under outcome 18 Staffing. Inspectors viewed the care plans of a number of residents with responsive behaviours and found inconsistencies. While there was much detail in the pre-printed interventions of the care plan, there was a lack of resident centred information regarding the triggers of and interventions to manage the behaviours. This was particularly relevant on one of the units where a consistent approach to care was essential. This is discussed and actioned under care plans in outcome 11. The inspectors viewed one plan that was much more comprehensive and did clearly guide staff on the triggers and responses required to ensure consistent care for the resident.

The inspectors were informed that there were 57 residents out of the current 91 residents using bedrails at the time of the inspection. Inspectors found this was a very large percentage of bedrail usage and required this to be reviewed to promote a reduction in the use of bedrails. Although there were some alternatives such as low profiling beds, crash mats and bed alarms in use for some residents, this needed to be extended to move towards a restraint free environment. The centre had a risk assessment tool in place to guide the appropriate use of bed rails for residents. However, the assessment did not adequately outline the requirement to document measures which had been taken/considered to protect residents prior to using bed rails. One step of the tool made reference to a detailed risk assessment which assessed the risk of injury of using bed rails and weighed this against the risk of injury of not using bed rails. However, this detailed risk assessment was not completed for each individual resident, despite forming part of the centre's policy on restraint. There was also some confusion around what was an enabler and what was a restraint. The system around restraint required review to ensure it was compliant with the national policy.

Judgment:

Non Compliant - Moderate

Outcome 08: Health and Safety and Risk Management

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

Theme:

Safe care and support

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

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

Findings:

The centre had an up to date health and safety statement and policies on health and safety in the centre. The risk management policy addressed the identification and management of the risks required by Regulation 26(1). The centre had a detailed infection prevention and control policy in place. Personal protective equipment, such as gloves, aprons and hand sanitizers were located throughout the premises. All hand-washing facilities had liquid soap and paper towels available. There were policies in place on infection prevention and control and staff that were interviewed demonstrated knowledge of the correct procedures to be followed. Hand hygiene training was on-going and staff demonstrated good hand hygiene practice as observed by the inspectors. Arrangements for the disposal of domestic and clinical waste management were appropriate. The centre had an up to date and detailed risk register and had identified many risks present in the centre. One unit had a designated outdoor smoking area and the other two units had a designated smoking room. Residents who were smokers had individual smoking risk assessments in place and all cigarettes and lighters were safely stored by staff. Although there were fire aprons in the smoking room there was no fire blanket. Fire extinguishers were down the corridor from the room and should be in closer proximity. The person in charge ordered a fire blanket on the day of the inspection and they were waiting its arrival.

Inspectors saw that the fire policies and procedures were centre-specific. The fire safety plan was viewed and found to be comprehensive. There were notices for residents and staff on "what to do in the case of a fire" appropriately placed throughout the building. Colour-coded floor plans were displayed throughout the centre which identified 'Where You Are Now' in line with best practice. Staff demonstrated an appropriate knowledge and understanding of what to do in the event of fire. Inspectors examined the fire safety register with details of all services and tests carried out. All fire door exits were unobstructed and fire fighting and safety equipment tested was up to date. The emergency lighting and fire alarm was last tested in February 2017. Detailed Personal Emergency Evacuation plans (PEEPS) were seen to be completed for residents outlining the assistance they would require in an emergency situation. However, there was no evidence of weekly in-house checks of emergency lighting and weekly testing of the break glass units beside fire doors had not been conducted since March 2016.

Fire training had been provided to staff on regular occasions during 2015 and 2016, however, there were a large number of staff that had not received up-to-date fire training. There was no evidence that recent and regular fire drills were taking place in the centre. In fact staff could not say when they last undertook a fire drill. The combination of a lack of all staff having had up-to-date fire training and no fire drills taking place in the centre lead inspectors to issue an immediate action plan to the provider, because of the risk to residents in the event of a fire. A comprehensive plan was returned to HIQA by the provider within the required time-frame.

Accidents and incidents were recorded on incident forms and were submitted to the person in charge and there was evidence of action in response to individual incidents. The CNM showed an inspector a comprehensive post falls review document they had just commenced using. This was used to fully review and identify reasons for the fall and if there was anything they could do to prevent the fall or manage it better. These were also reviewed and discussed at the daily hand-over meetings. There was a centre-specific emergency plan that took into account all emergency situations. Clinical risk assessments were undertaken, including falls risk assessment, assessments for dependency, assessments for malnutrition and assessments for pressure ulcer formation.

Staff training records confirmed that not all staff had completed their mandatory training in moving and handling of residents. The action for this is under outcome 18 Staffing.

Judgment:

Non Compliant - Major

Outcome 09: Medication Management

Each resident is protected by the designated centre's policies and procedures for medication management.

Theme:

Safe care and support

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

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

Findings:

Recently updated centre-specific policies on medication management were made available to inspectors. The policies included the ordering, receipt, administration, storage and disposal of medicines. The policies were comprehensive and evidence based. Medicines for residents were supplied by a community pharmacy.

Medicines were stored in a locked cupboard or medication trolley. Trolleys were generally stored in locked clinical rooms when not in use. Controlled drugs were stored in accordance with best practice guidelines and nurses checked the quantity of medications at the start of each shift. The inspector did a count of controlled medications with the nurse which accorded with the documented records. The

inspectors saw prescription creams and eye drops on residents lockers in multi-occupancy rooms. These prescription items were not securely stored as per best practice guidelines and could pose a risk if a confused resident picked them up.

Medication administration was observed and the inspectors found that the nursing staff generally adhere to professional guidance issued by An Bord Altranais agus Cnáimhseachais and adopted a person-centred approach. Nurses wore red aprons as a sign they were administering medications and they were not to be disturbed. The inspector reviewed a sample of residents' medicine prescription records and they were maintained in a tidy and organised manner, they were clearly labelled, they had photographic identification of each resident and they were legible. There was evidence that residents' medicine prescriptions were reviewed at least every three months by a medical practitioner, crushed medications were prescribed as crushed and maximum doses were recorded on PRN (as required medicines).

Medication audits were undertaken by the nursing staff medication errors and near misses were recorded and monitored by the CNM 2 on each unit. The CNM 2 reported to the inspectors that these were discussed at ward hand-over meetings to mitigate risk of recurrence.

Medicines for residents were supplied by an onsite pharmacist who also had responsibility for a number of other areas. The pharmacist was not available to meet with the residents or to provide training to staff, therefore was not facilitated in meeting his or her obligations to a resident under any relevant legislation or guidance issued by the Pharmaceutical Society of Ireland.

Judgment:

Non Compliant - Moderate

Outcome 11: Health and Social Care Needs

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

Theme:

Effective care and support

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

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

Findings:

A local GP practice provided medical services to Killarney Community Hospital and the GP's attended the centre on a daily basis. Out-of-hours medical cover was available via a doctor on call service. The inspectors met one of the GP's during the inspection and a sample of medical records reviewed confirmed that resident's were reviewed on a

regular basis. Specialist medical services were also available when required. Reviews and on-going medical interventions as well as laboratory results were evidenced. Residents in the centre also had access to psychiatry of older life via a local clinic in the town and the psychiatrist also visited the centre to review residents if required.

The centre provided in house physiotherapy services where residents are assessed and treated as required. The dietician visited the centre and reviewed residents routinely. There was evidence that residents had access to other allied healthcare professionals including occupational therapy, speech and language therapy, dental, chiropody and ophthalmology services. The inspectors met the Speech and Language Therapist (SALT) who was in the centre undertaking routine assessments of residents. Detailed plans were drawn up and these were evidenced in residents' care plans and dietary plans. Residents and relatives expressed satisfaction with the medical care provided and the inspectors were satisfied that residents' health care needs were very well met.

The inspector saw that each resident's needs were determined following a comprehensive admission assessment. The assessment process involved the use of a variety of validated tools to assess each resident's risk of deterioration. For example, risk of malnutrition, falls, level of cognitive impairment and pressure related skin injury among others. Pain charts in use reflected appropriate pain management procedures. The inspectors reviewed a number of care plans for residents and there were a number of inconsistencies noted. There was evidence of a very comprehensive plan in place for a resident who suffers from seizures, but this had been separated from the other plans so it was easily identified. Overall, the care plans seen tended to be medically focussed and were generally not person centred with residents likes/dislikes and their routines outlined. There was evidence of regular review of resident's assessments on a four monthly basis but it was difficult to establish if care plans were changed or updated as a result of these assessments. Some care plans were in place for a number of years, yet some of the core interventions outlined were around initial assessments and therefore were not appropriate. The inspectors met the practice development officer who showed the inspectors a new suite of assessment and care planning documentation which she plans to roll out with training for staff. The new documentation will have a much stronger emphasis on person centred care. It had been trialled and found to be appropriate in another centre. The inspectors saw evidence of residents signing their care plans indicating that they were consulted on their care at the centre. The residents' social care needs and preferences for activities were assessed using an activity assessment tool. The centre used a detailed form to record residents' social and personal histories. However, this was not completed for all residents. Nursing staff and health care assistants spoken with were familiar with and knowledgeable regarding residents up-to-date needs and agreed that further personalisation of care plans was required.

Residents at risk of developing pressure ulcers had care plans and pressure relieving mattresses and cushions were in place to prevent ulcers developing. Good wound care management was evident in the centre and there was evidence that wound care was evidence based. Inspectors saw that attention was given to promoting continence and assessments were completed to ensure correct use of continence products.

There were systems in place to ensure residents' nutritional needs were met, and that

the residents received adequate hydration. Residents were screened for nutritional risk on admission and reviewed regularly thereafter. Residents' weights were checked on a monthly basis and more frequently if evidence of unintentional weight loss was observed. Residents were provided with a choice of nutritious meals at mealtimes and the inspector saw staff assist residents with eating and drinking. This was undertaken in a discrete and sensitive manner. Residents were complimentary about the food provided. Nutritional supplements were administered as prescribed. All staff were aware of residents who required specialised diets or modified diets and were knowledgeable regarding the recommendations of the dietician and SALT. Inspectors observed that residents appeared to be well cared for, which was further reflected in residents' comments that their daily personal care needs were well met.

Judgment:

Substantially Compliant

Outcome 12: Safe and Suitable Premises

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

Theme:

Effective care and support

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

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

Findings:

The centre is located on the outskirts of Killarney town and is registered to provide long term, respite; palliative and dementia care for 96 residents. Resident accommodation is spread across three separate units; Fuschia which can accommodate 22 residents, Hawthorn which can accommodate 36 residents, and Heather which can accommodate 38 residents. Resident accommodation was mainly provided in large multi-occupancy rooms, with some twin rooms and only two single bedrooms used for end of life care. There was adequate communal space on Fuschia ward with a day room, a sitting room, a dining room, a snoozelan room and another activities room. However, on Heather and Hawthorn wards there was a large shared communal day room, activity room and dining adjacent to which was an area used for storing wheelchairs, hoists and other equipment. This area was only screened off with a curtain and took up a significant amount of space in the communal dining room. The dining room did not have enough tables set up to meet the dining needs of all the residents in the two units.

The centre had been refurbished and upgraded since the previous inspection. The Fuschia unit was provided with an assisted bath which staff said residents enjoyed using. A number of areas were redecorated in a homely and cosy fashion. Fuschia ward

had shop fronts, nice sitting, dining and snoozlene rooms and a garden. This unit was found to be more homely than the other units. . However, there remained significant limitations within the physical environment which negatively impacted on the freedom, choice, privacy, dignity and autonomy of residents and these have been described in detail in previous inspection reports. Similar to findings on all previous inspections, the design and layout of parts of the premises did not conform to the matters listed in Schedule 6 of the Health Act 2007(Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

The six-bed multi-occupancy bedrooms, several of the two-bed bedrooms on Heather and Hawthorn units, and six- and five-bedded rooms on Fuschia unit were unsuitable in design and layout to protect the privacy and dignity of the residents. The design and layout had a significant impact on residents as they were unable to undertake personal activities in private or to meet with visitors in their bedroom in a private area. This is discussed further in outcome 16, resident's rights dignity and consultation. In many cases there was not enough room beside the beds to place a visitors chair or a chair for the resident to sit out of bed. Many beds in the two-bed bedrooms were placed with one side up against the wall due to space restrictions. The limited space in these bedrooms had a negative impact on the storage of residents' clothes and personal belongings. Many residents' wardrobes were not located beside their bed but were located at the end of the bedroom. The wardrobe space was inadequate to meet the residents' storage needs with most residents having clothes stored in the locked linen room on each ward. This issue was also addressed under outcome 17, residents' clothing, personal property and possessions. A bedside locker was not always located beside each resident's bed and lockable storage was not available in the bedside lockers or the wardrobes. Although there was a beautiful well maintained enclosed garden area in Fuschia unit, the residents in Hawthorne and Heather units did not have access to an enclosed garden.

There was a functioning call-bell system in place. Inspectors saw evidence of the use of assistive devices, for example, hoists, wheelchairs, walking aids, clinical monitoring equipment and specialist seating provided for residents' use. However, a regular maintenance schedule of assistive devices could not be found and some devices were only serviced when they required repair.

Many of the requirements of Schedule 6 of the Regulations were not met by the centre including:

- as outlined above, many of the rooms were not of a suitable size or layout for residents
- there was no private visitors room in Hawthorn and Heather units
- the overall storage of wheelchairs, hoists and commodes in the centre was inadequate, for example commodes were seen stored adjacent to residents' toilet cubicles and in shower rooms
- the residents in Hawthorne and Heather units did not have access to an enclosed garden
- there were insufficient numbers of toilets and showers in close proximity to bedrooms on Hawthorn and Heather units to meet the needs of the residents
- many of the toilet and shower rooms did not have locks which meant that residents could not lock them if they wanted privacy

- one of the sluice rooms on Fuschia ward had no hand washing sink
- there was a hole noted in the wall in Heather unit
- in some rooms and corridors the plaster had bubbled and paint work had flaked off the walls.

Judgment:

Non Compliant - Major

Outcome 13: Complaints procedures

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.

Theme:

Person-centred care and support

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

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

Findings:

The centre had a clear policy and procedure in place which was accessible and named the complaints officer and the independent appeals person. The procedure was prominently displayed around the centre and clearly identified who you could complain to. The person in charge informed inspectors that she monitored the complaints and these were discussed at staff meetings.

The inspectors viewed the complaints logs and saw that complaints were recorded in line with the regulations, including, actions taken, the outcome and whether the complainant was satisfied with the outcome. The CNMs monitored complaints at unit level and endeavoured to resolve issues as soon as they arose. Records showed that complaints made to date were dealt with promptly and the outcome and satisfaction of the complainant was recorded. Staff and management spoke to inspectors about actions and improvements which were implemented as a result of complaints.

Judgment:

Compliant

Outcome 16: Residents' Rights, Dignity and Consultation

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

Theme:

Person-centred care and support

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

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

Findings:

There was evidence of consultation with residents and relatives, through residents meetings chaired by activity staff, and relative meetings chaired by the person in charge. Inspectors noted that issues raised by residents were brought to the attention of the person in charge and items were followed up on subsequent meetings. The person in charge told the inspectors that a comprehensive survey had been undertaken in 2016. Results of same showed residents satisfaction with the care and service they received. Inspectors also saw the results from the quality of life audit completed by eight residents where they identified they would like more trips out and these had been facilitated. A number of residents stated that the lack of a garden for Heather and Hawthorn units was a quality of life issue, which management said they were looking into.

Numerous visitors were observed throughout both days of inspection where staff members knew the names of visitors and vice versa. Feedback from relatives was that staff took time to talk with family members both when they visited and when they rang to enquire about their relative. Visitors told the inspectors that they were always made welcome and said that if they had any concerns they could identify them to staff and were assured they would be resolved. The centre operated an open visiting policy and this open visiting policy was observed throughout the inspection. However, the inspectors saw that many visitors visited residents in the multi-occupancy bedrooms as there were limited private or communal rooms for visiting. These visiting arrangements did not promote or protect the dignity of the residents in the other beds who may require personal care or be trying to sleep/rest watch television while visitors were in their bedroom.

The manner in which residents were addressed by staff was seen by inspectors to be respectful. Inspectors heard staff addressing residents by their preferred names and speaking in a clear, respectful and courteous manner. Staff paid particular attention to residents' appearance, dress and personal hygiene and were observed to be very caring towards the residents. Advocacy services were available to residents and residents were facilitated to vote.

Inspectors observed that religious beliefs were facilitated as there was a chapel attached to the building. Mass was held very regularly, which residents could attend if they wished and it was also televised so they could watch from their rooms. Residents also had access to ministers from other religious denominations as required. Residents and relatives confirmed that the spiritual and religious needs of residents were very well met.

A number of residents were facilitated to take part in meaningful activities which met their interests. Inspectors saw a variety of activities ongoing during the two days of inspection. Residents were offered a choice of group activities as well as one-to-one sessions. Some families and residents had completed a 'Life Story' as part of their reminiscence therapy. A daily activities record detailing the residents' involvement in the

activity was maintained. Activities included art therapy, music, bingo, exercises, card playing, gardening, and Sonas. Inspectors met the two activity staff who were providing individual and group activities. Inspectors noted that significant efforts had been made by staff to promote residents' independence with several residents being supported to engage in activities external to the centre and trips out.

Inspectors saw that although staff promoted residents privacy and dignity as best as they could in the multi-occupancy rooms. The location of a limited number of toilets and showers made accessibility challenging for some residents in Heather and Hawthorn units. It meant that residents had to travel through the whole ward in their night attire to the shower or to use the toilet. It also led to a greater reliance on commodes. Due to the close proximity of beds this did not protect residents' privacy and dignity. The inspectors saw one resident on a commode with curtains that did not fully encircle the bed area, gaps were seen and this did not protect the privacy of the resident.

The inspectors saw that on the units a large number of the residents spent long periods of the day in their bedrooms, either in bed or on a chair at their bedside. As residents sat by their own bedside and not close enough to engage in conversation with the resident in the bed next to them this meant that some residents had few opportunities to meet, interact and engage with each other on a social basis. In Fuschia unit many residents did attend the dining rooms for meals and activities. Some returned to their bedrooms immediately following same and others were seen to sit in a cosy sitting room. However, on this unit there were five bedded rooms where a number of residents were seen to spend their day. Staff told the inspector that residents from other bedrooms were also brought into these bedrooms so staff could supervise them. This practice is unacceptable and unnecessary as on this unit there were plenty of nicely decorated communal spaces where all of the residents could spend the day accompanied by staff and not intruding on residents' private space.

The inspectors visited every unit in the centre at 18.00 hours on the first evening of the inspection and found that the majority of residents in the centre were either in bed or sat beside their bed with the exception of one unit where approximately six of the residents were sitting in the day room watching TV. These practices did not fit in with person-centred care nor did it promote the privacy and dignity of the residents on the units which were open to visitors for the evening. On the first day of the inspection, at lunchtime on Heather and Hawthorn units, there were only four tables set and occupied for dinner. This catered for approximately 12 residents out of a total of 72 residents in the units. The remaining residents either had their dinner in their bed or on a bed table beside their bed. Although in the dining room the tables were attractively set and were by the window, the rest of the room was sparse with tables against the wall. The large day room next to it also required attention to make it an inviting place to spend the day. On the second day there was a much higher percentage of residents in the day and dining rooms and residents appeared to enjoy the change of position. The practice of the majority of residents spending their day in multi-occupancy rooms where they eat, slept, used commodes, received visitors was institutionalised and not in keeping with person-centred practices.

A number of residents described the multi-occupancy rooms as noisy and one resident told the inspector she had been disturbed from her sleep at night by the noise from other residents. The inspector saw that in one of the six-bedded rooms one resident was

watching TV and another resident was listening to the radio, both on at the same time, which was distracting and added to the noise level in the room.

Judgment:

Non Compliant - Major

***Outcome 17: Residents' clothing and personal property and possessions
Adequate space is provided for residents' personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.***

Theme:

Person-centred care and support

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

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

Findings:

Some residents had photos and pictures brought in from home displayed but the size and layout of the multi-occupancy rooms did not allow for much personalization of the bed space.

There was a policy in place on residents' personal property and possessions. A record is kept in each resident's file of their personal belongings which is kept up to date. However, residents did not have adequate storage space in their small single wardrobe and bedside locker to store all of their clothes. The majority of residents had extra clothing stored in labelled plastic boxes stored in a locked linen room on each ward which meant that residents' clothing was not accessible to them at all times. The inspectors found that this did not allow residents full choice around their clothing and did not fully enable them to retain control over their possessions and clothing.

There were laundry facilities on site and residents' clothes were labelled to identify who they belonged too. An inspector spoke with the staff member in charge of the centres laundry facility who described good practice in relation to laundry practices. There was good segregation of dirty and clean linen including separate entrances and exits to the laundry, to ensure best practice with infection control.

Judgment:

Non Compliant - Moderate

Outcome 18: Suitable Staffing

There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet

the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

Theme:

Workforce

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

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

Findings:

Inspectors observed warm and appropriate interactions between staff and residents and they observed staff chatting easily with residents. Residents and relatives spoke very positively of staff and indicated that staff were caring and responsive to their needs. This was seen by the inspectors throughout the inspection in the dignified and caring manner in which staff interacted and responded to the residents. Systems of communication were in place to support staff with providing safe and appropriate care. There were handover meetings each day to ensure good communication and continuity of care from one shift to the next. Inspectors saw records of regular staff meetings at which operational and staffing issues were discussed. In discussions with staff, they confirmed that they were supported to carry out their work by the CNM on each unit. The inspectors found staff to be well informed and knowledgeable regarding their roles, responsibilities and the residents' needs and life histories. There were separate cleaning staff who were managed by an outside contractor.

Duty rosters were maintained for all staff and during the two days of inspection the number and skill-mix of staff working was observed to be appropriate to meet the needs of the current residents. The ADON's had responsibility for the duty rosters for all of the units and ensured consistency of care by assigning regular staff to each unit.

There is a practice development officer in post who covers a number of hospitals in the area. The inspectors met her during the inspection and she clearly outlined the provision of training for staff that was ongoing. She highlighted plans for the roll out of new more person-centred assessment and care planning documentation and associated training for all staff. Inspectors saw and staff confirmed that there were many other training courses available to staff in areas such as nursing documentation, continence, preceptorship, medication management, male catheterisation, speech and language for nurses, dementia care, end of life care, restraint procedures, dementia champions training, infection control, food and nutrition hydration and the management of dysphagia. Nursing staff confirmed they had also attended clinical training including blood-letting and wound care. The inspectors saw evidence that other training courses had been booked and were scheduled for the coming months. Staff confirmed the availability of training and a number of staff had undertaken post registration training including higher diplomas in gerontology, palliative care, management and dementia care.

Mandatory training was in place, however as outlined on the previous inspection and in outcomes 7 and 8, not all staff had up to date training in fire safety, safe moving and handling, safeguarding vulnerable persons and the management of responsive behaviours as required by the regulations. This remained non-compliant on this inspection and inspectors saw there was not a comprehensive system in place to identify who had received mandatory training and when it was due. A comprehensive training matrix record is required to ensure all staff received mandatory training within the required time frames as required by regulations.

Supervision of staff was consistent with a clinical nurse manager in charge on each ward, reporting to an assistant director of nursing. The centre had a policy on the recruitment of new staff. However, the system in place to appraise the performance of staff had only commenced and very few staff had received appraisals to date. The centre provided placements for student nurses, Fetac students and transition year students. Appropriate mentorship and supervision was put in place for the students.

Current registration with regulatory professional bodies was in place for all nurses. A sample of staff files was reviewed, there were a number of gaps identified for example one staff file did not contain a full employment history, others did not include details and documentary evidence of any relevant qualifications or accredited training of the person. The centre had in place HSE Garda Vetting Liason Officers Garda vetting report confirmation forms for a number of staff. However, this is not a disclosure in accordance with the National Vetting Bureau Act 2012 as required by schedule 2 of the 2013 care and welfare regulations. The action for this is under outcome 5 Documentation.

Garda Síochána vetting for volunteers working at the centre had been acquired since the previous inspection. The roles and responsibilities of the volunteers were documented and signed for.

Judgment:
Non Compliant - Major

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Caroline Connelly
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	Killarney Community Hospitals (Fuschia, Hawthorn and Heather Wards)
Centre ID:	OSV-0000568
Date of inspection:	28/03/2017 and 29/03/2017
Date of response:	21/04/2017

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non-compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 05: Documentation to be kept at a designated centre

Theme:

Governance, Leadership and Management

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

A sample of staff files was reviewed, there were a number of gaps identified for example one staff file did not contain a full employment history, others did not include details and documentary evidence of any relevant qualifications or accredited training of the person. The centre had in place HSE Garda Vetting Liason Officers Garda vetting report confirmation forms for a number of staff. However, this is not a disclosure in

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

accordance with the National Vetting Bureau Act 2012 as required by schedule 2 of the 2013 care and welfare regulations.

1. Action Required:

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

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

A new staff member's file was missing a CV; this was obtained the following day.

Staff qualifications that are not in staff files will be obtained.

As per HSE policy, the available certification of Garda vetting was received in our centre and we are awaiting direction from a national perspective, with regards to additional information regarding Garda vetting.

Proposed Timescale: 3- 6 months

Proposed Timescale: 30/09/2017

Outcome 07: Safeguarding and Safety

Theme:

Safe care and support

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

There were 57 residents out of the current 91 residents using bedrails at the time of the inspection. Inspectors found this was a very large percentage of bedrail usage and required that this is reviewed to promote a reduction in the use of bedrails.

The centre had a risk assessment tool in place to guide the appropriate use of bed rails for residents. However, the assessment did not adequately outline the requirement to document measures which had been taken/considered to protect residents prior to using bed rails. a detailed risk assessment was not completed for each individual resident, despite it forming part of the centre's policy on restraint. There was also some confusion around what was an enabler and what was a restraint. The whole system around restraint in the centre required review to ensure it was compliant with the national policy.

2. Action Required:

Under Regulation 07(3) you are required to: Ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.

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

Appropriate interventions are being put in place following reassessments to address deficits identified during the HIQA unannounced inspection. These interventions include

purchasing more Ultra Low beds immediately. All residents with bedrails have been reassessed since inspection.

The Clinical Development Co-ordinator is working on new documentation

Proposed Timescale: 4 months for introduction of documentation. 6 weeks for addition of new beds

Proposed Timescale: 31/07/2017

Outcome 08: Health and Safety and Risk Management

Theme:

Safe care and support

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

Not all staff had up-to-date fire training

3. Action Required:

Under Regulation 28(1)(d) you are required to: Make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.

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

Immediate date requested for extra fire training for all out of date staff was held on 5th April 2017 with 4 further dates already booked during April and May which you reviewed at inspection. On these further 4 dates there will be two education sessions and two evacuations per day.

Proposed Timescale: Immediate and Ongoing yearly with at least 6 monthly evacuations

Proposed Timescale: 21/04/2017

Theme:

Safe care and support

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

No recent and regular fire drills had taken place in the centre.

4. Action Required:

Under Regulation 28(1)(e) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and residents are aware of the procedure to be followed in the case

of fire.

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

As per immediate action plan staff drills and evacuations carried out weekly for ten weeks, at staff induction for new staff and at least 6 monthly thereafter.

Proposed Timescale: immediate and 6 monthly

Proposed Timescale: 21/04/2017

Theme:

Safe care and support

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

There was no fire blanket in the smoking room and fire fighting equipment was not in close enough proximity to the smoking room.

5. Action Required:

Under Regulation 28(2)(i) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

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

Fire blanket put in place on 30/03/2017 in smoking room. The fire officer reviewed placement of fire fighting equipment and felt that they were appropriately placed as in the event of a fire they should not be used for people.

Proposed Timescale: Immediate

Proposed Timescale: 21/04/2017

Theme:

Safe care and support

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

The weekly testing of the break glass units beside fire doors was not conducted weekly and there was no evidence of weekly checks of the fire alarm since March 2016.

6. Action Required:

Under Regulation 28(1)(c)(iii) you are required to: Make adequate arrangements for testing fire equipment.

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

Contract to commence with outside fire company week commencing 24th April 2017 to carry out break glass unit testing and weekly checks for fire alarm.

Proposed Timescale: 2 weeks

Proposed Timescale: 21/04/2017

Outcome 09: Medication Management

Theme:

Safe care and support

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

The inspectors saw prescription creams and eye drops on residents lockers in multi-occupancy rooms. These prescription items were not securely stored.

7. Action Required:

Under Regulation 29(4) you are required to: Store all medicinal products dispensed or supplied to a resident securely at the centre.

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

Staff have been spoken to regarding the safe storage of creams and eye drops and all were immediately removed and stored correctly and safely

Proposed Timescale: Immediate

Proposed Timescale: 21/04/2017

Theme:

Safe care and support

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

Medicines for residents were supplied by an onsite pharmacist who also had responsibility for a number of other areas. The pharmacist was not available to meet with the residents or to provide training to staff, therefore was not facilitated in meeting his or her obligations to a resident under any relevant legislation or guidance issued by the Pharmaceutical Society of Ireland.

8. Action Required:

Under Regulation 29(2) you are required to: Facilitate the pharmacist concerned in meeting his or her obligations to a resident under any relevant legislation or guidance issued by the Pharmaceutical Society of Ireland.

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

A Business Case has been sent to the CEO in 2016 requesting a new post of pharmacy technician. This post is to assist the pharmacist to allow him time to provide training to staff and review resident medication and medication charts.

Proposed Timescale: Q4 2017

Proposed Timescale: 31/12/2017

Outcome 11: Health and Social Care Needs

Theme:

Effective care and support

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

It was difficult to establish if care plans were reviewed and updated on a four monthly basis as a number of care plans had interventions for newly admitted residents despite the resident residing in the centre for a number of years. Further personalisation of care plans was required.

9. Action Required:

Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.

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

Staff Education in the use of new nursing documentation (which was reviewed at inspection) commenced on 3rd April and is ongoing with the aim of roll out in early June once received from the printers at the end of May

Proposed Timescale: 3-6 months

Proposed Timescale: 30/09/2017

Outcome 12: Safe and Suitable Premises

Theme:

Effective care and support

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

Many of the requirements of Schedule 6 of the Regulations were not met by the centre including:

- many of the bedrooms were not of a suitable size or layout for residents
- there was no private visitors room in Hawthorn and Heather units
- the overall storage of wheelchairs, hoists and commodes in the centre was inadequate, for example commodes were seen stored adjacent to residents' toilet cubicles and in shower rooms
- the residents in Hawthorne and Heather units did not have access to an enclosed garden.

- there were insufficient numbers of toilets and showers in close proximity to bedrooms on Hawthorn and Heather units to meet the needs of the residents.
- many of the toilet and shower rooms did not have locks which meant that residents could not lock them if they wanted privacy
- one of the sluice rooms on Fuschia ward had no hand washing sink
- there was a hole noted in the wall in Heather unit
- in some rooms and corridors the plaster had bubbled and paint work had flaked off the walls.
- there was no evidence of regular servicing of beds and these appeared to be only serviced when they required repair.

10. Action Required:

Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

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

New build to replace our current building environment to be in place 2021 to address bedrooms and space for resident storage.

Locks to be applied to doors of toilets and showers.

Servicing will be put in place before the end of year for all chairs, beds.

Extra storage for wheelchairs commodes etc can be provided in adjacent building as kitchen department are moving over to a new build behind the St Columbanus

Community Hospital Building and this can be reassigned for storage.

Repair of walls and painting will be carried out to address areas with bubbled plaster holes and flaked paint work

Proposed Timescale: Locks and storage reassignment area 2 months

Service contracts in place 6- 9 months. Repair and painting – 3-6 months

Proposed Timescale: 31/12/2017

Outcome 16: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

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

In Heather and Hawthorn units the limited number of toilets and showers were located at either end of the ward. This meant that residents had to travel through the whole ward in their night attire to the shower or to use the toilet. The inspectors saw and staff confirmed that commodes were frequently used in the multi-occupancy room and due to the close proximity of the resident next door this did not protect or promote any of the residents privacy and dignity. The inspectors saw one resident on a commode and the curtains did not fully encircle the bed area therefore gaps were seen which did not protect the residents dignity.

In Fuschia unit staff told the inspector that residents from other bedrooms were also brought into the five bedded bedrooms so staff could supervise them. This does not protect the privacy and dignity of the residents in those rooms.

11. Action Required:

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

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

Curtains have been checked for size to ensure they fully enclose the bed space

All residents in Fuschia are encouraged to attend the day rooms with immediate effect and are supervised by staff there

New build 2021 to address number of toilets/showers.

Proposed Timescale: Immediate

Proposed Timescale: 21/04/2017

Theme:

Person-centred care and support

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

The practice of the majority of residents spending their day in multi-occupancy rooms where they eat, slept, used commodes, received visitors was institutionalised and not in keeping with person centred practices.

12. Action Required:

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

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

Immediate action was taken.

Heather/ Hawthorn Wards:

CNMs are working on encouraging all residents daily to go to the dining room. This will be closely monitored and if residents refuse this will be documented in their care plans. The dining room has further tables set up to increase room for residents to attend for meal times.

Fuschia ward:

Residents have the choice of the quiet dining room or the larger dining room depending on resident need/choice. Either is to be used for all residents as they wish.

Proposed Timescale: Immediate

Proposed Timescale: 21/04/2017

Theme:

Person-centred care and support

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

The inspectors saw that many visitors visited residents in the multi-occupancy bedrooms as there were limited private or communal rooms for visiting. These visiting arrangements did not promote or protect the dignity of the residents in the other beds who may require personal care or be trying to sleep/rest watch television while visitors were in their bedroom.

13. Action Required:

Under Regulation 11(2)(b) you are required to: Make suitable communal facilities available for a resident to receive a visitor and a suitable private area which is not the resident's room, if required.

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

There is a room available beside the staff dining room that can be used for resident's private meetings (such as solicitor). It is kept solely for this purpose.

Visitors and residents also sit in the quiet area off the large dining room and in the porch (a space inside the main door enclosed with another door).

Proposed Timescale: Immediate

Proposed Timescale: 21/04/2017

Outcome 17: Residents' clothing and personal property and possessions

Theme:

Person-centred care and support

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

Residents did not have adequate storage space in their small single wardrobe and bedside locker to store all of their clothes. The majority of residents had extra clothing stored in labelled plastic boxes stored in a locked linen room on each ward which meant that residents' clothing was not accessible to them at all times. The inspectors found that this did not allow residents full choice around their clothing and did not fully enable them to retain control over their possessions and clothing.

14. Action Required:

Under Regulation 12 you are required to: Ensure that each resident has access to and retains control over his or her personal property, possessions and finances.

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

New build will be available from 2021 for extra storage. Currently residents can request any non-seasonal items at any time as they are stored in the laundry room across the corridor. Generally wardrobes are stocked with seasonal clothes. (winter clothes are stored away from now until end of summer etc)

Proposed Timescale: new build 2021

Proposed Timescale: 31/12/2021

Outcome 18: Suitable Staffing

Theme:

Workforce

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

Mandatory training was in place, however as outlined on the previous inspection and in outcomes 7 and 8 not all staff had up to date training in fire safety, safe moving and handling, safeguarding vulnerable persons and the management of responsive behaviours as required by the regulations. This remained non-compliant on this inspection and inspectors saw there was not a comprehensive system in place to identify who had received mandatory training and when it was due.

15. Action Required:

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

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

Training matrix now in place, which will be reviewed on the first Wednesday of every month to identify when training expires for each staff member

Proposed Timescale: Immediate

Proposed Timescale: 21/04/2017

Theme:

Workforce

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

The system in place to appraise the performance of staff had only commenced and very few staff had received appraisals to date.

16. Action Required:

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

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

Due to the large volume of staff, priority will be given to staff appraisals and they will commence immediately.

Proposed Timescale: 6 month

Proposed Timescale: 30/09/2017

