

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	The Sheil Community Hospital
Centre ID:	OSV-0000624
Centre address:	College Street, Ballyshannon, Donegal.
Telephone number:	071 985 1300
Email address:	donnaj.reid@hse.ie
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Lead inspector:	Mary McCann
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	16
Number of vacancies on the date of inspection:	2

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.

Please note the definition of the following term used in reports: responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

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 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:
29 January 2018 10:30	29 January 2018 19:00
30 January 2018 09:00	30 January 2018 14:30

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

Summary of findings from this inspection

This report sets out the findings of an announced inspection of The Sheil Community Nursing hospital to assess compliance with the regulations and standards and to inform the renewal of registration for the designated centre. this centre is registered to provide care to 18 residents. On the days of inspection there were 16 residents in the centre. The provider has voluntarily reduced occupancy to 16 in order to

enhance the outcomes for residents as they have greater personal space in multi occupancy rooms. As part of the inspection process the inspector met with a number of residents, staff members, the person in charge, persons participating in management, and a relative. The inspector observed practice, assessed governance and reviewed clinical and operational documentation such as policies, procedures, risk assessments, residents care files, training records and accident and incident records. The inspector also reviewed the premises to assess whether it was fit for purpose and provided an appropriate environment for residents.

Residents had regular access to the services of a general practitioner (GP), and other healthcare professionals as required. The inspector reviewed questionnaires received from residents prior to and on inspection. This feedback was positive and was complimentary of the service including care, the staff and meaningful activities. Generally there was evidence of individual residents' needs being met and a high level of compliance with the regulations and standards

Areas which require review post this inspection include review and submission of the revised statement of purpose and creation of a more robust quality improvement plan post completion the annual review of the quality and safety of residents. Additionally there is a requirement for more detailed recording of fire drills, a risk assessment for the storage of plastic gloves and review of some of the care plans. Actions with regard to these matters that are required to ensure compliance with 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 are contained in the action plan at the end of this report.

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 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 Inspector reviewed the statement of purpose, which had been updated since the last inspection. It outlined the ethos and aims of the centre. While it contained all the matters as per Schedule 1 of the Regulations, it failed to provide adequate detail in some areas for example, a description of each room in the centre, its capacity and function. Additionally further detail was required with regard to procedures in place regarding associated emergency procedures.

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:

Previous inspections of the centre demonstrated a good standard of care and the last inspection which took place in May 2017 was a dementia thematic inspection where dementia care was evaluated and found to be of a good standard. A copy of that report is available at www.hiqa.ie. Areas for improvement identified during that inspection included review of the complaints process, ensuring all staff had up to date manual

handling training, ensuring that staff files were compliant with current legislation and an action which has been an on-going action with regard to the premises and the use of multi occupancy bedrooms and the way this impinges on the privacy and dignity of residents. The provider had ensured that three of these actions were addressed and the one with regard to the premises is in the process of being addressed. A new build which will see the amalgamation of the Rock Community Nursing Hospital and this centre is planned for this site.

Staff had received appropriate mandatory and other relevant training to ensure they had the required skills and knowledge to meet the specific assessed needs of residents. Due to the availability of senior staff who displayed a commitment to ensuring quality and safety for residents, on almost all day shifts led to good management systems that supported accountability and appropriate support and supervision arrangements were in place. On walking around the centre with the person in charge the inspector noted she was known by her Christian name to residents and staff. Appropriate respectful interactions were observed between the person in charge and staff and residents.

The centre was well resourced with access as required to a range of allied healthcare services such as physiotherapy, chiropody, occupational therapy, speech and language therapy and dietetics. The centre also had regular access to general practitioner (GP) services and the support of a palliative care team. The inspector found that staffing levels were appropriate taking into consideration the size and layout of the centre, and the assessed needs of residents.

There had been no change to the person in charge or the two persons nominated as persons participating in management since the previous inspection. The inspector met with both these nurses on the days of inspection. They demonstrated a good understanding of their statutory duties and responsibilities in the absence of the person in charge. Regular quality and safety meetings took place where incident and accident and risk management procedures were discussed.

The premises and external grounds were well maintained with input from maintenance as required. The provider representative has not changed since the last inspection and was described by the person in charge as interested in the provision of and committed to ensuring a good service was provided with positive outcomes for residents. A quality management system was in place which included a comprehensive audit schedule to include review of accident and incidents, falls, infection control, medication management and care documentation. While there was evidence that deficits identified had been addressed there was no process in place to identify a timeline for re-auditing to ensure sustainable improvement. To ensure consultation with residents there were regular resident meetings and regular consumer meetings which included relatives.

An annual review of the quality and safety of care delivered to residents had been completed. The annual review outlined the service provided, audits undertaken and results and feedback from resident and relatives' surveys. It outlined the improvements made in 2017, however it required a more robust quality improvement plan where any deficits or improvements planned were documented with a time line attached to them and details of personnel responsible for their enactment.

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:

The person in charge informed the inspector that a contract of care of had been agreed with each resident. The inspector reviewed a sample of these contracts and found they did not specify if the room to be occupied by the resident was a single or shared room as required by the 2016 regulations. The contract detailed services covered under the overall fee, such as accommodation, nursing and medical care, and provision of meaningful activities. Services incurring additional costs were also set out, such as hairdressing and taxi fares.

A residents' guide was available to residents. This contained all of the information required by the Regulations to include a description of care and a summary of the services provided, and related costs, as well as information on how to make a complaint. It also described the facilities available, visiting arrangements and identified the management team. It was accessible to residents with dementia or cognitive impairment.

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 person in charge was experienced and fulfilled the criteria required by the regulations in terms of qualifications. She qualified as nurse in 1992 and has worked in

management of elderly care services since 1998. She works full-time and also manages the 20 short stay rehabilitation beds.

She demonstrated good clinical knowledge and was knowledgeable regarding the Regulations, Standards and her statutory responsibilities. She has completed a post graduate diploma in gerontology and a national diploma in analytical science . Recent training completed included risk safeguarding training, dementia care, successful aging, hand hygiene, manual handling and fire safety seminar. Her registration was up to date with an Bord Altranais agus Cnáimhseachais na hÉireann (Nursing and Midwifery Board of Ireland) (ABA) was current.

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:

Records listed in Schedules 2, 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People Regulations 2013 (as amended) were available and were stored and maintained securely.

The inspector reviewed a sample of records to include accident and incident records, fire safety, staff personal files and residents' care and medical records. There was a visitors' record to monitor the movement of persons in and out of the building to ensure the safety and security of residents. This was up to date and located in close proximity to the reception desk which was manned by a receptionist.

The directory of residents' contained all information required by schedule 3 of the regulations and was maintained up to date. Inspectors also reviewed a sample of policies and procedures as required by Schedule 5 of the regulations. All the required policies were in place.

Judgment:

Compliant

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The inspector was satisfied that there were appropriate arrangements in place for the safe management of the centre in the absence of the person in charge. Two full time clinical nurse managers deputise in the absence of the person in charge. Both are registered nurses and their registration with An Bord Altranais was up to date. An on-call management rota was in place.

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 in place to protect residents included all staff had undertaken training in recognising and responding to abuse, policies and procedural guidelines with regard to safeguarding, good recruitment practices and vetting procedures. Staff members spoken with confirmed they had undertaken relevant training and in discussion with the inspector were able to state how they would recognise signs of abuse and what they would do if they witnessed abuse or a resident made an allegation of abuse. The inspector spoke with residents who confirmed that they felt safe and well cared for. Feedback in the questionnaires that were reviewed indicated that residents would feel able to raise a concern and who to approach. Staff had recorded background personal information which would foster good communication with residents and make them feel

secure and decrease their anxieties. An allegation of abuse was recently submitted to HIQA and is being appropriately managed.

The person in charge was familiar with the procedures on how to investigate an allegation, suspicion or disclosure of abuse. A visitor's book was maintained and all visitors were required to sign in and out of the centre. The entrance to the unit was secure and required a key pad code to open the doors.

A culture of promoting a restraint free environment with evidence of alternatives such as low-low beds and/or alarm mats was in place. The national policy, 'Towards of Restraint Free Environment in Nursing Homes (2011)' was available in the centre. Records indicated that restraint was only used following a risk assessment and restraints were regularly reviewed by staff. A minority of residents had bedrails in place. In discussion with the person in charge on the use of bedrails she described how most were used as enablers to enhance resident functioning for example to assist with comfort and turning. However care plans did not detail the enabling function of the restraint measure. There was evidence of discussion with the resident and/or their representative. Quarterly notifications were completed in keeping with regulatory requirements.

A policy on the management of responsive behaviours was in place. A review of the training matrix indicated that a high percentage of staff all had received training appropriate to their roles in relation to dementia care and the management of responsive behaviours. A person centred positive behaviour support plan was in place for any resident who displayed responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment), to ensure a consistent approach when working with residents. Staff informed the inspector how they manage the behaviour. There was very good evidence of access to psychiatry of later life who were available on a regular basis regularly to assess and support residents.

Judgment:
Substantially Compliant

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

Theme:
Safe care and support

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

Findings:
The health and safety of residents, staff and visitors was promoted and protected. There was evidence of proactive management of risk identified in the centre. The centre's risk management policy was available and included the required information and controls to manage the risks specified by regulation 26 (1). A detailed emergency plan was in place

to guide staff in responding to an emergency. This provided guidance in the event of fire, flood, power outage or any incident that could result in requiring evacuation structural damage to the centre was also available.

A safety statement which had been reviewed in January 2018 was also available. Individual risk assessments for service users had been undertaken with plans put in place to address risk identified, for example clinical risk assessments were undertaken, including falls risk assessment, nutritional care assessments and neurological observations were completed post un-witnessed falls to monitor neurological function. Good falls prevention measures were in place including low entry beds, crash mats and alarm sensors mats. The centre had an evidenced based falls prevention programme in place and all staff had attended training in falls prevention strategies. Those at risk of falling were identified to make staff aware of the risk and evidence of the level of assessed risk was available for all staff by way of a red code for high risk and amber for medium risk. The programme included the completion of regular comfort checks for residents. The inspector saw that these were occurring and were documented. Records were maintained of accidents and incidents which indicated the immediate response, a section to record action taken and further actions required to follow up the incident. All accident and incidents were reviewed to try and seek way to mitigate the risk of reoccurrence. The inspector found that the management team were proactive in promoting opportunities for learning to improve services and prevent incidents. The person in charge stated that any learning was shared with staff at staff meetings or handover times.

However some risks had not been identified and a risk assessment put in place to mitigate the risk identified. The centre was not completing regular missing persons drills to ensure that the staff could respond effectively to quickly locate any resident who left the centre unknown to staff. A missing person box with torches, high vis jackets was available. Missing persons profiles were available for all residents. Other risks were identified during the inspection that required controls. For example protective gloves were kept in an open dispenser along the corridors which could be accessed by residents with dementia and pose a risk of choking.

A procedure for the safe evacuation of residents and staff, in the event of fire, was prominently displayed. All residents had a personal emergency evacuation plan completed which considered the mobility and aids required to evacuate the resident. There were adequate means of escape. The fire assembly point was identified with appropriate signage in an area to the front of the building. The inspector found that there was recorded evidence available in the centre of the completion of fire evacuation drills.

However, some improvements were required in relation to the recording and completion of fire drills. The records indicated the duration of the drills and the staff that took part, however they did not identify if there were any impediments to swift evacuation and describe what actually occurred, was there a full or part evacuation. Additionally no drill had been undertaken with night staffing levels and in the area where the greatest number of residents would require evacuation. Completion of a simulated drill with night staffing levels would ensure that an assessment of adequacy of staffing levels available to safely evacuate residents in an emergency was undertaken and would provide an assurance that timely evacuation of residents in the event of an emergency

could be achieved.

Records showed that fire fighting equipment was serviced by an external company under a contract agreement. The fire alarm had been serviced quarterly and emergency lighting was serviced annually. All internal fire exits were clear and unobstructed during the inspection. Fire doors with self closing hinges were in place. The local fire services had attended the centre and were familiar with the layout including access points and of the numbers of persons who would possibly require evacuation. Review of the fire training records showed that all staff had undertaken annual training in fire safety. This was confirmed by staff. All staff spoken with knew what to do in the event of a fire and was confident they would be able to safely evacuate including at night time. Personal emergency evacuation plans (PEEPs) were available for each resident. Records were available in the centre to verify that fire extinguishers, fire alarms and emergency lighting were regularly checked.

All staff had received training in fire safety and evacuation procedures. Staff spoken with by the inspectors was clear on the fire safety procedures and knew what to do in the event of a fire. All fire exit doors were observed to be free from obstruction. Fire evacuation plans showing the building layout and nearest evacuation route were displayed.

Residents were supported by the use of appropriate aids to retain their independence. For example, walking aids and hand rails on both sides of corridors. There was a call bell facility in all bedrooms, sitting and dining rooms.

Contracts were in place for the regular servicing of equipment such as specialist beds, wheelchairs and mattresses. There were moving and handling assessments available for all residents.

Appropriate infection control procedures were observed in each unit including hand sanitising gels and protective equipment. All staff members had received training in hand hygiene. Sanitising hand-gel was readily accessible throughout the centre. A high standard of cleanliness was in evidence throughout the centre.

Records viewed by the inspector confirmed that staff had received training in moving and handling and staff confirmed this when speaking with the inspector. Staff was seen to use safe moving and handling techniques and to use appropriate aids. Lifting equipment, such as hoists, were serviced on a regular basis with records maintained. There was no designated smoking area and residents who smoked were not admitted. A nominated member of staff had responsibility for general maintenance.

Judgment:

Non Compliant - Moderate

Outcome 09: Medication Management

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

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

Safe management systems were in place with regard to medication management. A centre-specific policy was in place relating to the ordering, prescribing, storing and administration of medicines. This included guidance on the handling and disposal of out-of-date medicines. All medicines were stored securely. A pharmacist attended the centre monthly and reviewed each resident's medication chart and was available for consultation with residents if required. Administering staff confirmed that out-of-date medicines were disposed of in keeping with the policy.

The inspector observed medication administration practices and found that the nursing staff adhered to professional guidance of An Bord Altranais agus Cnáimhseachais. Medications were stored in a locked medication trolley. A medication fridge was available and the temperature was recorded daily to ensure medication was appropriately stored. Medications that required strict control measures (MDAs) were securely stored and were checked and counted twice daily by nursing staff.

Where medications were to be administered in a modified form such as crushing, this was individually prescribed by the medical practitioner on the prescription chart. Where medicines, usually liquid preparations or eye drops were opened for repeat usage the date of opening was recorded. Staff confirmed that appropriate and comprehensive information was provided in relation to medication when residents were admitted to the centre. This formed part of the pre admission process.

Prescription charts contained the residents, name, date of birth, any allergies, name of GP, weight and an up to date photograph. At the time of inspection no residents were responsible for administering their own medicine. A signature bank of administering staff was in place. A recording system to monitor and review any medication errors was in place. All staff nurses had completed medication management training

Judgment:

Compliant

Outcome 10: Notification of Incidents

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

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

The provider representative and the person in charge were aware of the requirements in relation to notifying the Authority of periods of absence of the person in charge, and there were suitable deputising arrangements in place in the event of such an absence.

The inspector reviewed the incident log and saw that all relevant details of each incident were recorded together with actions taken. To date all relevant incidents and quarterly returns had been notified to the Chief Inspector as required. When further information is requested by the inspector with regard to notifications the person in charge provides a comprehensive response.

An allegation of abuse was in process at the time of inspection and remains in process. An investigation is underway. An NF05 was submitted since the inspection. this is in process and the inspector is awaiting further information.

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 pre admission assessment was completed on all residents prior to admission to the centre to ensure the centre could meet their needs. Many residents had been in short stay care prior to admission for long term care. Observations such as blood pressure, pulse and weight were assessed on admission and according to assessed need thereafter. Residents had assessments of daily living and other assessments completed on admission which included, dependency level, moving and handling, falls risk, pressure sore risk and nutritional risk. Staff demonstrated good knowledge and understanding of each resident's background in conversation with the inspector. The Inspector found from talking with staff and residents and from review of the residents' questionnaires that residents' overall health care needs were met. Staff could describe changes to the identified needs of residents and corresponding delivery of care. The interventions described by the staff reflected the needs of the residents even though not always documented in the care plans. For example in one care plan reviewed two hourly turning was documented as an intervention, but a turning chart was not in place, however relatives confirmed that their loved one was regularly turned. Some care plans for residents required review to ensure they were linked to the assessments and were reflective of the current needs of the resident and to enhance

care more person centred.

Care plans were reviewed at four monthly intervals and in most instances contained enough detail to ensure the delivery of safe quality care. For example, care plans detailed the falls risk and what procedures were required to mitigate the risk of a fall. However some care plans reviewed where a resident was seen by a specialist service the advice of the specialist was not incorporated into the care plan. Where residents were deemed to be at risk of developing pressure ulcers preventative measures were identified including supportive equipment such as specialist cushions, mattresses and dietary supplements. Wound care was well managed with appropriate procedures in place to mitigate the risk of deterioration of the wound. The inspector could see from the documentation available that the wound was progressing well. There was evidence of access to appropriate specialist wound care services and staff in the centre had completed wound care courses.

Access to allied health professionals to include dietetic service, chiropody and speech and language therapy (SALT) services, opticians, audiology physiotherapy and psychiatry of later life was available. The inspector saw that where resident's needs changed they were referred to the appropriate service, for example where a resident had unintentional weight loss they were referred to a dietician. There was evidence that residents had been reviewed by the physiotherapist who was employed by the provider and reviewed all residents identified as being at risk of falling.

A review of residents' medical notes showed that residents had access to regular review by the general practitioner. A narrative record was recorded for residents each day, and this gave an overall clinical picture of the resident. However there was poor evidence available of engagement in social care activity. There was evidence of resident/relative involvement in the care planning process.

Systems were in place to prevent unnecessary hospital admissions. Staff had been trained in sub-cutaneous fluid administration and the centre described good links with the palliative care team. Good processes were in place in relation to transfers and discharge of residents and hospital admissions. There was good evidence available of communication between the centre and acute care services when a resident was being transferred for care. Discharge letters for residents who spent time in acute hospital care and letters from consultations detailing findings following out-patient clinic appointments were available.

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):

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

Findings:

No renovations have taken place to date to improve facilities to enhance the environment for residents who reside in multi-occupancy bedrooms. A restrictive condition is attached to the registration of this centre. This condition states that 'The physical environment in the designated centre must be reconfigured as outlined in the plans submitted to the Chief Inspector in April 2016. The reconfiguration must be completed by December 2021. The management team expressed the view that they are confident that a new build will be completed prior to this time line. Plans are in place for a new development which will replace the Sheil Community Hospital and the Rock Community Nursing Unit (both units are currently located in Ballyshannon). The inspector met with the project manager from the provider estates department with regard to the proposed new build. National approval has been authorised, planning permission has been granted and final plans have been agreed. The project manager stated that it is hoped that the project will soon go to tender with commencement of building works by end of year and completion two years thereafter. Once this centre has been completed it is envisaged that the centre will be in compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older Persons) Regulations 2013 and the National Standards for Residential Care Settings for Older People in Ireland. The provider has submitted the final plan of the proposed new build to HIQA.

The action with regard to accommodating residents in multi occupancy rooms remains live. Bedrooms currently consist of five single rooms, two twin rooms, one triple room and one four bedded room with a large ensuite. The current building poses a challenge to the delivery of care as described in the statement of Purpose. However, staff has made significant efforts to ensure the centre is homely and try to protect the dignity and privacy of residents. Screening curtains were in place in all shared rooms and 'care in progress notifications' were in use. The centre has voluntarily reduced occupancy to 16. Consequently, there is more space available for each resident in multi occupancy rooms. Adequate showers/toilets and bathrooms were available for residents. All residents have space to have a comfortable or specialist chair by their bedside. Wardrobes are located in close proximity to residents' beds. Some residents had personalised the area around their beds but was limited as to how much you could do this. There was appropriate equipment for use by residents. Staff was trained to use the equipment, and equipment was appropriately stored.

Judgment:

Non Compliant - Moderate

Outcome 13: Complaints procedures

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

Theme:

Person-centred care and support

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

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

Findings:

There was evidence of good complaints management. A complaints policy was in place and the complaints procedure, which outlined the name of the complaints officer and details of the appeals process, was prominently displayed.

The inspector viewed the complaints register and found that the complaints which had been made were recorded, investigated and resolved in a timely manner. There had been one recent written complaint which is in the process on being investigated. This was not related to care and welfare of residents.

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:

A comprehensive policy was in place on the delivery of care at end of life care. A high percentage of staff had undertaken training in end of life care. In the sample of care plans reviewed there was evidence of discussion with residents about their wishes and there was also evidence where appropriate of input from the families and significant others. The centre was well supported by community palliative care services. There was good evidence that practice and systems to prevent unnecessary hospital admissions were in place. Evidence of written and verbal communication between the acute hospital and the centre was recorded. Residents who had been transferred into and out of hospital had copies of their transfer letter from the centre to the acute hospital held on file together with nursing, medical transfer letters and discharge summaries from the acute hospital back to the centre.

Judgment:
Compliant

Outcome 15: Food and Nutrition

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

Theme:
Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

The nutritional needs of residents were well met. The inspector spoke with the chef who confirmed that fresh meat, vegetables, fish and fruit was available daily. Homemade scones, cakes and deserts were available. Likes and dislikes were recorded and residents told the inspector that these were respected. Residents on a modified diet could choose from the same menu as regular diets. The chef explained that if residents did not like what was on the menu he could prepare an alternative. All food was cooked fresh daily onsite. Weights were recorded monthly and more regularly according to clinical need. There was adequate staff on duty to support residents at meal times. Those with any identified nutritional care needs had a nutritional care plan in place. Residents who was assessed as at risk of nutritional deficit or had unintentional weight loss triggered a referral to the dietician.

Judgment:
Compliant

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:

Overall there was evidence that residents had the opportunity to participate in activities that were meaningful and purposeful to their individual needs and interests. An assessment of all residents preferred activities had been completed. This informed the activity schedule. The centre had developed the post of a homemaker who took a lead in activity provision. She was appropriately experienced and trained to provide a variety of activities to ensure that meaningful activities were provided to residents. She had completed Sonas (a therapeutic activity for residents who are cognitively impaired) training. An assessment of all residents preferred activities had been completed. This informed the activity schedule.

Different staff took responsibility for different areas of activities for example one care staff did a regular singing session. Some staff were local and knew the residents prior to their admission to the centre. Additionally some residents had been in short stay facilities for a period of time prior to admission and staff had developed a good knowledge of their day to day routine and preferred activities and had passed this on admission to the centre. The inspector observed staff providing assistance to residents where required and noted that the manner and attitude of staff was pleasant with a good rapport between staff and residents. Most staff had undertaken training in dementia care and management of responsive behaviour.

Mass and other religious activities were available regularly. A remembrance mass was held each November. Residents were engaged in a good range of activities. The activity timetable was displayed in the sitting room. There was a wide variety of meaningful activities available which included music sessions, art, exercise groups, quizzes, sonas and reminiscence.

The activity therapist explained that the activity schedule was very flexible and changed according to the views of residents. Residents who communicated with the inspector said that they enjoyed living in the centre, they could choose how they spent their time living in the centre, what activities they took part in. There was evidence of consultation with resident's and their representatives. Residents and relative consumer meetings are held monthly. Minutes were available of these meetings. Staff described informal individual consultation with residents which occurred on a daily basis.

Scheduled activities were person centred for example a work bench for one resident. This was found to allay his anxieties. Baking took place once a week. Residents with cognitive impairment were observed to receive one-on-one attention from staff. There was supporting documentation available detailing resident's attendance and engagement in activities

Residents are facilitated to exercise their civil, political, rights. Many residents were registered to vote. Residents had access to a radio and television. National and local newspapers were also available. There were no restrictions on visitors attending the centre. A priest attended the centre on a weekly basis to celebrate Mass. Other pastoral services could also be made available if required. There were no restrictions on visitors attending the centre. A quarterly newsletter is prepared detailing any changes in the centre and locality. Details of audits undertaken and any improvements as a result of these audits are documented together with any training that staff have recently attended.

The issues with regard to the protection of privacy and dignity of residents accommodated in multi - occupancy rooms are documented under Outcome 12. An independent advocate service was available with their contact details on display.

Judgment:

Compliant

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

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

Laundry was carried out in the centre and there was a system for the identification of items of clothing to ensure that residents' clothes were not lost or mislaid. No recent complaints were documented and there was no feedback from residents to suggest that clothing had been misplaced while laundering.

There were good systems in place with regard to protecting residents' finances. No residents' money was retained for safekeeping on the premises. A system was in place for the safekeeping of residents' money. Where monies were held in safe keeping by the provider residents could access these funds. The administrator requested a cheque for the said funds and a cheque was forwarded to the centre and money passed to the residents.

A sample of transactions was reviewed. These transactions were clearly recorded and verified with signatures of two staff for all transactions made. Internal and external audits of residents' finances were carried out annually and no discrepancies had been found in the most recent audit. Residents had secure storage provided in their bedrooms.

Judgment:

Compliant

Outcome 18: Suitable Staffing

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

Theme:
Workforce

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

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

Findings:

Actual and planned rosters for staff were reviewed. Staff spoken with confirmed that they had sufficient time to carry out their duties and responsibilities. There were 16 residents in the centre, 11 residents were assessed as maximum dependency, three as high dependency and two as medium dependency. There were two nurses and a clinical nurse manager was shared with the rehabilitation unit and the person in charge Monday – Friday from 8:45 -21:15. Two nurses were generally on duty Saturday and Sunday. There were two health care assistants rostered to care for residents up until 17:30 hrs with one from 17:30 until 21:00hrs. On night duty there were two staff, one nurse and one care assistant. In addition to nursing and care staff, a half time maintenance person, a full-time homemaker, laundry, catering and administrative staff were also available. The inspector noted that the day room was supervised at all times and a carer was available in addition to the homemaker to make sure she was not interrupted while completing activities.

The person in charge explained the systems in place to supervise staff, an experienced registered nurse is on duty at all times. Staff spoken with felt supported by the person in charge and the management team. Staff were observed to be pleasant and courteous to residents. Residents spoken with confirmed that they were well cared for and said that staff was readily available when they needed assistance. This was also confirmed by relatives in their questionnaires.

Training included mandatory training on safeguarding and patient moving and handling. Fire safety training was completed annually. The training matrix evidenced that all mandatory training was up to date. This was an action from the last inspection. Other training undertaken included dementia care, national frailty course which included falls, medication, safeguarding, nutrition, tissue viability, infection control and meaningful activity. Other courses attended by staff included care plan workshops and four staff had completed sonas training. Staff had also attended specialised academic courses on gerontology and on line medication training. There was a record maintained of the professional registration numbers (PIN) of all nurses employed and these were all up to date to December 2018.

There was a recruitment and selection policy and procedure in place. Recruitment was managed by the HSE human resources department. All newly appointed staff underwent a period of induction. A sample of staff files was made available for review, however the Garda Síochána vetting available on staff files was not the original vetting and was a letter of confirmation from the HSE stating that the staff member had garda vetting completed.

Judgment:
Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	The Sheil Community Hospital
Centre ID:	OSV-0000624
Date of inspection:	29/01/2018
Date of response:	22/03/2018

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 (Stakeholder) is failing to comply with a regulatory requirement in the following respect:

The statement of purpose failed to provide adequate detail in some areas for example, a description of each room in the centre, its capacity and function. Additionally further detail was required with regard to procedures in place regarding associated emergency procedures.

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:

The Statement of purpose will be updated to reflect the information set out in Schedule 1 and include recommendations as set out by the Inspector, description of each room within the centre and associated emergency procedure.

Proposed Timescale: 30/04/2018

Outcome 02: Governance and Management

Theme:

Governance, Leadership and Management

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

The annual review of the quality and safety of care delivered to residents required a more robust quality improvement plan where any deficits or improvements planned were documented with a time line attached and details of personnel responsible for their enactment.

While there was evidence that deficits identified had been addressed post audits there was no process in place to identify a timeline for re-auditing to ensure sustainable improvement

2. Action Required:

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:

The Annual review of the quality and safety of care in future will include a more robust Quality Improvement Plan in future this will be linked to the audit process and include a timeline of re-auditing to ensure sustainable improvements.

Proposed Timescale: 31/12/2018

Outcome 07: Safeguarding and Safety

Theme:

Safe care and support

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

Most bedrails were used as enablers to enhance resident functioning for example to

assist with comfort and turning. However care plans did not detail the enabling function of the restraint measure.

3. Action Required:

Under Regulation 07(2) you are required to: Manage and respond to behaviour that is challenging or poses a risk to the resident concerned or to other persons, in so far as possible, in a manner that is not restrictive.

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

Care Plans have been updated to detail bed rails as enablers.

Proposed Timescale: 22/03/2018

Outcome 08: Health and Safety and Risk Management

Theme:

Safe care and support

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

Protective gloves were kept in an open dispenser along the corridors which could be accessed by residents with dementia and pose a risk of choking.

4. 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:

The Danicentre is the only product available to store gloves, aprons in a safe and accessible way for staff in management of Infection Control. The infection control committee are seeking national advice and have asked companies supplying to consider how these centres can be made safer for patients with Dementia. Individual risk assessment for patients with Dementia will be undertaken and safety plans put in place. Where this is identified as a high risk.

Proposed Timescale: 22/03/2018

Theme:

Safe care and support

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

Some risks had not been identified and a risk assessment put in place to mitigate the risk identified. The centre were not completing regular missing persons drills to ensure that the staff could respond effectively to quickly locate any resident who left the centre unknown to staff.

5. Action Required:

Under Regulation 26(1)(c)(ii) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the unexplained absence of any resident.

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

More frequent missing person drills will be carried out within the centre to address the requirement set out in Schedule 5.

Proposed Timescale: 30/04/2018

Theme:

Safe care and support

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

Fire drill records did not identify if there were any impediments to a swift evacuation and describe what actually occurred and whether there was a full or part evacuation. Additionally no drill had been undertaken with night staffing levels and in the area where the greatest number of residents would require evacuation.

6. Action Required:

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

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

Fire Drills take place on a regular basis and simulate the low staffing levels on night duty.

Records will be maintained to describe in detail what occurred and include learning to be had from the drill to inform practice.

Proposed Timescale: 22/03/2018

Outcome 11: Health and Social Care Needs**Theme:**

Effective care and support

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

Some care plans reviewed where a resident was seen by a specialist service the advice of the specialist was not incorporated into the care plan.

There was poor evidence available of engagement in social care activity.

7. Action Required:

Under Regulation 05(1) you are required to: Arrange to meet the needs of each resident when these have been assessed in accordance with Regulation 5(2).

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

Care plans have been reviewed and now include specialist advice and social care activity

Proposed Timescale: 22/03/2018

Outcome 12: Safe and Suitable Premises**Theme:**

Effective care and support

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

The action with regard to accommodating residents in multi occupancy rooms remains live. The current building poses a challenge to the delivery of care as described in the statement of purpose.

8. Action Required:

Under Regulation 17(1) you are required to: Ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.

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

There is a new build planned in the Sheil. The details have been supplied to the Inspectorate subject to the normal approvals.

Proposed Timescale: 31/12/2021