

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	St. Gabriel's Community Hospital
Centre ID:	ORG-0000600
Centre address:	Colla Road, Schull, Cork.
Telephone number:	028 28120
Email address:	schull.ch@hse.ie
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Teresa O'Donovan
Person in charge:	Patrick Ryan
Lead inspector:	Geraldine Ryan
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	20
Number of vacancies on the date of inspection:	1

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

Compliance with Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
20 March 2014 08:30	20 March 2014 15:00

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

Outcome 01: Statement of Purpose
Outcome 11: Health and Social Care Needs
Outcome 06: Safeguarding and Safety
Outcome 07: Health and Safety and Risk Management
Outcome 08: Medication Management
Outcome 13: Complaints procedures

Summary of findings from this inspection

This inspection report sets out the findings of a follow up inspection of 20 March 2014 September in which six outcomes were inspected against. The purpose of this inspection was to follow up on the progress of the 20 actions generated from an unannounced monitoring inspection on 26 June 2013. The inspector noted that all 20 actions were either completed or in the process of being completed in a satisfactory manner. No action plan was generated post this inspection.

This follow up inspection was unannounced and took place over one day. As part of the inspection the inspector met with residents, a relative, a local general practitioner (GP) and staff members. Documentation such as the statement of purpose, the risk management policy and risk register, residents' care plans, the complaints log, records of residents' finances and personal belongings, medication management, policies and procedures were reviewed.

Phase two of the building development was in progress. It was evident that building works did not impede on the lives of the residents. A warm, homely and welcoming atmosphere prevailed in the centre. The decor and furnishings were of a high standard. Since the most recent inspection of 26 June 2013, the centre had added a piano, paintings and some furnishings. Students from the local school were in the centre during the inspection and were observed chatting to residents, playing cards and providing musical entertainment. Housekeeping and general cleanliness was of a high standard.

Section 41(1)(c) of the Health Act 2007 Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.

Outcome 01: Statement of Purpose

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

Theme:

Leadership, Governance and Management

Judgement:

Compliant

Outstanding requirement(s) from previous inspection:

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

Findings:

The statement of purpose now consisted of all matters listed in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended). It now set out the aims, objectives and ethos of the centre and the facilities and services provided to residents.

Outcome 11: Health and Social Care Needs

Each residents wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each residents 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

Judgement:

Compliant

Outstanding requirement(s) from previous inspection:

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

Findings:

Non-compliances noted on the previous inspection included:

- care plans were not under formal review as required by the resident's changing needs

or circumstances and no less frequent than at three-monthly intervals

- it was not clear if all residents were consulted when their care plan was reviewed
- a nursing record of the resident's health and condition and treatment given, was not completed on a daily basis
- residents' clinical risk assessments were not up to date or no less frequent than at three-monthly intervals
- a risk assessment carried out on the resident who smoked did not include information if the resident required supervision or not. The centre's policy on smoking did not include reference to the resident who smoked requiring supervision or not
- a resident's blood pressure not recorded in a regular manner
- not all residents were weighed on a regular basis
- the privacy, dignity and confidentiality of all residents' nursing records were not safeguarded in that this information was stored in an unsafe manner.

On this inspection significant improvements were noted in the residents' care planning process. These improvements included:

- all documentation was now maintained in an orderly manner and easy to retrieve
- information in the residents' care plans was up to date
- advices/instructions from allied health services were captured in the communication sheet
- clinical risk assessments were up to date.

The inspector reviewed a sample of residents' care plans and found that residents had timely access to GP services and appropriate treatment and therapies. There was evidence of referral to specialist/allied health care services. It was evident that the residents' care plans were reviewed three monthly and that this review was done in consultation with residents and/or their relatives, where possible.

A daily flow sheet capturing the activities of daily living was completed for all residents.

Comprehensive assessments for residents on whom restraint was used had been completed. The inspector reviewed the risk assessments of residents on whom restraint was used. There was documented evidence to reflect:

- the risks involved, if restraint was not used, outweighed the risks of using a restraint
- details of when bedrails were being used at the request of the resident
- evidence of regular checks of residents on whom restraint was used
- consent was sought from the resident/relative for the use of restraint.

There was evidence that residents were weighed regularly and any concerns regarding weight loss/gain was communicated to and subsequently addressed by the GP. A copy of the resident's speech and language assessment was readily accessible to all staff, including catering staff. Residents' blood pressure, temperature, pulse and respirations were regularly monitored.

A number of residents stated that they were very happy with the care they received.

There was evidence in residents' care plans that relevant information about the resident was provided and received when the resident was being admitted or transferred from another healthcare setting.

It was evident to the inspector that residents who experienced dysphagia (difficulty in swallowing) had care plans tailored to their particular needs and had been assessed by the speech and language therapist and the dietician.

All current residents are non-smokers.

The privacy, dignity and confidentiality of all residents were safeguarded in that information and documentation pertinent to residents was now stored in a safe manner.

Outcome 06: 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.

Theme:

Safe Care and Support

Judgement:

Compliant

Outstanding requirement(s) from previous inspection:

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

Findings:

The inspector reviewed the records held with regard to residents' finances and found that any monies retained on behalf of residents were properly accounted for. Dual signatories were evident on all financial lodgements or withdrawals. The centre had a policy with regard to safeguarding resident's finances.

There was evidence that residents had an inventory of personal belongings and that it was updated on a regular basis.

Outcome 07: Health and Safety and Risk Management

The health and safety of residents, visitors and staff is promoted and protected.

Theme:

Safe Care and Support

Judgement:

Compliant

Outstanding requirement(s) from previous inspection:

No actions were required from the previous inspection.

Findings:

Findings from the previous inspection included:

- the risk management did not include the specific risk of self-harm

- there was little evidence to indicate that staff had read the policies and procedures in the centre. Some policies and procedures were out of date
- a risk assessment of the size and ergonomics of the current sluice room had not been carried out
- a risk assessment of the height of the shelving holding the bedpans in the sluice room had not been carried out
- not providing appropriate storage for a commode, soiled linen trolleys, a clinical waste bin and a domestic waste bin.

On this inspection it was evident that all actions were addressed and completed where possible.

There was evidence that comprehensive and collaborative efforts had been made to ensure that a robust risk management policy and risk register, were in place. The risk management policy was up to date and the risk register identified clinical and environmental risks. Each risk was rated, and interventions identified. The specific risks as outlined in Regulation 31 relating to the unexplained absence of a resident, assault, accidental injury to residents or staff, aggression and violence, and self-harm were identified and there were measures in place to address each of these risks. It was evident that staff had signed as having read the centre's policies.

The issue with regard to the sluice room had been addressed. The installation of a larger sluice room was part of the second phase of the building development. Due to existing building works, this area was not accessible on the day of inspection. However, the person in charge pointed out the room designated to sluicing facilities.

Outcome 08: Medication Management

Each resident is protected by the designated centres policies and procedures for medication management.

Theme:
Safe Care and Support

Judgement:
Compliant

Outstanding requirement(s) from previous inspection:

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

Findings:

Findings from the most recent inspection included:

- there was no evidence of audit of medication management practices
- some medications kept as stock, were out of date, or were due to expire in four days
- there was no record of medication kept as stock
- the maximum dosage of medications prescribed as required (PRN) was not documented in a number of the residents' medication prescription charts
- medications prescribed as required (PRN) were administered routinely

- one resident prescribed a medication twice daily (BD), with a specific instruction that it was to be withheld if the resident was drowsy, was given the prescribed medication once daily (OD) over a period of three consecutive days. No reason was recorded for the non-administration of the medication
- quantities of controlled medication as documented in the controlled drug register did not concur with documented record of twice daily checks carried out by nursing staff
- dates and times of checks by staff of the controlled drugs, were incorrect.

On this inspection it was evident that all actions were addressed and completed in a satisfactory manner.

The inspector reviewed the centre's policy on medication management relating to the ordering, prescribing, storing and administration of medicine to residents and noted that it was up to date and signed as having been read by staff. Medications were supplied by an external pharmacy. The inspector saw evidence of secure storage of unused medication and the key senior manager stated that the external pharmacy supplier collected these medications on a regular basis. The centre had a standard operating procedure to guide staff on the disposal of unused medications.

A sample of medication prescription and administration charts were reviewed and all included the resident's name, date of birth, a photograph of the resident and details if the resident had an allergy/or not. The following was also noted:

- the maximum dose of medications prescribed on a PRN basis, was documented
- residents' medication prescription charts concurred with their medication administration charts
- discontinued medications that were documented, signed and dated in the residents' medication prescription chart.

Medications were not currently administered as crushed to residents. A list of medications that could/could not be crushed was available to guide staff.

There was documentary evidence indicating that residents' medication was reviewed by the GP on a three monthly basis. There was evidence of ongoing review and audit of residents' prescribed psychotropic medications.

There was a facility in place for the safe storage of scheduled controlled drugs. The inspector reviewed the controlled drug register and with the person in charge, carried out a spot check on all the controlled drugs (MDAs) and found that the totals corresponded and there was evidence that:

- two nurses signed and dated each entry
- the stock balance was checked and signed by two nurses at the change of each shift.

The controlled drugs were stored in a designated locked press. There was evidence of a regular stock control check of medication.

A locked fridge containing medication only was located in key-pad accessible medicines room. There was evidence that the temperature of the fridges was monitored daily. The medicines room was maintained in a clean, organised and tidy manner.

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

Judgement:

Compliant

Outstanding requirement(s) from previous inspection:

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

Findings:

There was evidence that a record of complaints was maintained, including the details of the complaint, the results of any investigations, any actions taken and whether or not the resident was satisfied with the outcome of the complaint. The inspector noted that all documented complaints were addressed in a satisfactory manner. There was evidence that the complainant was satisfied with the outcome.

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings, which highlighted both good practice and where improvements were required.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of the residents, relatives, and staff during the inspection.

Report Compiled by:

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