

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Killybegs Community Hospital
Centre ID:	OSV-0000620
Centre address:	Donegal Road, Killybegs, Donegal.
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Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Kieran Woods
Lead inspector:	Mary McCann
Support inspector(s):	Marie Matthews;
Type of inspection	Announced
Number of residents on the date of inspection:	29
Number of vacancies on the date of inspection:	12

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 inform a registration renewal decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
03 February 2015 11:30	03 February 2015 18:00
04 February 2015 09:30	04 February 2015 14:00

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

Outcome 01: Statement of Purpose
Outcome 02: Governance and Management
Outcome 03: Information for residents
Outcome 04: Suitable Person in Charge
Outcome 05: Documentation to be kept at a designated centre
Outcome 06: Absence of the Person in charge
Outcome 07: Safeguarding and Safety
Outcome 08: Health and Safety and Risk Management
Outcome 09: Medication Management
Outcome 10: Notification of Incidents
Outcome 11: Health and Social Care Needs
Outcome 12: Safe and Suitable Premises
Outcome 13: Complaints procedures
Outcome 14: End of Life Care
Outcome 15: Food and Nutrition
Outcome 16: Residents' Rights, Dignity and Consultation
Outcome 17: Residents' clothing and personal property and possessions
Outcome 18: Suitable Staffing

Summary of findings from this inspection

This was an announced inspection in response to an application by the provider to the Health Information and Quality Authority (the Authority) to renew registration of this centre. The current registration of this centre is due to expire in June 2015. This was the seventh inspection of this centre undertaken by the Authority.

Three residents and five relatives completed a pre-inspection questionnaire. On review of these inspectors found that residents and in the main relatives were positive in their feedback and expressed satisfaction about the facilities, services and care provided. One relative expressed concern with regard to the lack of storage space and one stated that staff were very busy on some occasions. Some residents

spoken with on the day of inspection were unable to verbalise their views but could respond by non verbal strategies which were interpreted by the inspectors as being well cared for. Residents who could verbalise their views were complimentary about their day to day life experiences, the meals provided and the staff team. Comments included "I am very comfortable here, I am treated the best, staff are very nice, I am spoilt by the staff".

This centre has recently had a change of provider representative; fitness of the Provider representative was determined by interview during this inspection. The person in charge was interviewed at the time of initial registration. Fitness of the provider and person in charge will continue to be determined by ongoing regulatory work, including further inspections of the centre and level of compliance with actions arising from all inspections. Fitness of the Person in Charge was determined by previous interview and will continue to be determined as per the provider representative.

Inspectors reviewed documentation submitted by the provider and person in charge since the last inspection ,met with residents, relatives and staff members, observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files. Systems were in place to ensure a safe environment was provided to residents. There were policies, procedures, systems and practices in place to assess, monitor and analyze potential risks with control measures in place to ensure risk minimisation.

The Person in Charge and her deputy demonstrated their knowledge of the legislation and standards throughout the inspection process. The provider representative and the service manager – older persons attended the feedback meeting and voiced a willingness to continually work with the Authority to ensure compliance with current legislation.

An unannounced thematic inspection reviewing Nutritional care and end of life care had previously been carried out by the Authority in May 2014. The areas which required review from the previous inspection related to health care, policy on end of life care and recording end of life care wishes. These actions had been addressed.

Overall, substantial compliance was found in the many outcomes. However, improvements were required in three outcomes as follows:

Outcome 1 – Review of the Statement of purpose

Outcome 2 - Consultation with residents and relative with regard to review of practices and procedures at the centre

Outcome 9 - Enactment of recommendations following a medication error review

Outcome 11 - Health and social care assessments and care plan records

Outcome 12 – Compliance with the national standards with regard to the premises post July 2015

These matters are discussed in the body of the report and outlined in the action plan at the end of this report for the providers' and person in charges' response.

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 provider had submitted a revised statement of purpose as part of the application to register. One of the inspectors reviewed the statement of purpose and found that it did not comply with all the requirements of the Regulations. The statement of purpose requires review to clearly describe the facilities available for long stay residents.

Judgment:

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

about as a result of the learning from the monitoring reviews for example the introduction of the new falls prevention programme. However, no overall report of the annual review annual review of the quality and safety of care delivered to residents which is prepared in consultation with residents and their families was available. The findings from some of the audits were detailed in the quarterly newsletter which was available to residents and their relatives/significant others

Judgment:
Substantially Compliant

Outcome 03: Information for residents
A guide in respect of the centre is available to residents. Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

Theme:
Governance, Leadership and Management

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

Findings:
A comprehensive resident's guide detailing a summary of the service provided was available. However, an easy to read/pictorial guide was not available which would facilitate a better understanding for residents who were cognitively impaired. The Person in Charge gave a verbal commitment to address this.

The inspectors viewed a sample of residents' contracts of care and found that there was an agreed written contract in place which included details of the services to be provided to the resident and the fee payable by the resident.

No additional fees were payable for social care, physiotherapy or occupational therapy.

Judgment:
Compliant

Outcome 04: Suitable Person in Charge
The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:
Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

There had been no change to the role of person in charge since the previous inspection. She has been in post as PIC of this centre since 2009. She is a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service and works 30.15 hours in the centre.

She demonstrated good clinical knowledge and understanding of her legal responsibilities under the Regulations and Standards. She had engaged in continuous professional development in the previous 12 months and had completed courses in legal aspects of nursing documentation, hand hygiene and medication management.

Her mandatory training in adult protection, manual handling and fire safety and her registration was up to date with an Bord Altranais agus Cnáimhseachais na hÉireann (Nursing and Midwifery Board of Ireland) (ABA) were all in date.

Judgment:

Compliant

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The inspectors reviewed a range of documents, including residents' and staff records, directory of residents and insurance policy. The inspector found that generally records were maintained in a manner so as to ensure completeness accuracy and ease of retrieval however, some improvements were required.

For example:

The directory of residents was noted to have minor omissions such as no address for a next of kin to a resident.

Schedule 2 records – documents to be held in respect of the person in charge and for each member of staff were not complete. Omissions included evidence of the person's identity, including a recent photograph, a vetting disclosure in accordance with the

National Vetting Bureau (Children and Vulnerable Persons) Act 2012 and two written references, including a reference from a person's most recent employer (if any).

Schedule 3 records were incomplete in respect of residents nursing care plans as they did not demonstrate that an evaluation of interventions and a review of decisions had taken place at intervals not exceeding four months and a record of consultation with the resident and their significant other if appropriate.

The inspectors reviewed a sample of the Schedule 5 policies and found that they were comprehensive and provided guidance to staff but some were in draft format. All schedule file policies were available.

Judgment:
Substantially Compliant

Outcome 06: Absence of the Person in charge
The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:
Governance, Leadership and Management

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

Findings:
Appropriate arrangements were in place for the management of the centre in the absence of the PIC. An experienced clinical nurse manager who worked full-time deputised in the absence of the person in charge.

One of the inspectors met with this nurse and found that she had engaged in continuous professional development and was familiar with most legal responsibilities of the person in charge including requirements in relation to the submission of notifications to the Chief Inspector.

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:

Measures to protect residents being harmed or suffering abuse were in place. A policy on, and procedures for the prevention, detection and response to allegations of abuse was in place. Staff had received training in adult protection to safeguard residents so as to protect them from harm and abuse.

Staff knew what constituted abuse and knew what to do in the event of an allegation, suspicion or disclosure of abuse, including who to report any incidents to. There were no active incidents, allegations, or suspicions of abuse under investigation.

There was a visitors' record located by the nurses' station on entry to the unit to monitor the movement of persons in and out of the building to ensure the safety and security of residents. This was signed by visitors entering and leaving the building. The centre was further protected by closed circuit television cameras at entrance and exit points.

Residents spoken with and those who had completed questionnaires reported that they felt safe in the centre and related this to the care provided and the premises being kept secure.

The centre had adapted the national policy on a restraint free environment to ensure residents were prevented from potential harm. Before implementing a restraint measure, an assessment was completed to determine the suitability of the restraint for the specific resident and alternatives to the use of restraint had been trialled prior to the enactment of the restraint measure. Following the enactment of the policy the use of bed rails was reassessed periodically and subsequently discontinued for some residents and alternative measures such as low-low beds and bed alarms had been put in place.

The person in charge informed the inspector that there was no resident who was displaying behaviour that challenges at the time of the inspection. There was a policy, which gave instructions to staff on how to manage behaviours that challenge. Some staff had attended training on behaviours that challenge.

Judgment:

Compliant

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):

No actions were required from the previous inspection.

Findings:

The provider had put systems in place to promote and protect the safety of residents, staff and visitors to the centre. There was an up-to-date health and safety statement. A comprehensive risk management policy to include items set out in regulation 26(1) had been developed but was in draft format. An emergency plan was in place to guide staff as to how to respond to serious untoward incidents. There was evidence that specific infection control measures had been implemented including the provision and use of hand sanitising agents by staff. Hand washing facilities with suitable means of hand drying facilities were located in all toilet areas. Hand gels were available throughout the centre.

Arrangements were in place for investigating and learning from serious incidents/adverse events involving residents. Measures are in place to prevent accidents in the centre and grounds. The centre was clutter free with grab rails and assistive devices such as tactile mats and a monitoring device were available to assist residents. The centre had recorded a medication error in April 2014. A comprehensive independent investigation had been completed. However all recommendations from this investigation had not been fully enacted by the person in charge and while there were some that may have been enacted the evidence of how this occurred was not sufficient.

Manual handling assessments had been carried out for residents and were kept up to date. All staff was trained in moving and handling of residents.

All Staff are trained in what to do in the event of a fire. The fire alarm was serviced on a quarterly basis and fire safety equipment was serviced on an annual basis. Regular fire drills are completed, however no fire drill had been completed with the least amount of staff that would be available for example at night time to ensure safe evacuation at all times.

There was adequate means of escape and fire exits are unobstructed. Notices displaying the procedure to adapt to safely evacuate were prominently displayed throughout the centre.

Judgment:

Substantially Compliant

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:

Staff members had completed medication management training to enable them to provide care in accordance with contemporary evidenced-based practice. One of the inspectors observed one of the nursing staff on part of their medication round and found that medication was administered in accordance with the policy and An Bord Altranais agus Cnáimhseachais na hÉireann (Nursing and Midwifery Board of Ireland) guidelines. There were draft written operation policies relating to the ordering, prescribing, storing and administration of medicines to residents. The person in charge demonstrated that there were ongoing audits of medication management in the centre. There was evidence that MDA drugs were checked twice daily by two nurses. The prescription sheet included the appropriate information such as the resident's name and address, any allergies, and a photo of the resident. The General Practitioner's signature was present for all medication prescribed and for discontinued medication. Maximum does of PRN (as required medication) was recorded.

Judgment:

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:

One of the inspectors reviewed records of accidents and incidents that had occurred in the designated centre. On review of these incidents and cross referencing with notifications submitted the inspector found that the centre adheres to the legislative requirement to submit relevant notifications to the Chief Inspector.

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):

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

Findings:

On this inspection the inspectors found that while all residents had care plans improvements were required in this area. On admission, a comprehensive nursing assessment and additional risk assessments were carried out for all residents. For example, a nutritional assessment tool was used to identify risk of nutritional deficit, a falls risk assessment to risk rate propensity to falling. The inspector noted that the assessments did not inform the care plans and where an event occurred for example loss of weight, or a fall, a reassessment was not always carried out, and where it was completed the care plan was not updated. For example, where a resident had fallen the falls risk assessment or any additional control measures that may have been required to mitigate the risk of re-occurrence was not reflected in the care plan. Additionally care plans were not linked together to give a global view of the residents care. For example, skin integrity, nutrition, mobility and pressure area care were not linked. Also some residents had three care plans for the same problem, for example maintaining a safe environment.

Where care plans were reviewed, the only evidence available of consultation with the resident was a staff signature and/or a residents signature that they were reviewed, but no narrative or changes to the identified need. A narrative record was recorded for residents each day but it was difficult to obtain an overall clinical picture of the resident. The records generally described aspects of physical care only and did not convey the full range of care provided on a daily basis such as the social and psychological support provided to ensure residents well-being.

While there was poor documentary evidence in the care files, the inspector found from talking with the staff and residents that it seemed that residents' overall healthcare needs were met. Staff could describe changes to the identified needs of residents and delivery of care in line with contemporary evidence based practice. The interventions described by the staff reflected the needs of the residents even though not documented in the care plans.

Residents had access to appropriate medical and allied healthcare professionals. Residents had good access to general practitioner (GP) services and out-of-hours cover was also readily available. Residents and staff informed the inspectors they were satisfied with the current healthcare arrangements and service provision.

There were processes in place to ensure that when residents were admitted, transferred or discharged to and from the centre, relevant and appropriate information about their care and treatment was available and maintained, and shared between providers and services.

Residents had opportunities to participate in activities that were meaningful and purposeful to them, and which suited their needs, interests and capacities. A specific activity co-ordinator worked in the service three days per week and on the days she was not available a care staff was allocated to this role.

There were no residents with pressure ulcers on the days of inspection. Specialist pressure relieving aids were in place.

Judgment:
Substantially Compliant

Outcome 12: Safe and Suitable Premises

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

Theme:
Effective care and support

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

No actions were required from the previous inspection.

Findings:

Killybegs Community Hospital opened in 2001 and provides a range of services that includes a 41-bedded residential centre, a day centre, x-ray facilities, phlebotomy testing clinics, physiotherapy and occupational therapy. The designated centre is located on the second floor of the hospital.

The majority of residents were accommodated in the centre on a short-term basis for convalescent, respite or palliative care. The building was comfortably warm, clean and odour free. The action with regard to accommodating residents in multi occupancy rooms remained live however, plans are in place to ensure that this centre will be in compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older Persons) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland. A final plan with costing attached is required to be submitted to the Authority to ensure compliance in this area post July 2015.

The layout and design of the multi occupancy rooms poses difficulties to provide for residents' individual and collective needs in a comfortable and homely way on a daily basis. The residents' personal space is not laid out so as to encourage and aid resident's independence and assure their privacy and dignity. There are eight multi-occupancy each of which accommodates four residents, six have en-suite facilities. There are four single bedrooms and two twin bedrooms. A palliative care suite is also provided enabling family members to be with their loved one at end of life.

At the time of this inspection the majority of long stay residents were being accommodated in multi occupancy rooms. The multi occupancy rooms provided only limited space for residents' belongings. While this was not an issue for residents receiving convalescent, respite and rehabilitative care, it did impact on residents receiving long term care.

There was appropriate equipment for use by residents or staff which was maintained in good working order. Equipment, aids and appliances such as hoist, call bells, hand rails were in place to support and promote the full capabilities of residents. Service records were available to demonstrate equipment was maintained in good working order. Staff were trained to use equipment, and equipment was observed to be stored safely and securely. There was suitable and sufficient toilet and bath/shower facilities. Dining room facilities were adequate and were centrally located.

Residents had access to a number of areas where they could sit, some of which had sea views. A chapel is available on the ground floor where Mass is celebrated weekly.

Judgment:
Non Compliant - Major

Outcome 13: Complaints procedures
The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:
Person-centred care and support

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

Findings:
Residents spoken with by the inspector and from completed residents questionnaires identified who they would speak to if they had any issues or wished to make a complaint. The complaints procedure was displayed at the entrance area and clearly described the steps to follow when making a complaint and how the complainant can appeal the outcome of a complaints investigation if not satisfied.

No complaints were documented since the last inspection. The complaints log was reviewed at the time of the last inspection as part of the thematic inspection process. A system to monitor complaints was in place which provides an opportunity for learning and improvement.

Judgment:
Compliant

Outcome 14: End of Life Care

Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.

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:

This outcome was inspected in May 2014 as part of the thematic inspection. The inspector was satisfied that caring for a resident at end-of-life was regarded as an integral part of care provision, although, some improvement was required to the associated assessment and care planning process and to the end of life care policy. The inspector reviewed a sample of residents' records and end-of-life preferences had been documented for all residents. The policy had been reviewed. A pain assessment and monitoring chart was in place to ensure analgesia was administered as required and monitored for its effectiveness.

The centre had established good links with the local palliative care team and were complimentary of the service provided to their residents. Overnight facilities and refreshments were available to residents' family members and friends during end-of-life care.

Judgment:

Compliant

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

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

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

Findings:

This outcome was inspected in May 2014 as part of the thematic inspection. The inspector found that a nutritious and varied diet was offered to residents that

incorporated choice at mealtimes and staff offered assistance to residents in an appropriate and sensitive way. Residents were offered snacks and refreshments at various times throughout the day.

A nutritional assessment tool was used but this was not linked to the care plan (an action with regard to this is contained under Outcome 11). Residents' weights were monitored monthly and more regularly when required. The inspector noted that input had been sought from residents' General Practitioners, a dietician and SALT (speech and language therapy) when required and recommendations were recorded in residents' files but not always reflected in the care plans. Staff had attended training on dysphasia and nutritional care.

Judgment:

Non Compliant - Minor

Outcome 16: Residents' Rights, Dignity and Consultation

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

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

Staff were observed engaging and communicating in a pleasant respectful manner with residents. Adequate arrangements were in place for consultation with residents on the running of the service. A consumer's forum met three times per year. Minutes of these meetings were available. A quarterly newsletter is prepared detailing any changes in the centre and locality. Details of audits undertaken and any improvements as a result of these audits are documented.

Residents confirmed that their religious and civil rights were supported. Mass was celebrated weekly and religious ministers and the priest could be contacted at any time. Residents were facilitated to exercise their political rights and could vote in local, European and national elections. Bedrooms were largely multi occupancy and opportunity to meet relatives/visitors in private was available to residents in the visitors' room or the sitting or dining room.

Residents had access to the television and/or radio and to daily newspapers and newspapers of special interest such as the Farmers Journal. Some residents had their own mobile phone and a cordless phone was also available so that residents and could receive or make telephone calls in private. Communication and notice boards were

provided with information regarding forthcoming events and local news items displayed. Many staff lived locally and could relay the local news to the residents. From the sample of files reviewed the inspector noted that residents' social needs had been documented and a varied full activity schedule was in place.

Judgment:
Compliant

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

Theme:
Person-centred care and support

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

Findings:
Insufficient storage space was noted by inspectors for long stay residents. (an action with regard to this is contained under outcome 12). This was also detailed in some of the relative questionnaires. Some rooms were personalised with personal photographs, pictures and other personal belongings. There was each resident also had a secure area where they could store personal valuables.

The laundry room was spacious and well equipped and minimised the risk of cross infection. Residents expressed satisfaction with the service provided and the safe return of their clothes to them. There were systems in place to safeguard residents' property and money. One of the inspectors reviewed these procedures and found that the provider was compliant in this area. The person in charge stated that they followed the HSE's policies on resident's finances and residents received regular statements from the central accounts department.

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):

No actions were required from the previous inspection.

Findings:

Actual and planned staff rosters were available however the nursing roster did not include the full names of the staff on duty. The Person in Charge rectified this immediately. A staff training programme was on-going. All staff had up to date mandatory training in fire safety, adult protection and manual handling in place.

Training and education relevant to the needs of the residents profile had been provided for example falls prevention, nutritional care and hand hygiene. Evidence of professional registration for all rostered nurses was available and current.

Recruitment procedures were in place and samples of staff files were reviewed. The inspector found moderate non compliance in the sample of staff files examined against the requirements of schedule 2 records, however, an improvement required is referenced in outcome 5 and the associated action plan.

Residents were observed to be relaxed and comfortable when conversing with staff and were complimentary of the staff when speaking with the inspector, stating "staff are great, they would do anything for you, staff is excellent, staff are very nice".

The inspector was satisfied that the numbers and skill mix of staff was appropriate to the assessed needs of residents and the size and layout of the centre on the day of inspection. Residents and staff spoken with expressed no concerns with regard to staffing levels. The inspector observed that call-bells were answered in a timely fashion, staff was available to assist residents and residents were supervised in the dining room throughout meal times.

There was a record maintained of An Bord Altranais professional identification numbers (PIN) for registered nurses. All registered nurses had up-to-date registration.

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:

Mary McCann
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:	Killybegs Community Hospital
Centre ID:	OSV-0000620
Date of inspection:	03/02/2015
Date of response:	28/04/2015

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 01: Statement of Purpose

Theme:
Governance, Leadership and Management

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

The statement of purpose requires review to clearly describe the facilities available for long stay residents.

Action Required:

Under Regulation 03(1) you are required to: Prepare a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Welfare of

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

Residents in Designated Centres for Older People) Regulations 2013.

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

The Statement of Purpose has been amended to describe the facilities available for Long stay Residents including the use of multi occupancy rooms which is discussed with residents prior to admission to Long term care. This has been forwarded to the inspectorate.

Proposed Timescale: 28/02/2015

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:

No overall report of the annual review of the quality and safety of care delivered to residents which is prepared in consultation with residents and their families was available.

Action Required:

Under Regulation 23(e) you are required to: Prepare the review referred to in regulation 23(1)(d) in consultation with residents and their families.

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

Newsletter will be amended and improved to give more detail. Audit results will now be discussed at Resident / Consumer Panel Meetings. An annual review/report will be submitted to the Registered Provider and made available to residents.

Proposed Timescale: 31/12/2015

Outcome 05: Documentation to be kept at a designated centre

Theme:

Governance, Leadership and Management

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

Some Schedule 5 policies were in draft format.

Action Required:

Under Regulation 04(3) you are required to: Review the policies and procedures referred to in regulation 4(1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.

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

Schedule 5 policies are reviewed by the Donegal PCCC Quality Safety and Risk Committee prior to final sign off. The working drafts have now been signed off by this group. They are available to staff on the shared server.

Proposed Timescale: 31/03/2015

Theme:

Governance, Leadership and Management

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

The directory of residents was noted to have minor omissions such as no address for a next of kin to a resident.

Action Required:

Under Regulation 19(3) you are required to: Ensure the directory includes the information specified in paragraph (3) of Schedule 3.

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

Staff have been informed to ensure that the directory of residents is completed in full for all residents and patients. Staff will be reminded of this at staff meetings. This will be kept under review by the Clinical Nurse Manager or Nurse in Charge.

Proposed Timescale: 28/02/2015

Theme:

Governance, Leadership and Management

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

Schedule 2 records – documents to be held in respect of the person in charge and for each member of staff were not complete.

Schedule 3 records were incomplete in respect of residents nursing care plans as they did not demonstrate that an evaluation of interventions and a review of decisions had taken place at intervals not exceeding four months and a record of consultation with the resident and their significant other if appropriate.

Action Required:

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

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

Schedule 2: All records have been reviewed, there are a small number of records incomplete. Documentation has been requested from relevant staff and must be

submitted within one month.

Schedule 3: the CNM II has met with all resident's/ families to discuss their care plans. Family / resident Review Meetings will take place 4 monthly and this will be documented within each care plan.

Proposed Timescale: 30/04/2015

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:

The centre had recorded a medication error in April 2014. All recommendations from this investigation had not been fully enacted by the person in charge.

Action Required:

Under Regulation 26(1)(d) you are required to: Ensure that the risk management policy set out in Schedule 5 includes arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents.

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

Recommendations from the Medication Error have been reviewed and most have been put in place. Ongoing meetings are scheduled with GP's and the pharmacist to improve drug prescribing and administration. The HSE has an adverse incident management policy which is available to staff. Medication audits are undertaken monthly.

Proposed Timescale: 31/05/2015

Theme:

Safe care and support

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

No fire drill had been completed with the least amount of staff that would be available in the centre for example at night time.

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Action Required:

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

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

A night time fire drill will be undertaken and will continue on a bi annual basis

Proposed Timescale: 31/05/2015

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:

Clinical assessments did not inform the care plans and where an event occurred for example loss of weight, or a fall, a reassessment was not always carried out, and where it was completed, the care plan was not updated.

General Practitioners, a dietician and SALT (speech and language therapy) when required and recommendations were recorded in residents' files but not always reflected in the care plans.

Action Required:

Under Regulation 05(3) you are required to: Prepare a care plan, based on the assessment referred to in Regulation 5(2), for a resident no later than 48 hours after that resident's admission to the designated centre.

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

13 nurses have received Care Plan training in 2013/2014 / and training is an ongoing process. Clinical Nurse Manager will take a leadership role in reviewing Care Plans including audit, and feedback to staff. All nursing staff have been informed re: HIQA Inspection findings on care planning. Nursing staff have been asked to consider these recommendations when drawing up, writing and reviewing care plans.

Proposed Timescale: 31/12/2014

Outcome 12: Safe and Suitable Premises

Theme:

Effective care and support

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

The multi occupancy rooms do not comply with the National Quality Standards for Residential Care Settings for Older People in Ireland. The residents' personal space is not laid out so as to protect residents' privacy and dignity.

The multi occupancy rooms provided only limited space for residents' belongings.

Action Required:

Under Regulation 17(2) you are required to: Provide premises which conform to the

matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

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

A design team has been appointed to review current accommodation, to provide plans to maximise the space available to meet the National Quality Standards for Residential Care. These plans will be submitted to HIQA. All staff are made aware of the need to maintain privacy and dignity for persons in their care in multi occupancy rooms.

Proposed Timescale: 31/07/2015