Health Information and Quality Authority
Regulation Directorate

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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	St Gabriel's Community Hospital
Centre ID:	OSV-0000600
Centre address:	Colla Road, Schull, Cork.
Telephone number:	028 28120
Email address:	berm.power@hse.ie
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Ber Power
Lead inspector:	Caroline Connelly
Support inspector(s):	None
Type of inspection	Unannounced Dementia Care Thematic Inspections
Number of residents on the date of inspection:	19
Number of vacancies on the date of inspection:	2

About Dementia Care Thematic Inspections

The purpose of regulation in relation to residential care of dependent Older Persons is to safeguard and ensure that the health, wellbeing and quality of life of residents is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer and more fulfilling lives. This provides assurances to the public, relatives and residents that a service meets the requirements of quality standards which are underpinned by regulations.

Thematic inspections were developed to drive quality improvement and focus on a specific aspect of care. The dementia care thematic inspection focuses on the quality of life of people with dementia and monitors the level of compliance with the regulations and standards in relation to residents with dementia. The aim of these inspections is to understand the lived experiences of people with dementia in designated centres and to promote best practice in relation to residents receiving meaningful, individualised, person centred care.

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 monitor compliance with specific outcomes as part of a thematic inspection. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
19 June 2017 10:45	19 June 2017 17:30
20 June 2017 09:15	20 June 2017 16:15

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

Outcome	Provider's self assessment	Our Judgment
Outcome 01: Health and Social Care Needs	Compliance demonstrated	Non Compliant - Moderate
Outcome 02: Safeguarding and Safety	Compliance demonstrated	Non Compliant - Moderate
Outcome 03: Residents' Rights, Dignity and Consultation	Compliance demonstrated	Substantially Compliant
Outcome 04: Complaints procedures	Compliance demonstrated	Substantially Compliant
Outcome 05: Suitable Staffing	Substantially Compliant	Non Compliant - Major
Outcome 06: Safe and Suitable Premises	Compliance demonstrated	Substantially Compliant

Summary of findings from this inspection

This inspection report sets out the findings of a thematic inspection which focused on specific outcomes relevant to dementia care. This inspection was undertaken by the Health Information and Quality Authority (HIQA) in the Health Services Executive (HSE) St Gabriels Community Hospital.

As part of the thematic inspection process, providers were invited to attend information seminars given by HIQA. In addition, evidence-based guidance was developed to guide the providers on best practice in dementia care and the inspection process. Prior to the inspection, the person in charge completed the provider self-assessment and compared the service with the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013 and the National Quality Standards for Residential Care

Settings for Older People in Ireland.

During this inspection the inspector focused on the care of residents with dementia in the centre. The inspection also considered progress on some findings following the last inspection carried out on in June 2015 and to monitor progress on the actions required arising from that inspection. The inspector met with residents, relatives, and staff members during the inspection. The inspector tracked the journey of a number of residents with dementia within the service, observed care practices and interactions between staff and residents using a validated observation tool. The inspector also reviewed documentation such as care plans, medical records, staff files, relevant policies and the self assessment questionnaire which was submitted prior to inspection.

The centre did not have a dementia specific unit however, at the time of inspection there were 7 of the 19 residents residing in the centre with a formal diagnosis of dementia. There were two further residents with cognitive impairment/suspected dementia. The inspector found that residents' overall healthcare needs were very well met and they had very good access to appropriate medical and allied healthcare services. The quality of residents' lives was enhanced by the beautiful surroundings and scenery and also by the provision of a choice of interesting things for them to do during the day. The inspector found that a ethos of respect for residents was evident. The inspector found that residents appeared to be very well cared and residents and relatives gave very positive feedback regarding aspects of life and care in the centre. Overall, the inspector found the person in charge; Clinical Nurse Manager 2 (CNM2) and the staff team were committed to providing a quality service for residents with dementia.

Since the last inspection there has been a change to the person in charge. The previous person in charge has returned to his substantive post and is now person in charge over Skibbereen Community Hospital and St. Gabriels Community hospital and divides his time between the two centres. He is supported in his role by a CNM 2 who works full time in the centre and is supernumerary to the nursing compliment.

The person in charge had submitted a completed self assessment tool on dementia care to HIQA with relevant policies and procedures prior to the inspection. The person in charge had assessed the compliance level of the centre through the self assessment tool as fully compliant with the exception of staffing which he assessed as substantially compliant. However the findings and judgments of the inspector did not concur with the centers judgments. The inspector found major non-compliance in one outcome moderate non-compliance in two outcomes and substantial compliance in three further outcomes.

The inspector found that a number of improvements required on the inspection in June 2015 had been implemented. However there were a number that remained non-compliant these included lack of mandatory staff training, lack of evidence of vetting for new staff, care planning, residents weights, complaint policy update. Actions required are discussed throughout the report and the Action Plan at the end of this report identifies areas where improvements are required to comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centre's for Older

People) Regulations 2013 and the National Standards for Residential Care Settings for Older People in Ireland 2016.

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

Outcome 01: Health and Social Care Needs

Theme:
Safe care and support

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

Findings:
This outcome sets out the inspection findings relating to healthcare, assessments and care planning. The social care of residents with dementia is discussed in Outcome 3. There were a total of 19 residents in the centre on the day of this inspection, 8 residents has assessed maximum and high dependency needs, twelve residents had medium dependency needs and five residents had low dependency needs. 7 residents had a formal diagnosis of dementia.

There was a local GP practice providing medical services to the centre and the GP's attended on a daily basis including Saturday mornings if required. Out-of-hours medical cover was available where necessary. The inspector met one of the GP's during the inspection and a sample of medical records reviewed confirmed that resident's were reviewed on a very 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 and attendance at outpatients was facilitated.

The centre provided in house physiotherapy services. Each resident was reviewed on admission and regularly thereafter by the physiotherapist who attended the centre two to three days per week and provided an exercise class for residents. The dietician 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.
Residents and relatives expressed satisfaction with the medical care provided and the inspector was satisfied that residents health care needs were very well met.

The inspector focused on the experience of residents with dementia in the centre on this inspection. The journey of four residents with dementia was tracked and also reviewed specific aspects of care such as nutrition, wound care and end of life care in relation to other residents.

The inspector saw that residents had a comprehensive nursing assessment completed on admission. 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. However the inspector saw that the staff were completing two different assessment tools for risk of pressure sore formation which gave different risk levels and could lead to errors. The inspector saw that there were suitable arrangements in place to meet the health and nursing needs of residents with dementia. Each resident's needs were determined by comprehensive assessment with care plans developed based on identified needs. Residents and their families, where appropriate were involved in the care planning process, which reflected the wishes of residents with dementia. The care plans were person centred and individualised. However assessments and care plans were not reviewed and updated on a four monthly basis or sooner if the residents condition required it, as is required by legislation. The person in charge explained that the centre had changed over their documentation to a new documentation system over the last six months and were only familiarising themselves with the new documentation and care planning process. The inspector saw there was some duplication of information and nutritional care plans had not been updated following review by the speech and language therapist. The inspector formed the view that the care plans were utilised to direct care to the residents.

Nursing staff told the inspector that a detailed hospital transfer letter was completed when a resident was transferred to hospital. Residents at risk of developing pressure ulcers had care plans and pressure relieving mattresses and cushions to prevent ulcers developing. Care of residents with pressure sores was seen to be appropriate with scientific measurements of wounds in place. Staff had access to support from the tissue viability nurse as required for advice and support.

There were systems in place to ensure residents' nutritional needs were met, and that they residents received adequate hydration. Residents were screened for nutritional risk on admission and reviewed regularly thereafter. Residents' weights were checked, however the frequency of checking of weights required review. Weights were checked on reassessment and as discussed above these reassessments had not taken place therefore some residents weights had not been checked for over four months. Residents were provided with a choice of nutritious meals at mealtimes and all residents spoken to were very complimentary about the food provided. There was an effective system of communication between nursing and catering staff to support residents with special dietary requirements. Mealtimes in the dining room was observed by inspectors to be a social occasion.

There were written operational policies and procedures in place on the management of medications in the centre. Medications requiring special control measures were stored appropriately and counted at the end of each shift by two registered nurses. There were appropriate procedures in place for the return of unused and out-of-date drugs to the pharmacy. Medication administration practices observed by the inspector were in compliance with relevant professional guidance. A sample of prescription and administration records viewed by the inspector contained appropriate identifying information. Medications requiring refrigeration were stored in a fridge and the temperature was monitored and recorded daily.

There were written operational policies and protocols in place for end-of-life care. Spiritual needs were facilitated with mass held monthly in the centre; other denominations visited the centre regularly as required and a service was provided. There were a number of resident's at end of life during the inspection. Residents were regularly reviewed by their GP and more frequently as they approached end-of-life. There was good access to palliative care and there was evidence of referral and review. Religious and cultural preferences were facilitated. Care practices observed showed that residents are cared for with the utmost respect at end of life. There were single rooms with en-suite facilities available. There was a newly refurbished family room available for families to use including a pull out bed and drinks and food preparation areas. This enabled families to stay overnight if required when a family member was at end of life. Families spoken to were very complimentary about end of life care practices in the centre and complimented staff on how caring the staff were to them and their families. The person in charge told the inspector that a number of staff had received training in "let me decide" advanced care planning directives however this had not been commenced and there was no evidence of end of life care plans in the current care planning documentation.

Judgment:
Non Compliant - Moderate

Outcome 02: Safeguarding and Safety

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:
There was a policy in place on responding to allegations of elder abuse. Residents spoken with by the inspector stated that they felt safe in the centre and would be comfortable approaching the person in charge or any member of staff in relation to any concerns they may have. Staff members spoken with by the inspector were knowledgeable of what constituted abuse and what to do in the event of an allegation of abuse. Training records indicated that most, but not all, staff had received training on recognising and responding to allegations of abuse. However none of the staff had received training in the new HSE safeguarding of vulnerable adults policy and their elder abuse training was not current. The action for this is under outcome 5 Suitable Staffing.

The inspector viewed a sample of records of residents' financial transactions managed by the administration staff and was satisfied that there were adequate procedures in place to safeguard residents' finances. The centre maintained day to day expenses for a number of residents and the inspector saw that money was kept in a locked drawer.

Monies were stored in envelopes with the name of the resident and receipts were kept for all purchases. However there were no signatures for lodgements and withdrawals and in fact these were not documented. Therefore there was no record of monies lodged or withdrawn and no ongoing rolling balance of what money was stored. This system was found not to be sufficiently robust to protect residents or staff.

There was a policy in place for managing challenging behaviour. Staff members spoken with by the inspector were knowledgeable of how to respond to behaviour that is challenging, however, not all staff had attended training and the action for this is also under outcome 5 Suitable Staffing. There was evidence that efforts were made to identify and alleviate the underlying causes of behaviour that posed a challenge. Residents were reviewed by the GP or psychiatrist if required. The records of residents who presented with responsive behaviours were reviewed by the inspector who found that these were managed in a very dignified and person centred way by the staff using effective de-escalation methods. Staff spoken to were very knowledgeable about residents and what worked with them to assist if responsive behaviours were exhibited. They used distraction techniques such as taking the resident out for a walk, singing with the resident, talking about their family members, their hobbies and interests. Care plans seen detailed these intervention and charts were maintained identifying triggers, responsive behaviours and actions to take in response.

There was a policy and procedure in place for the use of restraint. The CNM2 informed the inspector that there were 12 residents out of the current 19 residents using bedrails at the time of the inspection. The inspector found this was a very large percentage of bedrail usage and required this to be reviewed to promote a reduction in the use of restraint. Although there were some alternatives such as low profiling beds in use for some residents, this needed to be extended to move towards a restraint free environment. The centre had a risk assessment tool in place to guide the appropriate use of restraint for residents. However, the assessment did not adequately outline the measures which had been taken/considered to protect residents prior to using bed rails. The system around restraint required review to ensure it was compliant with the national policy.

Judgment:
Non Compliant - Moderate

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:
Person-centred care and support

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

Findings:

Residents were consulted in relation to how the centre was planned and run through residents' forums that were facilitated by an external organisation and were held approximately every three months. The inspector saw that the CNM2 knew all the residents well and spoke to them daily. The inspector saw minutes of the residents forum meetings which a large number of residents attended. Issues raised at these meetings were reported back to the Person in Charge/CNM for resolution and followed up on subsequent meetings with updates and progress. A full agenda of care and facilities were discussed with the residents and their feedback requested on same. Other issues discussed were food and menu choices, activities, trips out. Residents had access to newspapers TV and radio. Minutes of the meetings showed that issues identified during the meetings were actioned and followed up on. Residents commented on how they loved the views and having their own room and the peace and quiet of same. As identified on the previous inspection residents continued not to have access to independent advocacy services.

The centre operated an open visiting policy which was observed throughout the inspection. Numerous visitors were observed throughout both days of inspection where staff members knew the names of visitors and vice versa. Staff took time to talk with family members both when they visited and when they rang to enquire about their relative. Relatives who spoke to the inspector commended staff on how welcoming they were to all visitors and some had tea/coffee with their relative during their visits. They said that if they any concerns they could identify them to the CNM2 or the Person in Charge and were assured they would be resolved.

Residents privacy and dignity was respected. The inspector observed staff knocking on the doors of residents' bedrooms before entering and residents confirmed that this was usual practice. Bedrooms were personalised with residents' personal possessions. There were adequate facilities available for residents to meet with visitors in private. Staff confirmed that residents were facilitated to vote in local and national elections. Staff paid particular attention to residents' appearance, dress and personal hygiene and were observed to be caring towards the residents. The hairdresser visited as required and residents were facilitated to avail of the service

Staff were observed communicating appropriated with all residents including those who had dementia. Effective communication techniques were documented and evidenced in residents care plans. Staff members spoken with were knowledgeable of the communication needs of individual residents. Residents had access to a varied programme of activities that included group and one-to-one activities.

There was a varied programme of activities available to residents which included sonas, imagination gym, music, sing-songs, chair based exercise, religious activities, gardening and other more individualised activities. The inspector saw a number of group and individual activities being undertaken during the inspection. These included sing-songs, newspaper reading, quiz, residents going out for walks and out for trips accompanied by staff. There was a group music session in the day room and the singer and also did music by the bedside where they played music outside some residents bedrooms to ensure all residents had access to the music. Residents and relatives spoken with gave positive feedback on the activities and often joined in with the groups. The Person in Charge and A/CNM2 told the inspector that although they have a number of external

people providing activities it is also the role of all staff to provide social stimulation for residents. The inspector noted in the afternoon if there wasn't a planned activity the staff did not have time as the multitask attendants were allocated to cleaning duties.

As part of the inspection, the inspector spent periods of time observing staff interactions with residents. The inspector used a validated observational tool (the quality of interactions schedule, or QUIS) to rate and record at five minute intervals. The inspector spent time observing interactions in the morning and in the afternoon. These observations took place in the day room. Overall, observations of the quality of interactions between residents and staff in the communal area for a selected period of time indicated that the majority of interactions were of a positive nature with good interactions seen between staff and residents. An activity group was ongoing during one of the observation periods and the activity staff involved every resident in the activity including the residents with advanced dementia. The inspector noted that the staff tried to create an atmosphere of relaxation by playing background music appropriate to the age and era of residents.

The Person in Charge told the inspector about a number of trips out that the residents got to go on and the friends of the hospital had fundraised for a bus which is always available to take the residents out and also to outpatient appointments. The inspector saw this was a great addition to the services provided and to the quality of life for the residents.

Judgment:
Substantially Compliant

Outcome 04: Complaints procedures

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:
There was a policy and procedure in place for the management of complaints that identified the complaints officer and the independent appeals process. There was a notice on prominent display detailing how to make a complaint and how to appeal if not satisfied with the outcome of the complaints process. This also included contact details for the ombudsman. On the previous inspection the policy did not identify the person responsible for ensuring that all complaints are appropriately responded to and that adequate records were maintained. This remained the same on this inspection.

Residents and relatives all said that they had easy access to the CNM2 who was identified as the named complaints officer to whom they could openly report any

concerns and were assured issues would be dealt with. The CNM2 stated that she monitored complaints or any issues raised by being readily available and regularly speaking to residents, visitors and staff. The inspector reviewed the complaints log that contained details of complaints, details of investigations and whether or not complainants were satisfied with the outcome of the complaints process. Records showed that complaints made to date were dealt with promptly and the outcome and satisfaction of the complainant was recorded. The inspector also saw there was a comment and suggestion box and compliments were recorded and acknowledged accordingly.

Judgment:
Substantially Compliant

Outcome 05: Suitable Staffing

Theme:
Workforce

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

Findings:
Residents and relatives spoke very positively of staff and indicated that staff were caring, responsive to their needs and treated them with respect and dignity. This was seen by the inspector throughout the inspection in the dignified and caring manner in which staff interacted and responded to the residents. Relatives stated staff went beyond the call of duty to provide care and support 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. In discussions with staff, they confirmed that they were supported to carry out their work by the person in charge. The inspector found staff to be well informed and knowledgeable regarding their roles, responsibilities and the residents' needs and life histories. There was evidence that residents knew staff well and engaged easily with them in personal conversations.

Based on a review of the roster and observations of the inspector over the course of the inspection there were adequate numbers of staff and skill mix to meet the needs of residents. A member of staff undertook a lot of the centre's basic maintenance and cleaning and checking of equipment. However there were no dedicated cleaning staff on duty and the role of the multi-task attendant was unclear as they moved from caring to cleaning duties on the one shift. During the two days of inspection the multi-task attendants spent the first part of the morning on caring duties, then moved to cleaning. However the inspector saw that the staff members were also involved in giving out drinks and assisting with meals which is not good practice in relation to infection control.

Further segregation of roles is recommended to ensure consistent care for residents and to allow for more consistency for the purposes of cleaning.

There was an ongoing programme of training to support staff provide contemporary evidence-based care. Based on records seen by the inspector and as discussed under outcome 2 safeguarding not all, staff had received up-to-date training on fire safety, prevention and detection of abuse, responsive behaviours and manual handling. The person in charge and CNM acknowledged this and plans were in place to get staff on this training. None of the staff had undertaken dementia specific training but some had undertaken specific activity training for people with dementia such as Sonus training and Imagination Gym. Other training completed by members of staff included end of life care, hand hygiene, palliative care and dysphagia (difficulty swallowing).

Current registration was available for all nursing staff. A review of personnel records indicated that generally all of the requirements of Schedule 2 were met. However the centre had in place HSE Garda Vetting Liason Officers Garda vetting report confirmation forms for staff. However, this is not a disclosure in accordance with the National Vetting Bureau Act 2012 as required by schedule 2 of the 2013 care and welfare regulations. The inspector requested a copy of the original vetting forms from the HSE for all staff employed after 29 April 2016 but had not received same to date.

There was a volunteer working in the centre who provided a great service to the residents. However, the roles and responsibilities for the volunteer had not been set out and there was no vetting in place for the volunteer which is a requirement of the legislation.

Judgment:
Non Compliant - Major

Outcome 06: Safe and Suitable Premises

Theme:
Effective care and support

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

Findings:
St. Gabriel's Community Hospital is located on the outskirts of Schull village on well maintained grounds with beautiful views over Schull harbour. It is a two-storey building that was first constructed in the mid-twentieth century. A refurbishment programme commenced in 2012 resulting in the construction of a new single-storey wing consisting of 17 single bedrooms and two twin bedrooms, all of which were en suite with shower, toilet and wash-hand basin. All resident' accommodation was on the ground floor of the new wing.

All bedrooms had ceiling hoists installed, individualised colour schemes and complementing bed linen. Residents' bedrooms were personalised and furnished to a very high standard and there was adequate space provided for residents' personal possessions and clothing. Communal accommodation was extensive and included a large sitting room/recreational room with an adjacent lounge which overlooked the garden and sea. There was a decked balcony outside the lounge area with seating and a bird table. Further communal areas included a dining room with a built in kitchen area. A sluice room was located in the new extension.
The ground floor of the old building was used for physiotherapy/occupational therapy, it also contained a clinical room, a hairdressers room, kitchen and store rooms. The centre had developed a lovely visitors room with a pull out bed and cooking and dining facilities if families wished to stay overnight particularly if a family member was at end of life. The second floor was used for offices and staff facilities.

The centre was surrounded by large maintained gardens overlooking the harbour. A protective barrier circumvented the centre and the identified risk associated with living near the sea and road was addressed in the risk register. Assistive technology comprising a wandering system was available to residents with a tendency to wander. There was ample parking for visitors and staff. The premises and grounds were well maintained. The inspector noted that the centre was warm and homely and the level of cleanliness and hygiene was of a very high standard. There was evidence of a continuous programme of maintenance. An enclosed garden area opened off the dining room with plenty of tables, chairs, benches and plants for residents to enjoy.

There was appropriate assistive equipment available such as electric beds, overhead hoists, pressure relieving mattresses and cushions, and specialised chairs to meet the needs of high dependency residents. Records were available of the preventive maintenance of equipment such as beds, chairs, wheelchairs, weighing scales and hoists in the centre on the days of inspection.

All bed linen and residents' personal clothing was sent out to an external laundry. The system in place for managing residents' clothing was effective. Residents stated that they were happy with the way their clothing and personal belongings were managed in the centre and generally there were no problems with clothing going missing.

The staff had developed an area in the centre for reminiscence with older furniture an old telephone. Further items were provided for residents with dementia such as sock pairing and the use of art and textiles, locks and bolts boards for therapy. The inspector saw that residents had individual pictures on their doors to help them recognise their rooms. However pictorial signage for other areas such as dining, sitting rooms, bathrooms and toilets should be further developed to assist residents to find their way around the centre.

Judgment:
Substantially Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Caroline Connelly
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Provider's response to inspection report[1]

Centre name:	St Gabriel's Community Hospital
Centre ID:	OSV-0000600
Date of inspection:	19 and 20 June 2017
Date of response:	19 July 2017

Requirements

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

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

Outcome 01: Health and Social Care Needs

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Assessments and care plans were not reviewed and updated on a four monthly basis or sooner as required by legislation.

Residents weights were not monitored on a regular basis

1. Action Required:

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

Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.

Please state the actions you have taken or are planning to take:
All residents care plans will be updated every three months or more frequently if resident`s condition dictates same. Residents weights will be monitored four monthly and more frequently if residents condition or unexplained weight loss dictates same.

Proposed Timescale: complete and ongoing

Proposed Timescale: 19/07/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were no end of life care plans detailing residents preferences for end of life care in the records of residents reviewed by the inspector.

2. Action Required:
Under Regulation 05(1) you are required to: Arrange to meet the needs of each resident when these have been assessed in accordance with Regulation 5(2).

Please state the actions you have taken or are planning to take:
End of life care plans detailing residents preferences will be completed by July 25th 2017

Proposed Timescale: 25/07/2017

Outcome 02: Safeguarding and Safety

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was a high usage of bedrails in the centre and there was not evidence of this being the least restrictive alternative.

3. 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:
All usage of bed rails will be reviewed immediately and alternatives such as low low beds and sensor mats will be offered and same documented in the residents care plan.

Proposed Timescale: Complete and ongoing

Proposed Timescale: 19/07/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The system in place to manage some monies handed in for safekeeping was not sufficiently robust.

4. Action Required:
Under Regulation 08(1) you are required to: Take all reasonable measures to protect residents from abuse.

Please state the actions you have taken or are planning to take:
All money handed in for safe keeping will be documented and all transactions will be recorded and signed by two members of staff and the resident where possible.

Proposed Timescale: Complete

Proposed Timescale: 19/07/2017

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no external advocacy service available to the residents. This was also identified on the previous inspection.

5. Action Required:
Under Regulation 09(3)(f) you are required to: Ensure that each resident has access to independent advocacy services.

Please state the actions you have taken or are planning to take:
The SAGE support and advocacy service is now available to all residents. information on contacting the SAGE advocacy service is displayed in the Hospital and information leaflets on the service are also available.

Proposed Timescale: Complete

Proposed Timescale: 19/07/2017

Outcome 04: Complaints procedures

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The complaints policy did not identify the person responsible for ensuring that all complaints are appropriately responded to and that adequate records were maintained.

6. Action Required:
Under Regulation 34(3) you are required to: Nominate a person, other than the person nominated in Regulation 34 (1)(c), to be available in a designated centre to ensure that all complaints are appropriately responded to and that the person nominated under Regulation 34 (1)(c) maintains the records specified under in Regulation 34 (1)(f).

Please state the actions you have taken or are planning to take:
The complaints policy has been updated and now identifies the person responsible for ensuring that all complaints are appropriately responded too and that adequate records are maintained.

Proposed Timescale: Complete

Proposed Timescale: 19/07/2017

Outcome 05: Suitable Staffing

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A number of staff did not have up to date mandatory training in moving and handling, responsive behaviours, safeguarding of vulnerable adults and fire training.
Staff also did not have specialist dementia training.

7. Action Required:
Under Regulation 16(1)(a) you are required to: Ensure that staff have access to appropriate training.

Please state the actions you have taken or are planning to take:
All staff will have up to date training provided on or before the following dates:
Moving & handling – October 13th 2017

Responsive behaviours – September 30th 2017
Safeguarding of vulnerable adults – September 30th 2017
Fire training – September 30th 2017

Proposed Timescale: 13/10/2017

Theme:
Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The centre had in place HSE Garda Vetting Liason Officers Garda vetting report confirmation forms for staff. However, this is not a disclosure in accordance with the National Vetting Bureau Act 2012 as required by schedule 2 of the 2013 care and welfare regulations.

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

Please state the actions you have taken or are planning to take:
A vetting disclosure in accordance with the National Vetting Bureau act 2012 as required by schedule 2 of the care and welfare regulations act 2013 is held centrally by our Community Healthcare Organisation data controller, Ms. Violet Ross and are available on request.

Proposed Timescale: 19/07/2017

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
It was not set out in writing the roles and responsibilities of people involved on a voluntary basis with the designated centre as required by the legislation.

9. Action Required:
Under Regulation 30(a) you are required to: Set out in writing the roles and responsibilities of people involved on a voluntary basis with the designated centre.

Please state the actions you have taken or are planning to take:
The role and responsibility of our volunteer is now set out in writing as per regulation 30(a)

Proposed Timescale: Complete

Proposed Timescale: 19/07/2017

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was no vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 for people involved on a voluntary basis with the designated centre.

10. Action Required:
Under Regulation 30(c) you are required to: Provide a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 for people involved on a voluntary basis with the designated centre.

Please state the actions you have taken or are planning to take:
The person noted on the day of inspection as a volunteer is a visitor who visits her friends on a regular basis. She has been provided with a Garda vetting application. If she completes same she will continue to visit. If she does not complete same she will end her visiting.

Proposed Timescale: 31/08/2017

Outcome 06: Safe and Suitable Premises

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The inspector saw that residents had individual pictures on their doors to help them recognise their rooms. However pictorial signage for other areas such as dining, sitting rooms, bathrooms and toilets should be further developed to assist residents to find their way around the centre.

11. 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:
Pictorial signage for dining, sitting rooms, bathrooms and toilets will be developed and put in place in the centre

Proposed Timescale: 30/09/2017