Health Information and Quality Authority
Regulation Directorate

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

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

Centre name:	Killarney Community Hospitals (Fuschia, Hawthorn and Heather Wards)
Centre ID:	OSV-0000568
Centre address:	St Margaret's Road, Killarney, Kerry.
Telephone number:	064 663 1018
Email address:	killarney.hospitals@hse.ie
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Ber Power
Lead inspector:	Aoife Fleming
Support inspector(s):	Breeda Desmond;Liam Strahan;Vincent Kearns
Type of inspection	Announced
Number of residents on the date of inspection:	93
Number of vacancies on the date of inspection:	5

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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:
30 June 2015 09:00	30 June 2015 18:30
01 July 2015 08:30	01 July 2015 17:00

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

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

Summary of findings from this inspection

The inspection was an announced renewal of registration inspection and took place over two days and was the fifth inspection of the centre by the Authority. As part of the inspection process, the inspectors met with the person in charge, residents, relatives, visitors and staff members. The inspectors observed practices and reviewed documentation such as care plans, medical records, incident logs, policies and procedures, risk management documentation and staff records. The documentation

reviewed also included questionnaires completed by residents and relatives and the feedback was positive overall.

The findings of the inspection are set out under 18 outcome statements. These outcomes are based on the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Standards for Residential Care Settings for Older People in Ireland. The person in charge was newly appointed seventeen weeks prior to the inspection. The inspectors conducted an interview with her which established that she was capable and fit to manage the day to day running of the centre. She was easily accessible to staff, residents and visitors. There was evidence of the residents medical and social needs being met and residents were supported by staff to maintain their independence where possible. However, there were issues of non-compliance in relation to the design and layout of areas of the premises as regards the legislative requirement to protect residents' privacy and dignity and to provide adequate space for residents' personal belongings.

Improvements were required in the areas of documentation, safeguarding and safety, medication management, safe and suitable premises, residents clothing and personal property and food and nutrition.
The inspectors would like to acknowledge the preparations made before the inspection which facilitated the inspection process, as well as the response by staff throughout the inspection to address any actions as quickly as possible.

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

Outcome 01: Statement of Purpose
There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:
Governance, Leadership and Management

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

Findings:
The statement of purpose was up to date and was found to contain most of the information required by Schedule 1 of the Regulations. However, as the centre mainly cared for older, long term care residents, the section on nursing care provided which included care of the person with intellectual and functional disability and care of the young chronic sick, required amending to appropriately reflect practice in the centre. Also, the age range and gender of residents for whom care is provided were not outlined.

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:
The centre had a clearly defined management structure. The centre was managed by a full time person in charge who was a director of nursing. The person in charge was

supported by two assistant directors of nursing, one of whom is the nominated person participating in management. Each of the three units was managed by a full time clinical nurse manager. The lines of accountability and authority were clearly defined and all staff were aware of the management structure and were facilitated to communicate regularly with management.
Audits were conducted on many areas such as;
• skin integrity audit
• falls audit
• end of life care
• usage and legibility of prescriptions
• physical restraints
• oral hygiene
• resident identification systems on charts.

Evidence of resident satisfaction surveys were seen by inspectors. Residents meetings were held on a regular basis and they were consulted on the running of the centre.
An annual review of the quality and safety of care in the centre had been conducted in June 2015. While the review did set out the audits, education, policy updates and resident consultation that had taken place in the centre however, it did not adequately address the quality and safety of care delivered in the centre. In addition, the learning and improvements brought about as a result of the audit activity conducted in the centre were not addressed in the annual review.

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 residents' guide was available in the centre and was made available to all residents and visitors.
Signed contracts of care were viewed by inspectors. The contracts set out the fees for services provided in the centre and the details of the nursing home support scheme where applicable. However, the additional fees for items, such as hairdressing, chiropody and the purchase of toiletries, were not set out in the contract.

Judgment:
Substantially Compliant

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

Theme:
Governance, Leadership and Management

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

Findings:
A new person in charge had been recently appointed in the centre. This nurse had the suitable qualifications and experience, required by the regulations, to operate as person in charge of the centre. The person in charge was engaged full time in the day to day running of the centre and residents and staff were familiar with her and her role. The person in charge attended regular training sessions and provided training to staff in areas such as the use of restraint and elder abuse.

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 found that documentation in the centre was well organised and made very accessible during the course of the inspection. A sample of staff files were reviewed against the requirements of Schedule 2 of the Regulations. However, not all staff files had a full employment history set out.
The Directory of Residents did not outline for each resident the date on which the

resident was first admitted to the centre, the telephone number of the residents' general practitioner, or the name and address of any authority, organisation or other body which arranged the resident's admission to the centre, as required by Schedule 3(3) of the regulations.
There was a complaints record book in place in each unit of the centre. However, minor incidents and issues other than complaints were seen to be recorded in the complaints book. This issue was addressed under Outcome 13 Complaints.

All of the policies required by Schedule 5 of the Regulations were in place and available to staff in each unit in the centre. However, the policy on restraint was out of date as it was due for renewal in November 2013.

A copy of the statement of purpose, the residents' guide and recent Health Information and Quality Authority (HIQA) inspection reports were available to staff, residents and visitors in each unit in the centre. The person in charge had copies of all notifications submitted to the Authority as required under Regulation 31. A directory of visitors to the centre, and to each unit, was maintained, and all fire safety records were available.

The inspectors viewed a number of residents nursing notes and care plans. Residents had a detailed assessment of their medical, social needs and history on admission to the centre. Photographs were in place on residents' files and medication prescription and administration sheets. An on-going record of all medical, nursing and allied healthcare professional assessments and treatments were maintained in the residents' files. A record of all medications administered in the centre was maintained for each resident and medication errors were recorded in the centres incident record book. A restraint register was in place. Detailed care plans were in place for residents to meet their active clinical needs. However, there were some gaps in the documentation of care plans. This was outlined in Outcome 11 Health and Social Care Needs.

Judgment:
Non Compliant - Moderate

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

Theme:
Governance, Leadership and Management

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

Findings:
The person in charge was supported by an assistant director of nursing who was the nominated person participating in management. She worked full time at the centre and was familiar with the Regulations and standards, including the requirement to notify the

Authority if the person in charge was absent for more than 28 days.

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:
The policy on elder abuse was up to date and referenced the most recent Health Service Executive policy 'Safeguarding vulnerable persons at risk of abuse 2014'. However, one of the centres policies on protection of residents had an organogram which suggested that there was a line of reporting from the Authority to the Garda Síochána which does not reflect practice in every situation. Residents with whom inspectors spoke said that they felt safe in the centre. Relatives spoken with had no concerns regarding the care in the centre. Staff spoken with were familiar with the policy, with different types of abuse and with what action to take in the event of an allegation or incident of abuse. However, not all staff had up to date training in the detection and management of elder abuse.

The centre had a policy on the management of behaviours that challenge. All staff had up to date training in this area to guide them in day to day practice. Inspectors viewed the care plans of residents with behaviours that challenge. While there was much detail in the pre-printed interventions on the plan, there was a lack of resident centred information regarding the triggers of and interventions to manage the behaviours. The inspectors viewed a sample of residents' care plans and medication prescription sheets. Incidents of chemical restraint, where medication had been prescribed and administered to control behaviours that challenge, were seen. However, the policy on restraint in the centre only addressed physical restraint and did not include chemical restraint. In addition, such incidents had not been notified to the Authority. This was addressed in Outcome 10 Notifications and discussed with staff and management during the course of the inspection.

The centre had a risk assessment tool in place to guide the appropriate use of bed rails for residents. However, the assessment did not adequately outline the requirement to document measures which had been taken/considered to protect residents prior to using bed rails. One step of the tool made reference to a detailed risk assessment which assessed the risk of injury of using bed rails and weighed this against the risk of injury

of not using bed rails. However, this detailed risk assessment was not completed for each individual resident, despite it forming part of the centre's policy on restraint. As outlined in Outcome 5 Documentation the centre's policy on restraint was out of date. Also, there were gaps in the maintenance of the bed rail assessment documentation as forms were not always completed in full.

The systems to manage residents' finances were reviewed by inspectors. While a system to record payments into and out of residents finances stored on wards was in place however, the receipts in place to support transactions were often not individualised or double signed by two staff members when resident toiletries were often bought in bulk.

Judgment:
Non Compliant - Moderate

Outcome 08: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Safe care and support

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

Findings:
The centre had an up to date health and safety statement and policies on health and safety in the centre. The risk management policy addressed the identification and management of the risks required by Regulation 26(1). The centre had a detailed infection prevention and control policy in place. There were hand washing basins and hand sanitising agents available in all rooms. However, inspectors were not assured that the deep cleaning schedule appropriately covered all areas as in one bedroom accumulated dust was found on bed frames and wall pipes, and cobwebs were seen on the ceiling. This was pointed out to the person in charge and addressed immediately during the inspection.

The inspectors viewed the incident and accident log and found that appropriate action was taken to learn from incidents in order to improve safety in the centre. The centre had an up to date and detailed risk register and had identified many risks present in the centre. One unit had a designated outdoor smoking area and the other two units had a designated smoking room. Residents who were smokers had individual smoking risk assessments in place and all cigarettes and lighters were safely stored by staff.

However, not all risks in the centre had been identified and risk assessed. Lockers in residents' bedrooms were unsecured and stored latex gloves posing a risk of accidental injury to residents. A clinical room where oxygen cylinders were stored was not signed appropriately to identify the presence of a combustible gas. This was addressed during

the course of the inspection and a sign was put in place. In a cleaning store room there were old dusters and parts of old vacuum cleaners stored which were no longer in use and posed a risk of cross contamination. This was addressed immediately during the course of the inspection and the items were removed.

The centre's fire alarms, fire equipment and emergency lighting service records were all up to date. However, the weekly testing of the break glass units beside fire doors was not conducted weekly. Fire training was provided to staff on regular occasions and evidence of recent and regular fire drills were in place. However, the details of the fire drills did not always outline the number of staff who participated in the evacuation and the detail of the fire drill outcome. Not all staff had up to date training on fire safety. Daily checks of the fire equipment and fire exits were conducted and the centres fire evacuation policy was displayed prominently throughout the centre. On the first day of the inspection not all residents had a personal emergency evacuation plan (PEEP) in place; this was addressed immediately and on day two of the inspection all residents had a PEEP in place.

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:
The centre had an up to date policy for medication management. However, the policy did not adequately outline the processes in place for the return of controlled drugs to the pharmacy. Also, the policy did not outline the requirement to ensure that the maximum dose of PRN (as required) medications wass prescribed on the medication prescription. The policy did not outline the process of using and documenting the results of the anticoagulation point of care test device system in use in the centre to guide residents' warfarin doses.

The inspectors viewed a sample of medication prescription and administration sheets. The prescriptions were legible and contained the required resident information. However, there were some gaps in the administration fields of some prescriptions which did not explain whether the medication had been refused, withheld or missed. Residents' allergy status was not always recorded on the prescription. Medications for crushing were not annotated individually to indicate the prescriber's approval for this unlicensed administration of each medication on residents' prescriptions. Also, the maximum dose of PRN (as required) medications was not always prescribed. On one

prescription, the inspector saw that the same softening laxative had been prescribed twice in the PRN (as required) section of the prescription; in one case it was prescribed as one sachet as required, in the second case it was prescribed as one sachet once a day. The inspectors were not assured that the practice regarding the administration of laxatives was in line with evidence based practice as the softening laxative and an enema were administered to a resident at the same time, followed by a second dose of the softening laxative 3 hours later.

Medications were stored securely in locked trolleys and the trolleys were stored securely in locked rooms on each unit. However, eye drops did not always have a date of opening recorded on the bottle. The centre maintained up to date controlled drugs registers and the balances of all controlled drugs were checked twice daily at the start of each shift by two staff nurses. A random check of controlled drugs balances by the inspector found that these were in line with the documented records. Medication errors were recorded in the centre incident recording log. Evidence of learning from these errors was discussed by staff with inspectors. Audits on the 'usage and legibility of prescription chards' were also conducted in the centre on a regular basis.

The inspector spoke with the centre's pharmacist who is involved in the day to day supply of medications to the wards. The pharmacist also maintained a record of interventions and recommendations they made to the doctors. Staff reported that the pharmacist was available to provide support and advice regarding medication issues.

The centre was in the process of implementing a new system for the supply of medications. Medications on Fuschia ward were dispensed by the pharmacist, labelled for each individual resident, and stored in resident named trays on the medication trolleys. Medications on Heather and Hawthorn wards were not dispensed and labelled for individual residents but supplied as stock by the pharmacist and administered by nurses from the medication trolley; staff informed the inspectors that the new system would be implemented on these two wards in due course. The nurses on Fuschia ward reported that they found the new system safer and that it would the risk of medication error. On review of the system the inspector found that the new system for the supply of PRN (as required) medications had not yet been finalised. There were insufficient stocks on the trolley to meet the needs of the residents should they require a PRN (as required) medication. The inspector acknowledges that this system is in development, however the impact of this could result in a PRN (as required) medication not being available when needed for a resident.

Judgment:
Non Compliant - Moderate

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:
A record of all incidents in the centre was maintained and the person in charge kept copies of all notifications submitted to the Authority in the centre. The centre had submitted the required notifiable incidents with three working days over recent months. The quarterly report submitted to the Authority accurately reflected the number of residents using physical restraints. However, incidents of the use of chemical restraint that were seen on inspection were not submitted to the Authority.

Judgment:
Non Compliant - Moderate

Outcome 11: Health and Social Care Needs
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

Theme:
Effective care and support

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

Findings:
The residents were under the medical care of a medical officer and had a choice of male or female general practitioners from this practice. Staff reported, and inspectors observed, that general practitioners visited the centre on a daily basis to meet the needs of the residents. Residents had a record of regular blood samples maintained in their medical notes. Records of residents body mass index, blood glucose recording, warfarin monitoring were all in place where appropriate. Residents and relatives spoken with were all satisfied with the medical care in the centre.

There was evidence in residents' medical and nursing notes of timely access to allied health care professionals such as chiropody, occupational therapy, physiotherapy, dietician and speech and language therapy. Inspectors viewed a sample of residents' nursing and medical notes. Detailed assessments of residents activities of daily living and medical needs were documented on admission to the centre. However, the use of care plans was inconsistent between residents' files and there were gaps in care planning and assessment documentation. Inspectors found blanks on the fields of some residents' forms for the assessment of their activities of daily living. For one resident with a pain care plan, the pain medication listed on the front of the care plan did not

include the most up to date pain medication prescribed. There was no daily note made in the care plan for one month between 29 May 2015 and 29 June 2015. This resident also had diabetes and had detailed recommendations from the dietician regarding care of their nutritional needs. However, there was no care plan in place to support this part of the residents needs. This was addressed under Outcome 15 Food and Nutrition. Another resident had recently had an eye infection. Inspectors were assured that care was been given, however a care plan was not initiated to support the management and treatment of the infection. As care plans were often in place which had been initiated in 2014 with no updated interventions recorded, it was difficult for inspectors to evaluate whether or not the care plan had been reviewed regularly by nursing staff to reflect residents' most up to date needs.

There was evidence of residents signing their care plans indicating that they were consulted on their care at the centre. The residents' social care needs and preferences for activities were assessed using an activity assessment tool. The centre used a detailed form to record residents' social and personal histories. However, this was not completed for all residents.

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

Findings:
The actions of the last inspection were addressed with flour covering being in a good state of repair throughout the centre. The centre was found to be decorated in a homely manner. Emergency call bells were in place in all rooms.There was adequate communal space on Fuschia ward with a day room, a sitting room and another activities room. However, on Heather and Hawthorn wards there was a large shared communal dining room, adjacent to which was an area used for storing wheelchairs, hoists and other equipment. This area was only screened off with a curtain and took up a significant amount of space in the communal dining room.

The six-bed multi-occupancy bedrooms, and several of two-bed bedrooms on Heather and Hawthorn wards, were unsuitable in design and layout to protect the privacy and

dignity of the residents. The design and layout had a significant impact on residents as they were unable to undertake personal activities in private or to meet with visitors in their bedroom in a private area. In many cases there was not enough room beside the beds to place a visitors chair or a chair for the resident to sit out of bed. Many beds in the two-bed bedrooms were placed with one side up against the wall due to space restrictions. The limited space in these bedrooms had a negative impact on the storage of residents clothes and personal belongings. Many residents' wardrobes were not located beside their bed but were located at the end of the bedroom. The wardrobe space was inadequate to meet the residents' storage needs with most residents having clothes stored in the locked linen room on each ward. This issue was also addressed under Outcome 17: Residents' clothing, personal property and possessions. A bedside locker was not always located beside each residents' bed and lockable storage was not available in the bedside lockers or the wardrobes.

Many of the requirements of Schedule 6 of the Regulations were not met by the centre including:
- as outlined above, many of the rooms were not of a suitable size or layout for residents
- there was no private visitors room in Hawthorn and Heather wards
- the overall storage of wheelchairs, hoists and commodes in the centre was inadequate, for example commodes were seen stored adjacent to residents' toilet cubicles and in shower rooms
- there was no assisted bath in the centre (Fuschia ward only had a normal bath in place)
- there were insufficient numbers of toilets and showers on Hawthorn and Heather wards to meet the requirements of the National Quality Standards for Residential Care Settings for Older People in Ireland
- not all toilets and showers in the centre had hand rails or grab rails to assist residents
- many of the toilet and shower rooms did not have locks which meant that residents could not lock them if they wanted privacy
- one of the sluice rooms on Fuschia ward had no hand washing sink
- the second sluice room on Fuschia ward did not have air drying racks or a storage rack. Urinals which had been used were seen stored on the ground and empty urinals were stored on top of bins posing a risk of cross-contamination
- the curtain around one bed in a double room on Fuschia was not long enough to completely screen off the bed. This was amended by day two of the inspection as the second part of the curtain had been returned from the laundry after washing
- a pipe in a toilet room on Fuschia which was leaking and causing rust was mended during the course of the inspection
- in some rooms the plaster had bubbled and paint work had flaked off the walls.

Judgment:
Non Compliant - Major

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

Theme:
Person-centred care and support

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

Findings:
The centre had a clear policy and procedure in place which was accessible and named the complaints officer and the independent appeals person. The inspectors viewed the complaints logs which had evidence of complaints being documented and responded to in a timely manner. Staff and management spoke to inspectors about actions and improvements which were implemented as a result of complaints. However, other issues such as maintenance issues were recorded in the complaints logs which was not appropriate.

Judgment:
Substantially 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):
No actions were required from the previous inspection.

Findings:
The centre had an up to date policy on end of life care. However, the policy did not reference the detailed advanced care directive process which was being implemented in the centre. Inspectors saw evidence in many residents' care plans of a detailed discussion around advanced care planning which was held with residents, and their families and the general practitioner if appropriate. Inspectors saw that care for residents at end of life was guided by a detailed care plan. Evidence of specialist palliative care team involvement was seen in a care plan for a resident at end of life. Staff informed inspectors that where possible, a single occupancy room was made available for residents at end of life should they wish to move to this room. However, the spiritual needs of residents were not always recorded or considered in the end of life care plan. As outlined in Outcome 12 Safe and Suitable Premises, there was no a private visitors room on Heather and Hawthorn wards to accommodate residents' relatives or visitors at end of life.

Judgment:

Substantially 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):
No actions were required from the previous inspection.

Findings:
Inspectors spoke with the central kitchen staff and it was evident that they had a robust system in place regarding the storage and preparation of meals. All kitchen staff had training on Hazard Analysis and Critical Control Point (HACCP). Each ward had a kitchenette where meals were delivered to, from the central kitchen. There was a designated staff member working in each kitchenette every day and inspectors found that they were up to date on the dietary needs of residents and any modifications required for residents with swallowing impairment. They had an up to date record of recommendations for residents who had been reviewed by the dietician or speech and language therapist. The kitchen staff were familiar with the residents' particular likes and dietary requirements, for example diabetic and coeliac residents were known to kitchen staff and their needs were catered for. There was evidence of regular dietician and speech and language therapist reviews. Residents' Malnutrition Universal Screening Tool (MUST) scores, to assess their nutritional status, were kept up to date in their care plans. There were some residents who received nutritional supplements which were administered as prescribed by the dietician and a record of daily administration was maintained. However, in one case an inspector found that there were gaps in the administration dates for a nutritional supplement which was prescribed for daily administration for a resident with diabetes and a wound. The dietician had recommended a low fat diabetic diet for this resident. However, there was no care plan or detailed food chart or record to guide this resident's nutritional care.

The inspectors observed residents' mealtimes. Meals were served in a dignified manner and residents were assisted to eat their meals discreetly, on a one to one basis, where appropriate. Residents had the option of having their meal in the dining rooms, served in bed or at the bedside. Drinking water, snacks, and juices were readily available throughout the day. The food was nutritious and freshly prepared. Choice was provided to residents and they had chosen their meals on a daily basis. Inspectors saw that at dinner time a selection of meals was available to meet residents preferences. However, inspectors found that the meal times in the centre were largely governed by staff rosters and were not appropriately spaced out through the day. This was acknowledged in the feedback meeting by management and staff. Breakfast was served at 8.15, dinner was served at 12.15 and the evening supper was served at 16.20. While a tea round was

provided at 19.00 with snacks available, inspectors found that the main meal times were not at a time convenient for residents. It was noted that some residents had noted in residents meeting that the evenings were often very long. Inspectors formed the view that the early evening supper time, along with reduced activities in the evening, contributed to this.

Judgment:
Non Compliant - Moderate

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:
Inspectors saw evidence that residents were consulted about how the centre was run. Residents' satisfaction surveys were conducted. The minutes of residents meetings and family/relative meetings were viewed.
Residents had access to televisions in the day rooms and the bedrooms. However, the positioning of televisions in the bedrooms was not accessible for all residents to view comfortably. This was due to the layout of the beds in the multi-occupancy rooms and the location of televisions high up on the walls or at the end of the bedroom placed high up. In one six-bed multi-occupancy bedroom the television screen was not large enough to be viewed by all residents in the room.

Residents were facilitated to take part in meaningful activities which met their interests. However, activities were mainly dependent on the activities coordinators and there were records in the residents' meeting minutes that there was not enough activities in the evening. While staff told inspectors that residents often enjoyed activities such as cards and one to one chats in the evening with the staff on duty, this was not a structured arrangement.

Inspectors noted that significant efforts had been made by staff to promote residents' independence with several residents being supported to engage in activities external to the centre. However, inspectors also noted that the communication needs of one resident were not being met as staff were not trained to meet his specific communication needs and a detailed care plan regarding these needs was not in place. Many visitors were observed throughout the days of inspection with no restrictions

imposed on visiting times. Residents in Fuschia ward had the opportunity to meet with visitors in private in one of the activities rooms. However, there was no private visitors room on Heather or Hawthorn wards. Inspectors noted that mobile and fixed screens were used when residents were receiving care, to protect their dignity, as much as the environment allowed. However, due to the degree and layout of multi-occupancy bedrooms, there were insufficient facilities to provide all residents with adequate, comfortable, personal or private space. These issues were actioned under Outcome 12 Safe and Suitable Premises.

Staff were observed treating residents and speaking about residents in a courteous and respectful manner.

All residents spoke highly of their care in the centre and that they were treated well by all staff. Advocacy services were available to residents and residents were facilitated to vote. Their religious needs were well met in the centre.

Judgment:
Substantially 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:
There was a policy in place on residents' personal property and possessions. A record is kept in each residents file of their personal belongings which is kept up to date. However, residents did not have adequate storage space in their wardrobe and bedside locker to store all of their clothes. The majority of residents had extra clothing stored in labelled plastic boxes stored in a locked linen room on each ward which meant that residents' clothing was not accessible to them at all times. Residents did not have lockable storage in their bedrooms to store valuables or personal belongings.

Residents' clothes were labelled to identify who they belonged too. An inspector spoke with the staff member in charge of the centres laundry facility who described good practice in relation to laundry practices.

Judgment:
Non Compliant - Moderate

Outcome 18: Suitable Staffing
There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

Theme:
Workforce

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

Findings:
There was a clear management structure in place in the centre and lines of accountability were clear to all staff. Inspectors observed staff interacting warmly with residents and treating them with respect and dignity. Staff demonstrated a clear understanding of their roles and responsibilities with schedules in place to outline the daily duties for contract cleaning staff and kitchen staff. Inspectors viewed staffing rosters and skill mix. Nursing staff, with up to date professional registrations, were available on duty at all times to meet the needs of the residents. Supervision of staff was consistent with a clinical nurse manager in charge on each ward, reporting to an assistant director of nursing. The centre had a policy on the recruitment of new staff. However, there was no system in place to appraise the performance of staff. Records of staff meetings were viewed and the new person in charge was committed to conducting regular staff and management meetings.

However, inspectors found that there were some gaps in the training provided to staff in elder abuse, fire training and moving and handling. There were many other training courses available to staff such in areas such as nursing documentation, continence, preceptorship, medication management, male catheterisation, speech and language for nurses, dementia care and end of life care. A training needs analysis had been conducted in June 2015 to collect feedback from staff regarding their training needs.

Garda Síochána vetting for volunteers working at the centre had been recently applied for, however, they had been working at the centre without the vetting disclosure in place. The roles and responsibilities of the volunteers were documented and signed.

Judgment:
Non Compliant - Major

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Aoife Fleming
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[1]

Centre name:	Killarney Community Hospitals (Fuschia, Hawthorn and Heather Wards)
Centre ID:	OSV-0000568
Date of inspection:	30/06/2015
Date of response:	17/08/2015

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 section on nursing care provided which included care of the person with intellectual and functional disability and care of the young chronic sick, required amending to appropriately reflect practice in the centre.
The age range and gender of residents, for whom care is provided, were not outlined.

1. Action Required:

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

Under Regulation 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 Residents in Designated Centres for Older People) Regulations 2013.

Please state the actions you have taken or are planning to take:
Statement of purpose will be amended to contain the information set out in schedule 1 of the Health Act 2007 Regulations 2013

Proposed Timescale: 31/08/2015

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:
The annual review did not adequately address the quality and safety of care delivered in the centre. The learning and improvements brought about as a result of the audit activity conducted in the centre were not addressed in the annual review.

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

Please state the actions you have taken or are planning to take:
The annual review will be corrected to adequately address the quality and safety of care delivered in the centre and the learning and improvements as a result of audits will also be addressed.

Proposed Timescale: 28/09/2015

Outcome 03: Information for residents

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The additional fees for items, such as hairdressing, chiropody and the purchase of toiletries, were not set out in the contract.

3. Action Required:
Under Regulation 24(2)(d) you are required to: Ensure the agreement referred to in regulation 24 (1) includes details of any other service which the resident may choose to

avail of but which is not included in the Nursing Homes Support Scheme or which the resident is not entitled to under any other health entitlement.

Please state the actions you have taken or are planning to take:
The contracts of care specify that additional fees are required for chiropody, hairdressing and toiletries however the costs charged will now be specified in the contracts of care.

Proposed Timescale: 12/10/2015

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:
The policy on restraint was out of date as it was due for renewal in November 2013.

4. 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:
The reason the Restraint policy is out of date is because it is a national policy that is currently being reviewed by an expert national panel and is due to be finalised and distributed in the coming months.

Proposed Timescale: 31/10/2015

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The Directory of Residents did not outline for each resident the date on which the resident was first admitted to the centre, the telephone number of the residents' general practitioner, or the name and address of any authority, organisation or other body which arranged the resident's admission to the centre, as required by Schedule 3(3) of the regulations.

5. 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:
The Directory of Residents will include all information specified in paragraph (3) of schedule 3.

Proposed Timescale: 14/09/2015

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all staff files had a full employment history set out.

6. 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:
All staff files will have full employment history

Proposed Timescale: 07/12/2015

Outcome 07: Safeguarding and Safety

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The policy on restraint in the centre only addressed physical restraint and did not include chemical restraint. The care plans to guide the management of behaviours that challenge were not person centred.

A detailed risk assessment regarding the use of bed rails was not completed for each individual resident despite it forming part of the centre's policy on restraint. There were gaps in the maintenance of bed rail assessment documentation.

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

Please state the actions you have taken or are planning to take:
A national policy is currently being reviewed by an expert national panel and is due to be finalised and distributed in the coming months. A policy on the use of psychotropic is currently being drafted and will be in place in the coming months and will be used as

per HIQA Guidance for Designated Centres- Restraint Procedures (2014).

The care plan to guide the management of behaviours that challenge will be revised to ensure a more person centred care plan. Detailed risk assessments regarding the use of bed rails will be completed for each resident that require it.

Proposed Timescale: 07/12/2015

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
While a system to record payments into and out of residents cash held on wards was in place, the receipts in place to support transactions were often not individualised for the purchase of resident toiletries which were often bought in bulk.

8. Action Required:
Under Regulation 08(1) you are required to: Take all reasonable measures to protect residents from abuse.

Please state the actions you have taken or are planning to take:
Individualised receipts will be in place to support the purchase of resident's toiletries.

Proposed Timescale: 17/08/2015

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all staff had up to date training in the detection and management of elder abuse.

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

Please state the actions you have taken or are planning to take:
At the time of inspection all Nurses and Health Care Assistants had received training in the detection and management of elder abuse and the remaining 5 support staff who are on long term sick leave will receive the training on their return.

Proposed Timescale: ONGOING

Proposed Timescale:

Outcome 08: Health and Safety and Risk Management
Theme: Safe care and support **The Registered Provider is failing to comply with a regulatory requirement in the following respect:** Not all risks in the centre had been identified and risk assessed: - Lockers in residents bedrooms were unsecured and stored latex gloves posing a risk of accidental injury to residents **10. Action Required:** Under Regulation 26(1)(a) you are required to: Ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre. **Please state the actions you have taken or are planning to take:** Staff have been instructed to ensure all lockers in residents bedrooms containing latex gloves are secured.
Proposed Timescale: 17/08/2015
Theme: Safe care and support **The Registered Provider is failing to comply with a regulatory requirement in the following respect:** The weekly testing of the break glass units beside fire doors was not conducted weekly **11. Action Required:** Under Regulation 28(1)(c)(iii) you are required to: Make adequate arrangements for testing fire equipment. **Please state the actions you have taken or are planning to take:** The weekly testing of the break glass units beside fire doors will be conducted weekly
Proposed Timescale: 31/08/2015
Theme: Safe care and support **The Registered Provider is failing to comply with a regulatory requirement in the following respect:** Not all staff had up to date training on fire safety. **12. Action Required:** Under Regulation 28(1)(d) you are required to: Make arrangements for staff of the

designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.

Please state the actions you have taken or are planning to take:
The remaining 5 staff (nurses, HCA and support staff) will have up to date training on fire safety.

Proposed Timescale: 09/11/2015

Outcome 09: Medication Management

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Eye drops did not always have a date of opening recorded on the bottle.

13. Action Required:
Under Regulation 29(6) you are required to: Store any medicinal product which is out of date or has been dispensed to a resident but is no longer required by that resident in a secure manner, segregated from other medicinal products and dispose of in accordance with national legislation or guidance in a manner that will not cause danger to public health or risk to the environment and will ensure that the product concerned can no longer be used as a medicinal product.

Please state the actions you have taken or are planning to take:
At the time of inspection one resident's eye drops did not have a date of opening recorded on the bottle this has now been corrected and staff have been asked to ensure that all eye drops need to have a date of opening recorded on the eye drop bottle.

Proposed Timescale: 17/08/2015

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Medications for crushing were not annotated individually to indicate the prescribers approval for this unlicensed administration of each medication on a residents prescription.
The maximum dose of PRN (as required) medications was not always prescribed.
Residents' allergy status was not always recorded on the prescription.
The practice regarding the prescribing and administration of laxatives was not in line

with evidence based practice in all cases.
There were insufficient stocks on the trolley to meet the needs of the residents should they require a PRN (as required) medication on Fuschia ward.

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

Please state the actions you have taken or are planning to take:
All medications which require to be crushed will be prescribed as crushed. The maximum dose of PRN (as required) medications will be documented. Residents' allergy status will be recorded on all prescriptions. Laxatives will be prescribed in line with evidence based practice. There will be sufficient stocks on the trolley to meet the needs of the residents should they require a PRN (as required) medication on Fuschia ward.

Proposed Timescale: 17/08/2015

Outcome 10: 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 of the use of chemical restraint that were seen on inspection were not submitted to the Authority.

15. Action Required:
Under Regulation 31(3) you are required to: Provide a written report to the Chief Inspector at the end of each quarter in relation to the occurrence of any incident set out in paragraphs 7(2) (k) to (n) of Schedule 4.

Please state the actions you have taken or are planning to take:
Required quarterly notifications will include chemical restraint is used according to HIQA Guidance for Designated Centres (2014).

Proposed Timescale: ongoing

Proposed Timescale:

Outcome 11: Health and Social Care Needs

Theme:
Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A resident with diabetes, and specific recommendations from the dietician, did not have a detailed care plan in place to guide his care.

16. 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:
A detailed care plan with the specific recommendations from the dietician is now in place for this resident.

Proposed Timescale: 17/08/2015

Theme:
Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
As care plans were often in place which had been initiated in 2014 with no updated interventions recorded, it was difficult for inspectors to evaluate whether or not the care plan had been reviewed regularly by nursing staff to reflect residents' most up to date needs.

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

Please state the actions you have taken or are planning to take:
The care plans will ensure the 3 monthly updates are more evident.

Proposed Timescale: 09/11/2015

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:
As outlined in the report, the premises did not meet the requirements of Schedule 6 of the Regulations.

18. 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:
The HSE is fully committed to bringing the environment in our centre into compliance with HIQA standards and regulations. At Present a design team has been appointed to draw op detailed plans for Hawthorn , Heather and Fuschia Wards to meet the requirements of schedule 6 of the regulations.

Proposed Timescale: 31/10/2015

Outcome 13: Complaints procedures

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The complaints logs were also being used as a minor incident log to record issues such as maintenance referrals which was not appropriate.

19. Action Required:
Under Regulation 34(1)(f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.

Please state the actions you have taken or are planning to take:
The complaint log outlined a complaint that a resident made about maintenance not fixing her wheelchair. The correct maintenance request form was used to inform maintenance of the repair needed not the complaints log. Staff have been informed that separate logs are to be used for complaints and minor incidents.

Proposed Timescale: 17/08/2015

Outcome 14: End of Life Care
Theme: Person-centred care and support **The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:** The spiritual needs of residents were not always recorded or considered in the end of life care plan. **20. Action Required:** Under Regulation 13(1)(a) you are required to: Provide appropriate care and comfort to a resident approaching end of life, which addresses the physical, emotional, social, psychological and spiritual needs of the resident concerned. **Please state the actions you have taken or are planning to take:** Advance Care Planning using the 'Let me Decide' framework has been in place in the centre for the past two years. St Columbanus Community Hospital is committed to providing residents with choice and options. Advance care Directives or Advanced Healthcare Decisions provide people with an opportunity to document their choices about the type of care they wish to receive at end of life. This includes spiritual care. Unfortunately on the date of inspection this information was omitted from one resident's care plan
Proposed Timescale: 17/08/2015

Outcome 15: Food and Nutrition
Theme: Person-centred care and support **The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:** There were gaps in the administration dates for a nutritional supplement which was prescribed for daily administration. The recommendations of the dietician were not always incorporated into residents' care plans to appropriately guide their nutritional needs. **21. Action Required:** Under Regulation 18(1)(c)(iii) you are required to: Provide each resident with adequate quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietetic staff, based on nutritional assessment in accordance with the individual care plan of the resident concerned. **Please state the actions you have taken or are planning to take:** The administration dates will be included for all prescribed nutritional supplements. Staff have been advised to ensure that recommendations from the dietician are incorporated into residents' care plans.
Proposed Timescale: 17/08/2015

Theme:
Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Inspectors found that the meal times in the centre were largely governed by staff rosters and were not appropriately spaced out over the day.

22. Action Required:
Under Regulation 18(2) you are required to: Provide meals, refreshments and snacks at all reasonable times.

Please state the actions you have taken or are planning to take:
Following feedback from the Inspection team, Management are now making arrangements for supper time to be moved from 16.15 to 16.45

Proposed Timescale: 30/09/2015

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:
Due to the degree and layout of multi-occupancy bedrooms, there were insufficient facilities to provide all residents with adequate, comfortable, personal or private space.

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

Please state the actions you have taken or are planning to take:
The HSE has given a commitment to address the residential care needs by ensuring a design team is currently in place that will provide detailed plans to ensure the premises meet the requirements of schedule 6 of the regulations.

The management and staff of Killarney Community are aware of the constraints and will continue to enhance and improve the privacy of residents within the existing structure.

Proposed Timescale:

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The televisions in all bedrooms were not accessible for all residents to view comfortably.

24. Action Required:
Under Regulation 09(3)(c)(ii) you are required to: Ensure that each resident has access to radio, television, newspapers and other media.

Please state the actions you have taken or are planning to take:
This issue of the location of televisions in bedrooms to be reviewed and discussed with residents and their family's at Residents and Family Forums. An action plan will be developed from these discussions.

Proposed Timescale: 31/10/2015

Theme:
Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The communication needs of one resident were not being met as staff were not trained to meet his specific communication needs and a detailed care plan regarding these needs was not in place.

25. Action Required:
Under Regulation 10(2) you are required to: Where a resident has specialist communication requirements record such requirements in the resident's care plan prepared under Regulation 5.

Please state the actions you have taken or are planning to take:
At the time of inspection there was a detailed communication care plan in place outlining the resident's specific communication needs. This resident understands the written word and this is used as well as pictorial aids in his day to day communication with staff. A referral has been made to the Speech and Language therapist in relation to identifying other communication aids that may be helpful to the resident and staff.

Proposed Timescale: 17/08/2015

Outcome 17: Residents' clothing and personal property and possessions

Theme:
Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Residents did not have adequate storage space in their bedroom to store all of their clothes. Extra residents' clothing was stored in a locked linen room.

26. Action Required:
Under Regulation 12(a) you are required to: Ensure that each resident uses and retains control over his or her clothes.

Please state the actions you have taken or are planning to take:
The HSE has given a commitment to address the residential care needs by ensuring a design team is currently in place that will provide detailed plans to ensure the premises meet the requirements of schedule 6 of the regulations.
Currently we are working to ensure that residents have easy access to their personal clothing

Proposed Timescale: 30/09/2015

Theme:
Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Residents did not have adequate storage space in their wardrobe and bedside locker to store all of their clothes. Residents did not have lockable storage space in their bedrooms.

27. Action Required:
Under Regulation 12(c) you are required to: Provide adequate space for each resident to store and maintain his or her clothes and other personal possessions.

Please state the actions you have taken or are planning to take:
The HSE has given a commitment to address the residential care needs by ensuring a design team is currently in place that will provide detailed plans to ensure the premises meet the requirements of schedule 6 of the regulations.

Lockage storage space to be provided in residents bedrooms.

Proposed Timescale: 30/09/2015

Outcome 18: Suitable Staffing

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There were some gaps in the training provided to staff in elder abuse, fire training and moving and handling.

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

Please state the actions you have taken or are planning to take:
Training will be provided to the remaining staff that require a refresher course in elder abuse, fire training and moving and handling.

Proposed Timescale: 09/11/2015

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was no system in place to appraise the performance of staff.

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

Please state the actions you have taken or are planning to take:
A staff appraisal system will be in place by October 2015.

Proposed Timescale: 31/10/2015

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Volunteers had been working at the centre without a vetting disclosure in place.

30. Action Required:
Under Regulation 30(c) you are required to: Provide a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 for people involved on a voluntary basis with the designated centre.

Please state the actions you have taken or are planning to take:
All volunteers now Garda vetted.

Proposed Timescale: 17/08/2015