

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Kinsale Community Hospital
Centre ID:	OSV-0000584
Centre address:	Rathbeg, Kinsale, Cork.
Telephone number:	021 477 2202
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Type of centre:	The Health Service Executive
Registered provider:	Kinsale Community Hospital
Provider Nominee:	Teresa O'Donovan
Lead inspector:	Breeda Desmond
Support inspector(s):	Vincent Kearns
Type of inspection	Announced
Number of residents on the date of inspection:	37
Number of vacancies on the date of inspection:	3

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:
07 December 2014 08:30	07 December 2014 18:00
09 December 2014 08:30	09 December 2014 17:00

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

Outcome	Our Judgment
Outcome 01: Statement of Purpose	Compliant
Outcome 02: Governance and Management	Non Compliant - Moderate
Outcome 03: Information for residents	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 - Minor
Outcome 08: Health and Safety and Risk Management	Non Compliant - Major
Outcome 09: Medication Management	Non Compliant - Minor
Outcome 10: Notification of Incidents	Compliant
Outcome 11: Health and Social Care Needs	Non Compliant - Moderate
Outcome 12: Safe and Suitable Premises	Non Compliant - Major
Outcome 13: Complaints procedures	Compliant
Outcome 14: End of Life Care	Non Compliant - Minor
Outcome 15: Food and Nutrition	Non Compliant - Minor
Outcome 16: Residents' Rights, Dignity and Consultation	Non Compliant - Minor
Outcome 17: Residents' clothing and personal property and possessions	Non Compliant - Minor
Outcome 18: Suitable Staffing	Compliant

Summary of findings from this inspection

This report sets out the findings of an announced registration renewal inspection and it was the sixth inspection undertaken by the Authority in Kinsale Community Hospital. The provider applied to renew their registration which was due to expire on 7 May 2015. This renewal of registration inspection took place over two days. As part of the inspection the inspector met with the Person in Charge, newly appointed Designated Provider, Clinical Nurse Managers (CNM 2), residents, relatives, and staff

members. The inspectors observed practices and reviewed governance, clinical and operational documentation to inform this registration renewal application.

The provider and person in charge displayed knowledge of the standards and regulatory requirements.

A number of questionnaires were received and the inspector spoke with many residents and relatives during the inspection. The collective feedback from residents and relatives was one of satisfaction with the service and care provided. Family involvement was encouraged and this was observed throughout the inspection.

Overall, staff were kind and respectful to residents and demonstrated good knowledge of residents, however, this was not reflected in some care plans examined by the inspector. The activities staff provided residents with a wide variety of social and recreational activities as well as community involvement, however, this service was frequently disrupted due to staff shortages, that is, the activities co-ordinator was reassigned to care duties.

All staff had received training in elder abuse prevention and protection to safeguard residents in their care. Staff levels and skill-mix were adequate to meet the assessed needs of residents. Residents were encouraged to exercise choice and their views were sought informally on a daily basis and formally in the residents' committee, however, it was difficult to determine the frequency of residents' meetings.

While there was some improvement in the private accommodation provided for residents, overall, there were significant limitations within the physical environment which negatively impacted the freedom, choice, privacy, dignity and autonomy of residents along with infection prevention and control risk; these were identified in previous inspection reports and will be discussed under Outcome 12 Suitable and Safe Premises.

Extensive serious fire safety deficiencies were identified as part of the Fire Officers' inspections completed on 28 May and 4 June 2014. The Office of the Chief Inspector requested an immediate update of the action plan undertaken from the Fire Officers' inspection report of 10 June 2014. The response to this plan forms part of the action plan section at the end of this report. A compliant fire safety certificate was not submitted to the Authority as part of the registration application.

The inspector identified other aspects of the service requiring improvement to ensure compliance with the Regulations. These were identified in previous inspection reports.

These other improvements included:

- 1) most policies were out-of-date
- 2) reviewing and improving the quality and safety of care
- 3) care planning
- 4) privacy and dignity.

The action plan at the end of this report sets out the actions necessary to ensure compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

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

Outcome 01: Statement of Purpose

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

Theme:

Governance, Leadership and Management

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

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

Findings:

The Statement of Purpose (SOP) was reviewed and updated in December 2014 to reflect the recent changes to the management structure with the newly appointed designated provider. All items listed in Schedule 1 of the Regulations were detailed in the statement of purpose. While services and facilities were described, the inspector found that sometimes they did not reflect what was evidenced on inspection and these will be discussed under the relevant outcomes in the report.

Judgment:

Compliant

Outcome 02: Governance and Management

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

While audits were completed, a formal structure to ensure systems and processes were in place to effectively manage and implement an integrated programme of quality and safety was not embedded. That is, the quality and safety of care and the quality of life

for residents was not continually evaluated to determine outcomes for residents regarding the effectiveness of care and support received. The evaluations undertaken did not consider the philosophy and ethos described in the Statement of Purpose to ensure a holistic person-centred approach.

Quality data gathered on a monthly basis included pain, pressure sores, physical restraint, psychotropic medication, falls, significant weight loss, complaints, unexplained absences, significant events, vaccinations and immobile residents. The person in charge monitored these statistics on a monthly basis and trended the information to inform practice. For example, staff were working towards a restraint-free environment and comprehensive records, with appropriate supervision and interventions were demonstrated to show the reduction in usage of bed rails.

Routine clinical audits included hand hygiene, medication management with antibiotic and psychotropic usage, restraint and falls. A bed-space environmental audit was done in June 2013.

Residents were consulted on a daily basis. The activities co-ordinator offered a choice of group activities as well as one-to-one sessions. However, this service was often interrupted due to staffing levels, where some activities were cancelled. Some families and residents had completed the 'Life Story' as part of their reminiscence therapy. The activities co-ordinator completed a daily activities record detailing the residents' involvement in the activity. The art therapist attended the centre twice a week and residents gave positive feedback regarding these sessions. The art therapist outlined that she facilitated group sessions with those residents able to come to the day room and recently she commenced one-to-one sessions with residents in their bedrooms and has got very positive feedback from this. Relatives spoken with also gave positive feedback regarding communication and involvement with their relative's care and welfare and the ease of access to all staff to discuss matters.

Minutes of two residents' meetings held in 2014 were demonstrated and many residents attended these meetings. While positive feedback was relayed regarding the residents' committee, it was difficult to determine their frequency. Therefore, the degree in which residents could participate in how the centre was planned and run or their feedback sought to inform practice was difficult to establish.

Judgment:

Non Compliant - Moderate

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:

Contracts of care were maintained by administration staff. The contracts detailed fees to be charged as well as additional fees. Contracts of care for residents were signed and dated by either the resident or their next of kin in line with best practice. They were securely maintained in the administration office.

A residents' guide was available for residents and their relatives. Each resident received a copy of the guide on admission. It contained all the items listed in the Regulations.

Judgment:

Compliant

Outcome 04: Suitable Person in Charge

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The post of the person in charge was full time and held by a registered nurse with the required experience of nursing dependant people. She demonstrated knowledge and understanding of the Regulations and National Standards to ensure suitable and safe care. Clear management and accountability structures were in place. The person in charge was engaged in governance, operational management and administration associated with her role and responsibilities. There was evidence that the PIC had a commitment to her own continued professional development and had completed many courses such as diploma in Healthcare management.

The person in charge was supported in her role for by two CNMs 2 as well as senior staff nurses.

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 inspector was satisfied that the records required in Schedule 2 (staff files), Regulation 21 (provision of information to residents), Regulation 25 (medical records), Schedule 4 (general records) of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 were maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. However, most of the policies relating to Schedule 5 (operating policies and procedures) were out-of-date. Policies referenced the 2009 Regulations rather than the 2013 Regulations. Many policies were obsolete and had not been removed from the policy folders. Throughout the policies residents were referred to as patients rather than residents and this was not in keeping with the philosophy and ethos described in their Statement of Purpose. Care plans as described in Regulation 5 Schedule 3 (residents' records) were not in place for a sample of respite residents' documentation examined by the inspector. This will be discussed in detail under Outcome 11 Health and Social Care Needs. The register of residents was reviewed and had been transferred from hard copy to soft copy. While most of the information listed in Schedule 3 was in place, the software programme did not allow for the cause of death to be recorded and this was highlighted to the person in charge.

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 aware of her responsibilities regarding notification to the Authority should the occasion arise. Appropriate deputising arrangements were in place to ensure care and welfare of residents. CNMs 2 were in place on each floor with responsibility for the day-to-day running of their unit. Senior nurses were in place to support the management team also.

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 were in place to protect residents from being harmed or suffering abuse. Staff had completed training in adult protection and this training also formed part of the staff induction programme. Staff spoken with demonstrated their knowledge of protection of residents in their care and actions to be taken if care was untoward.

The CNMs spoke with residents on a daily basis and with relatives also and supervised staff as part of ensuring the safety of residents. Feedback from residents was positive and many stated they felt 'safe and secure' in the centre. Completed questionnaires stated that 'staff were kind' and they visitors were 'welcome' to visit anytime.

While there was an up-to-date policy for adult protection however, it was not comprehensive and it did not contain the information stipulated in Regulation 31 regarding immediate notification to the Authority of an allegation of abuse.

Residents' finances were maintained in line with best practice. They were securely retained in a safe within a locked cupboard. The person in charge and the office administrator had access to these finances.

Judgment:

Non Compliant - Minor

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

Theme:

Safe care and support

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

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

Findings:

While there was a health, safety and risk management policy in place which contained some details on the identification and prevention of risks however, it was not comprehensive, for example, free access to the stairs, sloping of upstairs corridors, free access to protective personal equipment (disposable gloves and aprons) dispensers throughout were not included in the risk assessments. The emergency plan was available with alternative accommodation detailed, should the need arise.

There was a policy in place for infection prevention and control. Advisory signage for best practice hand washing was displayed over some sinks hand-wash sinks. While there were hand hygiene gel dispensers available throughout the centre, there was none in place at the entrance to the kitchen to ensure hand hygiene was performed before staff entered the kitchen. This was highlighted during the inspection and a hand hygiene foam dispenser was placed at the entrance to the kitchen. Advisory signage for best practice use of hand hygiene gels was displayed and the inspector observed that opportunities for hand hygiene were taken by staff. Staff, including household staff, had completed training in hand hygiene and infection prevention and control.

A fire safety register was in place, with daily, weekly and monthly fire safety checks evidenced, in line with best practice guidelines. Staff had completed their mandatory fire training. Fire drills were completed six-monthly and this was evidenced by fire training records reviewed. Fire safety evacuation notices were displayed in a prominent position throughout the centre. However, the fire officers' report of 10 June 2014 demonstrated extensive 'serious fire safety deficiencies' in the centre. The inspector requested an immediate update in the progress of actions taken to date to mitigate the risks identified and remedy the issues detailed in the Fire Officers' report. A compliant fire safety certificate was not evidenced.

All staff had completed their mandatory training in moving and handling of residents.

A current insurance policy was demonstrated.

A record was maintained of incidents and accidents. These were reviewed by the CNMs and person in charge and followed up at the daily ward meeting or at staff meetings.

Laundry was segregated at source and staff demonstrated best practice regarding safe handling of unclean laundry with the use of alginate bags were appropriate.

The kitchen was inspected. There was some advisory signage indicating designated areas for preparation of different foods to ensure safe food preparation practices and mitigate risk of cross contamination, however, some signage was not replaced following deep-cleaning. Placement of food in the fridge was compliant with food safety. Food was stored appropriately in the 'dry goods' store room. Inappropriate items were stored on shelving in the kitchen making effective cleaning difficult. The inspector highlighted that there were several advisory signs inappropriately displayed on kitchen surfaces which inhibited effective cleaning and these were removed during the inspection.

Judgment:

Non Compliant - Major

Outcome 09: Medication Management

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

Theme:

Safe care and support

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

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

Findings:

The centre-specific medication management policy detailing procedures for safe ordering, prescribing, storing and administration of medicines and handling and disposal of unused or out-of-date medicines was being updated at the time of inspection. The area of self-medicating required updating. Transcription did not occur in the centre but this was not detailed in the policy. One CNM 2 was a qualified nurse prescriber, however, this was not identified in the medication management policy; neither was their reference made to the additional policy on the role and responsibility of the nurse prescriber. The 'red apron' identifying and alerting people regarding the nurse completing the medication round was being trialled and some nurses wore the apron and others did not. While photographic identification was in place for some residents as part of their prescription/drug administration record chart, others did not have photographic identification in place to mitigate risk, as described in best practice professional guidelines. Controlled drugs were maintained in line with best practice professional guidelines. Medication trolleys were securely maintained. Medication fridges were on place in each floor and temperatures were recorded.

A sample of prescriptions was reviewed and they were largely in compliance with professional guidelines, the maximum dosage was included in those reviewed. Quarterly medication reviews were undertaken by the pharmacist, doctor and CNM involved in the residents' care. The rationale for PRNs (as required medications), psychotropic medications was discussed and any change to the prescription was documented and this

form was input into individual residents' medical notes to ensure information was easily accessible for nursing staff for continuity of care. These were evidenced during inspection.

Medication errors and near misses were recorded and monitored by the CNM 2 on each floor. The CNM 2 reported to the inspector that these were discussed at ward hand-over meetings and again at staff meetings to mitigate risk of recurrence.

Judgment:
Non Compliant - Minor

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:
Notifications received by the Authority were reviewed upon submission and prior to the inspection. Notifiable incidents and quarterly returns submitted to the Authority were timely and comprehensive. Notification forms were recently upgraded and these were highlighted to the person in charge. Records were maintained of incidents occurring in the centre and were monitored by the person in charge.

Judgment:
Compliant

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

Theme:
Effective care and support

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

Findings:

A sample of residents' assessments and care plans were reviewed by the inspector on each floor. There was evidence that residents and/or relatives were involved in care planning. However, care plans reviewed did not reflect the in-depth knowledge that staff demonstrated of residents in their care. Documentation pertaining to respite residents showed that residents did not have care plans as described in the Regulations and one respite resident had neither a care plan or assessments completed on this admission. Information that was recorded was scant and did not inform the problem identification record to ensure safe care.

General practitioners (GPs) from different practices routinely attended the centre twice a week with out-of-hours cover when necessary. A sample of medical records reviewed demonstrated that residents were reviewed on a regular basis. Specialist medical services were also available when required. Reviews and on-going medical interventions as well as laboratory results were evidenced.

Residents had access to dental, optical, psychiatry, occupational therapy, chiropody and dietetic services. Residents had access to physiotherapy, speech and language therapy (SALT) and GPs in the primary care centre located in the adjacent building.

Judgment:

Non Compliant - Moderate

Outcome 12: Safe and Suitable Premises

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

Theme:

Effective care and support

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

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

Findings:

This centre was originally built in the 19th century and it had been refurbished and upgraded with many areas decorated in a homely and cosy fashion. However, there were significant limitations within the physical environment which negatively impacted on the freedom, choice, privacy, dignity and autonomy of residents and these have been described in detail in previous inspection reports. For example, some multi-occupancy rooms could only be internally accessed via other multi-occupancy rooms.

Other issues previously identified on inspections with regards to the limitations of the

premises included:

- 1) not all of the four-bedded rooms were suitable in size to meet residents' needs, and impacted on the privacy and dignity of the residents sharing these rooms
- 2) there was little room between some beds and limited space to personalise the area or to receive visitors
- 3) wardrobes were not adequately sized in the bedrooms for residents to store their clothes and personal possessions
- 4) there was just one communal room on the ground floor for sitting, dining and recreational space for 40 residents
- 5) some bed screens were inadequate to ensure privacy and dignity of residents.

The centre had capacity to accommodate 40 residents, however, the maximum number of residents that could be accommodated in the communal room at meal time was 15 and this would depend on the types of assisted seating residents were using which was totally inadequate. There were two other seating areas, one on each floor and these were homely in appearance. These areas included comfortable seating, a table, a lamp and bookshelves. There was a staff education/meeting room and a visitors/meeting room.

Sluice rooms were inspected and inspectors observed that while bed pans and urinals were cleaned appropriately however, they were not stored in line with best practice guidelines and this was identified in a previous inspection report.

The centre had installed circuit-television cameras (CCTV). All cameras were in public areas. There was a sign to inform residents, staff and visitors that CCTV was in operation. Inspectors identified that one CCTV was inappropriately placed to monitor a visitors' seating area and this was removed.

Inspectors saw evidence of the use of assistive devices, for example, hoists, wheelchairs, walking aids, clinical monitoring equipment and specialist seating provided for residents' use. There was a functioning call-bell system in place. The external gardens were well maintained and residents stated they enjoyed the garden during the summer and looking out at the garden in the cold weather.

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 complaints procedure was displayed prominently at main reception, as described in the Regulations. The complaints policy contained all the details listed in the Regulations. The complaints log was reviewed and complaints were recorded in line with the Regulations, including the outcome of whether the complainant was satisfied with the outcome. The CNMs on each unit monitored complaints and endeavoured to resolve issues as soon as they arose.

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):

No actions were required from the previous inspection.

Findings:

There was a policy in place for end-of-life care and this was in date. However, it did not reflect the new advanced end of life care plan initiated at to capture residents' wishes and needs, which was demonstrated on inspection.

Spiritual needs were facilitated with Mass held weekly in the centre; other denominations were facilitated upon request; volunteers from the local community visited the centre on a weekly basis and facilitated prayers with the residents. Residents had access to consultant palliative care and the hospice services. Staff had completed professional development regarding end of life care, palliative care and specialist syringe-driver. Care practices observed would suggest that residents would be cared for with the utmost respect. The person in charge had completed the thematic self-assessment relating to end-of-life care and nutrition.

Judgment:

Non Compliant - Minor

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:

While there was a policy in place for food and nutrition however, it did not reflect the risk assessment, monitoring and documentation of nutritional status evidenced in care plans reviewed. A recognised food and nutrition risk assessment tool formed part of the speech and language policy however, it was not referenced in the policy; in addition, this risk assessment was referenced to in the food and nutrition policy but was not included in the policy. Catering staff discussed nutritional needs including specialist diets with the inspector and demonstrated their knowledge regarding specialist diets and consistency for residents. Staff had completed training in modified consistency food preparation. Residents had choice at each mealtime and residents spoken with gave positive feedback regarding the degree of choice as well as the quality of their food. Residents' weights were documented on a monthly basis or more often if their clinical condition warranted; dietary intake was recorded when necessary and residents were prescribed supplements when their condition necessitated. Residents had access to fresh water and other fluids throughout the day.

Overall, because of very limited space, the dining experience for residents was significantly curtailed. Residents requiring assistance with their meals were helped appropriately and with respect in a dignified manner.

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:

Residents' privacy and dignity was significantly curtailed because of the design of the building, lack of private space, inadequate dining facilities and inadequate bed screens around some beds. Notwithstanding the constraints of the building and the layout of the wards, the inspector noted that residents received care in a dignified way.

The centre operated an open visiting policy. The open visiting policy was observed throughout the inspection. Completed relatives questionnaires commended staff on how welcoming they were to all visitors. The manner in which residents were addressed by staff was seen by inspectors to be appropriate and respectful.

Minutes of two residents' meetings held in 2014 were demonstrated and many residents attended these meetings. While positive feedback was relayed regarding the residents' committee, it was difficult to determine their frequency. Therefore, the degree in which residents could participate in how the centre was planned and run or their feedback sought to inform practice was difficult to establish.

Judgment:

Non Compliant - Minor

***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 on residents' personal property and possessions, however, this was out-of-date and it did not direct staff regarding maintaining residents' personal property to enable them to retain control over their personal possessions. The action relating to this is under Outcome 5, Documentation to be kept at a Designated Centre.

Judgment:

Non Compliant - Minor

Outcome 18: Suitable Staffing

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

Theme:

Workforce

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

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

Findings:

Previously it was identified that the role and responsibilities of multi-task attendants was such that the skill mix throughout the day was inadequate to meet the needs of residents and hygiene of the centre cognisant of the size and layout of the centre. This was now remedied. There were designated staff in place for healthcare duties and separate staff for household duties. Care staff reported that there was more time for residents and the separation of duties allowed for continuity of care; household staff took responsibility for the cleanliness of the centre.

There was evidence of staff education programme and staff had attended a wide range of training, for example, management, clinical supervision, dementia, cardio-pulmonary resuscitation, final journeys – what matters to me, prevention of elder abuse, manual handling, wound care, venepuncture (taking blood samples), food safety, hand hygiene, infection prevention and control, and restraint.

A sample of staff files were reviewed and those examined were compliant with the Regulations and contained all the items listed in Schedule 2. Current registration with regulatory professional bodies was in place for all nurses. Staff files demonstrated that staff appraisals were undertaken.

Judgment:

Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Breeda Desmond
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:	Kinsale Community Hospital
Centre ID:	OSV-0000584
Date of inspection:	07/12/2014
Date of response:	09/01/2015

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 02: Governance and Management

Theme:

Governance, Leadership and Management

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

While audits were completed, a formal structure to ensure systems and processes were in place to effectively manage and implement an integrated programme of quality and safety was not embedded. That is, the quality and safety of care and the quality of life for residents was not continually evaluated to determine outcomes for residents regarding the effectiveness of care and support received.

1. Action Required:

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

Under Regulation 23(c) you are required to: Put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

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

Establish a formal structure to monitor and evaluate the quality and safety of care delivered to the resident, and to implement changes to improve practice where deficits are identified.

Proposed Timescale: 30/06/2015

Theme:

Governance, Leadership and Management

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

The activities co-ordinator offered a choice of group activities as well as one-to-one sessions. However, this service was often interrupted due to staffing levels, where activities were cancelled, which was not in keeping with the activities and ethos described in their Statement of Purpose.

2. Action Required:

Under Regulation 23(a) you are required to: Ensure the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.

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

There is not a dedicated activities co-ordinator onsite at Kinsale Community Hospital. This role is co-ordinated amongst the staff. Ensure there are sufficient resources available to provide appropriate activities for residents each day of the week. Embed the activities within the daily care routines, so that all staff can become involved in the provision of activities.

Proposed Timescale: 31/03/2015

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:

There was a policy in place for end-of-life care and this was in date. However, it did not reflect the new advanced care plan initiated at end of life to capture residents' wishes and needs, which was demonstrated on inspection.

3. Action Required:

Under Regulation 04(1) you are required to: Prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.

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

The End of Life Care Policy now contains information on the Advanced Care Directives initiative.

Immediate

Proposed Timescale: 07/07/2015

Theme:

Governance, Leadership and Management

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

While there was a policy in place for food and nutrition it did not reflect the risk assessment, monitoring and documentation of nutritional status evidenced in care plans reviewed. A recognised food and nutrition risk assessment tool formed part of the speech and language policy but it was not referenced in the policy; in addition, this risk assessment was referenced to in the food and nutrition policy but was not included in the policy.

4. Action Required:

Under Regulation 04(1) you are required to: Prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.

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

The policy of Food and Nutrition now contains risk assessment, monitoring and documentation of nutritional status of residents. The food and nutrition risk assessment is now referenced in the Speech and Language policy. The food and nutrition policy now contains the must risk assessment tool.

Immediate

Proposed Timescale: 09/01/2015

Theme:

Governance, Leadership and Management

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

Most of the policies relating to Schedule 5 (operating policies and procedures) were out-of-date. Policies referenced the 2009 Regulations rather than the 2013 Regulations. Many policies were obsolete and had not been removed from the policy folders.

5. 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:

Review and update all policies listed on Schedule 5.

Proposed Timescale: 30/06/2015

Theme:

Governance, Leadership and Management

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

The centre-specific medication management policy detailing procedures for safe ordering, prescribing, storing and administration of medicines and handling and disposal of unused or out-of-date medicines was being updated at the time of inspection. The area of self-medicating required updating.

Transcription did not occur in the centre but this was not detailed in the policy.

One CNM 2 was a qualified nurse prescriber, however, this was not identified in the medication management policy; neither was their reference made to the additional policy on the role and responsibility of the nurse prescriber.

6. Action Required:

Under Regulation 04(1) you are required to: Prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.

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

The Medication Management policy will be updated completely to include Self-Medication. The policy will include details outlining that transcription does not occur. The policy will identify that there is a nurse prescriber within the nursing team, and outline her role and responsibility.

Proposed Timescale: 07/07/2015

Theme:

Governance, Leadership and Management

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

While most of the information listed in Schedule 3 was in place, the software programme did not allow for the cause of death to be recorded as part of the register of residents.

7. 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 register now includes the cause of death of the resident.

Immediate

Proposed Timescale: 07/07/2015

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:

While there was a health, safety and risk management policy in place which contained some details on the identification, assessment of risks with measures and actions in place to control risks identified, it was not comprehensive.

8. 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:

A comprehensive health safety and risk management policy will be developed to incorporate all risks identified, and how to minimize risk of adverse events occurring. A Health and Safety committee will be set up to perform audits and monitor compliance with quality improvement initiatives.

Proposed Timescale: 30/06/2015

Theme:

Safe care and support

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

Inappropriate items were stored on shelving in the kitchen making effective cleaning difficult.

9. Action Required:

Under Regulation 27 you are required to: Ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.

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

Appropriate storage of kitchen equipment.

Cleaning schedule for kitchen.
Immediate.

Proposed Timescale: 07/07/2015

Theme:

Safe care and support

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

A compliant fire safety certificate was not evidenced.

10. Action Required:

Under Regulation 28(1)(a) you are required to: Take adequate precautions against the risk of fire, and provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.

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

Fire Safety Certificate sent to HIQA prior to inspection. A fire blanket has been positioned in each bedroom on the first floor

New bed covers & furniture to be purchased and in place at the centre, where March 2015 (for purchase of bed covers & furnishings) fire fighting equipment purchased. Upgrade of work on the first floor to be completed by January 2016.

Completed & Ongoing

Proposed Timescale: 09/01/2015

Theme:

Safe care and support

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

Extensive serious fire safety deficiencies were identified as part of the Fire Officers' inspections completed on 28 May and 4 June 2014. The Office of the Chief Inspector requested an immediate update of the action plan undertaken from the Fire Officers' inspection report of 10 June 2014.

11. Action Required:

Under Regulation 28(1)(a) you are required to: Take adequate precautions against the risk of fire, and provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.

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

The following works have been carried out.

- Fire alarm system upgrade with the instillation of a new main panel and two fire alarm repeater panels positioned on the first floor.
- Bleep system installed so that instant fire alarm activation information is provided to staff carrying a bleep – 6.no bleeps provided and more will be provided if necessary.
- The fire alarm system is remotely monitored and on activation of the system the monitoring station will contact the hospital to see if the Fire Brigade should be contacted. This reduces the time frame for summoning the fire brigade should that be necessary.
- A fire blanket has been positioned in each bedroom on the first floor.
- A number of fire training and evacuation drill sessions have been undertaken. These sessions have concentrated on the evacuation of patients from first floor areas but has also included ground floor. This has resulted in a reduction of evacuation times on the first floor. Further training is in place for the coming months.
- A personal emergency evacuation plan (PEEP) has been developed and put in place for each patient.
- Fire Notices have been upgraded to reflect the new fire protocols and fire evacuation drawings are in place.
- The hospital Fire Safety Policy has also been reviewed to reflect new technology and procedures.

Proposed Timescale: 31/01/2016

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:

While there was an up-to-date policy for adult protection it was not comprehensive and it did not contain the information stipulated in Regulation 31 regarding immediate notification to the Authority of an allegation of abuse.

12. Action Required:

Under Regulation 31(1) you are required to: Give notice to the chief inspector in writing of the occurrence of any incident set out in paragraphs 7(1)(a) to (j) of Schedule 4 within 3 working days of its occurrence.

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

Update policy on adult protection to include notification to the authority of any allegation of abuse.

Proposed Timescale: 28/02/2015

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:

One respite resident had neither a care plan or assessments completed on this admission

13. Action Required:

Under Regulation 05(2) you are required to: Arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to the designated centre.

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

Review current admission method, develop appropriate documentation to reflect the health, personal and social care needs of each resident, and develop a person centred care plan to reflect anticipated care.

Proposed Timescale: 31/03/2015

Theme:

Effective care and support

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

Care plans reviewed did not reflect the in-depth knowledge that staff demonstrated of residents in their care. Documentation pertaining to respite residents showed that residents did not have care plans as described in the Regulations and one respite resident had neither a care plan or assessments completed on this admission. Information that was recorded was scant and did not inform the problem identification record to ensure safe care.

14. 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:

Review current admission method, develop appropriate documentation to reflect the health, personal and social care needs of each resident, and develop a person centred care plan to reflect anticipated care within 48 hours of admission.

Proposed Timescale: 31/03/2015

Theme:

Effective care and support

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

While photographic identification was in place for some residents as part of their prescription/drug administration record chart, others did not have photographic identification in place to mitigate risk, as described in best practice professional guidelines.

15. Action Required:

Under Regulation 06(1) you are required to: Having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care for a resident, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais.

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

Ensure that each drug administration record has a recent photograph of the resident.
immediate

Proposed Timescale: 09/01/2015

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:

Some multi-occupancy rooms could only be internally accessed via other multi-occupancy rooms.

Not all of the four-bedded rooms were suitable in size to meet residents' needs, and impacted on the privacy and dignity of the residents sharing these rooms.

Some bed screens were inadequate to ensure privacy and dignity of residents.

There was little room between some beds and limited space to personalise the area or to receive visitors.

Wardrobes were not adequately sized in the bedrooms for residents to store their clothes and personal possessions.

There was just one communal room on the ground floor for sitting, dining and recreational space for 40 residents. The size and layout of this room could not accommodate all the residents, so it was not fit for its stated purpose and function.

16. 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:

Enable Ireland to be contacted to increase height of bed screens.

Plans currently being & finalised by the Estates Dept regarding renovations of Kinsale Community Hospital, which will reduce the number of residents on first floor to 15.

Larger wardrobes to be purchased on completion of renovations.

Bed screens March 2015, renovations January 2016

Completed & Ongoing

Proposed Timescale: 31/01/2016

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:

It was difficult to determine the frequency of residents' meetings, therefore, the degree in which residents could participate in how the centre was planned and run or their feedback sought to inform practice was difficult to establish.

17. Action Required:

Under Regulation 09(3)(d) you are required to: Ensure that each resident is consulted about and participates in the organisation of the designated centre concerned.

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

Organize 3 monthly meetings for residents and/or their advocates.

Immediate

Proposed Timescale: 07/07/2015