Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People

Name of designated centre:	Bandon Community Hospital
Name of provider:	Health Service Executive
Address of centre:	Hospital Lane, Cloughmacsimon, Bandon, Cork
Type of inspection:	Announced
Date of inspection:	23 amd 24 August 2018
Centre ID:	OSV-0000557
Fieldwork ID:	MON-0024636

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

Bandon Community Hospital, established in 1929, is a single-storey building which had been extensively renovated. The designated centre is a Health Service Executive (HSE) establishment. It now consists of accommodation for 25 older adults set out in 21 single en-suite bedrooms and two double en-suite bedrooms. The centre provides long-term, respite and palliative care for local residents. There is an effective governance structure in place led by an experience person in charge. Residents receive a high standard of evidence-based care with good access to allied health services. There is 24 hour nursing and medical care available. There is a complaints management process in place which is effectively monitored. Visitors are welcome at all times. Systems are in place to monitor and augment the quality of care. Residents views are sought and their privacy and dignity is enhanced in the new accommodation. Fire safety is monitored and there is an emphasis on health and safety. The centre is supported by the Friends of Bandon Community Hospital who have raised money for the day-room refurbishment and many other aspects of the care setting.

The following information outlines some additional data on this centre.

Current registration end date:	24/10/2018
Number of residents on the date of inspection:	24

How we inspect

To prepare for this inspection the inspector or inspectors reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
23 August 2018	10:00hrs to 18:00hrs	Mary O'Mahony	Lead
24 August 2018	10:00hrs to 17:30hrs	Mary O'Mahony	Lead

Views of people who use the service

Residents expressed satisfaction with their new accommodation. They said that they enjoyed having access to a dining room, sitting room and kitchenette. They told the inspector that it was nice to be able to choose a view from the bedroom window and families were actively supporting them to decorate their rooms with items and pictures from home. Each resident had access to a new en-suite toilet and shower area which greatly enhanced their privacy and dignity. Residents said that they attended meetings and that they had choice in their daily lives such as choice of meal, choice of bedtime and choice of activity. They were praiseworthy of the person in charge, the doctors and the staff and said that they felt safe in the centre. They told the inspector about the various activities on offer and said that they often went out with family members on shopping trips or to social events. They felt that their concerns would be listened to and addressed.

Capacity and capability

Overall this was a well managed centre which supported safe care for residents. There was a clearly defined management structure in place that specified the lines of authority and accountability in the centre. The person in charge worked full time in an interim appointment and was supported in her role by an experienced clinical nurse manager 2 (CNM2). The inspector viewed minutes of staff meetings. There was evidence that issues were discussed and actions taken where required. Minutes of residents' meetings were reviewed and pre-inspection questionnaires were completed which were generally very positive about all aspects of care.

There were systems in place to assess the quality of life and safety of care. The health and safety statement had been reviewed and risk assessments had been updated. The inspector viewed audits on medication management, health and safety issues and infection control. Reporting systems were in place to notify events to HIQA, in accordance with regulatory requirements. The annual review of the quality and safety of care was made available to the inspector. It was seen to be detailed and informative and residents had been consulted in its development. Documentation seen by the inspector following audit of incidents indicated that each event had led to improved practice, if required, and staff had been informed of any new process. This proactive response to events was evident in positive findings under the Quality and Safety dimension of this report.

Appropriate resourcing arrangements were in place, as evidenced by a review of training records and staffing levels indicating that these were sufficient for addressing residents' needs. Policies on staff recruitment included a supervised

probationary period at which training needs could be accessed and addressed. Daily handover reports ensured that information on residents' changing needs was communicated effectively. Staff were found to be aware of their statutory duties in relation to the protection of residents and the promotion of person-centred care. Supervision was implemented through monitoring procedures such as staff meetings, observation and management presence.

Good systems of information governance were in place. The standards and regulations for the sector were available to staff which ensured awareness of best practice in older adult care. Maintenance records were seen for equipment such as hoists and fire safety equipment which minimised health and safety risks. Most of the records required under Schedule 2, 3 and 4 of the Regulations were maintained and easily retrievable. Residents' records such as care plans reflected findings on inspection and comments from staff and residents.

A number of staff files were viewed. They contained most of the regulatory documentation. However, a number of staff did not have the required Garda Vetting Clearance form on file as the previous forms had been shredded. According to the person in charge all of the effected staff had previously been vetted and dates were available to indicate on which dates vetting clearance had been received. Renewed vetting clearance had been sought. However in the absence of the required documentary proof of vetting the provider was issued with an immediate action plan in this regard. The provider was also asked to provide written assurance that all residents were safeguarded in the centre. This assurance was provided following the inspection with an undertaking that the issue had been prioritised.

Regulation 14: Persons in charge

The person in charge fulfilled the requirements of the Regulations. She was found to be competent and aware of her responsibilities under the regulations and standards for the sector. She had experience in charge management and was leading and supervising a new more person-centred culture of care.

Judgment: Compliant

Regulation 15: Staffing

Staffing levels were adequate to meet the needs of residents. A roster of staff working hours was maintained.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had received the mandatory and appropriate training to fulfil their respective roles.

Judgment: Compliant

Regulation 21: Records

Available records were accessible, securely stored and well maintained in the centre. Not all the required documents were available for staff. For example 15 staff did not have the required Garda Vetting (GV) clearance form on file. The initial GV forms for these staff had been shredded prior to applying for the new GV clearance.

Judgment: Not compliant

Regulation 22: Insurance

The centre was adequately insured.

Judgment: Compliant

Regulation 23: Governance and management

Prior to the inspection the provider representative had been called to HIQA head office to explain why he had not made a timely application for renewal of registration, as set out in the 2007 Health Act.

Judgment: Substantially compliant

Regulation 24: Contract for the provision of services

Contracts were in place and the required elements were included.

Judgment: Compliant

Regulation 3: Statement of purpose

The statement of purpose had been reviewed and it was compliant with regulatory requirements.

Judgment: Compliant

Regulation 31: Notification of incidents

Incidents were notified to HIQA as set out in the Regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

Complaints were documented and the satisfaction or not of each complainant was recorded.

Judgment: Compliant

Regulation 4: Written policies and procedures

Schedule 5 policies were developed, reviewed and implemented.

Judgment: Compliant

Quality and safety

The quality and safety of care in the centre was well managed. An emergency plan was in place. Fire evacuation procedures were displayed prominently around the centre to highlight the procedure to follow in the event of a fire. Fire equipment was checked and serviced at regular intervals. Fire training was provided to staff and fire evacuation drills were undertaken at suitable intervals which ensured that staff were constantly aware of the safety procedures. The risk management policy was

reviewed and was seen to comply with Regulation 26 (1). Infection control guidelines were followed. The inspector found that staff engaged in regular hand-washing and were seen to wear personal protective equipment, such as gloves and aprons. Hand sanitisers and hand washing facilities were in place, around the centre for residents and staff which minimised the risk of cross-infection.

The inspector viewed the record of accidents and incidents. Learning which had occurred as a result of each incident was documented. The minutes of health and safety meetings were reviewed. Clinical risk assessments were undertaken for residents, including falls risk assessment, skin integrity, smoking, pain, continence, moving and handling and the behaviour associated with the behaviour and psychological effects of dementia (BPSD). The inspector found that where appropriate plans of care were drawn up following completion of these clinical assessments. In the sample of residents' care plans reviewed there was evidence of timely access to allied health care professionals. Dental and optical services were provided through a referral system. There was evidence of access to chiropody, speech and language therapy, physiotherapy and dietitian services. The dietitian and the speech and language therapist provided regular training to staff on the care of residents with nutritional needs. The pharmacist carried out an audit of medicines and the staff nurses checked the medicine stock on a weekly basis. Residents had a choice of pharmacist where possible and five general practitioners (GPs) attended the centre. Advice provided by the pharmacist was accessed for staff and residents. The person in charge stated that the pharmacist facilitated staff training and was available to speak with residents. Some practices were not compliant with the guidelines set by an Bord Altranais for medicine management and this was addressed in the compliance plan sent to the provider.

Residents' social care needs were addressed and enhanced in the centre. Hairdressing services were available to residents. Residents were observed throughout the days of inspection having availed of this service. Relatives informed the inspector that they were very happy with the high standard of care in the centre. During the days of inspection there were groups of residents seen sitting in the sitting room availing of activities at different times of the day. In addition, residents had an imagination gym session and enjoyed the social occasion of coming together for their meals. Staff and residents said the layout of the the new building and the availability of communal space provided great opportunities for residents to come together for events and meaningful activities. Volunteers and external groups attended the centre to provide activities for residents and to plan fund-raising efforts which were were welcomed by residents and proved very successful.

Regulation 10: Communication difficulties

Residents with communication challenges were support by staff knowledge, care planning and policy.

Judgment: Compliant

Regulation 11: Visits

There was an open visiting policy and relatives confirmed this.

Judgment: Compliant

Regulation 12: Personal possessions

Each resident had a large double wardrobe and a locker for personal items. There was adequate room in the bedrooms to display and keep personal effects. A locked cupboard was available for valuable items.

Judgment: Compliant

Regulation 13: End of life

The centre accommodated residents who had end-of-life care needs. Palliative expertise, medical and social support was available to residents and their families.

Judgment: Compliant

Regulation 17: Premises

Premises were nicely laid out, newly constructed and colourful. There was adequate communal space available for residents' and relatives use. Residents had the opportunity to meet with the GP and friends in private. There was an accessible internal patio area which was seen to be in use by residents. Each room had an overhead hoist fitted.

Judgment: Compliant

Regulation 18: Food and nutrition

There was a good variety of food choices on the menu. Catering staff had the appropriate training and were knowledgeable of the various dietary requirements and preferences of residents. Snacks were available throughout the day in the accessible kitchenette.

Judgment: Compliant

Regulation 20: Information for residents

Information for residents was available from the statement of purpose, the residents' guide, relatives' visits, staff conversation, media and notice boards.

Judgment: Compliant

Regulation 26: Risk management

Risks were accessed and controls were implemented. Risks were minimised to maximise independence. However, as a result of a near miss incident a risk assessment had not been undertaken to prevent a similar incident. This was completed before the completion of the inspection.

Judgment: Substantially compliant

Regulation 27: Infection control

Staff were trained in hand hygiene techniques. Good laundry practices were in place. There was a colour-coded cleaning system in use. Clinical waste was managed and collected by a recognised company. Alginate bags were in use for soiled laundry and there were adequate sluicing facilities.

Judgment: Compliant

Regulation 28: Fire precautions

Fire checks were carried out and records were maintained. Fire training was undertaken annually by all staff. Fire drills were practiced and results recorded. Appropriate certificates were available for fire equipments servicing.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

Medicines were supplied by a local pharmacist. Audit was carried out on stock and on staff practices. The inspector found that some medical preparations were inappropriately stored in residents' lockers and some creams which were no longer in use were still in the medicine trolley. In addition, there was a discrepancy between the label on a number of drugs and the advice on the prescriptions.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Care plans were appropriate and informative. These guided practice and staff reviewed them on a four-monthly basis. Life story information was brief however for some residents where this knowledge may have supported understanding of residents' behaviour and preferences.

Judgment: Substantially compliant

Regulation 6: Health care

There was access to a range of health care supports such as GPs, dentist, optical, speech and language therapy (SALT), occupational therapy (OT), physiotherapy and chiropody. The psychologist was available and consultant appointments were facilitated. The geriatrician attended residents in the centre on a two-monthly basis where necessary.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Care plans were in place for residents who experienced the behaviour and psychological symptoms of dementia (BPSD). Appropriate documentation was reviewed which indicated that psychotropic medicine was used as a last resort in response to behaviour disturbance. Alternative strategies were utilised to manage

the behaviour such as distraction techniques and a supportive approach.

Judgment: Compliant

Regulation 8: Protection

Staff training in safeguarding older adults was up-to-date. The policy had been reviewed and staff were aware of how to report allegations of abuse.

Judgment: Compliant

Regulation 9: Residents' rights

Residents attended organised meetings. They had a range of interesting activities to participate in with external activity providers and staff. Mass was said weekly and local community personnel were consistently involved in fund raising for the development of the new day room and outside planting among other items.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Not compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 13: End of life	Compliant
Regulation 17: Premises	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management	Substantially compliant
Regulation 27: Infection control	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Bandon Community Hospital OSV-0000557

Inspection ID: MON-0024636

Date of inspection: 23 - 24/08/2018

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant 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 document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: All Garda Vetting disclosures documentation is available in a secure storage system in the Hospital which can only be accessed by the PIC or PPIM. In relation to an identified cohort of 15 staff members who are in the process of being re vetted due to the original Garda Vetting Disclosures not being available via the GVLO, I can confirm that 10 completed disclosures have been received and are on site whilst the remaining 5 staff submissions are currently being processed through the HSE Garda Vetting Liaison Office. These 5 staff will not be rostered for duty until the vetting disclosures are available and on site.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The delay in the application for renewal of registration was the subject of a meeting between HIQA and the Registered Provider Nominee Representative on 3rd July 2018 where assurances were given that all future applications for renewal of registration would be submitted 6 months in advance of the registration expiry date.	
Regulation 26: Risk management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management: Risk assessments are completed as per regulation 26(1) (a) and the findings from the risk assessments inform the measures and actions to be put in place to mitigate any risks identified, including hazard identification.	
Regulation 29: Medicines and pharmaceutical services	Substantially Compliant
Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services: A review was conducted by the CNM of medicine storage and all medicines are now stored in a secure manner with medicines no longer in use returned to the pharmacy in accordance with regulation 29(6). A review was conducted by the registered pharmacist regarding the labeling of medications to ensure the labeling on the medications corresponded with the advice on prescription as per regulation 29(5). There is ongoing training for staff on medication management	
Regulation 5: Individual assessment and care plan	Substantially Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan: All residents are comprehensively assessed on admission to inform care needs. Some residents are reluctant to give information on admission so obtaining life stories is continuous to inform care. All care plans will be reviewed and further information sought from residents and their families to inform resident behavior and preferences in the care plans.	

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Not Compliant	Red	1st October 2018
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Substantially Compliant	Yellow	15th July 2018
Regulation 26(1)(a)	The registered provider shall ensure that the risk management policy set out in Schedule 5	Substantially Compliant	Yellow	30th August 2018

	includes hazard identification and assessment of risks throughout the designated centre.			
Regulation 29(5)	The person in charge shall ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.	Substantially Compliant	Yellow	30th August 2018
Regulation 29(6)	The person in charge shall ensure that a medicinal product which is out of date or has been dispensed to a resident but is no longer required by that resident shall be stored in a secure manner, segregated from other medicinal products and disposed of in accordance with national legislation or guidance in a manner that will not cause danger to public health or risk to the environment and will ensure that the	Substantially Compliant	Yellow	30th August 2018

	product concerned can no longer be used as a medicinal product.			
Regulation 5(2)	The person in charge shall 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 a designated centre.	Substantially Compliant	Yellow	30 September 2018