

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Killarney Community Hospitals (Fuschia, Hawthorn and Heather Wards)
<b>Centre ID:</b>	OSV-0000568
<b>Centre address:</b>	St Margaret's Road, Killarney, Kerry.
<b>Telephone number:</b>	064 663 1018
<b>Email address:</b>	killarney.hospitals@hse.ie
<b>Type of centre:</b>	The Health Service Executive
<b>Registered provider:</b>	Health Service Executive
<b>Lead inspector:</b>	Caroline Connelly
<b>Support inspector(s):</b>	Mary McCann
<b>Type of inspection</b>	Unannounced Dementia Care Thematic Inspections
<b>Number of residents on the date of inspection:</b>	75
<b>Number of vacancies on the date of inspection:</b>	21

## **About Dementia Care Thematic Inspections**

The purpose of regulation in relation to residential care of dependent Older Persons is to safeguard and ensure that the health, wellbeing and quality of life of residents is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer and more fulfilling lives. This provides assurances to the public, relatives and residents that a service meets the requirements of quality standards which are underpinned by regulations.

Thematic inspections were developed to drive quality improvement and focus on a specific aspect of care. The dementia care thematic inspection focuses on the quality of life of people with dementia and monitors the level of compliance with the regulations and standards in relation to residents with dementia. The aim of these inspections is to understand the lived experiences of people with dementia in designated centres and to promote best practice in relation to residents receiving meaningful, individualised, person centred care.

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 monitor compliance with specific outcomes as part of a thematic inspection. This monitoring inspection was un-announced and took place over 2 day(s).

**The inspection took place over the following dates and times**

From:	To:
02 April 2019 12:30	02 April 2019 19:20
02 April 2019 12:30	02 April 2019 19:20
03 April 2019 09:00	03 April 2019 17:00
03 April 2019 09:00	03 April 2019 17:00

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

<b>Outcome</b>	<b>Provider's self assessment</b>	<b>Our Judgment</b>
Outcome 01: Health and Social Care Needs	Substantially Compliant	Non Compliant - Moderate
Outcome 02: Safeguarding and Safety	Substantially Compliant	Substantially Compliant
Outcome 03: Residents' Rights, Dignity and Consultation	Compliance demonstrated	Non Compliant - Moderate
Outcome 04: Complaints procedures	Substantially Compliant	Compliant
Outcome 05: Suitable Staffing	Compliance demonstrated	Compliant
Outcome 06: Safe and Suitable Premises	Substantially Compliant	Non Compliant - Major

**Summary of findings from this inspection**

This inspection of Killarney Community Hospital was unannounced and took place over two days. The centre was registered to accommodate the needs of 96 residents on the days of the inspection there were 75 residents in the centre and twenty one vacancies. This inspection report sets out the findings of a thematic inspection which focused on specific outcomes relevant to dementia care. As part of the thematic inspection process, providers were invited to attend information seminars given by the office of the chief inspector. In addition, evidence-based guidance was developed to guide the providers on best practice in dementia care and the inspection process. During this inspection the inspectors focused on the care of residents with a dementia in the centre. The inspection also considered progress on some findings

following the last inspection carried out on in November 2017 and to monitor progress on the actions required arising from that inspection. Inspectors met with residents, relatives, the provider representative, the person in charge, the two Assistant Directors Of Nursing (ADON), the Clinical Nurse Managers (CNM), nurses, care staff, activities staff, support staff and numerous other staff members. The inspectors tracked the journey of a number of residents with dementia within the service, observed care practices and interactions between staff and residents who had dementia using a validated observation tool. Inspectors also reviewed documentation such as care plans, medical records, staff files, policies, procedures, risk assessments, reports, residents' files and training records to inform this inspection.

The centre had a dementia specific unit which could accommodate 22 residents, on the day of the inspection there were 17 residents diagnosed with dementia living in the unit. The centre also had two further units where there were five residents with a diagnosis of dementia and fourteen residents suspected of having dementia or a cognitive impairment. Inspectors observed that many of the residents required a high level of assistance and monitoring due to the complexity of their individual needs but also observed that some residents functioned at high levels of independence. Overall, the inspectors found the person in charge, staff and management team were generally committed to providing a quality service for residents with dementia.

The inspectors found that residents' overall healthcare needs were met and they had very good access to appropriate medical and allied healthcare services. The quality of residents' lives was generally enhanced by the provision of a choice of interesting things for them to do during the day and an ethos of respect and dignity for residents was evident. Inspectors found that residents appeared to be very well cared for and residents and visitors gave positive feedback regarding care in the centre. However they did identify that there were issues with the multi-occupancy accommodation which will be discussed in the body of the report.

The person in charge had carried out on-going improvements to create an environment in the dementia unit where residents with dementia could flourish. The overall atmosphere in the dementia specific unit was homely, comfortable and in keeping with the overall assessed needs of the residents who lived there. Murals and shop fronts were used as focal points and a snoozlene room was available for relaxation and therapy. However bedroom accommodation continued to be a big issue and five residents with dementia sharing a multi-occupancy room was totally against the principals of good dementia care . Brightly coloured crockery had been purchased along with dementia friendly clocks and signage. The inspectors found the residents were generally enabled to move around as they wished Signs and pictures had been used in the unit to support residents to be orientated to where they were. The previous person in charge had submitted a completed self-assessment tool on dementia care to the office of the chief inspector. The person in charge had assessed the compliance level of the centre through the self-assessment tool and the findings and judgments of inspectors did not concur with the centres' judgments on three outcomes which were found non-compliant, but did so on two outcomes and the other outcome the centre assessed themselves as substantially compliant where the inspectors found the centre compliant. The main issues identified were around the

premises and residents privacy and dignity which were identified on all recent inspections of the service. Although plans were shown to the inspectors for a new building which will address these key areas, planning permission has yet to be obtained. Therefore the inspectors found that the Health Service Executive (HSE) is required to address deficits in governance and management as evidenced by:

- a failure to take all necessary action to improve the privacy and dignity of residents
- a comprehensive review of occupancy levels was not carried out to inform the profile and number of residents who could appropriately be accommodated in the centre
- long-term residents continued to be accommodated in situations which adversely impacted their daily quality of life, privacy and dignity following a reduction in the number of residents accommodated in the centre, the registered provider had failed to ensure that the space created by the reduced number of residents was utilized in all cases to enhance the quality of life and privacy and dignity of the remaining residents.

The action plan at the end of the report sets out the actions required to be implemented, by the provider, to address the findings of non-compliance.

**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: Health and Social Care Needs***

**Theme:**

Safe care and support

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

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

**Findings:**

This outcome sets out the inspection findings relating to healthcare, assessments and care planning. The social care of residents with dementia is discussed in Outcome 3. There were a total of 75 residents in the centre on the days of this inspection, 38 residents has assessed maximum dependency needs, 19 had high dependency needs, thirteen residents had medium dependency needs and the remainder of residents had low dependency needs. 22 residents had a formal diagnosis of dementia and a further fourteen residents had a suspected diagnosis of dementia.

A local GP practice provided medical services to Killarney Community Hospital and the GP's attended the centre on a daily basis. Out-of-hours medical cover was available via a doctor on call service. A sample of medical records reviewed confirmed that resident's 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 in the centre also had access to psychiatry of older life via a local clinic in the town and the psychiatrist also visited the centre to review residents if required. The centre provided in house physiotherapy services where residents are assessed and treated as required. The dietician and the Speech and Language Therapist (SALT) visited the centre and reviewed residents routinely. There was evidence that residents had access to other allied healthcare professionals including occupational therapy, speech and language therapy, dental, chiropody and ophthalmology services. Detailed plans were drawn up and these were evidenced in residents' care plans and dietary plans. Residents and relatives expressed satisfaction with the medical care provided and the inspectors were satisfied that residents' health care needs were well met.

Inspectors reviewed assessment and care planning documentation. There was a comprehensive assessment of all activities of daily living and the assessment process involved the use of a variety of validated tools to assess each resident's risk of deterioration. For example, risk of malnutrition, falls, level of cognitive impairment and pressure related skin injury among others. Pain charts in use reflected appropriate pain management procedures. Inspectors reviewed a selection of care plans for a number of

residents with a dementia and found them to be person centred and individualised. However there were discrepancies seen between units. In the dementia specific unit there were gaps found in documentation and a care plan for a resident that suffered seizures was not sufficiently detailed to direct care. Gaps were seen in wound care documentation where a section was left blank for a staff to retrospectively document wound care given which again does not follow with best practice on documentation. Some care plans were not updated on residents changing needs and fluid balance charts were not consistently completed or totalled. Audits of documentation should highlight these areas. Other care plans seen were comprehensive and detailed information on residents likes, dislikes, hobbies and interests. Responsive behaviour plans were also individualised and comprehensive and enable staff to provide appropriate distraction techniques. The inspectors noted that on a number of care plans there was not documentary evidence that the care plan had been discussed with the resident or relative as required. Consent to treatment was documented. The staff told the inspectors that a lot of work had gone into developing the person centred care plans with education and support from the practice development team. Further attention to detail is required in the monitoring and maintenance of documentation.

With the exception of what was outlined above wound care was generally well managed with regular scientific assessments of any wounds, including photographs of same showing if the wound had improved or deteriorated. Wounds were referred for assessment to a tissue viability nurse who advised on treatment and appropriate dressings. Training on wound care had been provided to a number of staff and there was evidence that a number of wounds had improved and some healed in recent months. Overall the inspectors observed that residents appeared to be well cared for, which was further reflected in residents' comments that their daily personal care needs were well met.

There was evidence of comprehensive discharge planning and the full involvement of the resident, relatives and the multi-disciplinary team in the planning for a safe and suitable discharge.

Resident's religious needs were facilitated with mass taking place regularly in the centre and the rosary said frequently. Residents from other religious denominations were visited by their ministers regularly as required. The inspectors reviewed the centre's policy on end-of-life care which was seen to be comprehensive to guide staff in providing holistic care at the end of life stage. The inspectors reviewed a sample of residents' care plans with regards to end-of-life care and residents who has recently died in the centre and noted that they comprehensively recorded residents' preferences at this time. All information was accessible to staff and staff indicated that relevant information was shared at report handover time. Staff training records indicated that a number of staff had attended training on palliative care issues including spiritual care, psychological support, pain management and communicating with the bereaved relatives. The person in charge stated that the centre was well supported by the specialist team from the local community. Records which the inspectors viewed indicated that the palliative team were responsive to the GP and the staff in providing specialist advice in pain relief and symptom management. Overall the inspectors found that care practices and facilities in place were designed to ensure residents received end of life care in a way that met their individual needs and wishes and respected their dignity and

autonomy. However a single room was not always available for end of life care and this is actioned under premises.

There were systems in place to ensure residents' nutritional needs were met, and that the residents received adequate hydration. The 'Malnutrition Universal Screening Tool' ('MUST') was used for residents on admission. Weights were recorded monthly for all residents and upon readmission from hospital. Oral cavity assessments also took place and a local dentist visited the centre on a regular basis. Nutritional care plans were available for some residents, which described the level of assistance required. Residents were provided with a choice of nutritious meals at mealtimes and the inspectors saw staff assist residents with eating and drinking. This was undertaken in a discrete and sensitive manner. Residents were complimentary about the food provided. Nutritional supplements were administered as prescribed. All staff were aware of residents who required specialised diets or modified diets and were knowledgeable regarding the recommendations of the dietician and SALT.

Inspectors were satisfied that each resident was provided with nutritious and wholesome fresh food and drink at times and in quantities adequate to their needs. Residents were offered a choice of whether to take their meals in their bedroom or the dining room. The centre had three dining rooms. Two dining rooms were located in the Fushia unit and a third very large dining room was located between the Heather and Hawthorn units. The inspectors saw that the dining room tables were attractively set and a large percentage of residents now attended the dining room for their meals and dining space had improved in the large dining room. An inspector spoke with the head chef who explained the layout of the kitchen and food safety precautions in place. The dry goods store was well stocked. Cold rooms and freezers were available. There was a separate meat preparation and gluten-free area, fire equipment and hand washing facilities. Food deliveries were labelled respecting ingredients and dates. A daily deep clean schedule was seen and there was a good standard of cleanliness.

The centre-specific policies on medication management were made available to the inspectors. The policies included the ordering, receipt, administration, storage and disposal of medicines. There had been a number of changes to medication management since the previous inspection in that medicines for residents were now supplied by a community pharmacy and the pharmacist was involved in stock control, review of residents medication in conjunction with the medical officer and in the provision of education for nursing staff. Records examined confirmed that the pharmacist was facilitated to meet his/her obligations as per guidance issued by the Pharmaceutical Society of Ireland.

Medication administration was observed and the inspectors found that the nursing staff adhered to professional guidance issued by An Bord Altranais agus Cnáimhseachais and adopted a person-centred approach. Nursing staff with whom the inspector spoke demonstrated knowledge of the general principles and responsibilities of medication management. The inspector reviewed a sample of residents' medicine prescription records and they were maintained in a tidy and organised manner, they were clearly labelled, they had photographic identification of each resident and they were legible. There was evidence that residents' medicine prescriptions were reviewed at least every three months by a medical practitioner and the pharmacist, crushed medications were



prescribed as crushed and maximum doses were recorded on PRN (as required medicines). Medication errors and near misses were recorded and monitored by the CNM 2 on each unit. There had been a recent medication error that included a number of nursing staff. This was identified and a review took place in conjunction with best practice guidelines. Although there had been a series of recommendations following the review the inspectors found that these had not been followed through in practice. Further training was recommended for all nurses but the inspectors saw that only two nurses out of the six nurses involved had received this training at the time of the inspection and this was three months after the error occurred. On the previous inspection the inspectors had recommended competency assessments to be undertaken on nursing staff and again these had not taken place to date. Clinical oversight of medication management is required to ensure medications are administered 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. This should include the procedure for returning medications safely to pharmacy which had not been fully followed in practice.

There had been an on-going reduction in the use of psychotropic medications and the inspectors reviewed a sample of care plans for residents who were prescribed 'as required' psychotropic medicines for the management of challenging behaviour. Care plans clearly outlined a proactive approach to behaviour that challenges including the identification of specific triggers and the use of reassurance and distraction techniques. It was clearly outlined that psychotropic medicines only be administered when all alternative less restrictive measures have been considered. Staff with whom the inspector spoke were knowledgeable in relation to the care plan in place and were observed to implement the measures outlined.

**Judgment:**

Non Compliant - Moderate

***Outcome 02: Safeguarding and Safety***

**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:**

The centre had measures in place to safeguard residents and protect them from abuse. There were policies and procedures in place for the prevention, detection and response to abuse. Inspectors spoke with a number of staff who confirmed they had received training in adult protection and were able to answer questions satisfactorily about what constitutes abuse and what to do in the event of an allegation, suspicion or disclosure of abuse, including who to report incidents to. Residents indicated that they could speak to

a number of staff if they had any concerns and confirmed that they felt they were well looked after at the centre. There was evidence when there were any safeguarding issues in the centre they were well managed reported and the safeguarding team was involved. Extra safety measures were put into use where residents were facilitated to have a room on their own

Staff training records indicated there was a commitment to ongoing training on safeguarding and training records indicated that the majority of staff had received training in adult protection and safeguarding during 2017 and 2018.

The provider facilitated residents in the management of their finances and inspectors reviewed the systems in place to safeguard residents' money. The centre was a pension agent for a number of residents, but this was all managed through the HSE national accounts in Tullamore where robust records were maintained of all transactions. The centre had robust payment arrangements in place to pay for extras such as chiropody and hairdressing which are all managed and invoiced through the finance office, following countersigned receipts by staff, confirming the service had been supplied to each individual resident. There were a number of residents who handed money in for safekeeping on the units for the purchase of cigarettes, sweets and personal items. Inspectors viewed the system used and saw money was kept in a locked safe. Each resident had an individual envelope and a book was maintained where each lodgement or withdrawal was recorded. All transactions were signed by staff members and by the resident or relative if appropriate. Receipts were maintained for all purchases.

Inspectors reviewed the policies on meeting the needs of residents presenting with responsive behaviour and restraint use. The policy on behaviours that challenged outlined guidance and directions to staff as to how they should respond and strategies for dealing with behaviours that challenged. The policy on restraint was based on the national policy and included clear directions on the use of restrictive procedures including risk assessment and ensuring that the least restrictive intervention was used for the shortest period possible. Staff told inspectors they were continued to promote a reduction in the use of bedrails. However there were approximately 50% of residents using bed rails at the time of inspection and the inspector saw that alternatives such as low low beds, crash mats and bed alarms were in use for some residents but due to the restrictions of the multi-occupancy rooms this was not practical for a large number of the residents. The inspectors reviewed a sample of files of residents using bedrails and found that risk assessments did not always detail alternatives tried and one alternative was documented as reassurance only. Further consideration is required so that restraint is used as a last resort and as a least restrictive alternative. Regular checks of all residents using bedrails were being completed and documented.

Inspectors observed that residents generally appeared relaxed, calm and content during the inspection. Inspectors reviewed a sample of files of residents presenting with responsive behaviours and noted that comprehensive care plans were in place to guide staff in addition to behavioural support plans. Inspectors viewed de-escalation methods being used in practice and these were seen to be very effective. There was evidence of regular involvement of psychiatric services including specialist review by the psychiatrist as required. There had been a reduction in the use of chemical restraint and a full review is undertaken when as required anti-psychotic or sedating medications are used. This was also the subject of audit.

Many staff spoken with and training records reviewed indicated that nursing staff had attended training on dementia care and in dealing with responsive behaviours. Care and other staff had undertaken responsive behaviour training. However training records showed that some staff were last trained in 2015. Therefore refresher training is required to ensure all staff have received up to date training in responsive behaviours as is required by legislation.

**Judgment:**

Substantially Compliant

***Outcome 03: Residents' Rights, Dignity and Consultation***

**Theme:**

Person-centred care and support

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

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

**Findings:**

As highlighted on all recent inspection and as identified again on this inspection feedback from residents and relatives during the inspection, confirmed that residents and relatives were very happy with the care provided and were very complimentary about the staff in the centre. However a few residents and relatives said they would like more storage space and a number talked about the noise levels in the six bedded room particularly at night. A number of residents stated that the lack of a garden for Heather and Hawthorn units was a quality of life issue. A number of residents said they were looking forward to the new building and having more space.

Staff were observed communicating appropriately with residents who were cognitively impaired as well as those who did not have a cognitive impairment. Effective communication techniques were documented and evidenced in some residents care plans. Residents were treated with respect. Inspectors heard staff addressing residents by their preferred names and speaking in a clear, respectful and courteous manner. Staff paid particular attention to residents' appearance, dress and personal hygiene and were observed to be caring towards the residents. Residents choose what they liked to wear. The hairdresser visited regularly and was doing a residents hair during the inspection. Advocacy services were available to residents and residents were facilitated to vote. Posters were up advertising advocacy services and the contact details of the confidential recipient.

There was evidence of consultation with residents and relatives, through residents meetings chaired by the activity staff. Inspectors noted that issues raised by residents were brought to the attention of the person in charge and items were followed up on

subsequent meetings. Numerous visitors were observed throughout both days of inspection where staff members knew the names of visitors and vice versa. Feedback from relatives was that staff took time to talk with family members both when they visited and when they rang to enquire about their relative. Visitors told the inspectors that they were always made welcome and said that if they had any concerns they could identify them to staff and were assured they would be resolved. The centre operated an open visiting policy and this open visiting policy was observed throughout the inspection. Since the previous inspection a new visiting room had been provided at the entrance to Hawthorn ward which has been a welcomed addition. However, the inspectors saw that many visitors continued to visit residents in the multi-occupancy bedrooms. These visiting arrangements did not promote or protect the dignity of the residents in the other beds who may require personal care or be trying to sleep/rest watch television while visitors were in their bedroom. Further encouragement and change of practice is required for visitors to use the visiting and day rooms instead of residents bedrooms.

Inspectors found that the centre had developed good links with the local community and the community were very supportive of the centre. Local schools visited the centre as part of their transition year programme and local choirs and school children performed for residents throughout the year. Local football teams and the Kerry Minor team visited with their winning cups. Some of the rose of Tralee participants visited residents and a number of local musicians. There was an extensive programme on display on the notice boards including photographs of previous activities were displayed throughout the centre. A daily activities record detailing the residents' involvement in the activity was maintained. Activities included art therapy, music, bingo, exercises, card playing, gardening, baking and Sonas. Inspectors met the activity staff who were providing individual and group activities. Residents were very complimentary about the variety of activities available and were particularly appreciative of the cooking and baking group. Inspectors noted that significant efforts had been made by staff to promote residents' independence with several residents being supported to engage in activities external to the centre and trips out. There were a number of activities specifically provided for residents with dementia and new equipment had been purchased such as Ipods with individual residents play lists which residents really enjoyed. Staff had undertaken dementia training and one nurse was undertaking a Masters Degree in dementia care. There was evidence of the introduction of the principals of good dementia care with appropriate signage clocks pictures and colourful crockery.

As part of the inspection, inspectors spent periods of time observing staff interactions with residents. Inspectors used a validated observational tool (the quality of interactions schedule, or QUIS) to rate and record at five minute intervals. Inspector spent time observing interactions during the morning, after lunch in the afternoon and in the evening. These observations took place in various communal room's in the dementia specific unit and in Hawthorn and Heather units. Overall, observations of the quality of interactions between residents and staff in the communal area for a selected period of time indicated that the majority of interactions were of a positive nature with good interactions seen between staff and residents. There had been continual improvements seen since the last inspection where the inspectors saw that there were a lot more residents up and about, the majority of residents on all units attended the dining room for their meals and the day rooms for activities and to watch TV. The introduction of the twilight activity shift providing evening activities was highlighted as a great addition by residents, relatives and staff and it was evident that the person in charge and

management team had placed a much greater emphasis on person-centred care, training was provided to the staff, care plans reflected residents likes, dislikes and wishes. Quality audits were conducted on the lived experience of residents and residents were facilitated to have more choice in their daily lives.

Although there had been continued improvements in person-centred practices since the previous inspections the multi-occupancy rooms continued to affect the privacy, dignity and quality of life for residents. Inspectors saw that although staff promoted residents privacy and dignity as best as they could in the multi-occupancy rooms. The location of a limited number of toilets and showers made accessibility challenging for some residents in Heather and Hawthorn units. It meant that residents had to travel through the whole ward in their night attire to the shower or to use the toilet. Inspectors saw this taking place during the inspection. It also lead to a greater reliance on commodes. Due to the close proximity of beds this did not protect residents' privacy and dignity. A number of residents described the multi-occupancy rooms as noisy and a number of residents told the inspectors they had been disturbed from their sleep at night by the noise from other residents. There were a number of complaints in the complaints log about noise in these rooms at night. Lack of personal space between and around the beds also affected the residents ability to make their bed area personalised and homely and the inspectors noted that although some residents had personalised their bed spaces others were sparse. Although some beds were removed taking into account the occupancy levels further beds come be moved and the space distributed to the residents.

Some residents had photos and pictures brought in from home displayed but the size and layout of the multi-occupancy rooms did not allow for much personalization of the bed space.

As identified on the previous inspections residents did not have adequate storage space in their small single wardrobe and bedside locker to store all of their clothes. The majority of residents had extra clothing stored in labelled plastic boxes stored in a locked linen room on each unit which meant that residents' clothing was not accessible to them at all times. The inspectors found that this did not allow residents full choice around their clothing and did not fully enable them to retain control over their possessions and clothing. In the six bedded rooms the inspectors saw residents had a number of their possessions stored in plastic boxes beside their beds due to lack of storage space. Residents told the inspector that they would love to have more space for personal belongings.

**Judgment:**

Non Compliant - Moderate

### ***Outcome 04: Complaints procedures***

**Theme:**

Person-centred care and support

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

No actions were required from the previous inspection.

**Findings:**

The centre had a clear policy and procedure in place which was accessible and named the complaints officer and the independent appeals person. The procedure was prominently displayed around the centre and clearly identified who you could complain to. The person in charge informed inspectors that she monitored the complaints and these were discussed at staff meetings.

The inspectors viewed the complaints logs and saw that complaints were recorded in line with the regulations, including, actions taken, the outcome and whether the complainant was satisfied with the outcome. The CNMs monitored complaints at unit level and endeavoured to resolve issues as soon as they arose. Records showed that complaints made to date were dealt with promptly and the outcome and satisfaction of the complainant was recorded. Staff and management spoke to inspectors about actions and improvements which were implemented as a result of complaints. Inspectors spoke with residents who stated they would be confident that if they made a complaint it would be dealt with appropriately.

**Judgment:**

Compliant

### ***Outcome 05: Suitable Staffing***

**Theme:**

Workforce

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

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

**Findings:**

Inspectors observed warm and appropriate interactions between staff and residents and they observed staff chatting easily with residents. Residents and relatives spoke very positively of staff and indicated that staff were caring and responsive to their needs. This was seen by the inspectors throughout the inspection in the dignified and caring manner in which staff interacted and responded to the residents. Systems of communication were in place to support staff with providing safe and appropriate care.

There were handover meetings each day to ensure good communication and continuity of care from one shift to the next. Inspectors saw records of regular staff meetings at which operational and staffing issues were discussed. In discussions with staff, they confirmed that they were supported to carry out their work by the CNM on each unit. The inspectors found staff to be well informed and knowledgeable regarding their roles, responsibilities and the residents' needs and life histories. There were separate cleaning staff who were managed by an outside contractor on the previous inspection but now formed part of the centres overall compliment of staff.

Planned and actual duty rosters were maintained for all staff which gave a clear reflection of rotas for all. Since the previous inspection there had been an increase in staffing levels in the evening on Hawthorn and Heather unit with the addition of a 17.00hrs to 21.00hrs shift this extra staff member was available to assist with the evening tea time and also to provide social stimulation for the residents in the lounge area. This additional staff member was welcomed by all but particularly by the residents who told the inspectors how they enjoyed the evening activities such as bingo. During the two days of inspection the number and skill-mix of staff working was observed to be appropriate to meet the needs of the current residents. The ADON's had responsibility for the duty rosters for all of the units and ensured consistency of care by assigning regular staff to each unit.

Inspectors saw and staff confirmed that there were many other training courses available to staff in areas such as nursing documentation, continence, preceptorship, medication management, male catheterisation, speech and language for nurses, dementia care, end of life care, restraint procedures, dementia champions training, infection control, food and nutrition hydration and the management of dysphagia. Nursing staff confirmed they had also attended clinical training including blood- letting and wound care. The inspectors saw evidence that other training courses had been booked and were scheduled for the coming months. Staff confirmed the availability of training and a number of staff had undertaken post registration training including higher diplomas in gerontology, palliative care, management and dementia care.

A training matrix was put in place and all staff training was implemented. Mandatory training in Safeguarding, fire safety, responsive behaviours and moving and handling were generally up to date for staff with further training booked.

Supervision of staff was consistent with a clinical nurse manager in charge on each ward, reporting to an assistant director of nursing. The centre had a policy on the recruitment of new staff. The system in place to appraise the performance of staff had commenced and staff had received appraisals, staff found the process beneficial particularly to identify training and development needs.

The centre provided placements for student nurses, Fetac students and transition year students. Appropriate mentorship and supervision was put in place for the students. Inspectors viewed evidence that staff were recruited, selected and vetted in accordance with best recruitment practice and in line with the requirements of Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. All staff nurses had up-to-date registration with An Bord Altranais agus Cnáimhseachas na hÉireann. Comprehensive induction programmes were in place with evidence of probationary meetings having taken place. There were a number of

items missing from some of the staff files viewed by the inspectors. However these were recovered during the inspection and shown to the inspectors.

**Judgment:**

Compliant

***Outcome 06: Safe and Suitable Premises***

**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:**

There had been a number of improvements made to the premises since the previous inspection including a full decoration throughout and the provision of a quiet/ visitors room in Hawthorn and Heather unit. However many of the findings of non-compliances identified on the previous inspection report in November 2017 of to the premises remained ongoing, particularly in relation to multi-occupancy accommodation and the location of showers and toilets..

The centre is located on the outskirts of Killarney town and is registered to provide long term, respite, palliative and dementia care for 96 residents. Resident accommodation is spread across three separate units; Fuschia which can accommodate 22 residents, Hawthorn which can accommodate 36 residents, and Heather which can accommodate 38 residents. Resident accommodation was mainly provided in large multi-occupancy rooms, with some twin rooms and only two single bedrooms used for end of life care. There was adequate communal space on Fuschia ward with a day room, a sitting room, a dining room, a snoozelan room and another activities room. In Heather and Hawthorn wards there was a large shared communal day room, activity room and dining adjacent. There were more tables and space available in the dining room since the last inspection and tables were attractively set for dinner. The day room also looked more inviting when there were more residents using it. An old kitchenette was converted to a quiet room/visitors room this included comfortable seating and facilities to make tea and coffee. This was a welcomed addition to the building for residents and visitors alike.

Fuschia unit which is the dementia specific unit was generally decorated in a homely and cosy fashion. It featured shop fronts on the corridors, nice sitting rooms and two dining rooms and a snoozlene rooms. Attention had been given to the premises and pictorial and word signage was used to aid residents to find their way around the unit. There was a lovely safe enclosed garden which residents could use with plenty of seating and walkways. There were colourful flowers and raised flower beds and the garden was easily accessible and highly visible on Fuschia unit. There was adequate toilet and bathrooms in proximity to the bedrooms and an assisted bath which staff said residents



enjoyed using. This unit overall was found to be more homely than the other units. However, there remained 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. Similar to findings on all previous inspections, the design and layout of parts of the premises did not conform to the matters listed in Schedule 6 of the Health Act 2007(Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. A bed had been removed from a five bedded room since the previous inspection which did facilitate more space for the other four residents residing there. However there were two further five bedded rooms on the unit which did not facilitate best practice in dementia specific care.

The person in charge showed the inspector where she had removed beds out of some of the six bedded rooms and a few of the two bedded rooms in Heather and Hawthorn units. It was agreed that the six-bed multi-occupancy bedrooms, several of the two-bed bedrooms on Heather and Hawthorn units, and six- and five-bedded rooms on Fuschia unit were unsuitable in design and layout to protect the privacy and dignity of the residents. However there remained a large number of these multi-occupancy rooms that were fully occupied or ones which continued to have up to six beds in them despite the occupancy levels of the centre being consistently well below full capacity for a number of years. The design and layout had a significant impact on residents as they were unable to undertake personal activities in private this is discussed further in outcome 3, resident's rights dignity and consultation. The limited space in these bedrooms had a negative impact on the storage of residents' clothes and personal belongings. Some residents' wardrobes were not located beside their bed but were located at the end of the bedroom. The wardrobe space was inadequate to meet the residents' storage needs with most residents having clothes stored in the locked linen room on each ward. This issue is also addressed under outcome 3

The provider had given assurances that as part of the capital plan for Kerry community hospitals, a new hospital, under Private Public Partnership is in the design stages, due for completion in 2021. The inspectors were shown plans for this new build however planning permission is yet to be obtained. The Health Service Executive (HSE) is required to address deficits in governance and management as evidenced by:

- a failure to take all necessary action to improve the privacy and dignity of residents
- a comprehensive review of occupancy levels was not carried out to inform the profile and number of residents who could appropriately be accommodated in the centre
- long-term residents continued to be accommodated in situations which adversely impacted their daily quality of life, privacy and dignity following a reduction in the number of residents accommodated in the centre, the registered provider had failed to ensure that the space created by the reduced number of residents was utilised to enhance the quality of life and privacy and dignity of the remaining residents.

Although there was a beautiful well maintained enclosed garden area in Fuschia unit, the residents in Hawthorn and Heather units did not have access to an enclosed garden.

There was a functioning call-bell system in place. 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. Since the previous inspection there was evidence of a regular maintenance schedule of assistive devices

Many of the requirements of Schedule 6 of the Regulations were not met by the centre including:

- as outlined above, many of the rooms were not of a suitable size or layout for residents
- the overall storage of wheelchairs, hoists and commodes in the centre was inadequate, for example commodes were seen stored adjacent to residents' toilet cubicles and in shower rooms
- the residents in Hawthorn and Heather units did not have access to an enclosed garden
- there were insufficient numbers of toilets and showers in close proximity to bedrooms on Hawthorn and Heather units to meet the needs of the residents and led to an over reliance on commodes.
- there is very limited availability of single rooms for end of life care.

**Judgment:**

Non Compliant - Major

## Closing the Visit

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

### **Acknowledgements**

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

### ***Report Compiled by:***

Caroline Connelly  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority

## Health Information and Quality Authority Regulation Directorate

### Action Plan



### Provider's response to inspection report<sup>1</sup>

<b>Centre name:</b>	Killarney Community Hospitals (Fuschia, Hawthorn and Heather Wards)
<b>Centre ID:</b>	OSV-0000568
<b>Date of inspection:</b>	02/04/2019
<b>Date of response:</b>	07/05/2019

### 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: Health and Social Care Needs

#### Theme:

Safe care and support

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

Inspectors found gaps in documentation and a care plan for a resident that suffered seizures was not sufficiently detailed to direct care. Gaps were seen in wound care documentation where a section was left blank for a staff to retrospectively document wound care given which again does not follow with best practice on documentation. Some care plans were not updated on residents changing needs and fluid balance

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

charts were not consistently completed or totalled.

The inspectors noted that on a number of care plans there was not documentary evidence that the care plan had been discussed with the resident or relative as required.

**1. Action Required:**

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

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

The 'special treatment and procedure care plan' of all residents at risk of seizures have been reviewed and updated to ensure the direct care in the event of a seizure has been outlined.

All nursing documentation has been reviewed for gaps and all nursing staff have received education on the Nursing and Midwifery Board of Ireland (2015) Recording Clinical Practice Guidelines to update their practice in line with this document

All resident records have been reviewed to ensure the nursing care plans address the changing needs of the residents.

All nursing staff have received education on correctly completing fluid balance charts.

All resident records have been reviewed to ensure that the residents involvement in the care planning process has been recorded

**Proposed Timescale:** 07/05/2019

**Theme:**

Safe care and support

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

There had been a recent medication error that included a number of nursing staff. Although there had been a series of recommendations following the review the inspectors found that these had not been followed through in practice. On the previous inspection the inspectors had recommended competency assessments to be undertaken on nursing staff and these had not taken place to date. Clinical oversight of medication management is required to ensure all medications are administered in conjunction 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.

**2. Action Required:**

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

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

All recommendations following the medication error review have now been implemented.

A new medication management audit tool is currently being developed in consultation with clinical development which will provide clinical oversight of medication management on the ordering, receipt, prescribing, storing and administration of medication to residents.

**Proposed Timescale:** 31/05/2019

**Outcome 02: 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:**

Training records showed that some staffs were last trained in responsive behaviours in 2015. Therefore refresher training is required to ensure all staff have received up to date training in responsive behaviours as is required by legislation.

**3. Action Required:**

Under Regulation 07(1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.

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

Refresher training in supporting the resident with responsive behaviour has been organised for all staff previously trained in 2015.

**Proposed Timescale:** 30/06/2019

**Theme:**

Safe care and support

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

There were approximately 50% of residents using bed rails at the time of inspection and the inspector saw that alternatives such as low low beds, crash mats and bed alarms were in use for some residents but due to the restrictions of the multi-occupancy rooms this was not practical for a large number of the residents. The inspectors reviewed a sample of files of residents using bedrails and found that risk assessments did not always detail alternatives tried and one alternative was documented as reassurance only. Further consideration is required so that restraint is used as a last resort and as a least restrictive alternative.

**4. Action Required:**

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

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

All bedrail risk assessments have been reviewed to ensure that details of alternatives tried have been recorded and that the alternatives offered are appropriate to ensure that the use of bedrails is a last resort.

More High Low beds have been bought.

**Proposed Timescale:** 07/05/2019

**Outcome 03: Residents' Rights, Dignity and Consultation****Theme:**

Person-centred care and support

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

In Heather and Hawthorn units the limited number of toilets and showers were located at either end of the ward. This meant that residents had to travel through the whole ward in their night attire to the shower or to use the toilet. The inspectors saw and staff confirmed that commodes were frequently used in the multi-occupancy room and due to the close proximity of the resident next door this did not protect or promote any of the residents privacy and dignity.

A number of residents described the multi-occupancy rooms as noisy and a number of residents told the inspectors they had been disturbed from their sleep at night by the

noise from other residents. There were a number of complaints in the complaints log about noise in these rooms at night.

Lack of personal space between and around the beds also affected the residents ability to make their bed area personalised and homely and the inspectors noted that although some residents had personalised their bed spaces others were sparse.

The inspectors saw that many visitors visited residents in the multi-occupancy bedrooms. These visiting arrangements did not promote or protect the dignity of the residents in the other beds who may require personal care or be trying to sleep/rest watch television while visitors were in their bedroom.

#### **5. Action Required:**

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

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

- The majority of residents are maximum dependency of care and many are physically unable to use the toilets. Any residents who are physically able to use the toilets will be assisted to the toilet.
- Plans for a New Build CNU are in final design phase and advancing through the National PPP (Public Private Partnership) process. Planning permission application will be submitted in June 2019
- Visitors will be encouraged to use visitor room for visiting
- In the interim staff will do their utmost to protect the dignity of residents in multi-occupancy wards

**Proposed Timescale:** 07/05/2019

### **Outcome 06: 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:**

Many of the requirements of Schedule 6 of the Regulations were not met by the centre including:

- many of the rooms were not of a suitable size or layout for residents
- the overall storage of wheelchairs, hoists and commodes in the centre was inadequate, for example commodes were seen stored adjacent to residents' toilet cubicles and in shower rooms
- the residents in Hawthorn and Heather units did not have access to an enclosed garden
- there were insufficient numbers of toilets and showers in close proximity to bedrooms on Hawthorn and Heather units to meet the needs of the residents and led to an over reliance on commodes.

- there is very limited availability of single rooms for end of life care.

**6. 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:**

- All of the above issues will be addressed in the New Build CNU.
- While there is no enclosed garden in Heather and Hawthorn staff will continue to ensure that residents enjoy the outside patio space available
- There is a designated single palliative room in both Heather and Hawthorn which is used at end of life and this facility will continue to be used when required.
- A multipurpose room is also available to be used in Fuschia for end of life care

**Proposed Timescale:** 07/05/2019