<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Killarney Community Hospitals (Fuschia, Hawthorn and Heather Wards)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000568</td>
</tr>
<tr>
<td>Centre address:</td>
<td>St Margaret’s Road, Killarney, Kerry.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>064 663 1018</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:killarney.hospitals@hse.ie">killarney.hospitals@hse.ie</a></td>
</tr>
<tr>
<td>Type of centre:</td>
<td>The Health Service Executive</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>Health Service Executive</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Ber Power</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Caroline Connelly</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>John Greaney</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Announced</td>
</tr>
<tr>
<td>Number of residents on the</td>
<td>85</td>
</tr>
<tr>
<td>date of inspection:</td>
<td></td>
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<tr>
<td>Number of vacancies on the</td>
<td>11</td>
</tr>
<tr>
<td>date of inspection:</td>
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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.

Please note the definition of the following term used in reports: responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).
Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to 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

<table>
<thead>
<tr>
<th>From:</th>
<th>To:</th>
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<tbody>
<tr>
<td>13 November 2017 10:30</td>
<td>13 November 2017 19:00</td>
</tr>
<tr>
<td>14 November 2017 08:45</td>
<td>14 November 2017 17:20</td>
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The table below sets out the outcomes that were inspected against on this inspection.

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Our Judgment</th>
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<tbody>
<tr>
<td>Outcome 01: Statement of Purpose</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 02: Governance and Management</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 03: Information for residents</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 04: Suitable Person in Charge</td>
<td>Compliant</td>
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<tr>
<td>Outcome 05: Documentation to be kept at a designated centre</td>
<td>Compliant</td>
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<tr>
<td>Outcome 06: Absence of the Person in charge</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 07: Safeguarding and Safety</td>
<td>Substantially Compliant</td>
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<tr>
<td>Outcome 08: Health and Safety and Risk Management</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 09: Medication Management</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 10: Notification of Incidents</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 11: Health and Social Care Needs</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 12: Safe and Suitable Premises</td>
<td>Non Compliant - Major</td>
</tr>
<tr>
<td>Outcome 13: Complaints procedures</td>
<td>Compliant</td>
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<tr>
<td>Outcome 14: End of Life Care</td>
<td>Compliant</td>
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<tr>
<td>Outcome 15: Food and Nutrition</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 16: Residents’ Rights, Dignity and Consultation</td>
<td>Non Compliant - Moderate</td>
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<tr>
<td>Outcome 17: Residents' clothing and personal property and possessions</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 18: Suitable Staffing</td>
<td>Non Compliant - Moderate</td>
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Summary of findings from this inspection

This report sets out the findings of an announced registration renewal inspection. The provider had applied to renew their registration which is due to expire on the 31 May 2018. As part of the inspection the inspector met with the residents, the person in charge, the provider, the two Assistant Directors Of Nursing (ADON), the Clinical Nurse Managers (CNM), nurses, care staff, activities staff, support staff and numerous other staff members. Inspectors observed practices, the physical
environment and reviewed all governance, clinical and operational documentation such as policies, procedures, risk assessments, reports, residents' files and training records to inform this application.

The person in charge was an experienced nurse manager and the inspectors interacted with her throughout the inspection process. The two ADON's were fully involved in all aspects of the management of the centre and interviews were conducted with them during the inspection. The ADON's deputised in the absence of the person in charge. The inspector was satisfied that there was a clearly defined management structure in place. The provider, person in charge and the staff team displayed good knowledge of the regulatory requirements and they were found to be committed to providing evidence-based care for the residents. The management team were proactive in response to the actions required from the previous inspection and inspectors viewed a number of improvements in the centre and plans for further development which are discussed throughout the report.

A number of quality questionnaires were received from residents and relatives and the inspectors spoke to many residents and relatives throughout the inspection. The collective feedback from residents and relatives was one of satisfaction with the service and care provided. Comments from residents included" Staff will do everything in their power to help you and anything you want they get for you" "food is excellent, very good activities" a number of residents praised the food and activities and described how they had made their own butter and then enjoyed eating it on scones and tea. Relatives stated collectively that they feel their relative is very well looked after. One relative stated that the "staff have great interaction with the residents and there is always a lovely friendly and welcoming atmosphere no matter how busy they are". Relatives were complimentary about their ability to visit and staff being open with information about their relative." A few residents and relatives said they would like more storage space and a number talked about the noise levels in the six bedded room particularly at night. A number of residents said they were looking forward to the new building and having more space. All of these issues were looked into and discussed further in the body of the report. Family involvement was encouraged and the inspectors saw numerous visitors in and out of the centre during the two day inspection. There was a residents committee which facilitated the residents' voice to be heard and this was run by the activity staff.

Inspectors found that residents' healthcare and nursing needs were met to a high standard. Residents had easy access to medical, allied health and psychiatry of later life services. A number of the allied health staff were on site or in close proximity to the centre. Staff interacted with residents in a kind and respectful manner and inspectors found that residents appeared to be very well cared for. Residents could exercise choice in their daily life and were consulted on an ongoing basis. Residents could practice their religious beliefs.

The management team displayed good knowledge of the regulatory requirements and they were found to be committed to providing evidence-based care for the residents. They were very proactive in response to a number of actions required from previous inspections however inspectors viewed a number of actions that remained non-compliant in relation to the premises and provision of privacy and
dignity. Resident accommodation consisted mainly of large multi-occupancy rooms and similar to findings on previous inspections the premises did not meet the individual and collective needs of residents in terms of their privacy, personal space, access to sanitary facilities. However the inspectors did see improvements in the overall quality of life for residents. The majority of residents were up and about on all of the units. Residents attended the dining rooms for their meals and this was seen to be a social experience. There had been improvements in the provision of activities and numerous group and individual activities were going on during the inspection. Residents were very complimentary about the changes in routine. Mandatory training had taken place and fire drills were taking place on a regular basis.

Premises issues with related privacy and dignity issues, medication management, bedrail usage and management of resident's property continued to require action. These areas and other actions required are detailed in the body of the report, which should be read in conjunction with the action plan at the end of this report. The action plan at the end of the report identifies improvements necessary to ensure compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Standards for Residential Care Settings for Older People in Ireland 2016.
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:
A detailed Statement of Purpose was available to both staff and residents. It contained a statement of the designated centre’s aims, objectives and ethos of care. It accurately described the facilities and services available to residents, and the size and layout of the premises. The inspectors observed that the statement of purpose was generally reflected in practice and the manner in which care is provided reflects the diverse needs of the residents.

The statement of purpose was kept under review and was found to meet the requirements of legislation.

Judgment:
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):
No actions were required from the previous inspection.

Findings:
The centre was operated by the Health Service Executive (HSE) who was the registered
provider. The provider nominee who had responsibility for a number of other centres had an office based in this centre and was available to the management team. Inspectors saw that there was a clearly defined management structure in place. The centre was managed by a full time person in charge who was supported in her role by two assistant directors of nursing and each of the three units was managed by a full time clinical nurse manager. The lines of accountability and authority were clear and all staff were aware of the management structure and were facilitated to communicate regularly with management.

There was evidence of monthly meetings between the provider and the person in charge from the community hospitals. These meetings were attended by practice development facilitators, bed managers and guest speakers as required. The person in charge said these were a forum for discussion sharing of ideas and promotion of developments in services and practices. Results of audits and key performance indicators were reviewed and discussed. The person in charge also held regular management meetings attended by ADONs CNM's and head of departments and minutes were available of these meetings for review.

There was a new ADON since the previous inspection and an interview was conducted with her and the management team during the inspection. Inspectors found the management team displayed good knowledge of the regulatory requirements. They were very proactive in response to a number of actions required during the inspection. The immediate action plans given on the previous inspection were treated with urgency and were completed within an acceptable time-frame. Mandatory fire training was in place for all staff and regular fire checks and drills were undertaken. Staff files were complete. There were significant changes in the care of the residents and the introduction and implementation of a much more person-centred approach to residents care which is discussed in more detail throughout the report. Workplace cultural observations were now taking place and the findings fed back to staff.

Inspectors saw evidence of the collection of key clinical quality indicator data including pressure ulcers, falls, the use of psychotropic medications, bed rails, medication management and administration, the assessment of risk, and health and safety. Inspectors saw that there were systems in place for monitoring the quality and safety of care provided to residents. These included internal audits and reviews such as falls audits, nursing documentation audit, infection control audit, oral hygiene audit, food and nutrition audit, end of life audit, social and recreational audit. These audits had taken place throughout 2017 and the centre had continued the use of a computerised system of auditing to monitor all of the units in accordance with evidenced based practice. Audit outcomes and any corrective actions were documented and had resulted in changes to practices particularly around falls and food and nutrition.

There was evidence of consultation with residents and relatives through residents meetings chaired by activity staff, and relative meetings chaired by the person in charge. Inspectors noted that issues raised by residents were brought to the attention of the person in charge and items were followed up on subsequent meetings. A comprehensive survey had been undertaken and results of same showed resident’s satisfaction with the care and service they received. The centre had been accepted as a pilot site for a national quality initiative. Staff have undergone training in quality
workaround's, which will commence in January 2018.

The inspectors saw and this had also been available on the previous inspection, that a comprehensive annual review of the quality and safety of care and support in the designated centre had been undertaken by the management team in accordance with the standards. This review was made available to the inspectors and there were a number of recommendations and actions from this review that are currently being actioned.

**Judgment:**
Compliant

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**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):**
No actions were required from the previous inspection.

**Findings:**
Each resident had a written contract of care that provided details of services to be provided for that resident and the fees to be charged. The inspectors reviewed a sample of residents' written contracts which had been agreed within a month of admission. Each resident’s contract addressed the care and welfare of the resident in the centre. The contracts set out the services and the fees to be charged for services provided in the centre. The contracts of care had been updated to detail the room that residents occupied and the costs of additional charges such as chiropody and hairdressing.

The inspectors viewed the residents' guide to the centre which was made available to all residents and contained all the required information.

**Judgment:**
Compliant

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**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 person in charge worked full time in the centre and displayed good knowledge of the standards and regulatory requirements. She had been instrumental in leading a number of changes to practice since the previous inspection.

The inspectors interacted with the person in charge throughout the inspection process. There was evidence that the person in charge was engaged in the governance, operational management and administration of the centre on a day-to-day basis. Inspectors were satisfied that she was a registered nurse, was suitably qualified and had a minimum of three years experience in nursing of the older person within the previous six years, as required by the regulations. She had extensive managerial experience and had been acting person in charge in another centre in the past. She demonstrated a commitment to her own professional development and held numerous post registration qualifications including a BA in Healthcare management, an MA in nursing and post graduate diploma's in Advancing Practice and Health Protection.

Staff, residents and relatives all identified her as the person who had responsibility and accountability for the service and said she was very approachable and were confident that all issues raised would be managed effectively.

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

Findings:
Residents' records were reviewed by the inspectors who found that they complied with Schedule 3 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. The records listed in Schedule 4 to be kept in a designated centre were all maintained and made available to the inspectors.

The designated centre had implemented 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 and these are reviewed and updated at intervals not exceeding three years as required by Regulation 4. The inspectors viewed the insurance policy and saw that the centre is adequately insured against accidents or injury to residents, staff and visitors.

The person in charge informed the inspector that they had really tightened up on their recruitment process since the last inspection and staff files were audited. No staff commenced employment until satisfactory Gardaí vetting, references and all the requirements of schedule 2 of the regulations had been attained. The inspector reviewed a sample of staff files and found that they contained all of the information required under Schedule 2 of the Regulations. Evidence of satisfactory Garda vetting was forwarded to the inspectors following the inspection as per the agreed HSE process.

Inspectors were satisfied that the records listed in Part 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 were maintained in a comprehensive manner as to ensure completeness and ease of retrieval.

Judgment:
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 designated 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:
There had been no instances since the last inspection whereby the person in charge was absent for 28 days or more and the person in charge was aware of the responsibility to notify HIQA of any absence or proposed absence.

Suitable deputising arrangements were in place to cover for the person in charge when she was on leave. One of the ADON's who works full time in the centre was in charge when the person in charge is on leave. The inspector met and interviewed the ADON's during the inspection. Both nurses demonstrated an awareness of the legislative requirements and their responsibilities and were both found to be suitably qualified and experienced registered nurses.

The ADON's and CNM's were in charge of the centre at weekends on a rota basis and the person in charge was available for advice as required.

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

Findings:
Inspectors were satisfied with the measures in place to safeguard residents and protect them from abuse. The policy on elder abuse was up to date and referenced the most recent Health Service Executive policy ‘Safeguarding Vulnerable Persons at Risk of Abuse’. Inspectors reviewed staff training records and saw evidence that since the last inspection staff had received up to date mandatory training on detection and prevention of elder abuse. Staff interviewed were familiar with the policy and knew what to do in the event of an allegation, suspicion or disclosure of abuse, including who to report incidents to. Residents with whom inspectors spoke said that they felt safe in the centre. Relatives spoken with had no concerns regarding the quality of care delivered in the centre.

The systems to manage residents' finances were reviewed by inspectors. The centre was a pension agent for a number of residents, but this was all managed through the HSE national accounts in Tullamore where robust records were maintained of all transactions. An inspector met the person responsible for residents finances and she explained the system used. The centre had recently changed payment arrangements for chiropody and hairdressing. This is now all managed and invoiced through the finance office, following countersigned receipts by staff, confirming the service had been supplied to each individual resident. There were a number of residents who handed money in for safekeeping on the units for the purchase of cigarettes, sweets and personal items. Inspectors viewed the system used and saw money was kept in a locked safe. Each resident had an individual envelope and a book was maintained where each lodgement or withdrawal was recorded. All transactions were signed by two staff members and by the resident or relative if appropriate. Receipts were maintained for all purchases. This system was found to be sufficiently robust to protect both the resident and the staff members.

There was a policy on responsive behaviour and since the previous inspection more staff were provided with training in the centre on behaviours that challenge which was confirmed by staff and training records. There was evidence that residents who presented with responsive behaviour were reviewed by the GP and referred to
psychiatry of old age or other professionals for full review and follow up as required. The inspectors saw improvements in care planning since the previous inspection and there was evidence of positive behavioural strategies and practices implemented to prevent responsive behaviours. The records of residents who presented with responsive behaviours were reviewed by the inspectors who found that these were managed in a very dignified and person-centred way by the staff using effective de-escalation methods as outlined in residents' care plans. Staff said these care plans and interventions were discussed at handover, but care staff did not have access to care plans this is discussed further in Outcome 11.

The inspectors saw that there had been a reduction in the use of bedrails since the previous inspection. The centre's risk assessment tool for restraint was up dated since the previous inspection and it now outline the requirement to document measures which had been taken/considered to protect residents prior to using bed rails. It contained a detailed risk assessment which assessed the risk of injury of using bed rails and weighed this against the risk of injury of not using bed rails. The inspectors saw that further alternatives to restraint were in place such as increased numbers of low profiling beds, alarm and sensor mats, demonstrating efforts were in place to reduce restraint usage. However there continued to be a high percentage of bedrail usage throughout the centre. The person in charge acknowledged this fact and was in the process of acquiring further equipment and providing education to staff to promote a reduction in the use of bedrails. The system around restraint continued to require review to ensure it was compliant with the national policy.

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

Findings:
The inspectors saw there had been great improvements in fire safety since the last inspection when an immediate action plan had been issued due to lack of fire training and fire drills. On this inspection training records and staff confirmed that they had received up-to-date fire training. There was evidence of fire induction training for new staff. Regular fire drills were undertaken on all of the units by day and by night. There was evidence of good documentation of actions taken and any learning from the drills. Residents had detailed personal emergency evacuation plans completed detailing their specific requirements for evacuation in the event of a fire. There was evidence of weekly in-house checks of emergency lighting and weekly testing of the break glass units beside fire doors.
Inspectors saw that the fire policies and procedures were centre-specific. The fire safety plan was viewed and found to be comprehensive. There were notices for residents and staff on “what to do in the case of a fire” appropriately placed throughout the building. Colour-coded floor plans were displayed throughout the centre which identified ‘Where You Are Now’ in line with best practice. Staff demonstrated an appropriate knowledge and understanding of what to do in the event of fire. Inspectors examined the fire safety register with details of all services and tests carried out. All fire door exits were unobstructed and fire fighting and safety equipment tested was up to date. The emergency lighting and fire alarm were tested quarterly. There was evidence of weekly in-house checks of emergency lighting and weekly testing of the break glass units beside fire doors.

There were a number of residents who smoked in the centre. One unit had a designated outdoor smoking area and the other two units had a designated smoking room. Residents who were smokers had individual smoking risk assessments in place and all cigarettes and lighters were safely stored by staff. There were fire aprons and call bells in the smoking room and since the last inspection there was a fire blanket. However, it was difficult to establish who was responsible for the supervision of residents who were smoking as this task had not been delegated to any specific staff member.

The centre had an up to date health and safety statement and policies on health and safety in the centre. The risk management policy addressed the identification and management of the risks required by Regulation 26(1). The centre had a detailed infection prevention and control policy in place. Personal protective equipment, such as gloves, aprons and hand sanitizers were located throughout the premises. All hand-washing facilities had liquid soap and paper towels available. There were policies in place on infection prevention and control and staff that were interviewed demonstrated knowledge of the correct procedures to be followed. Hand hygiene training was ongoing and staff demonstrated good hand hygiene practice as observed by the inspectors. Arrangements for the disposal of domestic and clinical waste management were appropriate. However the inspectors identified some torn upholstery on chairs which would pose as an infection control risk. The centre had an up to date and detailed risk register and had identified many risks present in the centre. However inspectors identified that the radiators were very hot to touch on the day of the inspection and could pose a burns risk to residents. Further control measures were required.

Accidents and incidents were recorded on incident forms and were submitted to the person in charge and there was evidence of action in response to individual incidents. The CNM showed an inspector a comprehensive post falls review document they had just commenced using. This was used to fully review and identify reasons for the fall and if there was anything they could do to prevent the fall or manage it better. These were also reviewed and discussed at the daily hand-over meetings. There was a centre-specific emergency plan that took into account all emergency situations. Clinical risk assessments were undertaken, including falls risk assessment, assessments for dependency, assessments for malnutrition and assessments for pressure ulcer formation.

Staff training records confirmed that since the previous inspection staff had completed their mandatory training in moving and handling of residents.
The records of safety checks for equipment and servicing records for beds, hoists, wheelchairs and other essential equipment were not seen to be completed in line with manufactures and regulatory guidelines and these required immediate review. The action for this is under outcome 12 Premises.

**Judgment:**
Non Compliant - Moderate

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

**Findings:**
The medication policies were updated during the inspection and were found to be centre-specific. The policies included the ordering, receipt, administration, storage and disposal of medicines. The policies were comprehensive and evidence based. Medicines were stored in a locked cupboard or on the medication trolley and since the last inspection eye drops and creams were all appropriately stored. Trolleys were generally stored in locked clinical rooms when not in use. Controlled drugs were stored in accordance with best practice guidelines and nurses checked the quantity of medications at the start of each shift. One of the inspectors did a count of controlled medications with the nurse which accorded with the documented records.

Medication administration was observed and the inspectors found that the nursing staff generally adhere to professional guidance issued by An Bord Altranais agus Cnáimhseachais and adopted a person-centred approach. Nurses wore red aprons as a sign they were administering medications and they were not to be disturbed. The inspector reviewed a sample of residents’ medicine prescription records and they were maintained in a tidy and organised manner, they were clearly labelled, they had photographic identification of each resident and they were legible. There was evidence that residents’ medicine prescriptions were reviewed at least every three months by a medical practitioner, crushed medications were prescribed as crushed and maximum doses were recorded on PRN (as required medicines). Medication errors and near misses were recorded and monitored by the CNM 2 on each unit. The CNM 2 reported to the inspectors that these were discussed at ward hand-over meetings to mitigate risk of recurrence.

Medicines for residents were currently supplied by an on-site pharmacy. However the person in charge said this was due to change in the near future when the contract to supply medications to the centre will be provided by a community pharmacy. This new pharmacist will provide training to staff, undertake stock control and provide on-site
audits of medication management. The inspectors saw that there were some audits undertaken by nursing staff on medication charts but these were found not to take into account all aspects of medication management that the inspectors found out of date injections in one of the units. Further monitoring and management of stock control was required. Competency assessments were also not being completed on nursing staff but the person in charge said they planned to also commence same.

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:**
The inspector saw that there was a comprehensive log of all accidents and incidents that took place in the centre.

Incidents as described in the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 have generally been reported in accordance with the requirements of the legislation. There were timely quarterly returns and written notifications were received within three days of accidents as required. However there had been one incident of a resident going absent without leave and an accident resulting in an injury that were not notified to HIQA as required by legislation.

Judgment:
Substantially 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:**
A local GP practice provided medical services to Killarney Community Hospital and the GP's attended the centre on a daily basis. Out-of-hours medical cover was available via a doctor on call service. The inspectors met one of the GP's during the inspection and a sample of medical records reviewed confirmed that resident's were reviewed on a regular basis. Specialist medical services were also available when required. Reviews and on-going medical interventions as well as laboratory results were evidenced. Residents in the centre also had access to psychiatry of older life via a local clinic in the town and the psychiatrist also visited the centre to review residents if required.

The centre provided in house physiotherapy services where residents are assessed and treated as required. The dietician and the Speech and Language Therapist (SALT) visited the centre and reviewed residents routinely. There was evidence that residents had access to other allied healthcare professionals including occupational therapy, speech and language therapy, dental, chiropody and ophthalmology services. Detailed plans were drawn up and these were evidenced in residents’ care plans and dietary plans. Residents and relatives expressed satisfaction with the medical care provided and the inspectors were satisfied that residents' health care needs were very well met.

Since the previous inspection there were significant changes in the assessment and care planning for residents in the centre through the introduction and implementation of a much more person-centred approach to residents care planning. The inspectors saw that each resident’s needs were determined following a comprehensive admission assessment. The assessment process involved the use of a variety of validated tools to assess each resident’s risk of deterioration. For example, risk of malnutrition, falls, level of cognitive impairment and pressure related skin injury among others. Pain charts in use reflected appropriate pain management procedures. The person in charge and staff demonstrated an in-depth knowledge of the residents and their physical, social and psychological needs. This was reflected in the care plans seen by the inspectors. Since the previous inspection improvements in care planning was seen. Care plans viewed by the inspectors directed personalised care administered to residents. The care plans were found to be fully reflective of the assessed needs of the residents, were personalised and detailed residents likes, dislikes, and preferences and took into account residents’ daily changing needs and choice. There was documentary evidence that the care plan had been discussed with the resident or relative as required and this discussion of care plans was confirmed by residents and relatives. Consent to treatment was documented. The staff told the inspectors that a lot of work had gone into developing the person centred care plans with education and support from the practice development team. Although the care staff were consulted about the care plans they currently do not have access to same. The person in charge said they are looking to address same.

Wound care was also looked at by the inspectors who found that there were regular scientific assessments of any wounds, including photographs of same showing if the wound had improved or deteriorated. Wounds were referred for assessment to a tissue viability nurse who advised on treatment and appropriate dressings. Training on wound care had been provided to a number of staff.

The inspectors observed that residents appeared to be well cared for, which was further reflected in residents’ comments that their daily personal care needs were well met. The inspectors were satisfied that facilities were in place so that each resident’s wellbeing
and welfare was maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care.

**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:**
Many of the findings of non-compliances identified on the previous inspection report in March 2017 for the premises remained ongoing.

The centre is located on the outskirts of Killarney town and is registered to provide long term, respite, palliative and dementia care for 96 residents. Resident accommodation is spread across three separate units; Fuschia which can accommodate 22 residents, Hawthorn which can accommodate 36 residents, and Heather which can accommodate 38 residents. Resident accommodation was mainly provided in large multi-occupancy rooms, with some twin rooms and only two single bedrooms used for end of life care. There was adequate communal space on Fuschia ward with a day room, a sitting room, a dining room, a snoozelan room and another activities room. However, on Heather and Hawthorn wards there was a large shared communal day room, activity room and dining adjacent to which was an area used for storing wheelchairs, hoists and other equipment. This area was only screened off with a curtain and took up a significant amount of space in the communal dining room. The number of tables in the dining room had increased since the last inspection. The day room also looked more inviting when there were more residents using it.

Fuschia unit was provided with an assisted bath which staff said residents enjoyed using. A number of areas were decorated in a homely and cosy fashion. Fuschia ward had shop fronts, nice sitting, dining and snoozlene rooms and a garden. This unit was found to be more homely than the other units. However, there remained significant limitations within the physical environment which negatively impacted on the freedom, choice, privacy, dignity and autonomy of residents and these have been described in detail in previous inspection reports. Similar to findings on all previous inspections, the design and layout of parts of the premises did not conform to the matters listed in
Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

The six-bed multi-occupancy bedrooms, several of the two-bed bedrooms on Heather and Hawthorn units, and six- and five-bedded rooms on Fuschia unit were unsuitable in design and layout to protect the privacy and dignity of the residents. The design and layout had a significant impact on residents as they were unable to undertake personal activities in private or to meet with visitors in their bedroom in a private area. This is discussed further in outcome 16, resident’s rights dignity and consultation. In many cases there was not enough room beside the beds to place a visitors chair or a chair for the resident to sit out of bed. Many beds in the two-bed bedrooms were placed with one side up against the wall due to space restrictions. The limited space in these bedrooms had a negative impact on the storage of residents’ clothes and personal belongings. Many residents’ wardrobes were not located beside their bed but were located at the end of the bedroom. The wardrobe space was inadequate to meet the residents’ storage needs with most residents having clothes stored in the locked linen room on each ward. This issue was also addressed under outcome 17, residents’ clothing, personal property and possessions. A bedside locker was not always located beside each resident’s bed and lockable storage was not available in the bedside lockers or the wardrobes. In one of the five bedded rooms in Fuschia unit there was not enough space between the beds and the room was not large enough for five beds.

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

There was a functioning call-bell system in place. Inspectors saw evidence of the use of assistive devices, for example, hoists, wheelchairs, walking aids, clinical monitoring equipment and specialist seating provided for residents’ use. However, a regular maintenance schedule of assistive devices could not be found and some devices were only serviced when they required repair. This had been also identified on the previous inspection.

Many of the requirements of Schedule 6 of the Regulations were not met by the centre including:
- as outlined above, many of the rooms were not of a suitable size or layout for residents
- there was no private visitors room in Hawthorn and Heather units
- the overall storage of wheelchairs, hoists and commodes in the centre was inadequate, for example commodes were seen stored adjacent to residents’ toilet cubicles and in shower rooms
- the residents in Hawthorne and Heather units did not have access to an enclosed garden
- there were insufficient numbers of toilets and showers in close proximity to bedrooms on Hawthorn and Heather units to meet the needs of the residents
- there was limited evidence that hoists were serviced on a six monthly basis.
- a number of areas required redecoration
- in some rooms and corridors the plaster had bubbled and paint work had flaked off the walls.
there was no evidence of regular servicing of beds and these appeared to be only serviced when they required repair.

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

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

**Judgment:**
Compliant

### 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:**
Resident’s religious needs were facilitated with mass taking place regularly in the centre
and the rosary said frequently. Mass took place during one of the days of the inspection and a large number of residents attended along with their family members. Residents from other religious denominations were visited by their ministers regularly as required. The inspectors reviewed the centre's policy on end-of-life care which was seen to be comprehensive to guide staff in providing holistic care at the end of life stage. The inspectors reviewed a sample of residents' care plans with regards to end-of-life care and noted that they comprehensively recorded residents' preferences at this time. All information was accessible to staff and staff indicated that relevant information was shared at report handover time. Most residents stated that in the event that their needs changed in the future they would prefer to be cared for in the centre.

Staff training records indicated that a number of staff had attended training on palliative care issues including spiritual care, psychological support, pain management and communicating with the bereaved relatives. The person in charge stated that the centre was well supported by the specialist team from the local community. Records which the inspectors viewed indicated that the palliative team were responsive to the GP and the staff in providing specialist advice in pain relief and symptom management.

Overall the inspectors found that care practices and facilities in place were designed to ensure residents received end of life care in a way that met their individual needs and wishes and respected their dignity and autonomy. However a single room was not always available for end of life care and this is actioned under premises.

**Judgment:**
Compliant

<table>
<thead>
<tr>
<th><strong>Outcome 15: Food and Nutrition</strong></th>
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</thead>
<tbody>
<tr>
<td>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.</td>
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</tbody>
</table>

**Theme:**
Person-centred care and support

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

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

Inspectors were satisfied that each resident was provided with nutritious and wholesome fresh food and drink at times and in quantities adequate to their needs. Residents were offered a choice of whether to take their meals in their bedroom or the dining room. The centre had three dining rooms. Two dining rooms were located in the Fushia unit and a third very large dining room was located between the Heather and Hawthorn units. On the previous inspection, at lunchtime on Heather and Hawthorn units, there were only four tables set and occupied for dinner. This catered for approximately 12 residents out of a total of 72 residents in the units. The remaining residents either had their dinner in their bed or on a bed table beside their bed. On this inspection the inspectors were happy to see that the dining room tables were attractively set and a large percentage of residents now attended the dining room for their meals. There was a table for two set for a husband and wife who enjoyed having their meals together.

Staff were seen to sit with residents, and offered assistance in a discreet and sensitive manner. One relative complimented staff for the patience and time taken to facilitate their relative to eat and drink as independently as possible.

An inspector spoke with the head chef who explained the layout of the kitchen and food safety precautions in place. The dry goods store was well stocked. Cold rooms and freezers were available. There was a separate meat preparation and gluten-free area, fire equipment and hand washing facilities. Food deliveries were labelled respecting ingredients and dates. A daily deep clean schedule was seen and there was a good standard of cleanliness.

**Judgment:**
Compliant

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**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:**
Feedback from questionnaires distributed prior to the inspection, and interviews with
residents and relatives during the inspection, confirmed that residents and relatives were generally happy with the care provided and staff in the centre. However a few residents and relatives said they would like more storage space and a number talked about the noise levels in the six bedded room particularly at night. A number of residents stated that the lack of a garden for Heather and Hawthorn units was a quality of life issue, which management said they were looking into. A number of residents said they were looking forward to the new building and having more space.

There was evidence of consultation with residents and relatives, through residents meetings chaired by activity staff, and relative meetings chaired by the person in charge. Inspectors noted that issues raised by residents were brought to the attention of the person in charge and items were followed up on subsequent meetings. Numerous visitors were observed throughout both days of inspection where staff members knew the names of visitors and vice versa. Feedback from relatives was that staff took time to talk with family members both when they visited and when they rang to enquire about their relative. Visitors told the inspectors that they were always made welcome and said that if they had any concerns they could identify them to staff and were assured they would be resolved. The centre operated an open visiting policy and this open visiting policy was observed throughout the inspection. However, the inspectors saw that many visitors visited residents in the multi-occupancy bedrooms as there were limited private or communal rooms for visiting. These visiting arrangements did not promote or protect the dignity of the residents in the other beds who may require personal care or be trying to sleep/rest watch television while visitors were in their bedroom.

The manner in which residents were addressed by staff was seen by inspectors to be respectful. Inspectors heard staff addressing residents by their preferred names and speaking in a clear, respectful and courteous manner. Staff paid particular attention to residents’ appearance, dress and personal hygiene and were observed to be very caring towards the residents. Advocacy services were available to residents and residents were facilitated to vote. Posters were up advertising advocacy services and the contact details of the confidential recipient.

Inspectors observed that religious beliefs were facilitated as there was a chapel attached to the building. Mass was held very regularly and was on in Fuchsia ward during the inspection, which residents could attend if they wished and it was also televised so they could watch from their rooms. Residents also had access to ministers from other religious denominations as required. Residents and relatives confirmed that the spiritual and religious needs of residents were very well met.

A number of residents were facilitated to take part in meaningful activities which met their interests. Inspectors saw a variety of activities ongoing during the two days of inspection. Residents were offered a choice of group activities as well as one-to-one sessions. Some families and residents had completed a ‘Life Story’ as part of their reminiscence therapy. A daily activities record detailing the residents’ involvement in the activity was maintained. Activities included art therapy, music, bingo, exercises, card playing, gardening, baking and Sonas. Inspectors met the art therapist and activity staff who were providing individual and group activities. Residents were very complimentary about the variety of activities available and were particularly appreciative of the cooking and baking group. The inspectors saw a group of male and female residents making
cheesecake. They told the inspector how they had recently made butter and they reminisced about their lives from years ago. The inspectors also saw Irish dancing and singing provided by staff which residents really enjoyed. Inspectors noted that significant efforts had been made by staff to promote residents' independence with several residents being supported to engage in activities external to the centre and trips out.

There had been improvements seen since the last inspection where the inspectors saw that on the units a large number of the residents spent long periods of the day in their bedrooms, either in bed or on a chair at their bedside. On this inspection there were a lot more residents up and about, the majority of residents on all units attended the dining room for their meals and the day rooms for activities and to watch TV. The person in charge and management team had placed a much greater emphasis on person-centred care, training was provided to the staff, care plans reflected residents likes, dislikes and wishes. Quality audits were conducted on the lived experience of residents and residents were facilitated to have more choice in their daily lives. The person in charge agreed this was ongoing process and further supervision, education and training was required.

On the previous inspection the inspectors visited every unit in the centre at 18.00 hours on the first evening of the inspection and found that the majority of residents in the centre were either in bed or sat beside their bed with the exception of one unit where approximately six of the residents were sitting in the day room watching TV. On this inspection although there were a number of residents in their beds or by their beds the majority of the residents were in the day rooms engaging in activities or up watching TV at this time. However staff said most of the residents would soon be returning to bed prior to the arrival of the night staff and reduction in staffing levels. To address some of these issues a twilight activity staff was due to commence employment to work between Heather and Hawthorn unit but this staff member had not commenced at the time of the inspection.

Although there had been great improvements in person-centred practices since the previous inspection the multi-occupancy rooms continued to affect the privacy, dignity and quality of life for residents. Inspectors saw that although staff promoted residents privacy and dignity as best as they could in the multi-occupancy rooms. The location of a limited number of toilets and showers made accessibility challenging for some residents in Heather and Hawthorn units. It meant that residents had to travel through the whole ward in their night attire to the shower or to use the toilet. Inspectors saw this taking place during the inspection. It also lead to a greater reliance on commodes. Due to the close proximity of beds this did not protect residents' privacy and dignity. A number of residents described the multi-occupancy rooms as noisy and a number of residents told the inspectors they had been disturbed from their sleep at night by the noise from other residents. There were a number of complaints in the complaints log about noise in these rooms at night. Lack of personal space between and around the beds also affected the residents ability to make their bed area personalised and homely and the inspectors noted that although some residents had personalised their bed spaces others were sparse. In one of the five bedded rooms the beds were too close together and did not allow residents space for possessions and privacy and dignity.
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:
Some residents had photos and pictures brought in from home displayed but the size and layout of the multi-occupancy rooms did not allow for much personalization of the bed space.

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

There were laundry facilities on site and residents' clothes were labelled to identify who they belonged too. An inspector spoke with the staff member in charge of the centres laundry facility who described good practice in relation to laundry practices. There was good segregation of dirty and clean linen including separate entrances and exits to the laundry, to ensure best practice with infection control.

Judgment:
Non Compliant - Moderate

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:**
Inspectors observed warm and appropriate interactions between staff and residents and they observed staff chatting easily with residents. Residents and relatives spoke very positively of staff and indicated that staff were caring and responsive to their needs. This was seen by the inspectors throughout the inspection in the dignified and caring manner in which staff interacted and responded to the residents. Systems of communication were in place to support staff with providing safe and appropriate care. There were handover meetings each day to ensure good communication and continuity of care from one shift to the next. Inspectors saw records of regular staff meetings at which operational and staffing issues were discussed. In discussions with staff, they confirmed that they were supported to carry out their work by the CNM on each unit. The inspectors found staff to be well informed and knowledgeable regarding their roles, responsibilities and the residents’ needs and life histories. There were separate cleaning staff who were managed by an outside contractor.

Duty rosters were maintained for all staff and during the two days of inspection the number and skill-mix of staff working was observed to be appropriate to meet the needs of the current residents. The ADON’s had responsibility for the duty rosters for all of the units and ensured consistency of care by assigning regular staff to each unit. However staffing levels in the evening required review as inspectors found that staffing levels decreased from 17.00hrs onwards in all units and two units operated with two nurse and two care staff until 20.00hrs and then further reduced to two nurses and one care staff for the evening and night. The night nurses had to do the night time medication round at different times and therefore this left only one other member of staff to give out evening drinks and assist residents to bed and with other personal care needs. The inspectors found that these staffing levels were not adequate to ensure residents had a choice in bedtimes. These practices did not fit in with person-centred care as the inspectors formed the opinion which was confirmed by staff that most residents were assisted back to bed before staffing levels decreased at 20.00hrs.

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

Since the previous inspection there was a great emphasis on the provision of mandatory training. A training matrix was put in place and all staff training was implemented. Mandatory training in Safeguarding, fire safety, responsive behaviours and moving and handling were up to date for staff. Supervision of staff was consistent with a clinical nurse manager in charge on each ward, reporting to an assistant director of nursing. The centre had a policy on the recruitment of new staff. The system in place to appraise the performance of staff had commenced and staff had received appraisals, staff found the process beneficial to identify training and development needs.

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

**Judgment:**
Non Compliant - Moderate

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**Closing the Visit**

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

**Acknowledgements**

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

**Report Compiled by:**

Caroline Connelly
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider’s response to inspection report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Killarney Community Hospitals (Fuschia, Hawthorn and Heather Wards)</th>
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</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000568</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>13/11/2017</td>
</tr>
<tr>
<td>Date of response:</td>
<td>15/01/2018</td>
</tr>
</tbody>
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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 07: Safeguarding and Safety

Theme:
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The inspectors saw that there had been a reduction in the use of bedrails since the previous inspection. However there continued to be a high percentage of bedrail usage throughout the centre. The system around restraint continued to require review to ensure it was compliant with the national policy.

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
1. **Action Required:**
Under Regulation 07(3) you are required to: Ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.

**Please state the actions you have taken or are planning to take:**
Nursing documentation for the use of bedrails has recently been reviewed and updated. Assessments are now more robust and there is an ongoing review with an emphasis on reducing the use of bedrails. More low beds are on order to help reduce the numbers further.

**Proposed Timescale:** 31/07/2018

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

**Theme:**
Safe care and support

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
Inspectors identified that the radiators were very hot to touch on the day of the inspection and could pose a burns risk to residents. Further control measures were required.

**2. 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:**
Estates have been informed and radiators are being reviewed by plumbers and estates, with covers being sought and ordered for any that are very hot to touch. Those particular radiators were turned off in the interim and electric heaters purchased.

**Proposed Timescale:** 31/07/2018

**Theme:**
Safe care and support

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
The inspectors identified some torn upholstery on chairs which would pose as an infection control risk.

**3. 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:
We have trialled chairs and purchased 8 and will recover damaged chairs that are appropriated to cover as structure has been accessed.

**Proposed Timescale:** 30/04/2018

**Theme:**
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
It was difficult to establish who was responsible for the supervision of residents who were smoking as this task had not been delegated to any specific staff member.

4. **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:
Two staff will be assigned each day to be responsible for the smoking room so that one is available all times that it is in use.

**Proposed Timescale:** 15/01/2018

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**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 inspectors found out of date injections in one of the units. Further monitoring and management of stock control was required.

5. **Action Required:**
Under Regulation 29(6) you are required to: Store any medicinal product which is out of date or has been dispensed to a resident but is no longer required by that resident in a secure manner, segregated from other medicinal products and dispose of in accordance with national legislation or guidance in a manner that will not cause danger to public health or risk to the environment and will ensure that the product concerned can no longer be used as a medicinal product.

Please state the actions you have taken or are planning to take:
1. A checklist has been put in place to ensure that the ward fridges are checked so that
there will be no out of date drugs remaining. Injections are always checked by two nurses for correct medication, dose and expiry date, which would eliminate the administration of out of date medication. This practice will continue.

2. A new pharmacy service has been tendered which will have stock control as part of it's remit and this will enhance the current process.

Proposed Timescale: 1. Immediate 2. 3 months

Proposed Timescale: 30/04/2018

<table>
<thead>
<tr>
<th>Outcome 12: Safe and Suitable Premises</th>
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<tr>
<td><strong>Theme:</strong></td>
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<tr>
<td>Effective care and support</td>
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**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**

Many of the requirements of Schedule 6 of the Regulations were not met by the centre including:
- many of the bedrooms were not of a suitable size or layout for residents
- there was no private visitors room in Hawthorn and Heather units
- the overall storage of wheelchairs, hoists and commodes in the centre was inadequate, for example commodes were seen stored adjacent to residents' toilet cubicles and in shower rooms
- the residents in Hawthorne and Heather units did not have access to an enclosed garden.
- there were insufficient numbers of toilets and showers in close proximity to bedrooms on Hawthorn and Heather units to meet the needs of the residents.
- there was limited evidence that hoists were serviced on a six monthly basis.
- a number of areas required redecoration
- in some rooms and corridors the plaster had bubbled and paint work had flaked off the walls.
- there was no evidence of regular servicing of beds and these appeared to be only serviced when they required repair.

6. **Action Required:**

Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

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

1. As part of the Capital Plan for Kerry Community Hospitals, a new hospital, under Private Public Partnership is in the design stages, due for completion in 2021. This new build will address any space/ garden issues. While residents in Hawthorn and Heather do not have access to an enclosed garden, they can access outdoor seating areas and they can be accompanied to the garden in Fuchsia Ward if requested.

As the new hospital is a Private Public Partnership, a company will need to be
appointed
The following has been advised by HSE Estates

• The PPP HSE project team is in place and is undertaking the process of appointing external professional teams.
• The program is a major national initiative.
• At this stage it is not possible to give detailed timelines.
• The national program is subject to significant constraints that need to be further clarified prior to being able to more closely define timelines these include:
  □ Capital funding
  □ Planning processes
  □ Detailed development of the construction process including any phasing required.
  □ Implementation of the PPP process.

2. Decoration is planned to address damage and distressed paint work on wards.
3. An inventory has being taken of all equipment and arrangements for servicing has been put in place to ensure that it is completed as required.

Proposed Timescale: 1. 3 years 2. 3 months 3. 3 months

Proposed Timescale: 31/01/2021

**Outcome 16: Residents' Rights, Dignity and Consultation**

**Theme:**
Person-centred care and support

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
In Heather and Hawthorn units the limited number of toilets and showers were located at either end of the ward. This meant that residents had to travel through the whole ward in their night attire to the shower or to use the toilet. The inspectors saw and staff confirmed that commodes were frequently used in the multi-occupancy room and due to the close proximity of the resident next door this did not protect or promote any of the residents privacy and dignity.

A number of residents described the multi-occupancy rooms as noisy and a number of residents told the inspectors they had been disturbed from their sleep at night by the noise from other residents. There were a number of complaints in the complaints log about noise in these rooms at night.

Lack of personal space between and around the beds also affected the residents ability to make their bed area personalised and homely and the inspectors noted that although some residents had personalised their bed spaces others were sparse. In one of the five bedded rooms the beds were too close together and did not allow residents space for possessions and privacy and dignity.

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

**Please state the actions you have taken or are planning to take:**
HIQA did not agree this action plan with the provider despite affording the provider two attempts to submit a satisfactory response.

**Proposed Timescale:**

**Theme:**
Person-centred care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The inspectors saw that many visitors visited residents in the multi-occupancy bedrooms as there were limited private or communal rooms for visiting. These visiting arrangements did not promote or protect the dignity of the residents in the other beds who may require personal care or be trying to sleep/rest watch television while visitors were in their bedroom.

**8. Action Required:**
Under Regulation 11(2)(b) you are required to: Make suitable communal facilities available for a resident to receive a visitor and a suitable private area which is not the resident's room, if required.

**Please state the actions you have taken or are planning to take:**
Staff will encourage relatives to avail of the dedicated quiet areas around the unit and to use the room designated for private use such as solicitors, or if private family issues need to be discussed. Families and residents are also welcomed in the hospital canteen/dining room for more social gatherings.

**Proposed Timescale:** 15/01/2018

**Outcome 17: Residents' clothing and personal property and possessions**

**Theme:**
Person-centred care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Residents did not have adequate storage space in their small single wardrobe and bedside locker to store all of their clothes. The majority of residents had extra clothing stored in labelled plastic boxes stored in a locked linen room on each ward which meant that residents' clothing was not accessible to them at all times. The inspectors found that this did not allow residents full choice around their clothing and did not fully enable them to retain control over their possessions and clothing.
9. **Action Required:**
Under Regulation 12(c) you are required to: Provide adequate space for each resident to store and maintain his or her clothes and other personal possessions.

**Please state the actions you have taken or are planning to take:**
Residents who are able to manage their own clothing and possessions will be provided with the code to the keypad on the linen room door to allow them to access their clothing as they wish. This will be added to the agenda for the next residents meeting. Seasonal clothing is kept in the wardrobe by the resident's bed for easy accessibility. Staff can assist residents to alternate clothing from linen room to wardrobe as they wish.

**Proposed Timescale:** 15/01/2018

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**Outcome 18: Suitable Staffing**

**Theme:**
Workforce

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
Staffing levels in the evening required review as inspectors found that staffing levels decreased from 17.00hrs onwards in all units and two units operated with two nurse and two care staff until 20.00hrs and then further reduced to two nurses and one care staff for the evening and night. The night nurses had to do the night time medication round at different times and therefore this left only one other member of staff to give out evening drinks and assist residents to bed and with other personal care needs. The inspectors found that these staffing levels were not adequate to ensure residents had a choice in bedtimes. These practices did not fit in with person-centred care as the inspectors formed the opinion which was confirmed by staff that most residents were assisted back to bed before staffing levels decreased at 20.00hrs.

10. **Action Required:**
Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

**Please state the actions you have taken or are planning to take:**
A review of staffing levels in the evenings will be undertaken to improve the numbers.

A Twilight shift HCA has been introduced to improve residents’ social care and activities.

**Proposed Timescale:** 31/07/2018