

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Castlecomer District Hospital
Centre ID:	OSV-0000544
Centre address:	Castlecomer, Kilkenny.
Telephone number:	056 444 1246
Email address:	AnneD.Slattery@hse.ie
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Anne Slattery
Lead inspector:	Kieran Murphy
Support inspector(s):	Ide Batan;
Type of inspection	Announced
Number of residents on the date of inspection:	16
Number of vacancies on the date of inspection:	2

About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

- Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- to carry out thematic inspections in respect of specific outcomes
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or wellbeing of residents.

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration renewal decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
06 January 2015 10:30	06 January 2015 17:30
07 January 2015 08:00	07 January 2015 15:30

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

Outcome 01: Statement of Purpose
Outcome 02: Governance and Management
Outcome 03: Information for residents
Outcome 04: Suitable Person in Charge
Outcome 05: Documentation to be kept at a designated centre
Outcome 06: Absence of the Person in charge
Outcome 07: Safeguarding and Safety
Outcome 08: Health and Safety and Risk Management
Outcome 09: Medication Management
Outcome 10: Notification of Incidents
Outcome 11: Health and Social Care Needs
Outcome 12: Safe and Suitable Premises
Outcome 13: Complaints procedures
Outcome 14: End of Life Care
Outcome 15: Food and Nutrition
Outcome 16: Residents' Rights, Dignity and Consultation
Outcome 17: Residents' clothing and personal property and possessions
Outcome 18: Suitable Staffing

Summary of findings from this inspection

Castlecomer District Hospital was under the overall management of the Health Services Executive (HSE) and provides care for 18 residents, to include convalescence, respite care, palliative care and one long stay resident.

Since the last inspection there had been a change to the person in charge who was also in charge of another designated centre approximately 37 kilometres away. The provider nominee was also the general manager of an acute general hospital. Since appointment in September 2014 the person in charge had only formally met the provider nominee on one occasion and minutes of that meeting were not available. The inspectors outlined their concerns that these management arrangements across

a number of centres could not ensure effective governance, operational management and administration of the designated centres concerned. This was particularly so as this inspection reviewed the actions required following the inspection of 7 January 2014. For the third consecutive inspection the action requiring the introduction of a system for reviewing the quality and safety of care was still to be completed. In addition the physical environment, facilities and resources had not been developed since the last inspection.

Other outstanding actions from the inspection in January 2014 which had not yet been implemented included:

- A sample of personnel files demonstrated that systems for recruitment were not robust with no evidence of Garda Síochána vetting and staff did not have the required two references
- no arrangements had been made for the provision of contracts for residents accessing the service on short stay or convalescent basis
- a number of required policies were either non-compliant with the regulations, as in the case of the complaints policy, or remained in draft form, as for example with the risk management policy
- there was no provision for the majority of residents to store property securely
- the two combined day-dining spaces were not equipped with sufficient soft seating.

The configuration the premises posed significant challenges to the provider in meeting the requirements of the 2013 regulations in relation to the availability of bedrooms of a suitable size and layout for the needs of the residents. The accommodation was divided into two sections, one male and one female. While the male ward was divided into "bays", accommodation was provided in what was essentially an open plan room with seven beds. All the beds on the male ward were on a walk-through corridor with privacy being afforded by a curtain. The female ward was contained in "bays" in one large room with ten beds. There was also a single palliative care room which could be used for either gender. The clinical nurse manager outlined a proposal to convert a sitting room into a further designated palliative care room. There was a resource/training room which had fixtures and fittings that could potentially accommodate two residents. There was a physiotherapy room with two separate treatment bays. Neither the resource room nor the physiotherapy room were used to accommodate residents.

Inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures. A number of questionnaires from residents and relatives were received prior to and following the inspection and the inspectors spoke to many residents and relatives during the inspection. The collective feedback from residents and relatives was one of satisfaction with the service and care provided.

Improvements were required also in a number of areas including:

- Statement of purpose
- information for residents
- records management
- hazard identification
- security of exit doors

- fire safety
- infection control
- medication management
- complaints management
- end of life care
- privacy
- personal property and possessions

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

Outcome 01: Statement of Purpose

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The statement of purpose and function was viewed by the inspectors, and it did not include the information set out in the certificate of registration including the registration date, expiry date and the conditions attached by the Chief Inspector to the designated centre's registration under Section 50 of the Health Act 2007.

The statement of purpose did not include the criteria used for admission to the designated centre, including the procedures for emergency admissions. It further did not clarify whether the centre provided any separate facilities for day care.

Judgment:

Substantially Compliant

Outcome 02: Governance and Management

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

Theme:

Governance, Leadership and Management

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

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

Findings:

Since the last inspection there had been a change in the overall governance structure. While the provider nominee remained the same and also continued in her role as the general manager of an acute general hospital, a new person in charge had been appointed in September 2014. The person in charge outlined to inspectors that she attended the centre one day per week as she was also the person in charge of another designated centre approximately 37 kilometres away. The other management roles outlined to inspectors were an assistant director of nursing appointed with shared responsibility over the two centres, a senior clinical nurse manager and a junior clinical nurse manager. On a day to day level the senior clinical nurse manager had responsibility for operational and management issues. There had been one formal management meeting since September 2014 with attendance by the person in charge and the provider nominee. However minutes of this meeting were not available.

The inspectors were not satisfied that the management systems in place were ensuring that the service provided was effectively monitored. Inspectors found that action from the two preceding inspections requiring the introduction of a system for reviewing the quality and safety of care had still not been implemented. Other outstanding actions from the inspection in January 2014 which had not yet been implemented included:

- A sample of personnel files demonstrated that systems for recruitment were not robust with no evidence of Garda Síochána vetting and staff did not have the required two references
- no arrangements had been made for the provision of contracts for residents accessing the service on short stay or convalescent basis
- a number of required policies were either non-compliant with the regulations, as in the case of the complaints policy, or remained in draft form, as for example with the risk management policy
- there was no provision for the majority of residents to store property securely
- the two combined day-dining spaces were not equipped with sufficient soft seating.

Since the last inspection the person in charge had begun a process of seeking formal feedback from residents and a satisfaction with meals questionnaire was distributed in December 2014. The results indicated that 62% of residents found the food to be very good, 31% found the meals to be good and 2% of residents indicated that the meals needed improvement. The person in charge outlined that a service user satisfaction survey had been recently distributed. However the results were not yet available. This survey had sought opinion on issues including:

- Hand hygiene
- provision of information to residents
- courtesy/assistance given by staff
- visiting arrangements
- signage
- overall opinion on the service.

The person in charge had introduced a system of audit including hand hygiene, equipment, health & safety and nutrition. The results of the audits were available with actions identified to remedy deficits. However, there was no formal annual review of the quality and safety of care delivered to residents as required by Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (the

regulations).

Judgment:

Non Compliant - Major

Outcome 03: Information for residents

A guide in respect of the centre is available to residents. Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

Theme:

Governance, Leadership and Management

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

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

Findings:

The statement of purpose outlined that "a contract of care is discussed and issued to each resident/relative on admission. Once this contract is agreed it is signed and a copy of the contract given to each patient/relative". However, as found on the last inspection in January 2014, contracts of care were not being provided to short stay or convalescent residents. Examination of the contract for the remaining long stay resident indicated that the contract was detailed, specified the services to be provided and the fees to be charged.

The residents' guide viewed by inspectors did not contain an accurate summary of services and facilities as it identified that there was a single en-suite room. However, while there was one single room it was not en-suite.

Judgment:

Non Compliant - Major

Outcome 04: Suitable Person in Charge

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The Health Act 2007 (Care and Welfare of residents in designated centres for older persons) Regulations and 2013 state that each centre has to have a person in charge. Prior to the inspection the Authority received a notification of change to the person in charge of Castlecomer District Hospital from September 2014. The new person in charge was a registered general nurse since 1998 and had a qualification in business studies. She had engaged in continuing professional development including a postgraduate diploma in gerontological nursing. The 2013 regulations further state at Article 14(4) that: "The person in charge may be a person in charge of more than one designated centre if the Chief Inspector is satisfied that he or she is engaged in the effective governance, operational management and administration of the designated centres concerned." The person in charge was in the centre one day per week and as outlined in Outcome 2 inspectors were not satisfied that this was sufficient.

Judgment:

Substantially Compliant

***Outcome 05: Documentation to be kept at a designated centre
The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.***

Theme:

Governance, Leadership and Management

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

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

Findings:

The senior clinical nurse manager outlined that the human resource function was coordinated from the acute general hospital with all personnel files being centrally stored there. As on the previous inspection in January 2014 a sample of personnel files demonstrated that systems were not robust with no evidence of Garda Síochána vetting in some files and a significant number of staff did not have the required references.

The directory of residents was found not to contain details in relation to the address and contact telephone number of residents' general practitioners (GP) as required by schedule 3 of the regulations.

Inspectors examined a sample of healthcare records and found that the mechanisms in place for managing residents' healthcare records required improvement. There was no evidence of a recent photograph of each resident in any of the healthcare records.

Photographic identification was not available on the medication administration records for each resident which would ensure the correct identity of the resident receiving the medication and reduce the risk of medication error. In one resident's healthcare file an outpatient appointment card was attached loosely to the front of the file with the potential that this appointment card could become dislodged or lost.

As on the previous inspection a number of policies required updating. There was a policy on, and procedures in place for, the prevention, detection and response to abuse. However, inspectors saw that the policy was generic to the HSE and not specific to the centre. The inspectors also noted that the policy was due for revision in April 2013 but there was no evidence available that the policy had been revised. There was a policy on and procedures for managing behaviours that challenge however it had not been distributed to staff yet. A number of other policies required review, for example the complaints policy, and these are discussed in more detail elsewhere in this report.

Inspectors viewed a letter from the administration section of the HSE which outlined that that the centre was adequately insured against all public liability incidents.

Judgment:

Substantially Compliant

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The person in charge outlined that, in addition to her own appointment, an assistant director of nursing had also been appointed with shared responsibility over the two centres. On a day to day level in Castlecomer District Hospital the senior clinical nurse manager had responsibility for operational and management issues. She was a registered general nurse and had worked in the centre since 2006. Based on her qualifications and experience the inspectors were satisfied that the senior clinical nurse manager had the requisite skills and experience in care of the older person to deputise for the person in charge.

Judgment:

Compliant

Outcome 07: Safeguarding and Safety

Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:

Safe care and support

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

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

Findings:

Inspectors found that there were measures in place to protect residents from being harmed or suffering abuse. Staff who spoke with the inspector were able to clearly articulate what constituted abuse and knew what to do in the event of an allegation, suspicion or disclosure of abuse, including who to report any incidents to. Two staff nurses had specific qualifications in training on prevention, detection and reporting of abuse. Records showed that all staff had received training in 2014 and further training for staff in 2015 had been planned. Residents spoken with by the inspectors stated that they felt safe in the centre and would have no problem reporting any concerns to staff. Throughout the inspection process the clinical nurse managers and staff were seen to be knowledgeable of individual residents and there appeared to be no barriers to residents engaging with staff.

Finances held on behalf of residents were appropriately accounted for and receipts were issued for all monies held or issued to residents. Two staff members signed for all transactions and if residents are unable to do so relatives signed on their behalf.

There was a policy on restrictive practices and a separate policy on the use of physical restraints. Inspectors noted that five residents were using bedrails. The rationale for use of the bedrails was clearly documented and consent had been obtained. The risk factors for the use of bedrails were considered and there was a clear system of tracking in place which included the date, time, duration and level of restraint used. A restraint audit had been completed by the clinical nurse manager in October 2014. The restraint register indicated that all male residents present during the inspection were on some form of night sedation.

Records indicated that two staff had training in dementia care from September to November 2014. Further training in dementia care was planned for March 2015

Judgment:

Compliant

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

Theme:

Safe care and support

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

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

Findings:

As outlined in more detail in Outcome 11 a number of residents were identified as having a methicillin resistant staphylococcus aureus (MRSA) infection, with some residents having MRSA in a wound. Inspectors found that the physical environment, facilities and resources had not been developed and managed since the last inspection to minimise the risk of service users, staff and visitors acquiring a healthcare acquired infection. In particular, bed spacing was not planned and managed in a way that minimised the risk of spread of healthcare acquired infection.

There was a risk management policy dating from 2006 and while it identified the hazard identification and incident reporting process it did not contain the measures and actions in place to control the following specified hazards:

- Abuse
- unexplained absence of a resident
- injury
- aggression and violence
- self harm.

There was a draft risk management policy but it also did not contain the measures to control the hazards outlined above. There was an incident reporting policy and records indicated that there had been 31 reported incidents from September 2014 to December 2014 namely, 17 resident falls, eight reported pressure sores, one diagnosis error and five medication management errors. Linked to the incident reporting system there was an organisation risk register which outlined assessments undertaken for issues like:

- Residents falling
- recruitment moratorium
- residents who may wander
- environment not being suitable for residents with cognitive impairment
- non-availability of single rooms for residents
- the management of violent and aggressive behaviour
- breaches of security
- ability of residents to evacuate independently
- fire door in the male ward was not connected to the on call system.

There was evidence that incidents were being reviewed and appropriate actions taken to remedy identified defects. There had been three reported incidents since September 2014 of residents exiting the male ward through the fire door and the senior clinical nurse manager outlined that this issued had been put on the risk register and subsequently had been rectified. In relation to the identified hazard of residents' ability to evacuate independently, while there was a centre specific emergency plan, individual

personal emergency evacuation plans were not available for each resident. This had been a finding on the last inspection in January 2014 also. The junior clinical nurse manager outlined that each resident had a mobility assessment undertaken on admission. During the inspection specific hazards were identified by the inspectors which were remedied immediately by the senior clinical nurse manager:

- A commode was left on a corridor blocking an identified escape route
- cleaning agent left opened in a toilet
- a large flower pot on the patio area in the garden was blocking an identified escape route.

The door to the physiotherapy room, which was identified to inspectors as a fire door, was observed to be wedged open. The door to a kitchenette area with a large water boiler was observed to be left open throughout the inspection. This was a potential burn hazard, particularly as the risk register identified that there were residents who may wander. The previous inspection had identified a potential hazard with the security of some exit doors. However, the senior clinical nurse manager outlined that these had not been replaced.

There was an infection control policy. The centre participated in a regional infection prevention and control nursing forum. The minutes of the last meeting of this forum showed that items discussed included updates on hand hygiene, influenza vaccination and any recent outbreaks of a virus. The centre was visibly clean with a cleaning schedule identifying areas to be cleaned and cleaning frequencies. Hand washing facilities were located in the main entrance lobby, and wall mounted alcohol hand gel was available throughout the centre. Household staff were knowledgeable in the area of infection control. However, mould was observed on the walls in the shower room for the male residents. Dust was visible in many air vents.

There was a valid fire certificate for the centre dated 03 October 2014. Inspectors saw evidence that suitable fire prevention equipment was provided throughout the centre and the equipment was adequately maintained by means of:

- Servicing of fire alarm system and alarm panel December 2014
- three monthly testing of the emergency lighting October 2014
- fire extinguisher servicing and inspection December 2014
- daily inspection of means of escape routes
- evacuation drills, with the most recent being undertaken in February 2014
- fire training with 20 staff receiving updated training in February and September 2014.

Judgment:

Non Compliant - Major

Outcome 09: Medication Management

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

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

Medications were generally stored and disposed of appropriately in line with An Bord Altranais agus Cnáimhseachais na hÉireann Guidance to Nurses and Midwives on Medication Management (2007). Medication Management practices were subjected to audit, the last audit had been completed in July 2014. However, based on a sample of prescriptions reviewed the inspector saw and staff agreed that:

- The dosage and maximum dosage of all medications prescribed on a pro re nata (as required/PRN) basis was not stated
- some prescriptions were not legible and required clarity from the prescriber
- not all medications were written in their generic name
- photographic identification was not available on the medication administration records for each resident which would ensure the correct identity of the resident receiving the medication and reduce the risk of medication error.

There was a general practitioner's (GP) signature for each medication prescribed and discontinued. Each resident's medication regime was routinely reviewed as observed by the inspector. Nursing staff told the inspector that generally residents retained the pharmacy of their choice. A pharmacist was available to provide guidance as required and also to audit medication.

The supply, distribution and control of scheduled controlled drugs was checked and deemed correct against the register in line with legislation. Nurses were checking the quantity of medications at the start of each shift. Staff spoken with and the inspection findings supported competency in medicines management practice.

There was evidence from the clinical incident reporting system that nursing staff were engaged in medication reconciliation when residents were admitted to the centre from an acute care hospital. Nurses were checking and clarifying prescriptions when received from the transferring hospital.

Judgment:

Substantially Compliant

Outcome 10: Notification of Incidents

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

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

It is a requirement that all serious adverse incidents are reported to the Authority. A record of all incidents occurring had been maintained and all notifications had been sent to the Authority. A number of notifications had been received in relation to residents being admitted with pressure sores which had occurred prior to admission.

The Authority was also in receipt of a specific notification relating to a staff issue. Prior to this inspection the Authority had requested further information on two separate occasions from the provider but only received the information while on site as part of the inspection.

Judgment:

Compliant

Outcome 11: Health and Social Care Needs

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

Theme:

Effective care and support

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

No actions were required from the previous inspection.

Findings:

In the sample of healthcare files seen by inspectors there was evidence of good communication from the hospital referring the resident for admission to the centre. There were up to date discharge letters from a medical and nursing perspective. This information was used to inform the assessment of the resident on admission. There was evidence that each resident was also assessed on admission for issues like nutrition, dependency levels, risk of falling and moving/handling. In the sample of care plans seen the assessments on admission informed the care planning process. In feedback submitted to the Authority prior to the inspection one resident specifically commented that they were able to discuss and take part in any decisions that were made about their care.

A number of residents were identified as having a methicillin resistant staphylococcus aureus (MRSA) infection, with some residents having MRSA in a wound. Wound management guidelines were available and wound care plans were in place for these residents. In some cases while the wound area was being protected with dressings it was not being actively managed with medication. The person in charge outlined that the guidance they had received was that the centre was not to treat MRSA, unless they received specific treatment instruction from the discharging medical professional.

Inspectors saw evidence that residents' health care needs were met through timely access to general practitioner (GP) services. There were good working relationships with specialist services such as the dietician and speech and language therapist. The inspector observed referrals for consultation to these services and from the records reviewed there was a timely response with assessments undertaken. Up to date swallow care plans recommended by the speech and language therapist were available in residents' healthcare files. There was evidence that, if required, residents were referred for further specialist swallowing testing in the acute hospital setting. Inspectors saw evidence of care planning for residents requiring percutaneous endoscopic gastrostomy (PEG or directly into the stomach) feeding with appropriate supervision provided by the dietician.

A physiotherapist was on site one day per week. A number of residents had complex physiotherapy requirements and there was evidence of coordination of physiotherapy services with the acute hospital services for these residents. There was evidence of good communication links between the centre and the acute general hospital when residents required review and treatment by consultant specialists.

A sample of medication administration charts were reviewed by the inspectors. These indicated that nutritional supplements were prescribed by the GP and administered by nursing staff accordingly. Access to diagnostic services was through the local hospital or outpatient department. Residents also had access to dental services.

When residents were being discharged there was evidence of a discharge care plan being put in place. There was evidence of liaison with the public health nursing service, GP and the multi-disciplinary support team in the community.

Judgment:

Compliant

Outcome 12: Safe and Suitable Premises

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

Theme:

Effective care and support

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

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

Findings:

Accommodation was provided for 18 residents. As found during the previous inspection in January 2014 the configuration these premises posed significant challenges to the provider in meeting the requirements of the 2013 regulations in relation to the availability of bedrooms of a suitable size and layout for the needs of the residents. There hadn't been any action taken in relation to the accommodation since the last inspection and it was still provided for in two sections, one male and one female. The male ward was divided into four separate "bays" and accommodation was provided in what was essentially an open plan room with seven beds. Each of these bays had a wash-hand basin. There were two bathrooms each with a toilet and a wash-hand basin. There was a third bathroom with a shower area, toilet and sink. All the beds on the male ward were on a walk-through corridor with privacy being afforded by a curtain. There was also a sluice room. There was access to a separate combined day-dining space The female ward was also contained in "bays" in one large room with ten beds. There was one bathroom with a shower, toilet and wash-hand basin and a second bathroom with a toilet and wash-hand basin. There was a sluice room with a stainless steel sink and a bedpan washer. There was access to a second combined day-dining space.

There was a large entrance lobby, a visitor's room, visitor's toilet and staff training/meeting room. The senior clinical nurse manager outlined a proposal to convert the visitor's room into an additional single room for residents requiring palliative care. The staff training room had sufficient fixtures and fittings to accommodate two residents but was currently in use as a resource room for staff.

There was a single palliative care room which could be used for either gender. There was access to a bathroom with a toilet and wash-hand basin across the corridor from the single room. There was a physiotherapy room which was laid out with two treatment tables. There were two store rooms in the older part of the building. There was also a second visitors' room, a kitchen and a separate toilet area for catering staff. There was also a ward kitchenette. The administrative offices were located upstairs and access was restricted.

There was an enclosed garden area which staff said was used by residents in the summer months.

Judgment:

Non Compliant - Major

Outcome 13: Complaints procedures

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

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

While there was the use of the HSE policy on "Your service your say" there wasn't a separate complaints policy for the centre.

Complaints were logged in an annual diary and the sample of complaints received included issues relating to heating, food and maintenance. For some complaints there was no evidence of the outcome of the complaint being recorded or measures for improvement being put in place in response to the complaint.

Judgment:

Non Compliant - Moderate

Outcome 14: End of Life Care

Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

The centre had participated in a national initiative by the Authority, the purpose of which was to assess compliance with the specific themes of end of life care and nutrition. The centre had assessed itself as being non-compliant with the regulations and standards in relation to end of life care because each resident did not have an end of life care plan at the time of submission of the self assessment. Inspectors found evidence to support this assessment.

At the time of inspection the inspectors were informed that there were no residents receiving end-of-life care. The inspectors reviewed the centre's policy on end-of-life care and noted that the policy was up to date and comprehensive. It provided good guidance on the management of the period prior to death and the care of the body. It outlined procedures for end of life care and provided guidance for staff on care planning for end of life and how to provide support to relatives. There was evidence of staff reading and signing off their understanding of the policy.

Residents who spoke with the inspectors spoke in a positive manner with regard to their care. If a resident did require admission to hospital the inspector saw that there were transition documents available to support continuity of care between the hospital and the centre. Care plans were reviewed when updating a care plan, following a medical review or when a resident's condition changed. However, the inspectors observed that some care plans did not reflect any discussions nor was there any documentation in

relation to end of life care planning that would ensure that residents receive end of life care in a way that meets their individual needs and wishes.

Staff were knowledgeable in how to physically care for a resident at end of life. The inspectors viewed care plans of deceased residents and noted that relatives were always with residents as they approached the end of their life. Care plans viewed indicated that residents had their end-of-life care needs addressed without the need for transfer to an acute hospital. The clinical nurse manager told the inspectors that residents had very good access to the specialist palliative care services. This was a nurse led service which provided onsite visits to residents and also advice via telephone.

Staff who spoke with inspectors were familiar with the use of a syringe driver (a mechanical pump used to administer medications) in symptom management. There was good access to medical services as evidenced by the medical and nursing records. Documentation such as care plans of deceased residents reviewed by the inspector indicated that symptom control was effective for residents to ensure adequate pain relief and comfort at end of life.

Religious and cultural practices were facilitated. Residents had the opportunity to attend religious services held in the centre. Inspectors were told that residents were visited by the local priest who provided pastoral care. There was a visitors room and an oratory available. Family and friends were facilitated to be with the resident at end of life as observed in a care plan.

A remembrance event had taken place in December 2014. Inspectors saw that there was a remembrance tree for deceased residents in the dining area. A bereavement leaflet for relatives had been developed. The leaflet offered practical information on what to do following a death, information on how to access bereavement/counselling services and how to register a death.

An end of life audit had been completed in September 2014 which indicated that further ongoing education was required in end of life care. The inspector saw that further training by the Irish Hospice Foundation (IHF) programme 'What matters to me' was scheduled to take place following inspection.

There was a procedure for the return of personal possessions. The inspectors saw that all belongings were recorded and returned following the death of a resident. Staff outlined to inspectors that designed canvas bags were used to return personal possessions. The inspectors observed these and other symbols used by the centre when end of life care was being provided.

Inspectors noted that the privacy of residents was respected as much as possible. As described under Outcome 12 the bedrooms consisted of hospital ward type accommodation. The centre was registered to accommodate 18 residents. There was one single room throughout the centre in total. The multi-occupancy bedrooms in each of the wards were not suitable to meet residents' needs due to their design and layout in relation to maintaining privacy and dignity. These multi-occupancy rooms accommodated up to ten residents in ward bay type setting in one unit. Therefore the option of a single room in the event of more than one resident requiring end of life care

could not always be guaranteed for residents. This is a repeat finding from the previous inspection.

Staff had received training in end of life care as observed by inspectors. Recent training included:

- Debriefing sessions
- end of life review
- 'what matters to me' programme.

Judgment:

Non Compliant - Moderate

Outcome 15: Food and Nutrition

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

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

There was an up to date policy on food and nutrition which was found to be comprehensive. Inspectors observed that food and hydration needs were assessed on admission using the malnutrition universal screening tool (MUST) and this was repeated on a three monthly basis or more frequently if required. Snacks and hot and cold drinks and fresh drinking water were readily available throughout the day. The inspector noted that staffing levels were adequate to meet the needs of the residents during mealtimes.

All residents had a nutritional assessment on admission and with information on their food preferences care plans for nutrition and hydration were drawn up. Care, nursing and catering staff worked together to ensure that information on residents' specialist needs were up to date and that appropriate food was available and prepared according to residents' requirements. Staff said that there were formal and informal arrangements in place such as team meetings to communicate changes in residents' diets to catering staff who kept records of all individual requirements in the kitchen.

The inspector met with the chef who confirmed that she met with the residents on a daily basis. Up-to-date information with regard to any changes in residents' dietary requirements was available in the main kitchen as observed by the inspector. The chef and staff who spoke with the inspector had in-depth knowledge of residents' likes and dislikes.

There was evidence that food available reflected choice. The daily menu was displayed

in a prominent position. Inspectors observed that residents were offered assistance in a discreet and appropriate manner. The chef told an inspector that meals were kept refrigerated for residents if they were out and provided at times they wished to eat. Snacks were available at all times for residents as observed by the inspector.

A review of menus had taken place in November 2014 with the dietician who had assessed the nutritional value of the meals. The nurse manager told the inspector that the new menus were ready to be implemented. Resident meal satisfaction surveys had been completed in December 2014. A sample viewed by the inspector indicated that residents were very happy with the food and choices provided. A further survey was to be completed following the introduction of the new menu cycle.

Recent training that had been completed in relation to nutrition and included:

- Nutritional policies and procedures
- MUST training
- four staff completed percutaneous endoscopic gastrostomy (PEG) training

The catering staff had completed food hygiene training.

Judgment:

Compliant

Outcome 16: Residents' Rights, Dignity and Consultation
Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

Theme:

Person-centred care and support

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

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

Findings:

At the last inspection it was found that there were limited meaningful activities for residents. While an activities programme was not yet fully implemented at the time of this inspection, the senior clinical nurse manager advised that a number of staff were participating in a committee with staff from other centres in relation to activities. Staff were also to liaise with another centre and observe the activities in place there with a view to implementing a fuller activities programme.

On the last inspection it was found also that both day/dining rooms, while equipped with televisions, were not equipped with sufficient soft seating. This had not been rectified by

this inspection and had been raised recently by residents with staff. In one resident's progress notes it had been specifically recorded that they had to watch television in the ward as there were no comfortable chairs in the day/dining room. This was found to be disturbing other residents trying to sleep in the ward.

There was closed circuit television in place on the external entrances/exits and gates.

Each resident's communication ability was assessed on admission. Based on this assessment communication care plans were in place if required.

There was an open visiting policy with no restrictions on visits. There were a number of areas throughout the centre where each resident could receive visitors in private.

Judgment:

Non Compliant - Moderate

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

Theme:

Person-centred care and support

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

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

Findings:

At the last inspection it was found that there wasn't a policy on resident's personal property and possessions. Since then the centre had adopted the HSE policy on patients' private property but this policy was undated. While wardrobes were provided for storage of clothing and personal property these wardrobes were too narrow to adequately store personal possessions. A number of residents were observed by inspectors using suitcases to store their possessions. Similarly there was no provision for the majority of residents to store property securely in locked presses. There was also limited scope for residents to personalise their bed-spaces.

Judgment:

Substantially Compliant

Outcome 18: Suitable Staffing

There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet

the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

Theme:
Workforce

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

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

Findings:

Based on the review of the staff rota, inspectors were satisfied that there were sufficient staff with the right skills, qualifications and experience to meet the assessed needs of residents at all times. Staff included at least two staff nurses at all times.

As outlined in Outcome 5 improvements were required in relation to effective recruitment procedures and in particular appropriate reference checking and garda vetting.

Staff confirmed to inspectors that they had been facilitated in accessing continuing professional education by the provider. There was a training programme in place and all staff had received mandatory training as required by the regulations. Training records seen by inspectors indicated that training had been received on infection control, manual handling and palliative care.

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:

Kieran Murphy
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Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	Castlecomer District Hospital
Centre ID:	OSV-0000544
Date of inspection:	06/01/2015
Date of response:	06/05/2015

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non-compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 01: Statement of Purpose

Theme:

Governance, Leadership and Management

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

The statement of purpose did not include the information set out in the certificate of registration.

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

Action Required:

Under Regulation 03(1) you are required to: Prepare a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

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

The Statement of Purpose has been updated in accordance with the Certificate of Registration to include the registration date, expiry date with the conditions attached. Details of the admissions procedure has also been updated with clarification provided in relation to the adjacent Voluntary Daycare facility.

Proposed Timescale: 06/05/2015

Theme:

Governance, Leadership and Management

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

The statement of purpose did not include the criteria used for admission.

Action Required:

Under Regulation 03(1) you are required to: Prepare a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

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

Ammended as required to reflect information required in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013

Proposed Timescale: 06/05/2015

Theme:

Governance, Leadership and Management

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

The statement of purpose did not clarify whether the centre provided any separate facilities for day care.

Action Required:

Under Regulation 03(1) you are required to: Prepare a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

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

Castlecomer District Hospital has no responsibility for the governance of the adjacent

Day Care centre. Specific community services are accessed by patients at the district hospital in the day care centre as necessary. It is a separate entity run by a Voluntary agency and provides a Leg Ulcer Clinic service under the governance of the HSE Community Care PHN team.

This is clarified in the statement of purpose

Proposed Timescale: 06/05/2015

Outcome 02: Governance and Management

Theme:

Governance, Leadership and Management

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

For the third consecutive inspection a system for reviewing the quality and safety of care was still to be completed. Other outstanding actions from the inspection in January 2014 which had not yet been implemented included:

- A sample of personnel files demonstrated that systems for recruitment were not robust with no evidence of Garda Síochána vetting and staff did not have the required two references
- no arrangements had been made for the provision of contracts for residents accessing the service on short stay or convalescent basis
- a number of required policies were either non-compliant with the regulations, as in the case of the complaints policy, or remained in draft form, as for example with the risk management policy
- there was no provision for the majority of residents to store property securely
- the two combined day-dining spaces were not equipped with sufficient soft seating.

Action Required:

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

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

Management systems in place currently include –

Regular meetings with staff to continue- review of audits and discussion and implementation of action plans.

To improve monitoring an annual review report will be completed annually, outcomes from regulatory inspections and clinical audits will be reported to hospital manager (provider nominee) at meetings to be held 4-8 week intervals or more frequently as required.

In addition Risk register, absenteeism, resident feedback, (surveys/complaints/compliments), staffing, maintenance, training, health and safety, hygiene standards to be reviewed at these hospital management meetings and minutes of meetings taken to record same.

Nursing Quality Care Metrics being introduced July 2015 to improve quality monitoring
CNM2 in Castlecomer District will continue to attend Quality and Patient Safety
Committee meetings in St. Columba's Hospital
Co facilitation of training & policy review i.e Elder abuse, End of Life, risk management
will continue on both sites with ADON, CNM and staff involvement
(Ongoing)

Update on the new management structures; Approved by Mr. David Walsh interim CHO
Area 5

It's been acknowledged that in order for the complete management function to be
transferred to community services from Acute's additional administrative and clinical
supports are required.

Register Provider: Patricia Mcevoy - Manager of Older Person Services Carlow/Kilkenny
to assume the role of Register Provider & Manager of the units
Effective from 24th April'15

To support the overall administrative function an additional grade 6 & Grade 3 will be
appointment on fixed term purpose contracts. Until these posts are in place these
administrative functions remain with the acute's

Person in Charge

Georgina Bassett DON will remain as PIC for both St Columba's and Castlecomer District
Hospital

To ensure effective governance, operational management and administration of both
centres.

- CNM2 Castlecomer District is supernumerary and will deputise for the P.I.C in her
absence.
- The existing 0.5WTE administrative CNM2 post in St Columba's will be upgraded to
1.0 WTE ADON to support the PIC in carrying out her function of both designated
centres and will deputise for P.I.C in her absence.
- The relevant documentation has been submitted to upgrade this post and
permanently fill it.

Outstanding actions

- personnel files

Provider Nominee has requested the Personnel Department in St. Luke's Hospital to
allocate a specific staff member to finalise personnel files for Castlecomer District
Hospital –The required references and garda clearance is being actively pursued for any
outstanding staff members. (to be completed by June 30 2015)

- provision of contracts for residents accessing the service on short stay or convalescent
basis

All short stay residents will be provided with contracts of care as is currently the
practice for long stay residents – a national contract is being sought for this purpose.
Services for Older People. Social Care Division have been contacted to advise if an
interim contract can be developed on site until HSE provide required document. (14th

May 2015)

- policies were either non-compliant or in draft form

All policies have been amended to meet regulations – policies judged non compliant have been made centre specific, draft policies have been finalised and implemented – all policies in place as required by regulations –(completed)

- store property securely

All storage areas were reviewed, larger wardrobes requested and locks are being fitted as required. Plan in place to complete purchase and complete works by 30 June 2015

- the two combined day-dining spaces were not equipped with sufficient soft seating
Funding sought from Friends of Castlecomer District in December 2014 prior to the inspection which has been approved, furniture identified and ordered and awaiting delivery (completed March 31st 2015)

Proposed Timescale: 30/06/2015

Theme:

Governance, Leadership and Management

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

There was no formal annual review of the quality and safety of care delivered to residents.

Action Required:

Under Regulation 23(d) you are required to: Ensure there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.

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

As the inspection took place on the 7th of January 2015, it was not feasible to have an annual review completed and this review has now been completed

Annual Review of Quality and Safety completed

Proposed Timescale: 30/04/2015

Outcome 03: Information for residents

Theme:

Governance, Leadership and Management

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

The residents' guide did not contain an accurate summary of services and facilities.

Action Required:

Under Regulation 20(2)(a) you are required to: Prepare a guide in respect of the designated centre which includes a summary of the services and facilities in the centre.

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

Delivery of a new updated booklet received that includes an accurate summary of the current services and facilities.

Proposed Timescale: 31/03/2015

Theme:

Governance, Leadership and Management

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

Contracts of care were not being provided to short stay or convalescent residents.

Action Required:

Under Regulation 24(1) you are required to: Agree in writing with each resident, on the admission of that resident to the designated centre, the terms on which that resident shall reside in the centre.

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

All short stay residents will be provided with contracts of care as is currently the practice for long stay residents – a national contract template is being sought for this purpose. Services for Older People. Social Care Division have been contacted to advise if an interim contract can be developed on site until HSE provide required document

Proposed Timescale: 14/05/2015

Outcome 04: Suitable Person in Charge**Theme:**

Governance, Leadership and Management

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

The person in charge was in the centre one day per week and inspectors were not satisfied that this was sufficient to ensure effective governance operational management and administration of the designated centre.

Action Required:

Under Regulation 14(4) you are required to: If the person in charge is in charge of more than one designated centre provide evidence to the chief inspector that the person in charge is engaged in the effective governance, operational management and administration of the designated centres concerned.

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

The HSE has included the governance structure at Castlecomer District Hospital as part of the overall review of the governance of elderly service provision in Carlow/Kilkenny Hospital. The new governance structure for the district hospitals is currently under negotiation, taking into account the requirements set down by HIQA to ensure effective management systems are in place that support and promote the delivery of quality care services and that there is clearly defined management structure that identifies the lines of authority and accountability. The Discussion Document on Nurse Management Structures for Community Hospital (March '13) and the Service Plan 2013 recommended that community hospital management structures should be reconfigured and amalgamated on a geographical basis to maximize efficiencies and strengthen governance arrangements including flexibility of service provision. Castlecomer has recently been placed under the governance of the Director of Nursing who also has responsibility for St. Columbas Hospital in Thomastown. The concern raised by HIQA in terms of the current hours allocated by the person in charge to be on site at Castlecomer was escalated to the HSE Area Manager who has over all governance responsibility for Community/Elderly Services as this matter cannot be resolved by the provider nominee.

Proposed Timescale: 01/09/2015

Outcome 05: Documentation to be kept at a designated centre**Theme:**

Governance, Leadership and Management

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

A number of policies required updating.

Action Required:

Under Regulation 04(3) you are required to: Review the policies and procedures referred to in regulation 4(1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.

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

All outstanding policies are updated as required.

Trust in care policy / elder abuse updated policy is being rolled out by CNME - Staff responsible for implementing this policy attended on the 9th – Training completed- implementation of new site specific policy in progress

Proposed Timescale: 28/02/2015

Theme:

Governance, Leadership and Management

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

The directory of residents was found not to contain details in relation to the address and contact telephone number of residents' general practitioners (GP) as required by schedule 3 of the regulations.

Action Required:

Under Regulation 19(1) you are required to: Establish and maintain a Directory of Residents in the designated centre.

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

Plans in place to replace current register book, awaiting response from stores and company involved. This will reflect GPS information as requested.
Staff manually adding information required in the interim.

Proposed Timescale: 06/05/2015

Theme:

Governance, Leadership and Management

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

A sample of personnel files demonstrated that systems were not robust with no evidence of Garda Síochána vetting in some files and a significant number of staff did not have the required references.

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:

References as requested have been sourced for any outstanding staff, returned to HR and have been placed on files.
Garda Vetting forms have been returned to the relevant dept.

Proposed Timescale: 30/04/2015

Theme:

Governance, Leadership and Management

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

There was no evidence of a recent photograph of each resident in any of the healthcare records.

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:

Implemented immediately

Proposed Timescale: 06/05/2015

Outcome 08: Health and Safety and Risk Management**Theme:**

Safe care and support

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

The risk management policy it did not contain the measures and actions in place to control the specified hazard of abuse.

Action Required:

Under Regulation 26(1)(c)(i) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control abuse.

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

Completed and implemented

Proposed Timescale: 06/05/2015

Theme:

Safe care and support

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

The risk management policy it did not contain the measures and actions in place to control the specified hazard of unexplained absence of a resident.

Action Required:

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

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

Completed and implemented

Proposed Timescale: 06/05/2015

Theme:

Safe care and support

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

The risk management policy it did not contain the measures and actions in place to control the specified hazard of injury.

Action Required:

Under Regulation 26(1)(c)(iii) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control accidental injury to residents, visitors or staff.

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

Completed and implemented

Proposed Timescale: 06/05/2015

Theme:

Safe care and support

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

The risk management policy it did not contain the measures and actions in place to control the specified hazard of aggression and violence.

Action Required:

Under Regulation 26(1)(c)(iv) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control aggression and violence.

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

Completed and implemented

Proposed Timescale: 06/05/2015

Theme:

Safe care and support

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

The risk management policy it did not contain the measures and actions in place to control the specified hazard of self harm.

Action Required:

Under Regulation 26(1)(c)(v) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control self-harm.

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

Completed and implemented

Proposed Timescale: 06/05/2015

Theme:

Safe care and support

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

The door to a kitchenette area with a large water boiler was observed to be left open throughout the inspection. This was a potential burn hazard.

Action Required:

Under Regulation 26(1)(a) you are required to: Ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.

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

Requested maintenance to provide code locking system, also notified staff, poster put in place to remind staff re hazard
Key code lock in place

Proposed Timescale: 06/05/2015

Theme:

Safe care and support

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

The previous inspection had identified a potential hazard with the security of some exit doors. However, the senior clinical nurse manager outlined that these had not been replaced.

Action Required:

Under Regulation 26(1)(a) you are required to: Ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.

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

Male exit door was addressed however the green door at the end of male ward remains outstanding
Office door at end of male ward is alarmed to alert staff of wandering residents.

Maintenance services have been requested to fit key code or replace lock on external door. The door is currently not open to external access to the building and risk of security thereby minimised in the interim.

Proposed Timescale: 10/05/2015

Theme:

Safe care and support

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

Mould was observed on the walls in one toilet area.

Action Required:

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

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

The 'mould' observed was a stain on the wall from a previous water leak. Maintenance contacted to repair the damaged wall. This is being addressed by Maintenance.

Proposed Timescale: 06/05/2015

Theme:

Safe care and support

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

Dust was visible in many air vents.

Action Required:

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

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

Proposed Timescale:

Theme:

Safe care and support

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

Bed spacing was not planned and managed in a way that minimised the risk of spread of healthcare acquired infection.

Action Required:

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

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

Following the inspection some bed space areas were reorganised to reduce the risk of spread of infection. Advice was sought from the Infection Prevention Control Nurse Specialist regarding treatment of MRSA in view of bed spacing deficit- no further action advised apart from continuation with compliance with the HSE infection prevention control procedures.

A control measure that is routinely implemented to minimise risk if there is an infection outbreak is to cease/reduce admissions and to cohort patients as necessary during any outbreak in accordance with specialist infection control guidance.

See Outcome 12 action plan to reduce beds in 8 bedded female bay. Plan to reduce beds by 8 to 7 initially and then to a further 6 beds when single rooms occupied which will address infection control risks.

In Addition to ongoing adherence to infection control policy and monitoring infection control/prevention procedures including hand hygiene training/compliance.

Proposed Timescale: 10/05/2015

Theme:

Safe care and support

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

The fire door to the physiotherapy room was kept open with a wedge.

Action Required:

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

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

Informed staff, held session re update on fire policy
all wedges removed from clinical areas

Proposed Timescale: 06/05/2015

Outcome 09: Medication Management

Theme:

Safe care and support

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

The dosage and maximum dosage of all medications prescribed on a PRN basis was not stated.

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:

Contacted the Chief Pharmacist at St Lukes General Hospital: medication management education session held, GPs were consulted and advised re proper prescribing.

Proposed Timescale: 06/05/2015

Theme:

Safe care and support

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

Some prescriptions were not legible and required clarity from the prescriber.

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:

GP's advised regarding legible writing particularly when writing prescriptions. Medication management education session completed 26 01 15 for staff nurses.

Proposed Timescale: 06/05/2015

Theme:

Safe care and support

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

Photographic identification was not available on the medication administration records for each resident which would ensure the correct identity of the resident receiving the medication and reduce the risk of medication error.

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:

Completed and implemented

Proposed Timescale: 06/05/2015

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

Effective care and support

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

Limited availability of bedrooms of a suitable size and layout for the needs of the residents.

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 Technical Services/ Estates were notified to examine bed spacing and layout with a view to improving the current facilities in order to achieve compliance. It was agreed with Estates that an option appraisal will be undertaken and recommendations will be made in order to achieve the required standard taking into account the building limitations.

Update: 24/4/2015

The HSE Estates Department, acknowledges the challenges posed with the structure of Castlecomer District Hospital in relation to the work required to enable compliance with HIQA Standards

The options considered were as follows:

- Complete replacement of the building
- Full upgrade
- Partial Upgrade with internal reconfiguration

The optimal solution is to replace the building with a Community Nursing Unit at an alternative site , however, this is a longer term project, and is under consideration by HSE Estates and the CHO. Funding for this development is not included in the HSE capital plan for 2015.

A full upgrade would cost at minimum €5million, and is not considered a cost effective option particularly if replacement is agreed in the near future.

A Partial Upgrade with internal reconfiguration pending replacement of the building is feasible as confirmed with HSE Estates this week pending the decision on the longer term replacement of the building.

1. The immediate action that has been agreed since the inspection is the reassignment of the resource room to become a single room with optional family facilities thus facilitating palliative care requirements and improved infection control.
2. The resource room facility will be relocated to the nursing administration area, and this single room will allow for the removal of a bed from the 8 bedded ward bay in the female ward, improving overall space between beds and reducing the number of patients in this area to 7.
3. The former smoking room will be reassigned for a single room patient accommodation, and this will allow for the removal of a further bed from the female ward bay reducing the bed capacity to 6 patient beds. A wash hand basin needs to be installed in the former smoking room, and this work will be completed by 20/5/2015. This reconfiguration of the resource room and the smoking room to single room patient accommodation facilitates the removal of 2 beds from the 8 bedded female ward bays and the creation of 2 single patient rooms.
4. A further reconfiguration is also proposed;
Proposed decommissioning of the onsite physiotherapy department to provide 2 new single patient rooms with ensuite facilities.(The physiotherapy department is only used occasionally, and agreement has been obtained from the Physiotherapy Manager regarding the alternative use of this area for reconfiguration in to 2 single ensuite rooms)

The redesign is close to completion by HSE Estates, and an application (business case) for €130,000 funding to enable this work to proceed will be made by HSE Estates, before 15 May 2015, as this work is not included in the capital plan for 2015.

Confirmation has been provided by Mr Ciarán Ruane, CATSO, HSE Estates, Lacken, Kilkenny and it was also acknowledged that this submission will be prioritised for expedited approval in view of HIQA requirements. Planning permission will not be required to carry out this work, and it is not possible at the moment to provide a timeframe as to when this work will be undertaken, however, it is expected that the work will commence in Q4 2015, subject to the required funding approval. This proposal will allow for a reduction of a further 2 beds in the larger ward bays and the creation of 2 new single rooms with ensuite facilities

The proposals above are an interim measure to improve bedspacing, layout and single room access pending the decision on the future location of the new community nursing unit(s) for Carlow/Kilkenny which will replace the overnight beds at Castlecomer District Hospital. In summary, The overall number of beds will remain at 18 with the proposals above, however, 4 single rooms will be developed while reducing 4 bed spaces in the open plan ward area.

Proposed Timescale: 15/5/2015(for completion of option appraisal)

Proposed Timescale: 15/05/2015

Outcome 13: Complaints procedures

Theme:

Person-centred care and support

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

There wasn't a separate complaints policy for the centre.

Action Required:

Under Regulation 34(1) you are required to: Provide an accessible and effective complaints procedure which includes an appeals procedure.

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

Complaints policy was reviewed and made centre specific.

Proposed Timescale: 06/05/2015

Theme:

Person-centred care and support

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

The nominated person wasn't maintaining a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.

Action Required:

Under Regulation 34(2) you are required to: Fully and properly record all complaints and the results of any investigations into the matters complained of and any actions taken on foot of a complaint are and ensure such records are in addition to and distinct from a resident's individual care plan.

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

Complaints log in place. All disciplines were notified about the complaints procedure particularly in relation to recording outcomes in the log book which had been observed by the Inspectors as deficient in detail although there was evidence elsewhere to show that issues had been dealt with appropriately by the Clinical Nurse Manager.

Proposed Timescale: 06/05/2015

Outcome 14: End of Life Care

Theme:

Person-centred care and support

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

The option of a single room in the event of more than one resident requiring end of life care could not always be guaranteed for residents.

Action Required:

Under Regulation 13(1)(d) you are required to: Where the resident approaching end of life indicates a preference as to his or her location (for example a preference to return home or for a private room), facilitate such preference in so far as is reasonably practicable.

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

It was agreed with Estates that an option appraisal will be undertaken and recommendations will be made in order to achieve the required standard of accommodation taking into account the building limitations (while encompassing requirements for end of life care) including provision of more single room accommodation.

Proposed Timescale: 24/4/2015 -30/1/2016

Proposed Timescale: 30/01/2016

Theme:

Person-centred care and support

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

Some care plans did not reflect any discussions nor was there any documentation in relation to end of life care planning that would ensure that residents receive end of life care in a way that meets their individual needs and wishes.

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:

Work completed on assessment tool which specifically includes the four Domains Psychological, Social, Spritual and Physical condition/symptoms as per HSE end of life guidelines and HIQA recommendations.

Proposed Timescale: 04/02/2015

Outcome 16: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

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

Both day/dining rooms were not equipped with sufficient soft seating.

Action Required:

Under Regulation 09(2)(a) you are required to: Provide for residents facilities for occupation and recreation.

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

Soft seating has been sourced and in place.

Proposed Timescale: 06/05/2015