

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	CareChoice Clonakilty
Centre ID:	OSV-0000230
Centre address:	Clogheen, Clonakilty, Cork.
Telephone number:	023 883 6300
Email address:	clonakilty@carechoice.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	CareChoice Clonakilty Limited
Provider Nominee:	Paul Kingston
Lead inspector:	Caroline Connelly
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	49
Number of vacancies on the date of inspection:	1

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.

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 Quality Standards for Residential Care Settings for Older People in Ireland.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 22 June 2016 09:35 To: 22 June 2016 19:00

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

Outcome	Our Judgment
Outcome 01: Statement of Purpose	Compliant
Outcome 02: Governance and Management	Substantially Compliant
Outcome 04: Suitable Person in Charge	Compliant
Outcome 07: Safeguarding and Safety	Non Compliant - Moderate
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 09: Medication Management	Substantially Compliant
Outcome 10: Notification of Incidents	Compliant
Outcome 11: Health and Social Care Needs	Non Compliant - Moderate
Outcome 13: Complaints procedures	Substantially Compliant
Outcome 18: Suitable Staffing	Compliant

Summary of findings from this inspection

This report sets out the findings of an unannounced monitoring inspection which was the sixth inspection of the centre undertaken by the Health Information and Quality Authority (HIQA). This inspection took place over one day. As part of the inspection the inspector met with the provider, the person in charge, the Clinical Nurse Manager (CNM), residents, relatives, and various staff members. The inspector observed practices and reviewed all governance, clinical and operational documentation.

The provider and person in charge displayed knowledge of the Standards and regulatory requirements and were found to be committed to providing quality person-centred care for the residents. They were proactive in response to the actions required from the previous inspection and the inspector viewed a number of improvements throughout this inspection which are discussed throughout the report.

The inspector spoke with many residents and relatives during the inspection. The collective feedback from residents and relatives was one of satisfaction with the service and care provided. Family involvement was encouraged and there were a number of visitors observed in the centre on the day of the inspection. Staff and

relatives spoke of the residents' summer party that was taking place later in the week, which they were all invited to.

The physical environment was suitable for its stated purpose and was found to be bright and comfortable. The atmosphere was homely, comfortable and in keeping with the overall assessed needs of the residents who lived there. There were plenty of communal space and seating areas along the corridors. Bedrooms were seen to be much personalized. The inspector found that further attention could be placed on colour, signage and décor to create an environment where residents with dementia could flourish. Independence of residents was promoted and many were observed mobilizing freely throughout the centre and outdoor spaces.

The inspector found that residents' overall healthcare needs were met and they had access to appropriate medical and allied healthcare services. The quality of residents' lives was enhanced by the provision of a choice of interesting things for them to do during the day and an ethos of respect and dignity for residents was evident. There were dedicated activity staff that fulfilled a role in meeting the social needs of residents and the inspector observed that staff connected with residents as individuals. The inspector found that residents appeared to be very well cared for and residents and visitors generally gave positive feedback regarding the activities in the centre.

In summary, the inspector was satisfied that the centre was generally operating in compliance with the current conditions of registration granted to the centre. However the inspector did identify that aspects of the service requiring improvement and found assessments, care plans and emergency evacuation plans were not updated in accordance with the changing needs of the residents and in compliance with regulatory requirements. Not all staff had received up-to-date mandatory training in safeguarding and responsive behaviours. The action plan at the end of this report sets out the actions 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 Quality Standards for Residential Care Settings for Older People in Ireland. Improvements included

- 1) care plans required updating to meet the changing needs of the residents
- 2) not all mandatory training was in place
- 3) restraint practices required review
- 4) some residents emergency evacuation plans required updating
- 5) medication administration practices
- 6) complaints management.
- 7) completion of the annual review

The action plan at the end of this report sets out the actions 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 Quality Standards for Residential Care Settings for Older People in Ireland.

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 Quality Standards for Residential Care Settings for Older People in Ireland.

Outcome 01: Statement of Purpose

There is a written statement of purpose that accurately describes the service that is 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.

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The Statement of Purpose was very recently updated with a change to the senior management structure. It was available to staff and residents. It contained a statement of the designated centre's aims, objectives and ethos of care, and all other information required under Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

The inspector found that the statement of purpose accurately described the facilities and services available to residents, and the size and layout of the premises. Residents were provided with the Statement of Purpose on admission and a copy was displayed in the entrance hallway.

Judgment:

Compliant

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):

No actions were required from the previous inspection.

Findings:

There was a clearly defined management structure. The person in charge was supported in her role by two Clinical Nurse Managers (CNM). The person in charge reported to a clinical director who was also responsible for a number of other centres. The clinical director reported to the chief executive officer (CEO). Since the last inspection there had been a change to the directorship of the organisation and to the provider nominee and the statement of purpose was updated to reflect this change.

There were regular management meetings held in the centre that were attended by the person in charge, the CEO, the clinical director, chief financial officer, facilities manager and human resources manager. Minutes of these meetings were available for review and indicated that issues discussed included staffing levels, staff training and all managerial aspects of the running of the centre. The person in charge met formally with nursing staff and care staff on a regular basis and informally on a daily basis.

The auditing programme was well established with key performance indicators (KPIs) reviewed monthly. There was a monthly programme of audits that included audits of falls, medication management, accidents/incidents, psychotropic medications, end of life, restraint and the environment. Although there was some evidence of action in response to issues identified this could be further developed. There was a relative satisfaction survey undertaken in 2015, even though only a small number of relatives completed the questionnaire the feedback was predominantly positive with the exception of one relative who felt staff appeared under pressure at times.

Questionnaires completed by residents also identified that at times they did not feel there was enough staff on duty. This is discussed further under outcome 18 staffing.

There was an annual review of the quality and safety of care completed for 2015 however this had not been finalised to date. It addressed issues such as recent improvements to the premises, evaluation of falls, results of residents and relatives questionnaires and the residents' dining experience and was presented in a format that was accessible to both residents and relatives. Action plans were in place following questionnaires and goals were set and outlined for 2016. This review required completion to ensure it was a sufficiently comprehensive review of the quality and safety of care to ensure that such care was in accordance with relevant standards set by HIQA.

There was an active residents committee and residents with dementia were represented on the committee. Regular residents meetings took place and residents spoken to said their input into the daily running of the centre was encouraged. This was evidenced during the inspection in that a culture of openness and transparency was observed. Residents stated they had influenced the activity programme and new activities had been introduced this year as a result of their suggestions along with changes to the dining experience. Relatives spoken with also gave positive feedback regarding communication and involvement with their relative's care and welfare and the ease of access to staff and the person in charge to discuss matters as they arose.

Judgment:

Substantially 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 has been in post since 2009. She is a registered nurse, with the required experience of nursing dependant people (as detailed in the Regulations). She has years of managerial experience in running the centre and other centres. The post of the person in charge was full-time.

The person in charge demonstrated knowledge and understanding of the Regulations and the National Standards as well as the clinical knowledge to ensure suitable and safe care. Clear management and accountability structures were in place. The person in charge was engaged in the governance, operational management and administration associated with her role and responsibilities.

Staff, residents and relatives identified her as the one with the overall responsibility and accountability for resident care.

There was evidence that the PIC had a commitment to her own continued professional development and had completed many courses such as dementia mapping, person-centred care, and leadership and management. At the time of this inspection she was undertaking a dementia care trainers programme which she planned to implement in the centre. A diverse range of clinical audits were ongoing to inform practice and improve quality of service and safety of residents. The person in charge along with the management team and support staff demonstrated a clear commitment to delivering quality care to residents, continually striving for excellence.

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):

No actions were required from the previous inspection.

Findings:

On the previous inspection the inspector found that although there was an up-to-date policy for adult protection it did not contain the information as stipulated in Regulation 36 regarding immediate notification of an allegation of abuse. On this inspection it was noted that this was now in place which had been updated following the previous inspection. The inspector reviewed staff training records and saw evidence that most staff had received up to date mandatory training on detection and prevention of elder abuse and further training was scheduled for later in 2016. However, there were three new staff that did not have training but the person in charge said this was planned. Staff interviewed were familiar with the policy and knew what to do in the event of an allegation, suspicion or disclosure of abuse, including whom to report incidents to. There was evidence that all allegations of abuse in the centre had been documented, investigated, appropriate action taken and notified in accordance with regulatory requirements.

The centre maintained day to day expenses for a number of residents and the inspector saw evidence that complete financial records were maintained. The inspector reviewed the systems in place to safeguard residents' finances which included a review of a sample of records of monies handed in for safekeeping. Money was kept in a locked safe in the administration office, all lodgements and withdrawals were documented in a ledger and a running balance was maintained. All entries were signed and checked by two staff and there were regular audits of accounts and receipts by the person in charge and the external audit by the accounts department. The system was found to be sufficiently robust to protect residents and staff.

A policy on managing responsive behaviours was in place. The inspector saw training records and although a number of staff had undertaken dementia training there was no evidence that staff had received training in responsive behaviours and specialist dementia training. There was evidence that efforts were made to identify and alleviate the underlying causes of behaviour that posed a challenge. The support of the community psychiatry service was availed of as appropriate to residents needs as further outlined under Outcome 11. From discussion with the person in charge and staff and observations of the inspector there was evidence that residents who presented with responsive behaviours were responded to by staff in a very dignified and person-centred way by the staff using effective de-escalation methods as highlighted in their records.

There was a centre-specific restraint policy which aimed for a restraint free environment and included a direction for staff to consider all other options prior to its use. The inspector saw that the person in charge and staff promoted a reduction in the use of bedrails, at the time of the inspection there were four bedrails in use and the inspectors saw that alternatives such as low low beds, crash mats, and bed alarms were in use for a number of residents. Assessments and regular checks of all residents were being completed and documented. However, there was a form of restraint being used on one resident at the time of the inspection that required immediate review. The inspector was

not satisfied that all other avenues had been explored and that the centre was using the least restrictive alternative for this resident. There was no detailed assessment by an occupational therapist and no clear rationale for use. The person in charge assured the inspector she would give this her immediate attention.

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):

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

Findings:

The centre had an up-to-date health and safety statement and comprehensive policies and procedures were in place relating to health and safety. The risk management policy contained comprehensive details on the identification and prevention of risks in conjunction with the recording, investigation and learning from serious or untoward incidents or adverse events. As part of the continuous monitoring of safety of services, the health and safety committee met once a month and members included heads of each department. A comprehensive health and safety checklist audit was undertaken each month for the protection of residents and staff. Responsibilities were assigned for each issue identified in the audits and these were followed up in the subsequent meeting.

There were arrangements in place for responding to emergencies and the inspector saw that there were suitable arrangements in place if there was a need to evacuate residents which were prominently displayed throughout the centre. Arrangements were also in place with a local hotel to accommodate residents in an emergency situation if they were unable to return to the centre following evacuation.

There were arrangements in place for maintaining a safe environment and a visitors' book was in place for visitors to sign in and out. A reception desk was in the main foyer where staff working at reception had full view of visitors coming and going in the centre. There were grab-rails in place in toilet/bathroom areas. Floor coverings were found to be well maintained. Access to high risk areas such as the sluice room and treatment room was restricted. There was a current policy in place for infection prevention and control. There were hand-sanitising units throughout the centre and wash hand basins were readily accessible. Advisory signage for best practice hand washing was displayed over hand-washing basins. Gloves and aprons were available as required and hand hygiene and infection control training was provided to staff. Staff training records confirmed that staff had up-to-date trained in safe moving and handling practices.

There was suitable fire equipment provided in the centre. Records were available to the inspector that showed the fire alarm was serviced on a quarterly basis and also checked weekly to ensure it is in working order. Fire safety equipment had been serviced as per the Regulations. The centre's training matrix indicated that not all staff had received mandatory annual fire training from a suitably qualified trainer; however, internal training had been provided by fire marshals to enable staff to respond appropriately until the next annual training date. All staff spoken to were found to be aware of what to do in the event of a fire. The fire register was maintained and showed daily checks of the fire escape routes and alarm panel. Fire drills were completed at least biannually and there was documentary evidence of more frequent fire drills, response time and learning from same.

Emergency lighting was serviced quarterly and there were records of the last service which was 06 June 2016. A designated smoking area outside was provided for residents and this was equipped with a fire fighting blanket, call bell, smoking aprons and metal ashtrays. On the day of the inspection there was not a fire extinguisher in close proximity to the smoking area but the provider ordered one on that day to put in place outside. The inspector received an email confirming the order. The inspector saw that personal emergency evacuation plans for individual residents were completed and were easily accessible to all staff. However the personal evacuation plans had not all been kept up-to-date and the inspector saw that a resident whose mobility had deteriorated and was now immobile, continued to have a personal emergency evacuation plan stating he could mobilise with a walking frame. This required immediate updating along with the care plan as identified further under Outcome 11.

A record was maintained of incidents and accidents and these were reviewed by the inspector. They correlated with notifications submitted to HIQA and residents' care plans were reflective of interventions documented in the incidents and accident forms completed. The inspector noted that the issues in relation to the kitchen on the previous inspection had been rectified and appropriate actions had been taken.

Judgment:
Non Compliant - Moderate

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):
No actions were required from the previous inspection.

Findings:
There was a centre-specific, up-to-date medication management policy detailing

procedures for safe ordering, prescribing, storing and administration of medicines and handling and disposal of unused or out-of-date medicines. Nursing staff with whom the inspector spoke, demonstrated good practice regarding administration of medicines with the exception of one nurse touching medications throughout the administration process which is not in line with best practice guidelines. Photographic identification was in place for all residents as part of their prescription/drug administration record chart. Controlled drugs were maintained in line with best practice professional guidelines and the count undertaken by the inspector was found to tally with records in the centre. The medication trolley was securely maintained and a nurses' signature sheet was in place as described in professional guidelines.

Medication management audits were completed six-monthly in conjunction with the pharmacist and these were evidenced during inspection. The person in charge and staff reported to the inspector that the pharmacist is easily accessible regarding advice relating to drug interactions, dosages, crushing of medicines and possible alternatives in prescriptions and regularly liaised with the relevant general practitioners (GPs) regarding prescriptions.

Medications were delivered in monitored dosage units and these were checked by nursing staff to verify that what was delivered corresponded with prescription records. Inspectors reviewed prescription and administration records. Crushed medications were seen to be prescribed as crushed by the GP and maximum doses were in place for as required medications on the sample of drug charts seen by the inspector.

Judgment:
Substantially Compliant

Outcome 10: Notification of Incidents
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:
Safe care and support

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
HIQA had received a number of notifications from the centre and notifications received were reviewed upon submission and prior to the inspection. The follow up to these notifications and actions taken were reviewed on inspection and the inspector was satisfied that all appropriate action was taken in response to all notifiable events.

All notifiable incidents and quarterly returns submitted to HIQA were timely. A record was maintained of incidents occurring in the centre and these correlated with relevant notifications submitted to HIQA.

Judgment:
Compliant

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):

No actions were required from the previous inspection.

Findings:

There were a number of different GP practices providing a service to the residents and residents' health status was reviewed regularly by the doctor including their medication.

Residents' additional healthcare needs were met. Physiotherapy services were available via fit for life exercise classes once a week. If additional physiotherapy is required it is paid for privately. The chiropodist visited regularly and saw all residents as required. Dietician, speech and language and tissue viability services were provided by professionals from a nutritional company who were also contactable by telephone for advice as required. All residents have regular nutritional screening and regular weight monitoring.

Optical and dental services were accessed locally. Mental health services were provided by community psychiatric services and regular reviews by a psychiatrist were available in a local clinic as required. The inspectors were satisfied that facilities were in place so that each resident's wellbeing and welfare was maintained by appropriate medical and allied healthcare services. Residents, where possible, were encouraged to keep as independent as possible and inspectors observed residents moving freely around the corridors.

The inspector saw that residents had a comprehensive nursing assessment completed on admission. 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. There was evidence that non-verbal residents experiencing pain had a pain assessment completed using a validated assessment tool. Pain charts in use reflected appropriate pain management procedures. Each resident had a care plan developed within 48 hours of their admission based on their assessed needs. The inspector found that the care plans were person-centred and individualised. Generally, there were care plans in place that detailed the interventions necessary by staff to meet residents' assessed healthcare needs. However, a number of care plans had not been updated to account for residents' changing needs and on a four-monthly basis as required by the regulations. The inspector viewed the care plan of a resident at end of life which not been updated since

December 2015. The care plan in place did not detail all the residents changed needs and did not direct the required end of life care. There was evidence that residents and their family, where appropriate participated in care plan reviews. Nursing staff and health care assistants spoken with were familiar with and knowledgeable regarding residents needs.

Residents had opportunities to participate in meaningful activities appropriate to their interests and needs. The activities coordinator completed a social history hobbies and interests social assessment for each resident and this formed part of the resident's overall plan of care which facilitated all staff involvement to ensure a holistic approach to care. It included past hobbies, present interests and planned activities, which was signed by the resident. The inspector observed residents reading the daily newspaper, knitting, card playing, and enjoying hand, neck and shoulder massage. The massage therapist visited once a week and residents told the inspector how much they enjoyed massage and felt so relaxed after it. A computer was available for residents in a designated room and one resident regularly used it. Residents' art, poetry and photographs were viewed throughout. One assisted bathroom was redecorated to a spa therapy bathroom with soft lighting, candles, music and aromatherapy. Staff reported that residents, especially those with restricted movement found this bath time very relaxing.

Some residents were interested in gardening and horticulture. There were two enclosed gardens to enhance outdoor activities. There was a chicken coop with four chickens. Further enclosed courtyards were developed to include raised vegetable beds, extra seating, walkways and shrubbery. The garden spaces were picturesque and were seen to be used and enjoyed by residents and one included the smoking area for the centre.

Judgment:

Non Compliant - Moderate

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 complaints policy for the centre had been recently reviewed and clearly outlined the different stages of the complaints investigation process. However, it stated that if complaints were resolved by local resolution then they should just be documented in the resident's notes which is contrary to the regulations which require all complaints to be documented and such records are in addition to and distinct from a resident's individual

care plan.

There was a nominated person separate to the centre's complaints officer to ensure that all complaints were appropriately responded to and records kept. The independent appeals process was included and contact details for the office of the ombudsman.

The complaints procedure was prominently displayed in the centre and outline the independent appeals process. There was a nominated person separate to the centre's complaints officer to ensure that all complaints were appropriately responded to and records kept. The independent appeals process was included and contact details for the office of the ombudsman. The complaints log was reviewed by the inspector who saw that complaints were being recorded. The results of the investigation process and actions taken on foot of a complaint were clearly laid out. The outcome and whether the resident was satisfied was recorded and dated. Relatives and residents to whom the inspector spoke said the person in charge and staff were open and felt they could bring issues to them and they would be resolved.

Judgment:

Substantially Compliant

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):

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

Findings:

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. The inspector saw records of regular staff meetings at which operational and staffing issues were discussed. The inspector saw that staff had available to them copies of the Regulations and Standards. In discussions with staff, they confirmed that they were supported to carry out their work by the person in charge. The inspector found staff to be well informed and knowledgeable regarding their roles, responsibilities and the residents' needs and life histories. There was evidence that residents knew staff well and engaged easily with them in personal conversations.

Residents and relatives generally spoke very positively of staff and indicated that staff were caring, responsive to their needs and treated them with respect and dignity.

The numbers and skill-mix of staff on the day of the inspection was adequate to meet the assessed needs of residents. However, there was evidence in residents meetings that staff were slow to respond to call bells and as discussed under outcome 2 Governance and management, resident and relative questionnaires also identified staffing numbers as an issue. The person in charge explained that the centre had gone through a period of staff shortages and had difficulty recruiting nursing staff. She assured the inspector that they have recruited and employed new staff and are back to full compliment of staff. Residents spoken to said staffing levels were better now. However the inspector requested that they keep the staffing levels and skill mix under constant review to ensure they are meeting the needs of the residents. Staff rosters were in place and staff appeared to be supervised appropriate to their role and responsibilities and this was enabled through the person in charge, CNMs, senior nurses and senior carers.

Mandatory training was in place and staff had received up to date training in fire safety, safe moving and handling. As discussed and actioned under Outcome 7, not all new staff had received training in safeguarding vulnerable persons and not all staff had received training in responsive behaviours. Other training provided included dementia specific training, infection control, end of life, continence promotion, food and nutrition hydration and the management of dysphagia. Nursing staff confirmed they had also attended clinical training including blood-letting and wound care.

There were policies in place for staff recruitment and training which were found to be comprehensive. A sample of staff files was reviewed and those examined were compliant with the regulations and contained all the items listed in Schedule 2. Current registration with regulatory professional bodies was in place for all nurses. Staff files demonstrated that annual staff appraisals were undertaken.

Judgment:
Compliant

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:	CareChoice Clonakilty
Centre ID:	OSV-0000230
Date of inspection:	22/06/2016
Date of response:	21/07/2016

Requirements

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

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

Outcome 02: Governance and Management

Theme:
Governance, Leadership and Management

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

There was a annual review of the quality and safety of care completed for 2015 however this had not been finalised to date. This review required completion to ensure It was a sufficiently comprehensive review of the quality and safety of care to ensure that such care was in accordance with relevant standards set by HIQA.

1. Action Required:

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

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

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

Proposed Timescale:

Outcome 07: Safeguarding and Safety

Theme:

Safe care and support

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

Staff did not have up to date training in management of responsive behaviours.

2. Action Required:

Under Regulation 07(1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.

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

Proposed Timescale:

Theme:

Safe care and support

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

There was a form of restraint being used in the centre at the time of the inspection that required immediate review. The inspector was not satisfied that all other avenues had been explored and that the centre was using the least restrictive alternative for this resident.

3. 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:

Proposed Timescale:

Theme:

Safe care and support

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

Not all staff had received training in safeguarding of residents.

4. Action Required:

Under Regulation 08(2) you are required to: Ensure staff are trained in the detection and prevention of and responses to abuse.

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

Proposed Timescale:

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:

Residents personal evacuation plans had not all been kept up-to-date and the inspector saw that a resident who's mobility had deteriorated and was now immobile, continued to have a personal emergency evacuation plan stating he could mobilise with a walking frame.

5. Action Required:

Under Regulation 28(2)(iv) you are required to: Make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and safe placement of residents.

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

Proposed Timescale:

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:

Best practice was not always adhered to in the administration of medications

6. Action Required:

Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.

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

Proposed Timescale:

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:

A number of care plans had not been updated to account for residents changing needs and on a four monthly basis as required by the regulations. The inspector viewed the care plan of a resident at end of life which not been updated since December 2015. The care plan in place did not detail all the residents' changed needs and did not direct the end of life care.

7. 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:

Proposed Timescale:

Outcome 13: Complaints procedures

Theme:

Person-centred care and support

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

The complaints policy required review to ensure records are kept of all complaints and such records are in addition to and distinct from a resident's individual care plan.

8. Action Required:

Under Regulation 34(2) you are required to: Fully and properly record all complaints and the results of any investigations into the matters complained of and any actions taken on foot of a complaint are and ensure such records are in addition to and distinct from a resident's individual care plan.

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

Proposed Timescale: