

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Killybegs Community Hospital
Centre ID:	OSV-0000620
Centre address:	Donegal Road, Killybegs, Donegal.
Telephone number:	074 973 2044
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Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Mary Gwendoline Mooney
Lead inspector:	Mary McCann
Support inspector(s):	None
Type of inspection	Unannounced Dementia Care Thematic Inspections
Number of residents on the date of inspection:	35
Number of vacancies on the date of inspection:	6

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.

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to 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:
04 August 2016 11:00	04 August 2016 19:00
05 August 2016 09:30	05 August 2016 13:00

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

Outcome	Provider's self assessment	Our Judgment
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	Substantially Compliant	Substantially Compliant
Outcome 04: Complaints procedures	Compliance demonstrated	Compliant
Outcome 05: Suitable Staffing	Compliance demonstrated	Substantially Compliant
Outcome 06: Safe and Suitable Premises	Substantially Compliant	Non Compliant - Moderate
Outcome 07: Health and Safety and Risk Management		Compliant
Outcome 08: Governance and Management		Compliant
Outcome 09: Statement of Purpose		Compliant

Summary of findings from this inspection

This was an unannounced inspection with a special focus on the provision of dementia care. The focus of this inspection was to evaluate the quality of live for residents with dementia. The inspector focused on six outcomes that had direct impact on dementia care and followed up on the actions from the previous inspection completed in February 2015. Seven actions were documented post this inspection, five had been completed, one was partially complete this related to care planning and one had not been addressed. This related to the premises.

Killybegs Community Hospital (KCH) opened in 2001 and is registered with HIQA to provide care to 41 residents. It is located in close proximity to the local amenities of Killybegs Town. The Hospital provides a range of services and comprises of ten long stay beds, seven respite beds, seven convalescent beds, seven rehabilitation beds and three palliative care beds. A Day Hospital, X-ray facilities, blood testing clinics, physiotherapy and occupational therapy services are also available onsite. The designated centre which provides residential facilities to vulnerable persons over 18 years of age is located on the second floor of the hospital. Killybegs Community Hospital had over 300 admissions last year, approximately 50% of these were admissions for respite care. At the time of inspection the centre had 10 long stay residents, three of whom had a diagnosis of dementia. Accommodation consists of single rooms, twin rooms and four bedded rooms. Adequate sitting and dining room space is available Car parking is available to the front and back.

The Person in Charge had attended information seminars given by the Health Information and Quality Authority (HIQA) regarding dementia inspections. The centre does not have a dementia specific unit. The inspector tracked the journey of the three residents with a diagnosis of dementia and looked at aspects of care provided to some of the other long stay residents. An observational tool (QUIS) in which social interactions between residents and care staff are coded as positive social, positive connective care, task orientated care, neutral, protective and controlling or institutional care/controlling care was used by the inspector. The results reflect the effect of the interactions on the majority of residents (This is discussed under the Outcome on Rights, Dignity and Consultation). A mental state assessment is completed on all residents on admission and repeated at regular intervals. This looks at memory or other mental abilities and helps to diagnose dementia and assess its progression and severity. It is also used to assess changes in a person who has already been diagnosed with dementia and can help to give an indication of how severe a person's symptoms are and how quickly their dementia is progressing.

At the request of HIQA the provider had submitted a completed self assessment on dementia care. This stated that the centre was substantially compliant with outcomes relating to health and social care needs, safeguarding and safety, residents' rights, dignity and consultation, suitable premises and compliant regarding complaints management and suitable staffing and safe and suitable premises. Actions to achieve compliance in these areas were documented and included further staff training in dementia care, and responding to behaviour that challenge, completion of life stories, training on the safeguarding policy and procedures, and upgrading the physical environment. All of these areas had had input.

The inspector found that residents were well known by staff and the care needs of residents with dementia were met. Residents' healthcare needs were met and the general practitioners visited regularly. Sonas (a therapeutic activity for residents who are cognitively impaired) was available for residents. Reminiscence therapy was part of the activity schedule. However, care plans required review to ensure they were more person centred and to ensure they utilised and collated the information that was known by staff that was contained in assessments and the life story books. Residents looked well cared for and told the inspector that the staff treated them

well and helped them with their daily needs.

At the feedback meeting at the end of the inspection, the findings were discussed with the person in charge, nursing, care and catering staff. Matters requiring improvement are discussed throughout the report and set out in the action plan at the end of this report in order to comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

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

Outcome 01: Health and Social Care Needs

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:

This outcome sets out the inspection findings relating to assessments and care planning, access to allied health professional, maintenance of records and policies supporting contemporary evidence based practice. The social care of residents with dementia is reported under Rights Dignity and Consultation. The inspector followed the pathway of three residents with dementia and tracked the journey from referral, to admission, to living in the centre. All aspects of care provided to include physical, psychological, social and emotional care was reviewed.

Admissions are discussed at multi disciplinary team meetings and admission assessments were completed to identify residents' individual needs and choices. There was evidence of communication with family members and the referring agency/person. An admission policy was available. On review of residents' care files the inspector found that their hospital discharge documentation was available and a copy of the Common Summary Assessment (CSARS) which details the assessments undertaken by a geriatrician, a medical social worker and a comprehensive nursing assessment were available in long stay resident's files. No residents had pressure wounds on the days of inspection.

Some issues identified regarding care planning had not been addressed. Clinical assessments did not link to the care plans and where an event occurred for example loss of weight the care plan was not updated or an updated assessment to provide the current risk rating was not available. While residents were seen by specialist personnel for example a dietician and/or speech and language therapist the recommendations were not reflected in the care plans.

13 nurses have received Care Plan training in 2013/2014 and training is on-going in this area. The person in charge had completed a care plan audit and deficits identified in this audit had been brought to the attention of nursing staff, however the inspector identified that these deficits still continued. For example, care plans were not reviewed at four monthly intervals or in response the changing needs of the resident. There was

poor evidence available of any consultation with the resident and where appropriate with the residents family regarding the care plan. Care plans were not person centred and failed to identify if the resident was on a fortified diet or if they were prescribed oral nutritional supplements.

A narrative record was recorded for residents each day. These records described the clinical aspect of care provided but poorly documented psychological well being. There was evidence of access to specialist and allied health care services to meet the care needs of residents such as opticians, physiotherapy and chiropody services. Access to palliative care specialists, dietician, physiotherapy and speech and language were also available.

The centre had recorded a medication error in April 2014. At the time of the last inspection recommendations from this investigation had not been fully enacted by the person in charge. This had been addressed. There were written policies and procedures in place governing the management of medications in the centre. The inspector observed medication administration practices and was satisfied that they were in compliance with relevant professional guidance. Prescription and administration records contained appropriate identifying information including residents' photographs and were clear and legible. Appropriate procedures were in place for the return of unused /out of date medications.

The inspector observed residents having their evening tea in the dining room. Adequate staff were available to assist and monitor intake at meal times. Some residents choose to dine in their own bedrooms, and this was facilitated. A list of residents on special diets including diabetic, high protein and fortified diets, and also residents who required modified consistency diets/thickened fluids was available to catering and care staff. Residents confirmed that they enjoyed the food. Snacks were available at all times. The inspector saw residents being offered drinks throughout the day.

Arrangements were in place to review accidents and incidents. Residents at risk of falling were assessed using a validated falls assessment tool. A validated falls prevention programme was in place and audits supported that the level of falls had decreased. Falls prevention care plans were in place. These provided guidance to staff in the delivery of safe care and aids required such as sensor mats/walking aids to mitigate the risk of further falls for the resident. Evidence was available that post-fall observations including neurological observations were undertaken to monitor neurological function after a possible head injury as a result of a fall. All residents who fell were reviewed by the physiotherapist post the fall.

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. Systems were in place in relation to transfers and discharge of residents and hospital admissions. The inspector saw in some files reviewed that residents had on occasions been admitted to the local acute hospital. There was

evidence available of communication between the centre and acute care services when a resident was being transferred for care. Residents were accompanied by a relative or a staff member to their out-patient clinic appointments and hospital admissions.

Staff had attended training in End of Life Care and provided end of life care to residents with the support of their General Practitioner and the palliative care team as required. Most residents had their end of life preferences recorded and an end of life care plan in place, however some of these required review to ensure they were comprehensive. Some failed to reflect resident's wishes and preferred pathway at end of life. However, where specific instructions with regard to wishes regarding resuscitation had been discussed with the resident and or their relatives these were documented.

Judgment:

Non Compliant - Moderate

Outcome 02: Safeguarding and Safety

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

Systems were in place to protect residents at risk of abuse. Staff spoken with by the inspector, displayed adequate knowledge of how to manage an allegation of abuse and clearly outlined how the resident would be safeguarded. A policy on and procedures for safeguarding vulnerable adults at risk of abuse was in place. All staff had attended adult protection training and 60% of staff had attended training on safeguarding vulnerable adults at risk of abuse. A review of incidents since the previous inspection showed that there were no allegations of abuse had been recorded.

There were policies in place about managing behavioural and psychological signs and symptoms of dementia (BPSD) and restrictive practices. The inspector reviewed behaviour support plans for some residents. While these were person centred, only some included a reactive strategy in order to guide and inform staff regarding the management of behaviours expressed.

The inspector reviewed the use of restraint within the centre. A policy on enabler/restraint use was in place to guide practice. There were risk assessments completed for residents who had bed rails in place. Some bedrails were in use that had an enabling function. The rationale for the use of the enabler was documented in some care plans reviewed.

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:

The inspector found that residents were consulted on the organisation of the centre. Resident meetings were held with residents every six months and staff informally consulted with staff on a daily basis. The last meeting was held in March 2016 and one was planned for September. Minutes of these meetings supported that residents were involved, in discussing activities, staffing, the food and their views of the service provided

A range of activities were available, including reading the newspapers, reminiscence therapy, ball games, chatting about bygone day's proverbs crafts and music. The activity co-ordinator, known in the centre as the 'homemaker' explained that she tried to ensure that suitable and preferred activities was available for each resident. An activity attendance record was not available for each resident. While the homemaker had completed life histories for all long stay residents and was in the process of completing these for short stay residents, there was no evidence available that the information collected in these was utilized to ensure person centred meaningful activities for residents. Care plans for residents with dementia were not ability focused to try and ensure that their independence was maintained A quarterly newsletter was produced which was available to residents and relatives. Residents were facilitated to exercise their civil, political and religious rights. Mass was celebrated weekly in the centre. There were no restrictions on visitors and residents could meet visitors in private. Some residents chose to spend time in their bedrooms watching TV or with visitors or friends according to their own individual preferences.

Observations of the quality of interactions between residents and staff in communal areas of the centre for selected periods of time indicated there was a good level of positive interactions between staff and residents. Staff chatted with and responded positively to residents when they initiated conversation and it was clear that staff had an intimate knowledge of residents likes dislikes and how they liked to spend their time. Many staff knew the residents or their relatives prior to them coming into the centre. The Inspector observed that staff chatted with residents as they met them around the centre. Staff were available at all times in the communal areas. An independent advocacy service was available.

Judgment:

Substantially Compliant

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:

A complaints policy was in place. Complaints that could not be resolved locally were escalated up to management. Complaints were detailed in the complaints log. The inspector reviewed the complaints records and details were maintained about each complaint, details of any investigation into the complaint and whether or not the complainant was satisfied with the outcome. The inspector found that complaints were appropriately responded to and records were kept as required. No resident, staff member or relative spoken with by the Inspector raised any concern with regard to the care or service provided. One complaint was currently at independent appeal stage.

Judgment:

Compliant

Outcome 05: Suitable Staffing

Theme:

Workforce

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

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

Findings:

With regard to the direct delivery of care to residents, there was nine staff on duty in the morning and five in the afternoon. In addition there was a chef, cleaning, laundry, administration and an activity co-ordinator. Two nurses and one carer were rostered on night duty. The inspector observed that staff delivered care in a respectful and timely manner. Staff were supervised appropriate to their role. The inspector found that there were appropriate staff numbers to meet the needs of residents. A planned and actual staff roster was in place, with any changes clearly indicated and the staffing in place on the day of inspection was reflected in this roster. The Inspector noted that these were the standard staffing levels. This was also confirmed by staff.

Confirmation of up to date registration with An Bord Altranais agus Cnáimhseachais Na hÉireann for all nursing staff was available. Training records were reviewed and

evidenced that all staff had been provided with training in fire safety, moving and handling and adult protection. An-ongoing training programme was in place including hand hygiene, wound management, dementia training, falls prevention, encountering assessing and managing pain. achieving excellence in the care of older person.

At the time of the last inspection schedule 2 records – documents to be held in respect of the person in charge and for each member of staff were not complete. This had not been addressed. Staff files reviewed by the inspector failed to contain a full employment history, together with a satisfactory history of any gaps in employment.

Judgment:

Substantially 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:

The residents' personal space is not laid out so as to protect resident's privacy and dignity. A design team has been appointed to review current accommodation, to provide plans to maximise the space available to meet the National Quality Standards for Residential Care. Funding has been agreed and this project is due for completion in Quarter1 2017.

The environment was calm and relaxed and conducive to the provision of dementia care. There were 35 residents in the centre on the day of inspection and the centre. The centre is registered with HIQA to provide care to 41 residents.

The centre was clean and bright and residents were free to walk around the premises but there was no safe secure garden area. Floor coverings were a neutral colour and design throughout and bold patterns were avoided. Signage was available to give cues to residents to direct them towards their bedrooms, however bedroom doors did not have personalised features to make them easily identifiable to residents with dementia. Consideration should be given to greater use of colour to aid and assist residents and allay anxiety while maintaining independence. The dining room double doors were generally kept open to orientate residents. Toilets and bathrooms had non verbal signage. The centre was decorated and fitted with domestic style furnishings. Adequate wardrobe space was available to residents. There was a functioning call bell system in place within the centre. Hoists and pressure relieving mattresses were available, with records available supporting that they were regularly serviced.

Judgment:

Non Compliant - Moderate

Outcome 07: Health and Safety and Risk Management**Theme:**

Safe care and support

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

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

Findings:

No fire drill had been completed with the least amount of staff that would be available in the centre for example at night time. This had been addressed.

A night time fire drill will be undertaken and is planned to continue on a bi-annual basis

Judgment:

Compliant

Outcome 08: Governance and Management**Theme:**

Governance, Leadership and Management

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

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

Findings:

At the time of the last inspection no overall report of the annual review annual review of the quality and safety of care delivered to residents which is prepared in consultation with residents was available. This had been addressed. A quarterly newsletter is developed which contains an overview of the reviews completed and a copy is available to residents and relatives. Additionally the review is discussed at Resident and Consumer Panel Meetings.

Judgment:

Compliant

Outcome 09: Statement of Purpose

Theme:

Governance, Leadership and Management

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

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

Findings:

At the last time of the last inspection the statement of purpose required review to clearly describe the facilities available for long stay residents. The statement of purpose had been amended and detailed services and facilities available for long stay residents.

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:	Killybegs Community Hospital
Centre ID:	OSV-0000620
Date of inspection:	04/08/2016
Date of response:	24/10/2016

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:

Care plans were not reviewed at four monthly intervals or in response to the changing needs.

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

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

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:

Care plans will be reviewed at four monthly intervals in consultation with the resident or more often in response to a change in their needs

The Clinical Nurse Managers will keep plans under review and ensure documentation reflects any consultation which takes place.

Proposed Timescale: 19/09/2016

Theme:

Safe care and support

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

There was poor evidence available of any consultation with the resident and where appropriate with the residents family regarding the care plan.

2. Action Required:

Under Regulation 05(5) you are required to: Make the care plan, or revised care plan, prepared under Regulation 5 available to the resident concerned and, with the consent of that resident or where the person-in-charge considers it appropriate, to his or her family.

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

Care plans will be reviewed at four monthly intervals in consultation with the resident or more often in response to a change in their needs

The Clinical Nurse Managers will keep plans under review and ensure documentation reflects any consultation which takes place

Proposed Timescale: 19/09/2016

Theme:

Safe care and support

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

Care plans were not person centred and failed to identify if the resident was on a fortified diet or if they were prescribed oral nutritional supplements.

3. Action Required:

Under Regulation 05(3) you are required to: Prepare a care plan, based on the assessment referred to in Regulation 5(2), for a resident no later than 48 hours after that resident's admission to the designated centre.

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

All staff have been informed of the outcome of the inspection.
A review of all Residents care plans was undertaken to ensure that care plans reflect all aspects of a residents care needs, and are resident focused.
The Practice development Co-ordinator for Older People's Services has been contacted to provide additional Care Plan Refresher Training for Nursing Staff. Three dates will be organised for Care Plan Training Sessions. The first of which is scheduled for November 16th 2016
A further 2 dates will be scheduled before 31st December 2016.
A Care Plan Check list/prompting tool will be devised to assist staff when completing care plans.

Proposed Timescale:

All residents care plans were reviewed on 9th September 2016.

3 Care Plan Refreshers Training Sessions will be completed by 31st December 2016

Care Plan check list/ prompting tool will be devised by 31st December 2016

Proposed Timescale: 31/12/2016

Theme:

Safe care and support

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

Some end of life care plans required review to ensure they were comprehensive. Some failed to reflect resident's wishes and preferred pathway at end of life

4. Action Required:

Under Regulation 13(1)(a) you are required to: Provide appropriate care and comfort to a resident approaching end of life, which addresses the physical, emotional, social, psychological and spiritual needs of the resident concerned.

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

The palliative Care Nurse Specialist has been contacted for advice in relation this action. End of life care plans have been reviewed to reflect resident's wishes and preferred pathway at end of life.

An education programme in relation to End of Life Care is ongoing with staff released to attend training in the CNME in Letterkenny.

Proposed Timescale: 31/12/2016

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:

Only some behaviour support plans reviewed included a reactive strategy in order to guide and inform staff regarding the management of behaviours expressed.

5. 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:

Advance Practice Nurse Specialist in Mental Health for Older Peoples Services has been contacted to provide staff training to assist staff in identifying and implementing reactive strategies for individual residents.

An information folder will be produced containing useful information for both staff and family members to use as a guidance tool when dealing with residents who display behaviour that is challenging.

21/10/2016: The ANP plans in collaboration with the CNME to Present a Master Class for staff in relation to Reactive Strategy care planning.

Proposed Timescale: 31/12/2016

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

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

An activity attendance record was not available for each resident. While the homemaker had completed life histories for all long stay residents and was in the process of completing these for short stay residents, there was no evidence available that the information collected in these was utilized to ensure person centred meaningful activities for residents. Care plans for residents with dementia were not ability focused to try and ensure that their independence was maintained

6. Action Required:

Under Regulation 09(2)(b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests and capacities.

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

An activity attendance record will be available.

Life stories information will be utilised to ensure meaningful activities are provided.

In the care planning training there will be a focus on the person's ability to ensure they maintain their independence.

Proposed Timescale: 31/12/2016

Outcome 05: Suitable Staffing

Theme:

Workforce

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

Schedule 2 records – documents to be held in respect of the person in charge and for each member of staff were not complete. Staff files reviewed by the inspector failed to contain a full employment history, together with a satisfactory history of any gaps in employment history.

7. Action Required:

Under Regulation 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

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

All schedule 2 records will be reviewed to ensure that they include a full employment history, together with a satisfactory history of any gaps in employment history.

Proposed Timescale: 31/12/2016

Outcome 06: Safe and Suitable Premises

Theme:

Effective care and support

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

There was no safe secure garden area.

8. 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:

HSE estates have included a proposal for a safe and secure garden during the construction works. The construction work commenced on October 17th and is expected to take eight weeks to complete. The Project Manager has issued drawings which were reviewed today (21/10/16). Amendments have been suggested by KCH staff. The project manager will incorporate suggestions into the garden plan for further review.

Proposed Timescale: 31/12/2016

Theme:

Effective care and support

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

The residents' personal space is not laid out so as to protect resident's privacy and dignity.

9. 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:

Privacy Screens to be provided during the construction works due to commence within the next four weeks as previously discussed with HIQA.

Proposed Timescale: 31/12/2016