<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Gorey District Hospital</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>ORG-0000676</td>
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<tr>
<td>Centre address:</td>
<td>Mc Curtin Street, Gorey, Wexford.</td>
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<tr>
<td>Telephone number:</td>
<td>053 942 1102</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:Barbara.Murphy@hse.ie">Barbara.Murphy@hse.ie</a></td>
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<tr>
<td>Registered provider:</td>
<td>Health Service Executive</td>
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<tr>
<td>Provider Nominee:</td>
<td>Lily Byrnes</td>
</tr>
<tr>
<td>Person in charge:</td>
<td>Anne Coakley</td>
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<tr>
<td>Lead inspector:</td>
<td>Caroline Connelly</td>
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<tr>
<td>Support inspector(s):</td>
<td>None</td>
</tr>
<tr>
<td>Type of inspection:</td>
<td>Announced</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>22</td>
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<td>Number of vacancies on the date of inspection:</td>
<td>7</td>
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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 judgements 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 Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.

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

The inspection took place over the following dates and times
From: 06 February 2014 09:00  To: 06 February 2014 18:00

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

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<td>Outcome 06: Safeguarding and Safety</td>
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<td>Outcome 07: Health and Safety and Risk Management</td>
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<td>Outcome 08: Medication Management</td>
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<td>Outcome 11: Health and Social Care Needs</td>
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<td>Outcome 12: Safe and Suitable Premises</td>
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<td>Outcome 16: Residents Rights, Dignity and Consultation</td>
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Summary of findings from this inspection
This was the third inspection of Gory District Hospital by the Health Information and Quality Authority’s Regulation Directorate. As part of the inspection the inspector met with the person in charge, residents, the clinical nurse managers, nurses, relatives and numerous staff members. The inspector observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files.

The findings of the inspection are set out under 11 outcome statements. These outcomes set out what is expected in designated centres and are based on the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland. Residents’ comments are found throughout the report.

Although the centre had previously been inspected the centre had not been registered by the Authority as the centre provided care for short stay residents for example residents admitted for respite, convalescent, palliative care and residents waiting long stay placements. The centre now requires to be inspected and registered under the Health act 2007. Although there were actions identified on
previous inspections these have not been included in this report as the provider was under the impression at the time there was not a requirement for their completion.

The person in charge and members of the management team displayed a good knowledge of the standards and regulatory requirements and were found to be committed to providing quality person-centered care to the residents.

The inspector found that Gorey District Hospital was clean and bright. Residents received a good standard of healthcare and a system was in place to review the quality and safety of care. There was good communication between staff and residents and relatives. There were systems in place to protect residents. Staff demonstrated clinical competency, kindness and a respect for residents. Clinical care was closely monitored and evaluated on a daily basis by the person in charge. There was a commitment to the training and professional development of staff. There was evidence of the involvement of the dietician, physiotherapist and other members of the multidisciplinary team on a regular basis in the residents care, with good access to general practitioners (GP) services.

The inspector found that the premises posed numerous challenges in the provision of care due to the lack of private and communal space and facilities for residents. The majority of residents were accommodated in multi-bedded rooms. There was no dining room and there were insufficient sitting areas for residents. The social needs of residents were not adequately addressed or catered for as there were no staff designated as activities coordinator and residents were offered little opportunity to engage in meaningful activities. Mealtimes were found not to be social occasions for the majority of residents and generally residents spent their day by their bedsides in multi occupancy rooms.

These improvements and others improvements were required to comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.

Improvements required are described under each outcome statement and are set out in detail in the action plan at the end of this report.

These included improvements in the following areas:

- The premises
- provision of a secure garden
- provision of fire drills
- provision of fire equipment in the smoking shelter.
- elder abuse training
- moving and handling training
- prevention of accidents to residents
- notifications to the Chief Inspector
- the statement of purpose required further information
- care planning
- provision of meaningful activities for residents
Section 41(1)(c) of the Health Act 2007 Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.

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:
Leadership, Governance and Management

Judgement:
Non Compliant - Minor

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

Findings:
The inspector viewed the statement of purpose, which had been updated since the previous inspection. It outlined the ethos and aims of Gorey District Hospital and described the services and facilities that are provided. It outlined the staffing complement and the organisational structure. It also described the arrangements for the development and review of their care plans.

However, the statement of purpose and function did not meet all the requirements of Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended). Omissions included the following: the qualifications and experience of the registered provider, the sizes of rooms, the type of nursing care provided needs to state 24 hour nursing care is provided, the arrangements for residents to engage in social activities, hobbies and leisure interests and the arrangements made for consultation with residents about the operation of the centre.

Outcome 03: Suitable Person in Charge
The designated centre is managed by a suitably qualified and experienced nurse with authority, accountability and responsibility for the provision of the service.

Theme:
Leadership, Governance and Management
Judgement: Compliant

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

Findings:
The person in charge who worked full time in the centre was found to be very clear on her roles and levels of responsibility and was committed to creating an environment that supported quality improvement. She was registered with An Bord Altranais and had been in charge of the centre since 1997.

She demonstrated that she had the clinical knowledge to ensure the suitability and safety of care to residents. She completed a nursing degree in 1999, a master’s degree in health service management in 2004, and a higher diploma in gerontological nursing in 2010. Training records confirmed she had kept her clinical knowledge current showing that she had attended relevant training courses, including train the trainer courses in restraint and in elder abuse.

She was very involved in the day-to-day management of the organisation. The nursing and care staff all reported to her. The person in charge visited all the clinical care areas on a regular basis and was knowledgeable about the residents and their care needs. She was found to be committed to quality improvement and the provision of person-centred care.

Residents, relatives and staff identified the person in charge as the one with overall authority and responsibility for the service. She displayed a good knowledge of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.

Acting up arrangements were in place with the clinical nurse manager taking care of the centre in the absence of the person in charge.

Outcome 06: 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.

Theme: Safe Care and Support

Judgement: Non Compliant - Moderate

Outstanding requirement(s) from previous inspection:
No actions were required from the previous inspection.
Findings:
Inspectors found that there were measures in place to protect residents from suffering harm or abuse. There was a generic HSE policy on the prevention, detection and response to elder abuse. Staff interviewed by the inspector demonstrated a good understanding of elder abuse and were clear about their responsibility to report any concerns or incidents in relation to the protection of a resident.

The person in charge told the inspector that she had completed a train the trainer course and that she monitored the training records of staff. Records showed that update elder training was provided to ten staff in January 2014 with further training sessions planned. However not all staff had received training as is required by legislation.

Records of residents’ finances and invoicing for care were maintained in accordance with HSE policy and best practice guidelines which were also the subject of regular external audit. However, it was identified that the records maintained of money and valuables handed in by a resident/relative for safekeeping at the ward level was not sufficiently robust. Money was stored in a locked cupboard and transactions were not signed and witnessed by resident/relative and staff members which did not safeguard resident’s finances and was not in accordance with the requirements of Schedule 4.

Outcome 07: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Safe Care and Support

Judgement:
Non Compliant - Major

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

Findings:
The fire policies and procedures were centre-specific. The fire safety plan was viewed by the inspector and found to be very comprehensive. There were notices for residents and staff on “what to do in the case of a fire throughout the building. The inspector viewed records which showed that fire training was provided to staff on 2 December 2013. Certification was available to show that the fire alarm system and fire fighting equipment were tested in November 2013. Staff interviewed demonstrated an appropriate knowledge and understanding of what to do in the event of fire however there was no evidence to show that fire drills were being held on a regular basis as required by legislation.

There was a no smoking policy in the centre but there was a designated smoking area for residents in a smoking shelter in the grounds where residents could smoke outside in a covered-in area ensuring adequate ventilation. There was easy access to this smoking shelter from the centre. The inspector found there were not adequate controls in place...
to protect residents as there was no fire blanket or fire fighting equipment available in the shelter. There was not a nurse call system in place and the system of resident supervision when smoking was not sufficiently robust.

There was a centre-specific health and safety statement in place dated August 2013. There was also a risk management policy and a register of risks, detailing the precautions in place to control them. Arrangements were in place for investigating and learning from serious/adverse events involving residents.

Measures had been put in place to facilitate the mobility of residents and to prevent accidents. These included the provision of handrails in circulation areas, grab-rails in assisted toilets and safe flooring in toilets and bathrooms. The centre had a wide corridor enabling easy access for residents in wheelchairs and those people using walking frames or other mobility appliances. The centre had a large, well-maintained garden to the front and an area with a tarmacadam surface to the rear. Seating was provided for residents and visitors. However, the gardens were not safe and secure due to car parking areas and unrestricted access to the main road going through the town. The area to the rear of the premises also allowed access to an unlocked storage shed, which contained gardening and other equipment and the waste bins were also in this vicinity.

The inspector viewed training records which showed that although the majority of staff had received training in moving and handling there were a number of staff who had not received training since 2010. There were a number of different hoists available in the centre. These hoists were serviced on a regular basis as required by legislation and records of same were seen by the inspector. The inspector observed staff assisting residents using the hoists which was completed in a safe manner following best practice guidelines.

The environment was observed to be bright and clean both inside and outside the premises. Personal protective equipment, such as gloves and 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. The CNM1 had undertaken train the trainer in infection control and was providing training and education to staff. Access to the sluice rooms, treatment room and nurses’ office was controlled. However, the inspector observed that the sluice rooms were unlocked and trolleys with chemicals were left on the corridors unattended which could pose a risk to residents.

Although emergency plans were in place in relation to fire and staff demonstrated their knowledge of what to do in an emergency situation, this needed to be formalised and documented in a centre-specific emergency plan to take into account all emergency situations and where residents could be relocated to in the event of being unable to return to the centre.

Clinical risk assessments are undertaken, including falls risk assessment, assessments for dependency, continence, moving and handling.
The provider has contracts in place for the regular servicing of all equipment and the inspectors viewed records of all equipment serviced.

The inspectors saw that there was a comprehensive log of all accidents and incidents that took place. Residents’ accidents and incidents were documented in their nursing notes and the entries corresponded with the accident and incident log.

**Outcome 08: Medication Management**
*Each resident is protected by the designated centres policies and procedures for medication management.*

**Theme:**
Safe Care and Support

**Judgement:**
Non Compliant - Moderate

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

**Findings:**
The inspectors observed a nurse administering the medications, and this was carried out in line with An Bord Altranais agus Cnáimhseachais na hÉireann Guidelines 2007. Medications are prescribed and disposed of appropriately in line with An Bord Altranais agus Cnáimhseachais na hÉireann Guidance to Nurses and Midwives on Medication Management (2007).

The supply, distribution and control of scheduled controlled drugs was checked and deemed correct against the register in line with legislation. Nurses were checking the quantity of medications at the start of each shift. The nurses spoken to displayed a good knowledge of medications and the procedure outlined for administration.

There was a centre-specific policy on medication management in place. It was signed and dated by the person in charge and by nursing staff.

Medications were ordered from the pharmacy in Wexford General Hospital and generally delivered one day per week. Medications could also be delivered at short notice from Monday to Friday. The person in charge told the inspector an arrangement was in place with a local pharmacy to supply medication at the weekend if required and that there was access to a pharmacist in Wexford General Hospital in the case of an emergency. A general stock of medications was maintained for all residents with the exception of residents’ receiving respite care, who brought in their own medication on admission. Some of these medications were stored in compliance monitoring containers which did not contain medication identifiers on them and therefore could lead to errors particularly in the event of a medication that required to be withheld for medical reasons or if the medication fell and required replacing.
An inspector viewed the medication records. Medications were prescribed and disposed of appropriately in line with professional guidelines. However, there were no photographs of residents on the prescription sheet and medication to be crushed were not prescribed by the GP. Nursing staff did not transcribe medications. There was a GP’s signature for each medication prescribed and discontinued. The prescription sheets were designed so that they had to be renewed every 12 weeks. Medications were stored in the drugs trolleys, and secured in the treatment room when not in use. Medication was also stored in a locked cabinet. There was a fridge available for items requiring cool storage.

Outcome 09: 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

Judgement:
Non Compliant - Moderate

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

Findings:
The inspector saw that there was a comprehensive log of all accidents and incidents that took place in the centre.

Incidents as described in the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) had not been reported in accordance with the requirements of the legislation. The person in charge explained this was due to the uncertainty of the requirement to do so for short stay residents and said she would re commence the reporting process.

Outcome 11: Health and Social Care Needs
Each residents wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each residents 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
Judgement:
Non Compliant - Major

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

Findings:
The centre had sufficient GP cover and an out of hour’s service was also provided. A contract was in place with three GP practices in the town. Each practice was responsible during a two month period for assessing newly admitted residents. Residents were seen by a GP within 24 hours of admission. Records confirmed that residents were reviewed regularly by a GP which included regular medication reviews.

Residents had access to a range of other health and social care services. There was evidence of regular visits to residents by a dietician and the inspector met and spoke to the dietician during the inspection who confirmed individual dietary plans were in place for residents which were seen in their notes. Chiropody services were provided in the centre as required. There was a physiotherapy unit located to the rear of the centre and physiotherapy was available one day a week for assessment and the implementation of treatment plans. Consultant geriatrician services were provided from two consultants based in Wexford general hospital services. There was also evidence that residents had access to the local mental health services and other specialist services.

The inspector was satisfied that facilities were in place so that each resident’s wellbeing and welfare was maintained by a good standard of evidence-based nursing care and appropriate medical and allied health care. Residents and relatives said they were satisfied with the healthcare services provided.

Residents had assessments completed on admission which included; dependency level, moving and handling, falls risk, pressure sore risk assessment, nutrition, and mental test score examination. These assessments were generally repeated on a three-monthly basis or sooner if the residents’ condition had required it. The person in charge and staff demonstrated an in-depth knowledge of the residents and their needs however this was not fully reflected in the care plans. Although the care plans were comprehensive and there was evidence of resident/relative involvement they required further personalisation to the resident to ensure person-centred care was delivered.

The management of residents using bedrails required review particularly in relation to obtaining of consent for same. Residents consent to treatment forms were viewed by the inspector and were found to require review as relatives and next of kin had signed consent forms, which do not have any legal standing. Best practice guidelines would advocate the discussion of the requirement for restraint with the next of kin but not the signing of the consent which can only be done by the resident. There was also evidence of uncertainty of what was considered restraint and what was considered an enabler. The person in charge informed the inspector they were using alternatives to restraint in the use of low beds and alarm mats. There was evidence of assessment for the use of bed rails consideration of alternatives and discussion with relatives.
A hairdresser visited every Thursday but apart from that the inspector found that there was little emphasis on the social needs of residents and there was no programme of activities in place. The inspector observed that the majority of residents spent the day by their beds except for a few who spent part of the day in the day room. The inspector observed that residents spent long periods of the day with no social stimulation provided for them apart from reading or watching the television. The inspector also found that, for those residents with dementia, there was little evidence of sufficient activity-focused care to enhance interaction and communication.

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

Theme:
Effective Care and Support

Judgement:
Non Compliant - Major

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

Findings:
Gorey District Hospital was observed to be bright and clean. However the inspector found that the premises posed numerous difficulties in the provision of care due to the lack of private and communal space and facilities for residents. The inspector found that the centre required a number of actions to ensure it met the requirements of legislation. The majority of residents were accommodated in two nine-bedded rooms which afforded little space, privacy or room for personal storage or for the use of assistive equipment. These and other multi-bedded rooms were not personalised. In many cases, lockers and wardrobes were quite small and did not accommodate sufficient clothing to allow residents to exercise choice. There was no lockable storage for residents. There was insufficient communal seating for residents in the day room and there was no separate dining room or separate room for activities.

The inspector noted that there were not enough sockets above resident’s beds and one resident was unable to have a call bell plugged in as the socket was used for the purpose of an alarm mat. There was also a lack of overhead bedside lamps for residents in a number of rooms.

The inspector noted that there were a number of areas around the centre where there was paint coming off the walls particularly around window areas and a chair in the nine bedded room was worn and torn.
There were a sufficient number of bathrooms, shower rooms and toilets. There was appropriate assistive equipment available such as profiling beds, hoists, pressure relieving mattresses, a chair scales, wheelchairs and walking frames. There was an assisted bathroom, which contained a specialist bath that was accessible from both sides. There was ample storage space for special equipment, which was in good condition and had been serviced by an external contractor within the past year. The treatment room, laundry, hairdressing salon and two sluice rooms all had appropriate facilities. The main and side corridors were free of obstacles.

There was a staff changing room, which was clean and tidy and had sufficient lockers and toilets.

Access to garden facilities was discussed under Outcome 7.

During 2013 two further single rooms were upgraded to provide palliative care. There are now three single rooms which are dedicated palliative care rooms and have en suite shower, toilet and wash-hand basin facilities. They also contain reclining chairs for visitors who are facilitated to stay overnight if required. One of the rooms has an adjoining door leading to a room for relatives which has a table and chairs and facilities to prepare drinks and snacks. These were seen to be furnished to a high standard.

**Outcome 15: Food and Nutrition**

*Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.*

**Theme:**

Person-centred care and support

**Judgement:**

Compliant

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

No actions were required from the previous inspection.

**Findings:**

The inspector observed that mealtimes were not social occasions. Although there were two tables in the day room available for residents use all the residents had their meals by their beds in their bedrooms. As previously described two of these rooms were nine bedded this did not afford residents any space or dignity during mealtimes. This is discussed and action is required under outcome 12. Staff said that staffing difficulties and lack of the availability of care staff did not help with the encouragement of residents to move to another area to enjoy their meals. This will be discussed further under outcome 18 staffing.
The food was cooked in Wexford General Hospital. The food was seen to be nutritious and residents stated they had choice and adequate portions. There was a three-week menu cycle. The kitchen staff told inspectors that they advised the cook/chill supplies department in the general hospital of their requirements in advance. There was a choice of main courses on the day and residents told inspectors that they always have choices available to them. Picture menus were available for residents. The dietary needs of residents were conveyed by nursing staff to the kitchen staff.

Many residents required assistance and the inspector observed that this assistance was provided in an appropriate manner.

The inspector observed that residents had access to drinking water at all times. Jugs of drinking water and glasses were present by the bedsides of residents. Water was available in the day room throughout the day and at meals. Residents told inspectors that water is always available and that they are offered a choice of drinks and snacks during the day.

There was a policy on nutrition and as discussed previously the dietician was fully involved in nutritional planning for residents. The inspector viewed a number of residents’ care plans and observed that the weight of each resident was taken regularly and that the Malnutrition Universal Screening tool (MUST) was completed.

The kitchen was clean. There was a food safety management system in place and there was no evidence non-compliance with the requirements of food safety authorities. Kitchen staff had received food handling training.

**Outcome 16: Residents Rights, Dignity and Consultation**

Resident 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.

**Theme:**
Person-centred care and support

**Judgement:**
Non Compliant - Major

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

**Findings:**
Residents who spoke to the inspector said that staff addressed them respectfully and they screening curtains were used in shared rooms when personal care was being delivered. However, the inspector found that residents did not have sufficient space and privacy. There were two nine-bedded rooms, the size and layout of the rooms meant that there was very little space between some of the residents’ beds. The inspector
observed that some residents were trying to rest while other residents were talking or receiving visitors alongside them. There was no lock on the inside of the bathroom door and inspectors found that this could compromise the privacy and dignity of residents. The only communal seating provided for residents on the premises was in the day room, which could accommodate approximately 14 residents.

On previous inspections there had been a residents/family committee meeting held once a month, but this was no longer ongoing. Currently there was no system in place to ensure that residents are consulted with and participate in the organisation of the centre as is required by legislation.

A national newspaper was made available to residents each day and local weekly newspapers were also provided. There was also a small library in the day room which provided access to a supply of books. Residents had access to televisions and radios. Some of the residents had their own mobile phones. A public telephone was available near the entrance and a nurse told an inspector that residents were facilitated to use a phone in the nurses’ office when they needed to make or receive a call in private.

Relatives told the inspector that the staff kept them informed regarding the healthcare and general wellbeing of their relatives and that they were welcome in the centre at any time. A small quiet room was available to see relatives in private if required.

An oratory was available upstairs but could only be accessed by residents who were mobile. Mass took place weekly in the day room.

### 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.

**Theme:**
Workforce

**Judgement:**
Non Compliant - Moderate

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

**Findings:**
The inspector observed warm and appropriate interactions between staff and residents and observed staff chatting easily with residents. Residents and relatives told the inspector that staff were very kind and caring.
The inspector found that staffing levels and skills-mix of staff were not sufficient to meet all the needs of residents on the day of inspection.

It was evidence on the day of inspection that the role of the multi task assistant did not best meet the needs of the residents. Following personal care duties for the first two hours of duty in the morning the multitask assistants then moved onto cleaning and other duties at around 10am. This left two nursing staff to provide direct care to the residents unless there is a health care assistant on duty who is also only assigned to providing care. Further segregation of roles is required to ensure consistent care for residents and to allow for more socialisation for residents. This would also provide more consistency for the purpose of cleaning.

Recruitment was not carried out at a local level. There was a national HSE policy for the recruitment, selection and Garda Síochána vetting of staff. The current registration details were maintained for all nursing staff. An inspector viewed a sample of five personnel files. The files were well organised. However, none of the files contained all the documentation required under Schedule 2. Omissions in some of the files included photographic identification and evidence of physical and mental fitness and references.

Staff told inspectors that copies of the regulations and the standards had been made available to them and that these were also discussed at staff meetings. The inspector viewed minutes of staff meetings and saw that issues covered by the legislation and standards were on the agenda. Minutes of the staff meetings were posted in the staff room.

The inspector viewed the staff training and education records. An overall training matrix was in place and individual records were maintained. The records showed that staff had received training in fire safety and basis life support within the past year. But not all staff had received update training in moving and handling and elder abuse training as discussed previously in the report. Training records also showed that staff had attended training in dementia care, training in palliative care, training in stroke management, wound care and gerontology. One nurse specialised in venapuncture and had provided training and supervision to other nursing staff. One staff had also completed train the trainer in infection control and was rolling the training out for all staff.
Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings, which highlighted both good practice and where improvements were required.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of the residents, relatives, and staff during the inspection.

Report Compiled by:

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

Action Plan

Provider’s response to inspection report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Gorey District Hospital</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>ORG-0000676</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>06/02/2014</td>
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<tr>
<td>Date of response:</td>
<td>17/04/2014</td>
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Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure Compliance with Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.

Outcome 01: Statement of Purpose

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The statement of purpose and function did not meet all the requirements of Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended). Omissions included the following: the qualifications and experience of the registered provider, the sizes of rooms, the type of nursing care provided needs to state 24 hour nursing care is provided, the arrangements for residents to engage in social activities, hobbies and leisure interests and the arrangements made for consultation with residents about the operation of the centre.

Action Required:
Under Regulation 5 (1) (c) you are required to: Compile a Statement of purpose that consists of all matters listed in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Please state the actions you have taken or are planning to take:
Statement of purpose has been updated to reflect requirements under regulation 5 (1) (c)

Proposed Timescale: 14/04/2014

Outcome 06: 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:
Records showed that updated elder training was provided to ten staff in January 2014 with further training sessions planned. However, not all staff had received training as is required by legislation.

Action Required:
Under Regulation 6 (2) (a) you are required to: Make all necessary arrangements, by training staff or by other measures, aimed at preventing residents being harmed or suffering abuse or being placed at risk of harm or abuse.

Please state the actions you have taken or are planning to take:
A training programme is ongoing in elder Abuse. 99% staff trained

Proposed Timescale: 30/05/2014

Outcome 07: 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:
The centre had a large, well-maintained garden to the front and an area with a tarmacadam surface to the rear. Seating was provided for residents and visitors. However, the gardens were not safe and secure due to car parking areas and unrestricted access to the main road going through the town. The area to the rear of the premises also allowed access to an unlocked storage shed, which contained gardening and other equipment and the waste bins were also in this area.

Action Required:
Under Regulation 31 (4) (a) you are required to: Take all reasonable measures to prevent accidents to any person in the designated centre and in the grounds of the designated centre.

Please state the actions you have taken or are planning to take:
A Plan is being devised to ensure safety measures are put in place within the garden to comply with Regulation 31 (4) (a) A landscape gardener has been requested to look at the garden in effort to secure area for clients.
The grounds man has been instructed to ensure that the shed is kept locked when he is not in it.

**Proposed Timescale:** 31/07/2014  
**Theme:** Safe Care and Support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
Access to the sluice rooms, treatment room and nurses’ office was controlled. However, the inspector observed that the sluice rooms were unlocked and trolleys with chemicals were left on the corridors unattended which could pose a risk to residents.

**Action Required:**  
Under Regulation 31 (4) (a) you are required to: Take all reasonable measures to prevent accidents to any person in the designated centre and in the grounds of the designated centre.

**Please state the actions you have taken or are planning to take:**  
1. Lock on sluice rooms effective immediately  
2. Staff were made aware re importance of safety and correct storage of chemicals.

**Proposed Timescale:** 10/02/2014  
**Theme:** Safe Care and Support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
Although emergency plans were in place in relation to fire and staff demonstrated their knowledge of what to do in an emergency situation, this needed to be formalised and documented in a centre-specific emergency plan to take into account all emergency situations and where residents could be relocated in the event of being unable to return to the centre.

**Action Required:**  
Under Regulation 31 (3) you are required to: Put in place an emergency plan for responding to emergencies.

**Please state the actions you have taken or are planning to take:**  
Staff fire training records are maintained in the fire register. Fire training is ongoing. Fire policy been developed in conjunction with Fire officer. Emergency plan is been developed for the centre that will be centre specific to ensure that all clients could be relocated in the event of being unable to return to the centre.

**Proposed Timescale:** 30/05/2014
**Theme:** Safe Care and Support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The inspector viewed training records which showed that although the majority of staff had received training in moving and handling there were a number of staff who had not received training since 2010.

**Action Required:**
Under Regulation 31 (4) (f) you are required to: Provide training for staff in the moving and handling of residents.

**Please state the actions you have taken or are planning to take:**
Staff training in patient moving and handling is ongoing. Arrangements are in place to provide training for staff who had not received training since 2010. This will be completed by 30/6/2014

**Proposed Timescale:** 30/06/2014

**Theme:** Safe Care and Support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was no evidence to show that fire drills were being held on a regular basis as is required by legislation.

**Action Required:**
Under Regulation 32 (1) (e) you are required to: Ensure, by means of fire drills and fire practices at suitable intervals, that the staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire, including the procedure for saving life.

**Please state the actions you have taken or are planning to take:**
Fire training and fire drills have taken place and 85% of staff are trained and the remaining will be trained by June 2014

**Proposed Timescale:** 30/06/2014

**Theme:** Safe Care and Support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The inspector found there were not adequate controls in place to protect residents in the smoking shelter as there was no fire blanket or fire fighting equipment available in the shelter. There was not a nurse call system in place and the system of resident supervision when smoking was not sufficiently robust.
**Action Required:**
Under Regulation 32 (1) (a) you are required to: Take adequate precautions against the risk of fire, including the provision of suitable fire equipment.

**Please state the actions you have taken or are planning to take:**
Since 01/04/2014 Gorey District Hospital is no smoking campus which complies with Regulation 32(1)

**Proposed Timescale:** 01/04/2014

**Outcome 08: Medication Management**

**Theme:** Safe Care and Support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
A number of medication management practices required review to be in compliance with professional guidelines and legislative requirements.

Some of these residents’ medications were in compliance monitoring containers which did not contain tablet identifiers on them and therefore could lead to errors particularly in the event of a medication that required to be withheld or if medications fell.

There were no photographs of the residents on the prescriptions sheet

Medications to be crushed were not prescribed by the general practitioner (GP) as is required by legislation.

**Action Required:**
Under Regulation 33 (1) you are required to: Put in place appropriate and suitable practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents and ensure that staff are familiar with such policies and procedures.

**Please state the actions you have taken or are planning to take:**
Medication management policy is been updated to ensure compliance with Regulation 33(1) All tablets stored for Respite clients must have the name of tablets identified on containers. Management have put in place appropriate and suitable practices and operational policies in relation to the ordering, prescribing, storage and administration n of medication to residents. Same has been disseminated to staff.

Medication management policy is updated to ensure compliance with Regulation 33(1). Same has been disseminated to staff.

Blister pack medication is not accepted as indicated in policy.

No patient required crushed medication on day of inspection. Medications to be crushed are always prescribed by the general practitioner (GP) in keeping with legislation.
As discussed—As patients here are short stay ID wrist bracelets are used to identify patients prior to administering medication.

Patients who are over one month will have photographic ID on their prescription charts.

**Proposed Timescale:** 01/04/2014

### Outcome 09: Notification of Incidents

**Theme:** Safe Care and Support

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

Incidents as described in the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) had not been reported in accordance with the requirements of the legislation.

**Action Required:**
Under Regulation 36 (4) (e) you are required to: Provide a written report to the Chief Inspector at the end of each quarter of the occurrence in the designated centre any incident that the Chief Inspector may prescribe.

**Please state the actions you have taken or are planning to take:**
A written report was submitted commencing the end of March 2014 and will be submitted every quarter from then onwards.

**Proposed Timescale:** 31/03/2014

### Outcome 11: Health and Social Care Needs

**Theme:** Effective Care and Support

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

The inspector found that there was little emphasis on the social needs of residents and there was no programme of activities in place. The inspector observed that the majority of residents spent the day by their beds except for a few who spent part of the day in the day room. The inspector observed the residents spent long periods of the day with no social stimulation provided for them apart from reading or watching the television. The inspector also found that, for those residents with dementia, there was little evidence of sufficient activity-focused care to enhance interaction and communication.

**Action Required:**
Under Regulation 6 (3) (d) you are required to: Provide opportunities for each resident to participate in activities appropriate to his/her interests and capacities.

**Please state the actions you have taken or are planning to take:**
Plan of activities is been put in place to ensure compliance under regulation 6 (3) (d)
The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Although the care plans were comprehensive and there was evidence of resident/relative involvement they required further personalisation to the resident to ensure person-centred care was delivered.

Action Required:
Under Regulation 8 (1) you are required to: Set out each resident’s needs in an individual care plan developed and agreed with the resident.

Please state the actions you have taken or are planning to take:
Pre printed care plans have been personalised for all patients

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Residents consent to treatment forms were viewed by the inspector and were found to require review as relatives and next of kin had signed consent forms, which do not have any legal standing. Best practice guidelines would advocate the discussion of the requirement for restraint with the next of kin but not the signing of the consent which can only be done by the resident.

Action Required:
Under Regulation 9 (2) (c) you are required to: Respect and document each residents right to refuse treatment and bring the matter to the attention of the residents medical practitioner.

Please state the actions you have taken or are planning to take:
Consent forms will be amended to reflect consultation with next of kin.

Outcome 12: Safe and Suitable Premises

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The inspector found that the premises posed numerous difficulties in the provision of care due to the lack of private and communal space and facilities for residents. The majority of residents were accommodated in two nine-bedded rooms which afforded little space, privacy, room for personal storage or the use of assistive equipment. There
was insufficient communal seating for residents in the day room and there was no separate dining room or separate room for activities as is required by legislation.

**Action Required:**
Under Regulation 19 (1) you are required to: Provide suitable premises for the purpose of achieving the aims and objectives set out in the statement of purpose, and ensure the location of the premises is appropriate to the needs of residents.

**Please state the actions you have taken or are planning to take:**
1. Minor capital funding has been applied for, to refurbish the existing staff rest room to have a separate dining area, and locate the staff rest room upstairs.
2 beds have been closed

**Proposed Timescale:** 31/03/2014
**Theme:** Effective Care and Support

The inspector noted that there were not enough sockets above resident’s beds and one resident was unable to have a call bell plugged in as the socket was used for the purpose of an alarm mat. There was also a lack of overhead bedside lamps for residents in a number of rooms.

**Action Required:**
Under Regulation 19 (3) (p) you are required to: Provide ventilation, heating and lighting suitable for residents in all parts of the designated centre which are used by residents.

**Please state the actions you have taken or are planning to take:**
Application has been made under minor capital monies for extra sockets and over bed lightening for the building.

**Proposed Timescale:** 31/07/2014
**Theme:** Effective Care and Support

The inspector noted that there were a number of areas around the centre where there was paint coming off the walls particularly around window areas.

**Action Required:**
Under Regulation 19 (3) (d) you are required to: Keep all parts of the designated centre clean and suitably decorated.

**Please state the actions you have taken or are planning to take:**
New window boards have been installed. Application has been made to tender for repainting of the wards.
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<tr>
<td><strong>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</strong></td>
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<tr>
<td>The inspector noted that there was a chair in the nine-bedded room that was worn and torn.</td>
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<tr>
<td><strong>Action Required:</strong></td>
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<tr>
<td>Under Regulation 19 (3) (c) you are required to: Maintain the equipment for use by residents or people who work at the designated centre in good working order.</td>
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<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong></td>
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<tr>
<td>The chair has been removed. Quotes have been requested to source a new reclining chair.</td>
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<td><strong>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</strong></td>
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<td>In a number of rooms there was no lockable storage for residents use and lockers and wardrobes were found to be quite small and did not accommodate sufficient clothing to allow residents to exercise choice.</td>
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<td><strong>Action Required:</strong></td>
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<tr>
<td>Under Regulation 19 (3) (m) you are required to: Provide suitable storage facilities for the use of each resident.</td>
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<td><strong>Please state the actions you have taken or are planning to take:</strong></td>
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<tr>
<td>Plans to provide suitable storage facilities for all patients is in place.</td>
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| **Proposed Timescale: 31/03/2014** |
| **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:** |
| The inspector found that residents privacy and dignity was not always facilitated particularly in the multi-occupancy rooms, the size and layout of the rooms meant that there was very little space between some of the residents’ beds. |
| There was no lock on the inside of the bathroom door and the inspector found that this would compromise the privacy and dignity of residents. |
**Action Required:**
Under Regulation 10 (c) you are required to: Provide residents with privacy to the extent that each resident is able to undertake personal activities in private.

**Please state the actions you have taken or are planning to take:**
Two beds has been removed from wards and locks applied where necessary. In the overall context of meeting the requirement the HSE nationally and in the South are completing detailed plans in relation to existing buildings to achieve compliance with the environmental standards required this piece of work as not been completed for Gorey hospital as yet. These plans consider the options of refurbishment, extension or full replacement of these facilities. This plan and the overall funding requirement for the HSE will then be put forward for discussion with The Department of Health and ultimately for consideration by The Minister for Health.

**Proposed Timescale:** 31/07/2014

**Theme:** Person-centred care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The inspector saw that there was no system in place to ensure that residents are consulted with and participate in the organisation of the centre as is required by legislation.

**Action Required:**
Under Regulation 10 (g) you are required to: Put in place arrangements to facilitate residents consultation and participation in the organisation of the designated centre.

**Please state the actions you have taken or are planning to take:**
Because of the short stay of many patients it is not always possible to consult with them on an ongoing basis. The Director of Nursing meets every patient on her morning rounds at least 4 times a week and consults with them regarding their satisfaction or concerns and addresses them as they occur promptly. This is recorded in a specific patient satisfaction diary.

Food/menu satisfaction survey are conducted yearly.

A exit survey is in the process of being developed to present to clients on their discharge.

**Proposed Timescale:** 31/05/2014
### Outcome 18: Suitable Staffing

**Theme:** Workforce

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

The inspector found that staffing levels and skills-mix of staff were not sufficient to meet all the needs of residents on the day of inspection.

It was evidence on the day of inspection that the role of the multi task assistant did not best meet the needs of the residents. Following providing personal care for the first two hours of duty the multi-task assistants then moved onto cleaning and other duties at around 10am. This left two nursing staff to provide direct care to the residents unless there is a health care assistant on duty who is also only assigned to providing care. Residents did not receive social stimulation and most remained by their beds for the day and were not assisted to the day room.

**Action Required:**
Under Regulation 16 (1) you are required to: Ensure that the numbers and skill mix of staff are appropriate to the assessed needs of residents, and the size and layout of the designated centre.

**Please state the actions you have taken or are planning to take:**
Plans are being devised to engage with staff and unions regarding the division of roles with care staff. This will address the skill mix and staffing levels.

**Proposed Timescale:** 30/09/2014

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**Theme:** Workforce

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

None of the staff files contained all the documentation required under Schedule 2. Omissions in some of the files included photographic identification and evidence of physical and mental fitness and references.

**Action Required:**
Under Regulation 18 (2) (a) and (b) you are required to: Put in place recruitment procedures to ensure no staff member is employed unless the person is fit to work at the designated centre and full and satisfactory information and documents specified in Schedule 2 have been obtained in respect of each person.

**Please state the actions you have taken or are planning to take:**
A plan in place to ensure compliance with Regulation 18 (2) (a) and (B)

**Proposed Timescale:** 31/05/2014