Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	Killybegs Community Hospital
Name of provider:	Health Service Executive
Address of centre:	Donegal Road, Killybegs, Donegal
Type of inspection:	Unannounced
Date of inspection:	10 May 2023
Centre ID:	OSV-0000620
Fieldwork ID:	MON-0039580

About the designated centre

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

Killybegs Community Hospital is a purpose built two-storey centre for 38 residents which opened in 2001 in the town of Killybegs in County Donegal. It provides long stay accommodation for 13 residents and there are five respite, four convalescent, four rehabilitation, six assessment and two palliative care beds available to people from the catchment area of South West Donegal and there are approximately 300 admissions and discharges to the centre each year. Accommodation is provided on the first floor and a shaft lift and stairs allows residents and visitors to move between floors. There are six single bedrooms, four of which have accessible en-suite bathroom facilities. The remaining two have a wash hand basin in the room and are located in close proximity to an accessible toilet. There is also an additional single room used for palliative care which has en-suite bathroom facilities and a sitting room with overnight facilities and a kitchenette. Overhead tracking hoists have been installed in all bedrooms to assist residents. There is a spacious dining room and sitting room facing the front of the centre which have large floor -ceiling windows and provide a pleasant view of the sea. There is an enclosed garden provided for the residents. Car parking is available to the front and back. A range of additional HSE community health services are based on the ground floor and these are also available to residents including physiotherapy, occupational therapy, X-ray facilities and blood testing clinics.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	32

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 10 May 2023	10:15hrs to 18:20hrs	Gordon Ellis	Lead
Wednesday 10 May 2023	10:15hrs to 18:20hrs	Nikhil Sureshkumar	Support

What residents told us and what inspectors observed

Overall, the inspectors found several improvements in the care and service provided to the residents in this centre from the previous inspection. Residents' feedback was positive about the care provided to them at the centre.

The inspectors spoke with several residents in the centre, and some residents said that,'' I like the activities here'', ''staff are great'', ''the food is great here'', ''I get plenty of visitors'', '' the new television in the day room is nice'', ''I could enjoy the views of the harbour from this day room''.

The centre is located in the town of Killybegs and is close to local amenities and Killybegs harbour. The centre can accommodate 13 long-stay residents and 28 short-stay residents. The inspectors were informed that the provider has a clear process in place to ensure that the number of residential places for long-stay residents would not exceed ten. However, some residents had overstayed for more than 60 days in the centre, and there were 13 long-stay residents in this centre on the day of inspection.

The centre is in a two-story building with a small lower ground floor. The residents were accommodated on the first floor of the building, and door locks were in place at its exit doors. Residents required staff assistance to exit the second floor and access the garden area, which is located on the first level of the building. Nevertheless, some residents who spoke with the inspectors said they were assisted to go out to the garden when the weather was good.

A range of activities were on offer for residents on the day of the inspection. Residents were busy playing card games and participating in one-to-one sessions with staff in the centre on various occasions. Inspectors were informed that the pupils from the local school visited the centre, and some residents told the inspectors that they enjoyed the visits by the kids.

Residents had access to newspapers and television in the centre. Those residents who did not have individual televisions in multi-occupancy rooms had access to individual portable electronic tablets to access their favourite entertainment programmes when they were in bed.

There was a warm and friendly atmosphere in the home, and inspectors saw staff greet residents in a respectful and friendly manner when entering rooms to provide personal care in the morning. Residents were well dressed and groomed according to their own style. The residents' call bells were answered in a timely manner, and staff attended to their care needs.

In general, residents' rooms were well maintained, and there were a sufficient number of wardrobes and storage spaces available for the residents to store their

personal belongings.

The inspectors met with a staff member in charge on the day. After the opening meeting the inspectors walked around the designated centre. During this walk around, significant fire safety risks were identified.

In a treatment room, unsecured oxygen cylinders were found to be stored in a treatment room, and were at risk of falling over and becoming damaged. The same room was not fitted with a fire door and a door closer was missing to prevent the spread of fire and smoke in the event of an fire developing. Inspectors brought this to the attention of the person in charge on the day of the inspection and assurances were given that this would be addressed.

Inappropriate storage of flammable items were identified in a boiler room and underneath an electrical panel. The presence of these items increased the risk and fuel loading for a fire to develop. In addition to this, the inspectors observed a tea making facility which contained a kettle, toaster, fridge and a microwave. The room was not designed for this function and appropriate fire safety measures were not being taken, which created a fire risk. This was brought this to the attention of the person in charge on the day of the inspection, and assurances were given that these risks would be addressed. The areas observed in relation to fire are further detailed under regulation 28 Fire Precautions.

The centre has a spacious dining room where residents were found to be enjoying the views of Killybegs harbour from the large windows while dining. The inspectors observed a large television was being fitted in this room for the residents to enjoy. This dining room was also used as a day room for residents. A nurses station was located adjacent to this dining room, and this arrangement increased staff supervision of residents in the centre.

The inspectors saw that residents were offered a choice during meal times, and the food served to residents appeared appetising and nutritious. Those residents dining who required assistance were provided with assistance in a timely manner in the centre.

Many visitors were seen coming and going to the centre during the course of the inspection, and residents also enjoyed days out with their relatives. Residents could meet their visitors in the privacy of their rooms or in a designated visitors' room near the main reception. Visitors who spoke with the inspectors were happy with the visiting arrangements in place in the centre.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impacted the quality and safety of the service being delivered.

Capacity and capability

Overall, the centre was found to be generally well run. Although several improvements were found in this inspection, the provider is required to take additional actions to come into full compliance with the regulations.

This risk-based, unannounced inspection was carried out to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013 (as amended). There was a clearly defined management structure in place, and the management team members were aware of their lines of authority and accountability.

Nevertheless, the day-to-day management and oversight of fire safety by the provider was not effective in ensuring that risks were identified and mitigated. The inspectors found a number of risks which had not being identified or addressed by the provider. Significant non-compliance was found in relation to Regulation 28: fire precautions. This was evidenced by the following findings:

- Inappropriate storage of accelerant and flammable items.
- Conflicting and lack of emergency exit directional signage in some internal corridors.
- The inspectors were not assured of the ability of a selection of fire doors to contain the spread of smoke and fire.

This is discussed in further detail in the quality and safety section and under regulation 28 of this report.

There was a person in charge in the centre, and clear deputising arrangements were in place for when the person in charge was absent. The person in charge and the clinical nurse managers facilitated this inspection.

An annual review had been completed, which included residents' feedback. Residents' meetings were held regularly, and they were involved in planning various activities in the designated centre. Management and staff meetings were held regularly in this centre. A comprehensive schedule of clinical audits was in place to monitor the quality and safety of care provided to residents. The provider had arrangements to review accidents and incidents occurring within the centre. However, the provider's management systems were insufficient to ensure that the service provided was safe and effectively monitored. The provider had submitted a satisfactory compliance plan following the previous inspection, and they were not fully implemented. As a result, the inspectors found repeated non-compliances in this inspection. This is further discussed under Regulation 23.

The staff team working in the centre was well established and experienced. The inspectors reviewed the duty roster, and there were a minimum of two nurses working at all times in the centre. The provider reported some staff vacancies in the centre and informed the inspectors that recruitment was ongoing and that they were managing the current staff vacancies with existing staff and agency staff. Activity staff were rostered seven days a week, and this was an improvement from the previous inspection.

The person in charge informed the inspectors that the centre's laundry is partially outsourced. However, several long-stay residents' personal clothes were continued to be laundered in this centre, and additional staff were not allocated to carry out this task. As a result, staff continued to perform laundry duties in addition to their caring duties. This is a repeated finding from the previous inspection held in March 2022.

A sample of staff records reviewed by the inspectors indicated that Garda vetting was obtained before they began their employment in the centre. The staff files contained information about their employment history, and where gaps were identified, they had clear explanations. The inspectors reviewed a sample of residents' care files and found that there was an electronic record system in place. Nursing records such as progress notes, assessments records and care plans were recorded in electronic format. However, some residents' nursing notes did not contain all the information set out in Schedule 3 of the regulation, and this is a repeated finding from the previous inspection.

This inspectors found that the provider had addressed the majority of actions in regard to regulation 28 from the compliance plan following the previous inspection. However, the inspectors were still not assured that the fire evacuation strategy was effective and residents accommodated in the centre could be safely evacuated in a timely manner in the event of a fire with the staffing resources on night duty.

Furthermore, the inspectors were not assured that the current compartmentation boundaries provided adequate containment measures and were in line with the current evacuation procedures as they did not reflect the attic compartment boundaries, which spanned over sleeping accommodation for 18 residents.

The fire alarm detection system and emergency light systems were serviced and up-to-date. The emergency plan procedures were detailed, weekly checks of fire fighting equipment, means of escape and fire exits were all up-to-date. The fire alarm was being tested weekly, staff fire training and fire warden training were up-to-date and fire drills were being carried out almost on a monthly basis.

The person in charge informed the inspectors that there was no general maintenance person currently employed but there was a plan to recruit for this position. This may have impacted on the deficiencies identified in regard to fire doors. The person in charge reported that a fire door specialist had conducted a survey of fire doors and a report had been sent to the provider eight weeks prior to this inspection.

There was a fire policy plan and emergency fire action plan in place. These were found to be comprehensive and informed robust fire safety management in the centre.

Further improvements that the provider needs to make in relation to day-to-day fire safety in the centre are set out in the next section of this report.

Regulation 15: Staffing

The inspectors noted that the numbers and skill mix of staff were not adequate with regard to the residents' dependency levels and the size and layout of the centre. For example, additional staff were not allocated to carry out laundry duties, and care staff were found to be carrying out laundry duties in addition to their caring roles. This reduced the time available to meet residents' care needs.

Furthermore, the provider's statement of purpose mentions that the centre has one whole-time equivalent post for a general operative; however, this post was vacant on the day of inspection.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff had access to appropriate training and there was good oversight of the training needs of staff, and arrangements were made to plan for training, as required.

Judgment: Compliant

Regulation 21: Records

The inspectors noted that some residents' care files maintained in the centre did not contain all the information required in Schedule -2 of the regulations. For example, the daily nursing progress notes were not sufficiently detailed to ensure that any changes in their clinical conditions were appropriately recorded and that the residents received care in line with their care plans.

Judgment: Substantially compliant

Regulation 23: Governance and management

Management systems were insufficient to ensure that the service provided was safe, appropriate, consistent and effectively monitored. For example:

- The audits on the use of restraints carried out recently by the provider had failed to identify the issues related to the use of restrictive practices the inspectors identified on this inspection.

- Actions identified in the compliance plan from the previous inspection held on March 2022 to address the issues with staffing, record keeping, residents' rights and infection control had not been progressed to completion in a timely manner.
- The current night time staffing of two nurses and one carer required review. The current dependency of 18 residents in one area on the first floor required a high number of bed, mattress and wheelchair evacuation. Furthermore, the evacuation procedures did not reflect the attic compartment boundaries which spanned over sleeping accommodation for 18 residents. The current arrangement would not ensure the safety of residents during an evacuation. This is further described under regulation 28 Fire precautions.
- Deficiencies in containment measures of fire were identified by the inspectors. This carried a risk of fire and smoke to spread more easily without adequate containment measures in place.
- Day-to-day fire management systems were ineffective. There was a number of unsecured oxygen cylinders within a storage room and inappropriate storage of flammable items.

Judgment: Not compliant

Regulation 31: Notification of incidents

A record of accidents and incidents involving residents, that occurred in the centre was maintained. Notifications and quarterly reports were submitted within the specified time frames and as required by the regulations.

Judgment: Compliant

Regulation 4: Written policies and procedures

The centre's policies and procedures as outlined in Schedule 5 of the regulations were reviewed and updated within the previous three years.

Judgment: Compliant

Quality and safety

Overall, the residents were found to be enjoying a good quality of life in this centre. The residents were encouraged to be involved in the organisation of the centre.

However, the provider is required to take several improvement actions in relation to the use of restrictive practises in the centre and to promote residents' rights. Furthermore, the provider is required to take additional actions to improve the centre's premises and support infection control and fire precautions.

The premises of the centre were generally well maintained. There was new flooring in place for the sluice room. Although some improvements were made in the centre's premises, the provider was required to take additional actions in a number of areas. For example, the floor lining in some bedrooms and some corridors had significant gaps between the floor lining and the skirting board. A planned schedule of maintenance was in place, and the inspectors observed that many bedrooms, including the corridors, were repainted.

Regular resident meetings were held, and resident and relative surveys were completed to help inform ongoing improvements in the centre. However, some residents in multi-occupancy rooms were unable to maintain their privacy in their bed space. This is a repeated non-compliance finding from the previous inspection.

The provider had a comprehensive policy for infection prevention and control. Furthermore, the provider had a vaccination programme in place, and eligible residents had received their COVID-19 boosters and influenza vaccines. The centre collected information about the infection risks of residents during admission and transfer to the centre for both long and short-stay residents. Hand sanitisers were located at appropriate intervals in the centre where residents were accommodated. However, additional improvements were required to ensure that the provider came into full compliance with the regulation and national standards, and this is further discussed under Regulation 27.

Staff were knowledgeable about managing responsive behaviour, and a record of residents' responsive behaviour (How residents who are living with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment) was maintained in line with the centre's responsive behaviour policy.

Behavioural records maintained for residents were not sufficiently detailed to explain and monitor the use of chemical restraints. The records showed that medication interventions were provided without carrying out appropriate de-escalation or distraction measures.

The registered provider was failing to meet the regulatory requirements on fire precautions in the centre and had not ensured that residents were protected from the risk of fire. The provider must make significant improvements in order to comply with the regulations. The inspectors found uncertainty over fire-containment boundaries, visual deficiencies in the building fabric and fire doors, inadequate evacuation planning, inappropriate storage practices of oxygen cylinders, and flammable materials, poor signage and staffing resources during night time hours which could lead to serious consequences for residents in an emergency.

The inspectors reviewed the fire safety register and noted that it was well organised and comprehensive. Staff were up-to-date with fire safety training. The in-house

periodic fire safety checks were being completed and logged in the register as required. However the checks did not identify the fire risks and deficiencies found on the day of the inspection.

Regulation 11: Visits

Visiting for residents with their families was taking place in line with public health guidance for visitation in long term care facilities.

Judgment: Compliant

Regulation 17: Premises

Although some improvements were made in the centre's premises, the centre was still in need of redecoration in a number of areas. As a result, the premises did not conform to the matters set out in Schedule 6 of the regulations.For example: There were gaps between the skirting board and the lining of the floor in several bedrooms. As a result, the staff could not perform effective cleaning. In addition, some bedrooms required repainting. Furthermore, In a laundry room, the layout of the room did not allow for the separation of clean and dirty laundry items.

Judgment: Substantially compliant

Regulation 27: Infection control

The infection prevention and control processes in the centre required improvement to ensure compliance with the national standards for infection prevention and control in community health services 2018 and other national guidance. For example:

- The clinical handwash sinks in the designated centre did not comply with the current recommended specifications.
- The centre's laundry was found to be poorly maintained, with no clear distinction between clean and dirty areas to facilitate handling and segregation of clean and used linen in line with best practise recommendations and to prevent cross-infection in the centre. In addition, this laundry room was dusty, and this room was not included in the provider's regular cleaning schedule.
- Furthermore, several storage areas on the first level of the building were found to be dusty and not sufficiently maintained. The inspectors found a

clean food trolley with clean utensils being stored in a room where chemicals such as detergents were stored. This posed a potential risk of chemical contamination of the cutlery that the residents use in the centre.
- In addition, the inspectors noted gaps between the skirting board and the lining of the floor in several bedrooms. As a result, the staff could not perform effective cleaning.

Judgment: Substantially compliant

Regulation 28: Fire precautions

At the time of inspection, the registered provider had not taken adequate precautions to ensure that residents were protected from the risk of fire. Improvements were required to comply with many of the requirements of the regulations. The service was non-compliant with the regulations in the following areas:

Day-to-day arrangements in place in the centre did not provide adequate precautions against the risk of fire. For example:

- The inspectors observed three oxygen cylinders were stored in a treatment and were unsecured. This created a fire risk as the cylinders could have been knocked over and damaged, which could have serious consequences.
- Flammable materials were found by the inspectors to be stored underneath an electrical panel and in a boiler room. Storing flammable materials in these spaces increases the risk and also the fuel load within the space should a fire occur.
- In a physiotherapy room, the inspectors observed a tea making facility which contained a kettle, toaster, fridge and a microwave. The kettle was located beside a electrical multi-socket lead and the room was lacking a fire door. The room was not designed for this function and appropriate fire safety measures were not being taken, which created a fire risk.
- In a chapel room, the inspectors found two portable heaters. Portable heaters are a potential fire risk. From a review of records there was no risk assessment as to the suitability and safety for the use of these heaters in a nursing home setting.

The provider needed to improve the means of escape for residents and emergency lighting in the event of an emergency in the centre. For example, there was a lack of emergency exit directional signage in some internal corridors to indicate the route to access a fire exit In the event of an emergency. In another area, the inspectors noted some of the directional signage that was in place gave incorrect direction to a final fire exit. This was evident near an x-ray area which directed the route of escape into an x-ray room and not to the nearby final fire exit. This resulted in confusion as it was unclear which direction to take in order to reach a final fire exit. Furthermore, in some corridors large advertising signage obscured the directional

signage.

Externally, the inspectors were not assured that suitable emergency lighting was provided along some external routes to illuminate the route of escape in the event of a fire evacuation, particularly at night-time. This was evidenced by the lack of green indicator light-emitting diodes (LEDs) on the existing light fittings.

This could have a significant impact as it would cause a delay and confusion in the event of a fire emergency. This requires a review by a competent fire consultant to ensure the centre is provide with suitable directional signage throughout.

The provider needs to improve the maintenance of the means of escape and the building fabric. For example, the inspectors observed some means of escape routes had been compromised. On the first floor, a desk area was positioned along a means of escape. The Inspectors noted a large amount of flammable materials such as files and documents were being stored in this area and needed to be stored in a fire resistant enclosure. On the ground floor, the inspectors noted a hoist was charging and was being stored along a corridor. This created an obstruction and a potential fire source risk. to a protected means of escape.

Externally, the inspectors observed refuge bins were being stored adjacent to an external means of escape route which could compromise a protected means of escape. This should be reviewed by the provider.

The provider needs to improve the maintenance of the building fabric. For example, the inspectors observed numerous gaps under some bedroom doors sampled and at the laundry room fire door where the double doors met. Furthermore, a compartment cross-corridor door had gaps which were over the maximum allowable tolerance and the double doors did not align when in the closed position. This created a situation for smoke and fire to spread.

In addition to this, some areas in the centre were noted to have utility pipes or ducting that penetrated through the fire-rated ceilings (ceilings built in a way to provide a certain amount of fire resistance time), and these required appropriate fire sealing measures.

From an assessment of a sample of residents' personal emergency evacuation plans (PEEPs), the inspectors noted they required a review in terms of clarity and to represent a true reflection of residents needs and requirements (particularly for temporary or agency staff who may be on duty during an emergency). For example, the peeps did not indicate the room number for staff to easily locate a resident in the centre. While most of the Peeps were up-to-date, not all were a true reflection of the staffing resources needed to evacuate a resident. For example, one residents peeps indicated two staff were required during an evacuation. However, the inspectors noted this resident had to be evacuated via a bed and then vertically evacuated via a mattress. The resident also required constant oxygen supply. As a result, the inspectors were not assured that two staff members would be adequate to evacuate this resident.

Arrangements for containment of fire in the event of a fire emergency in the centre

required improvement by the provider. For example, the inspectors were not assured that the current compartmentation boundaries provided adequate containment measures. This was evidence by the following:

- Currently there is a common attic space on the first floor that spans over 18 registered residents bedrooms and comprises of Ward E to Ward H, which also includes Ward N and Ward O. In addition to this, there is another common attic space that spanned over sleeping accommodation for 13 registered beds, which comprises of Ward I to Ward M. As there is a common attic space over the mentioned areas, there is potential for rapid fire and smoke to spread and develop in the attic space when moving residents from the source of a fire to an adjoining area.
- Some of the fire resistant boundaries terminated at the ceiling level and did not extend through the attic space and as such there was a common attic which spanned over sleeping accommodation for18 registered beds.

The inspectors were not assured of the ability of a selection of fire doors to contain the spread of smoke and fire. A number of fire doors observed by the inspectors had door-closer mechanisms and fire door seals missing. Gaps were noted at the bottom and between doors. A fire door into a chapel and the main entrance area on the ground floor were found to not meet the required fire rating. Furthermore, a number of fire doors did not meet the criteria of a fire door and a cross corridor door did not close fully when released. These deficiencies posed a significant risk to residents in the event of a fire

Furthermore, the inspectors were not assured that fire rated glazing was fitted in some areas of the centre. This was evident at the nurses station on the first floor which overlooked a protected means of escape and above some fire doors. In addition to this, the inspectors noted a reception/office window hatch, located on the ground floor did not provide adequate containment. The sliding screen did not appear to be fire rated to provide adequate containment along a means of escape.

The inspectors were not assured by the providers arrangements for evacuating where necessary in the event of a fire of all persons in the designated centre and safe placement of residents. For example, The inspectors were not assured that the current fire resistant boundaries and strategy were suitable for progressive horizontal evacuation. The evacuation strategy was to move residents from the source of fire to an adjoining fire resistant boundary. However, some of the fire resistant boundaries terminated at the ceiling level. This resulted in a common attic space that spanned over 18 registered bedrooms. As such, there is potential for rapid fire and smoke to spread and develop in the attic space when moving residents from the source of a fire to an adjoining perceived safe area.

Furthermore, the current evacuation procedures did not reflect the attic compartment boundaries which spanned over 18 residents bedrooms. From a review, fire drills were being completed on a monthly basis. However, these were based on a maximum of seven residents (area registered for 10 residents) with three staff members at night time and were not an accurate reflection of the attic compartment boundaries. As a result, the inspectors were not assured that residents

could be safely evacuated in a timely and safe manner in the event of a fire with the staffing resources on night duty.

Evacuation floor plans were not up-to-dated to reflect the current layout of the centre. For example, a new store room had been erected in the occupational room.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

A range of best evidenced-based clinical assessment tools were used to inform the development of relevant, personalised care plans. Care plans in general were well maintained and reflected the assessed needs of residents.

Judgment: Compliant

Regulation 6: Health care

Residents had timely access to general practitioners (GPs) from local practice, specialist medical and nursing services, including psychiatry of older age, community palliative care and tissue viability specialists as necessary. Allied health professionals provided timely assessment and support for residents as appropriate. Residents were supported to attend out-patient appointments in line with public health guidance.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

The behavioural records maintained for residents were not sufficiently detailed to explain and monitor the use of chemical restraints. The records showed that medication interventions were provided without trialling alternative de-escalation or distraction measures. In addition, for some residents, bed rails and lap belts were used without trialling alternative measures.

In addition, the inspectors observed that the use of lap belts was not consistent with the centre's own policy and national policy. For example, restraint release logs were not maintained consistently in line with the centre's policy when lap belts were being used for residents.

Furthermore, the assessments carried out to recommend the use of lap belts were

not sufficiently detailed to recommend the use of lap belts for residents in the centre. For example, the centre's policy only supports the use of lap belts if there is a serious injury risk for residents and there is no other alternative. However, the assessments carried out did not show a serious injury risk to some residents and did not substantiate the use of a lap belt.

Judgment: Not compliant

Regulation 8: Protection

Measures in place included facilitating all staff to attend safeguarding training. Staff were knowledgeable regarding safeguarding residents and were aware of their responsibility to report any allegations, disclosures or suspicions of abuse. Staff were familiar with the reporting structures in place. Residents who spoke with the inspectors confirmed that they felt safe in the centre.

Judgment: Compliant

Regulation 9: Residents' rights

The inspectors noted that wash hand basins were located inside the bed space of residents in all the three and four-bedded rooms. As a result, the residents accommodated in that bed space could not maintain their privacy when other residents or staff were using the wash hand facility.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Killybegs Community Hospital OSV-0000620

Inspection ID: MON-0039580

Date of inspection: 10/05/2023

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Laundry Services have been outsourced to a local launderette therefore staff are now not allocated to carry out laundry duties. A permanent general operative is currently being recruited by the HR Department Currently all maintenance requests are Logged onto the TRIGGA Electronic maintenance notification portal and the HSE Maintenance Manager organises for tasks to be completed. A general operative from another unit is assigned one day per week to carry out safety checks eg legionella's, generator and Fire checks.	
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: Additional Training has been organised for staff in September 2023, in order to address the daily nursing progress notes, to ensure more detail is recorded and that residents receive care in line with their care plans.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and	

management:
Training has been organised for September/October 2023 in relation to the use of Restrictive Practices and Audit on the use of Restraint. An independent Restrictive practice Audit will be completed on the 28th and 29th of August 2023, a quality improvement plan will be devised following this audit to improve the use of restrictive practices and promote Residents rights.

An active recruitment program is in progress and all vacant positions will be filled from this campaign.

See Regulation 28 response

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
There is an ongoing maintenance program in place and four X Four bed bedrooms have new floors and 7 Single rooms and 1 X four bed bedroom has been painted as well as the main dining room. The painter is organised to return the week of September 28th to continue with the painting schedule

See regulation 27 Response

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
Please see diagram attached indicating where new Hand wash sinks will be located

HSE, IPC and Estates department reviewed the existing laundry facilities and have advised that there is adequate space in the current laundry room, allowing it to have acceptable zoning of dirty to clean linen processes and in terms of current national IPC guidance has been assessed that KIllybegs CH is compliant in terms of laundry management but needs work completed to help improve procedures within the current space. The flow of linen management within the room will be identified by placing signage on the walls of the laundry room.
The sink and drainer will be removed as it is not in use. A storage unit will be installed that will allow for the safe storage of detergents and fabric softeners and cleaning equipment, such as a flat mop wet floor cleaning equipment (hung pole) and dust attracting flat mop hung pole.

Washed items will go directly from the washing machine into the tumble dryer for drying. Items from the tumble dryer will be sorted on a clean portable counter top surface, and then returned directly to an appropriate storage area.
An airing rack with cleanable surfaces will be installed
An extraction ventilation system will be installed in the room
The floor covering will be replaced
The radiator will be sanded and re painted with rust resistant paint

Clean Utensils were stored in a small kitchen area that also contained washing powder and washing up Liquid
The clean food trolley and utensils have been removed from this room.

Store Rooms have been tidied and cleaned.

There is an ongoing maintenance program in place and four X Four bed bedrooms to date, have new floors fitted. These floors extend up onto the wall eliminating the need for skirting boards.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: The Emergency lighting system has been serviced recently and is in perfect working order and meets current Irish standards. The fire Detection and Alarm System and Fire extinguishers also continue to be serviced and maintained to current standards Additional external light fittings were fitted to the external doors leading from Physiotherapy and dining room areas.

The centre is provided with suitable directional signage throughout. All light fittings are tested and serviced periodically to current Irish Standards

The files and documents at the Small Nurse's desk area have been removed.

It is recommended a Fire Risk Assessment will be carried out by a third party competent external fire consultant to review the fire strategy for the building to meet the requirements of Part B (Fire) of the Building Regulations.

The hoist has been removed from the corridor

Compartmentation will be fully assessed in detail as soon as a copy of the fire risk is made available to the HSE. Killybegs CNU is different from most other units in the county in that it was granted a fire safety certificate application prior to its build. The fire consultant has been instructed to assess in great detail the overall compliance of the building in terms of and compartmentation layouts etc in line with the granted fire safety certificate vis-à-vis the as built layout. – Timeline for completion 30/09/2023.

Updated evacuation floor plans are currently being drafted to reflect the current layout of the centre and will include the new store room - timeline for completion is 30/09/2023

The compliance plan response from the registered provider does not adequately assure the chief inspector that the action will result in compliance with the regulations.

Regulation 7: Managing behaviour that is challenging	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
A log book is maintained when PRN Psychotropic medication has been administered, The ward managers have been tasked with monitoring the log book daily, and ensuring that if Psychotropic medication has been administered, that all measures have been completed eg ABC charts have been completed and alternative measures have been considered.

Staff have been advised to ensure that there are no gaps in documentation in relation to lap belts.

Following a nursing assessment, if the assessment indicates the use of a lap-belt is required, residents/patients are referred to the Occupational Therapist for assessment and advice.

During supervised activities, lap-belts are removed from use.

A new Restraint Assessment is being trailed for the use of restrictive practices including lap belts and bed rails. All assessments for bed rails and lap belts, have been reassessed and any trials of alternative measures is clearly documented including a risk assessment.

Staff Training is being organized for September 2023 in relation to Restrictive practices and an independent Audit in relation to Restrictive practices will be conducted.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
Please see attached diagram indicating where new hand wash sinks will be located.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	31/12/2023
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	31/05/2024
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre	Substantially Compliant	Yellow	31/10/2023

	and are available for inspection by the Chief Inspector.			
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	31/12/2023
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Substantially Compliant	Yellow	30/11/2024
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Orange	30/09/2023
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including	Not Compliant	Orange	30/09/2023

	emergency lighting.			
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	30/09/2023
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	30/09/2023
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.	Not Compliant	Orange	30/09/2023
Regulation 28(3)	The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place in the designated centre.	Substantially Compliant	Yellow	14/07/2023
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on	Not Compliant	Orange	31/10/2023

	the website of the Department of Health from time to time.			
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Not Compliant	Orange	30/11/2024