Killybegs Community Hospital inspection report, 17 April 2013

Health Information and Quality Authority
Regulation Directorate

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

Centre name:	Killybegs Community Hospital
Centre ID:	0620
Centre address:	Donegal Road Killybegs County Donegal
Telephone number:	074-9732044
Email address:	Catherine.mitchell@hse.ie
Type of centre:	☐ **Private** ☐ **Voluntary** ☒ **Public**
Registered provider:	Health Service Executive
Person authorised to act on behalf of the provider:	Kieran Doherty
Person in charge:	Catherine Mitchell
Date of inspection:	17 April 2013
Time inspection took place:	**Start:** 09:10 hrs **Completion:** 17:45 hrs
Lead inspector:	P.J Wynne
Support inspector(s):	N/A
Type of inspection	☐ **announced** ☒ **unannounced**
Number of residents on the date of inspection:	32
Number of vacancies on the date of inspection:	9

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 their 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
- 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. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.

Summary of 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*.

This inspection report sets out the findings of a monitoring inspection, in which 11 of the 18 outcomes were inspected against. The purpose of the inspection was:

- ☐ to inform a registration decision
- ☐ to inform a registration renewal decision
- ☒ to monitor ongoing compliance with Regulations and Standards
- ☐ following an application to vary registration conditions
- ☐ following a notification of a significant incident or event
- ☐ following a notification of a change in person in charge
- ☐ following information received in relation to a concern/complaint

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

Outcome 1: Statement of Purpose	☒
Outcome 2: Contract for the Provision of Services	☐
Outcome 3: Suitable Person in Charge	☒
Outcome 4: Records and documentation to be kept at a designated centres	☒
Outcome 5: Absence of the person in charge	☐
Outcome 6: Safeguarding and Safety	☒
Outcome 7: Health and Safety and Risk Management	☒
Outcome 8: Medication Management	☒
Outcome 9: Notification of Incidents	☐
Outcome 10: Reviewing and improving the quality and safety of care	☒
Outcome 11: Health and Social Care Needs	☒
Outcome 12: Safe and Suitable Premises	☒
Outcome 13: Complaints procedures	☒
Outcome 14: End of Life Care	☐
Outcome 15: Food and Nutrition	☐
Outcome 16: Residents' Rights, Dignity and Consultation	☐
Outcome 17: Residents' clothing and personal property and possessions	☐
Outcome 18: Suitable Staffing	☒

This report set out the findings of an unannounced monitoring inspection. This inspection took place over one day and was the fifth inspection carried out by the Health Information and Quality Authority's Regulation Directorate (the Authority). The findings of previous inspections concluded that improvements were required to meet all of the requirements in the Regulations. These inspection reports can be found at www.higa.ie.

There were four actions plans identifying five areas of non compliance with the legislation outlined in the action plan report of the inspection report dated 5 March 2012. These were reviewed during this inspection. The inspector found that two

actions had been completed satisfactorily. Two were not completed from the inspection of 5 March 2012 to include regular fire drills and reviewing the use of multiple-occupancy rooms for continuing care residents to meet the Authority's Standards for space, privacy or the dignity of residents. These actions are reinstated in the action plan of this report. The previous inspection in the centre was a registration inspection in June 2011. An action plan identifying two areas for improvement was issued to the provider. The provider submitted an action plan agreed with the inspector to address the matters identified in the report.

The person in charge and staff team conveyed a very positive attitude to the care of older people and conveyed a commitment to supporting residents.The person in charge has not changed since the last inspection and there were arrangement to provide cover when the person in charge was off duty or on leave. The majority of residents were accommodated in the centre on a short-term basis for convalescent, respite or palliative care. The building was comfortably warm and in a clean condition.

Residents were seen routinely by their GP and there was timely access to medical care. However, there was limited acces to speech and language services. Most aspects of medication management were in line with professional guidelines. Residents had access to a varied and nutritious diet and were facilitated to practice their religious beliefs.

The inspector identified the following aspects of the service that needed improvement to comply with the Regulations:

- a review of the care assistant staff levels is required to meet the needs of residents
- provision of access to speech and language therapy
- mandatory training in safe moving and handling of residents and fire evacuation was not maintained up-to-date for all staff and not all staff had participated in routine fire drill practices
- the localised health and safety statement was not reviewed and updated regularly
- care planning required review to fully meet the assessed needs of all residents
- aspects of restraint management required further review to adhere to promoting a restraint free environment
- the physical environment did not comply with the Regulations and the Authority's Standards for continuing care residents.

The areas for improvement are further discussed in the body of the report. The Action Plan at the end of this report identifies mandatory improvements required to come into compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

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*.

Theme: Leadership, Governance and Management

Effective governance, leadership and management, in keeping with the size and complexity of the service, are fundamental prerequisites for the sustainable delivery of safe, effective person-centred care and support.

Outcome 1

There is a written statement of purpose that accurately describes the service 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.

References:

Regulation 5: Statement of Purpose
Standard 28: Purpose and Function

Actions required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

The inspector was satisfied that the statement of purpose accurately described the aims, objectives and ethos of the centre and the service that was provided.

The statement of purpose set out the services and facilities provided in the designated centre and contained all the requirements of Schedule 1 of the Regulations. The statement of purpose is kept under review by the provider.

Outcome 3

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

References:

Regulation 15: Person in Charge
Standard 27: Operational Management

Actions required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

The person in charge has not changed since the last inspection. The person in charge is a registered general nurse with the required experience in the area of nursing of older people as well as additional training in management. She has worked in the centre since 2000 as a clinical nurse manager and had taken up the director of nursing post in an acting capacity in October 2009.

Adequate arrangements were in place to provide cover when the person in charge was off duty or on leave. There was an organisational structure in place to support the person in charge. Two clinical nurse managers deputised in the absence of the person in charge. The arrangements and reporting systems were known to staff and were described in the statement of purpose. The maanger for services for older people supported the person in charge in her role.

Outcome 4
The records listed in Part 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) 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 2009 (as amended).

References:
Regulations 21-25: The records to be kept in a designated centre
Regulation 26: Insurance Cover
Regulation 27: Operating Policies and Procedures
Standard 1: Information
Standard 29: Management Systems
Standard 32: Register and Residents' Records

Inspection findings:
**Where "Improvements required" is indicated, full details of actions required are in the Action Plan at the end of the report.*

General Records (Schedule 4)

Substantial compliance ☐ Improvements required * ☒

The maintenance of some records required attention to include the fire register and staff training records. These matters are discussed in more detail under Outcome 7 and Outcome 18.

Operating Policies and Procedures (Schedule 5)

Substantial compliance ☐ Improvements required * ☒

As discussed under Outcome 7 and Outcome 13, the risk management and complaints policy required additional review to fully meet all aspects of the Regulations.

Staffing Records

Substantial compliance ☐ Improvements required * ☒

The improvements related to staffing records are discussed in more detail under Outcome 18.

Theme: Safe care and support

Safe care and support recognises that the safety of service users is paramount. A service focused on safe care and support is continually looking for ways to be more reliable and to improve the quality and safety of the service it delivers.

In a safe service, a focus on quality and safety improvement becomes part of a service-wide culture and is embedded in the service's daily practices and processes rather than being viewed or undertaken as a separate activity.

To achieve a culture of quality and safety everyone in the service has a responsibility to identify and manage risk and use evidence-based decision-making to maximise the safety outcomes for service users.

Outcome 6

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.

References:

Regulation 6: General Welfare and Protection
Standard 8: Protection
Standard 9: The Resident's Finances

Actions required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

Measures were in place to protect residents from being harmed or suffering abuse. No incidents, allegations or suspicions of abuse have been recorded or notified to the Authority in the preceding 12 months at this centre.

Documentation reviewed confirmed that all staff had received training on identifying and responding to elder abuse. Staff spoken with were able to inform the inspector of what constituted abuse and of their duty to report any suspected or alleged instances of abuse. Staff identified a senior manager as the person to whom they would report a suspected concern. However, refresher training in adult protection

had not been undertaken in line with the time frames outlined in the HSE policy on adult protection.

There was a centre-specific policy in place on the protection of residents from abuse. The policy defined the various types of abuse and outlined clear steps to investigate any issues should they arise. Protected disclosure procedures and a good faith reporting procedure to guide staff in their reporting of a suspicion of abuse were documented in the policy. The policy contained the contact details of the Health Service Executive (HSE) elder abuse case worker and a referral form to report matters should they arise.

The inspector reviewed four staff files. The outcome of Garda Síochána vetting was not available for staff in all files reviewed.

The systems in place to manage residents' finances were not reviewed during the course of this inspection.

Outcome 7
The health and safety of residents, visitors and staff is promoted and protected.

References:
Regulation 30: Health and Safety
Regulation 31: Risk Management Procedures
Regulation 32: Fire Precautions and Records
Standard 26: Health and Safety
Standard 29: Management Systems

Actions required from previous inspection:

Ensure, by means of fire drills and fire practices at suitable intervals, that the staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire, including the procedure for saving life.

Inspection findings

This action was not completed. There was an ongoing program of fire safety training arranged for 2013. Seventeen staff had completed training on the 15 April 2013. However, the inspector was not provided with evidence that all staff were trained in fire safety and evacuation annually. Not all staff were retrained in fire safety and evacuation procedures within the required time frame. Furthermore, records did not indicate fire drill practices were undertaken routinely. Not all staff had participated in fire drill practices within the past 12 months to reinforce their annual training and to ensure they are aware of the procedures to follow to include simulated evacuation and safe placement of all persons in the event of fire.

Notices were located at intervals around the building on the procedure to follow on hearing the alarm or discovering a fire. Fire exit signage was in place to indicate the location of fire exit doors and escape routes from the building. The inspector viewed

contracts which indicated the fire alarms, smoke and heat detectors and extinguishers were checked and serviced. Fire evacuation sheets were fitted to the beds of all residents. Residents had a fire evacuation plan in their plan of care.

The inspector reviewed the fire register. However, the register was not bound to secure pages. While the fire register recorded the number and type of fire equipment, the register was not maintained up to date. Records were not maintained for all fire alarm tests undertaken. The records could not clearly demonstrate what was checked and how often to ensure all fire equipment was in proper working order. They was no evidence of routine checks to ensure fire exits were unobstructed and all equipment was in place and intact.

The inspector viewed the infection control policy and found it provided appropriate guidance for staff when managing a range of infectious illness including noro virus, Clostridium difficile and influenza. The contact details for infection control team were provided. There was separate cleaning staff rostered each day of the week. A multi-task attendant was able to describe to the inspector the cleaning systems in place and how these worked in practice. Staff could access latex gloves and disposable aprons. Staff were observed using the alcohol hand gels which were available at the entrance to each bedroom and at wash hand basins in bedrooms. A separate color coded cleaning system was in place and the method to clean was explained to the inspector by the staff member assigned to cleaning. They were suitable chemicals available to clean spillages or other potentially infectious material. Two notification of an outbreak of infection was notified to the Authority as required by the Regulations in January and April 2012. All residents care was managed in the centre and no residents were transferred to an acute hospital. All residents sympotomatic recovered. However, there was no review of the situation to inform learning to minimse risk of future possible incidents.

A moving and handling assessment was available for each resident in case files reviewed. There was sufficient equipment available to assisting in moving and handling residents. A new overhead hoist tracking system was being installed and work was completed in seven bedrooms to date. Residents moving and handling assessments were printed and displayed discreetly on the inside of their wardrobe doors. However, not all staff had up-to-date moving and handling training as their current certificate of training had expired.

The was a service contract in place which covered breakdown and repair for all hoists, wheelchairs, beds, air mattresses and other equipment, used by residents. The inspector reviewed the records of servicing for equipment.

A centre-specific missing person’s policy was in place developed and a missing person’s file contained a photograph and biographical information on residents assessed as being at risk of leaving the centre unescorted. There was an alarm system in place to alert staff if a resident assessed as being at risk should leave the centre unaccompanied. Additional closed circuit television (CCTV) cameras were installed since the last inspection on the stair case and in the entrance lobby in the interest of residents’ safety.

There was a corporate and localised health and safety statement and policy in place aimed at promoting the health and safety of residents, visitors and staff. An organisational safety structure outlining reporting roles and lines of accountability was included in the health and safety procedures. A risk register was maintained and hazards identified on the risk register were forwarded to the provider. An example of systems in place to ensure residents safety included:

- handrails were provided on both sides of the corridors
- grab rails and call alarms were fitted in bathrooms
- floor covering in bedrooms and communal areas was safe
- restrictors were fitted to windows
- access to the sluice, cleaning and treatment room was secured in the interest of safety to residents and visitors
- the temperature of hot water was controlled to minimise the risk of scalds
- corridors were suitably wide and all parts of the building were bright and well lit.

The localised health and safety statement was not reviewed and updated regularly. Risk assessments were generally completed in the aftermath of an event. There was a limited pro-active approach to ongoing hazard identification. There were no routine checks to review control for existing hazards or to identify potential new hazards. There was no documentation of checks on work practices and the premises through regular audits to ensure a pro active response to minimise hazards occurring. There was limited documenting of identification of potential hazards with controls specified for physical aspects of the building in particular the care environment, communal areas and residents' bedrooms and bathrooms areas. The localised health and safety statement was not reviewed and updated regularly.

There was a risk management policy in place containing procedures to guide staff actions in the event of violence and aggression with further procedures outlined in the policy on challenging behaviour. However, there was not a specific policy with procedures to guide staff actions in the event of self harm.

An emergency plan was in place to guide staff in responding to untoward events. A designated senior person was nominated to be the contact point in the event of an emergency. The plan outlined clear procedures to follow in the event of various emergencies. Specific action instructions for each grade of staff were available. Contingency arrangement were provided for should it be deemed necessary to evacuate the building.

There were arrangements in place for recording and investigating untoward incidents and accidents. All incident and near miss events were recorded which were reviewed by the person in charge. Information recorded included factual details of the accident/incident, date and time event occurred, name and contact details of any witnesses and whether the GP and next of kin had been contacted. The inspector noted that falls and near misses were well described and that neurological observations and vital signs were checked and recorded.

Outcome 8
Each resident is protected by the designated centres' policies and procedures for medication management.

References:
Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines
Standard 14: Medication Management

Actions required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

There was a comprehensive medication management policy in place which provided guidance to staff to manage aspects of medication from ordering, prescribing, storing and administration. There was a signature bank available containing nurses and GP's signatures.

The inspector reviewed a sample of drugs charts. Photographic identification was available on the drugs chart for each resident to ensure the correct identity of the resident receiving the medication and reduce the risk of medication error. The maximum amount for PRN medication was indicated on the sample of prescription sheets viewed by the inspector.

The medication administration sheets viewed were signed by the nurse following administration of medication to the resident and recorded the name of the drug and time of administration. The drugs were administered within the prescribed timeframes. There was space to record when a medication was refused on the administration sheet. However, administration sheets were not secured to the prescription charts and were loosely placed in each resident's drug kardex.

Medicines were being stored safely and securely in the clinic room which was secured with a coded keypad. The temperature ranges of the medicine refrigerator was being monitored. A separate fridge was available to store specimens.

Medications that required strict control measures were kept in a secure cabinet which was double locked in keeping with the Misuse of Drugs (Safe Custody) Regulations. Nurses kept a register of controlled drugs. The inspector checked a selection of the balances and found them to be correct. Controlled drugs were checked and signed by two nurses however, they were only checked once daily and not at the change of each shift.

Theme: Effective care and support
The fundamental principle of effective care and support is that it consistently delivers the best achievable outcomes for people using a service within the context of that service and resources available to it. This is achieved by using best available national and international evidence and ongoing evaluation of service-user outcomes to determine the effectiveness of the design and delivery of care and support. How this care and support is designed and delivered should meet service users' assessed needs in a timely manner, while balancing the needs of other service users.

Outcome 10
The quality of care and experience of the residents are monitored and developed on an ongoing basis.

References:
Regulation 35: Review of Quality and Safety of Care and Quality of Life
Standard 30: Quality Assurance and Continuous Improvement

Actions required from previous inspection:

Make a report in respect of any review conducted by the registered provider for the purposes of Regulation 35, and make a copy of the report available to residents and, if requested, to the Chief Inspector.

Consult with residents and their representatives in relation to the system for reviewing and improving the quality and safety of care, and the quality of life of residents.

Inspection findings

The person in charge demonstrated a positive attitude to the value of audit and had in place a number of tools to monitor the quality of care provided.

Audits had been undertaken in relation to a range of topics that included medication management, accidents and incidents, care plans, restraint practices, hand hygiene and environmental audits. Documentation reviewed by the inspector confirmed that audits were carried out on a regular basis. However, there was no audit of infection control outbreaks to inform learning to minimise the risk of possible further events.

The clinical data collected was assessed to assist observation of trends. Reports on the findings were submitted to the provider. However, while significant data was collected, developing and implementing improvements plans to ensure enhanced outcomes for residents was limited. A system of action taken required to respond to findings was not fully established.

Outcome 11

Each resident's 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 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.

References:

Regulation 6: General Welfare and Protection
Regulation 8: Assessment and Care Plan
Regulation 9: Health Care
Regulation 29: Temporary Absence and Discharge of Residents
Standard 3: Consent
Standard 10: Assessment
Standard 11: The Resident's Care Plan
Standard 12: Health Promotion
Standard 13: Healthcare
Standard 15: Medication Monitoring and Review
Standard 17: Autonomy and Independence
Standard 21: Responding to Behaviour that is Challenging

Actions required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

There were five residents residing in the centre on a long-term basis. The remaining residents were accommodated in the centre on a short-term basis for convalescent, respite or palliative care.There were 32 residnets accommodated in the centre at the time of inspection. There were 20 residents with total or maximum care needs. Eight residents were assessed as moderately dependent. Many residents were noted to have a range of healthcare issues and the majority had more than one medical condition.

The arrangements to meet residents' assessed needs were set out in individual care plans. The centre used an electronic record management system and in conjunction with a registered nurse, the inspector reviewed a sample of two care plans in detail and certain aspects within other plans of care. A checklist was completed on admission for all residents and review dates for future assessments were entered into the electronic record management system. A reminder prompted staff when routine reviews were due. Recognised assessment tools were used. These included risk assessments for falls, moving and handling, nutrition, tissue viability and cognitive functioning. There was a record of the resident's health condition and treatment given completed daily. The sample of care plans reviewed confirmed that each resident's weight was checked on a monthly basis or more frequently if required. Some residents were weighed weekly in the sample reviewed. Nutrition

assessments were used to identify residents at risk of malnutrition and daily intake charts were completed for each resident at risk.

While care plans were regularly reviewed risk assessments were not updated at the required intervals to inform care plans developed or reviewed. Additionally reviews did not always outline the conclusion or judgment on the care pathway being followed. There was evidence in the sample of care plan examined they were agreed with the resident or their representative. There were some good examples of person-centred care plans, however, this was not uniformly the case. Some plans of care were generic in nature. The interventions outlined were not specific enough to guide staff actions and interventions in the delivery of quality, safe care for each resident. An example of this is discussed further in the report on restraint management.

All residents remained under the care of their own general practitioners (GPs) and a total of six GPs visited the centre. The sample of medical records reviewed confirmed that the health needs and medications of residents were being monitored on an ongoing basis and no less frequently than at three-monthly intervals. There was an established and agreed a rota with the GP's to visit on certain days each week to see residents in their care for routine checks. This was evidenced on reviewing medical files. There was evidence of referral to allied services such as physiotherapy and occupational therapy. Records indicated residents received the flu vaccine and a checklist was maintained for all short-term care resident to record their vaccine status. A chiropodist attended the centre routinely.

There was limited access to speech and language services. There were a number of residents on modified consistency diets. Nursing staff and the person in charge confirmed that the residents had not been seen by a speech and language therapist in all cases since commencement of specialised diets. There was limited evidence in files reviewed of access to speech and language therapy. While all residents on specialised diets had care plans for eating and drinking in place and nursing staff were pro active in assessing residents to ensure their diet consistency was suitable specialist input was not available to their support decision making.

There was one resident with a wound on the day of inspection. The inspector reviewed the resident's wound care plan. There was a plan of care to guide staff on the provision of pain relief, dressings and movement. There was an assessment completed for the wound. The inspector viewed evidence of mutlidisciplinary input in to the resident's care. The wound care plan was developed following review by a wound specialist. Advice in relation to the type of dressing to apply to the wound and frequency of changing was being adhered to by nursing staff. From speaking with the clinical nurse manager and on review of the wound documentation, to include measurements it was clear that this wound was improving.

The policy on restraint was based on the national policy and the person in charge and clinical nurse manager were keen to promote a restraint free environment. There was a high level of awareness of restraint safety. Stickers were provided to all bed where bedrails were not integrated into the bed to ensure the safe positioning of the bedrail. A restraint record was maintained daily. The documentation recorded the type of restraint and the time the restraint measure was secured and released. All residents with a restraint measure were checked at half hourly intervals. There was a

risk assessment completed prior to the use of the restraint and assessments were regularly revised. Signed consent was obtained by the resident or their representative. Eight low-low beds and crash mattress had been obtained since the last inspection. However, not all nursing staff who complete the restraint risk assessments and care plans were trained on best practice in promoting a restraint free environment. Many of the restraint care plans were generic and did not outline individual interventions in restraint management well. There was limited evidence of other health professionals involvement in the concluding decision to use bedrails where restraint was deemed necessary as part of resident care.

The dedicated activity coordinator has resigned from her post. The person in charge advised that a replacement activity coordinator was being recruited and awaiting Garda Síochána vetting prior to commencement in post. However, there was limited activity provision while awaiting this post to be filled. Residents were facilitated to practice their religious beliefs and mass took place each week and an oratory was available to residents.

Outcome 12
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. There is appropriate equipment for use by residents or staff which is maintained in good working order.

References:
Regulation 19: Premises
Standard 25: Physical Environment

Actions required from previous inspection:

Ensure the physical design and layout of the premises meets the needs of each resident, having regard to the number and needs of the residents.

Inspection findings

There were five single bedrooms, each with an en suite toilet, shower and wash-hand basin. There are two twin bedrooms and eight bedrooms each accommodating four residents. Staff had made efforts to make the environment as homely as possible. This was most evident in single and twin-bedded rooms. There was evidence of photographs, ornaments and other personal mementos within the vicinity of beds where residents were receiving continuing care. One resident in the centre a number of years was provided with additional storage cupboards. However, not all continuing care residents were accommodated in single or twin rooms. The four-bedded rooms were more clinical in nature and provided only limited space for residents' belongings. While this was not an issue for residents receiving convalescent, respite and rehabilitative care, it did impact on residents receiving continuing care to ensure privacy and dignity was fully maintained.

Theme: Person-centred care and support
Person-centred care and support has service users at the centre of all that the service does. It does this by advocating for the needs of service users, protecting their rights, respecting their values, preferences and diversity and actively involving them in the provision of care. Person-centred care and support promotes kindness, consideration and respect for service users' dignity, privacy and autonomy.

Outcome 13
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.

References:
Regulation 39: Complaints Procedures
Standard 6: Complaints

Actions required from previous inspection:

Maintain a record of all complaints detailing the investigation and outcome of the complaint and whether or not the resident was satisfied.

Inspection findings

The inspector reviewed the complaints log for the past 12 months which contained two complaints. The log contained the facility to record all relevant information about the complaint, investigation made and the outcome. The complaints were resolved to the complainant satisfaction. No complaints were being investigated at the time of inspection.

The complaints procedure was prominently displayed within the centre and also described in the Residents' Guide and the statement of purpose. The person in charge explained issues of concern are addressed immediately at local level without recourse to the formal complaints procedure, unless the complainant wishes otherwise. This ethos was outlined in the complaints policy.

The inspector reviewed the complaints procedure and noted it did not meet all the requirements of the Regulations. Timescales were outlined in the policy to acknowledge a complaint, investigate or inform a complainant of the outcome of their complaint. However, a designated individual was not nominated with overall responsibility to investigate complaints in the centre. Two people were identified to whom complaints could be submitted, namely the person in charge and an individual in the consumer services offices. A nominated person who would monitor that the complaints process was followed and recorded (independent of the person responsible to investigate the complaint) was not clearly identified in the local complaints procedure. The independent appeals process if the complainant was not satisfied with the outcome of their complaint was not clear. The procedures referred residents to two agencies, one being the Authority which does not assist to resolve issues of concern on behalf of residents.

Theme: Workforce
The workforce providing a health and social care and support service consists of all the people who work in, for, or with the service provider and they are all integral to the delivery of a high quality, person-centred and safe service. Service providers must be able to assure the public, service users and their workforce that everyone working in the service is contributing to a high quality safe service.

Outcome 18
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.

References:
Regulation 16: Staffing
Regulation 17: Training and Staff Development
Regulation 18: Recruitment
Regulation 34: Volunteers
Standard 22: Recruitment
Standard 23: Staffing Levels and Qualifications
Standard 24: Training and Supervision

Actions required from previous inspection:

No actions were required from the previous inspection.

Inspection findings

The provider employs 56 staff in total which includes a whole-time equivalent of 15 registered nurses and 19 care assistants. The inspector viewed the staff duty rota for a four week period. The rota showed the staff complement on duty over each 24-hour period. However, the staff roster was not clear as it did not detail staff positions or their full name. An actual and planned roster was not available. Changes were made to the planned copy of the rota. Furthermore, the rota was not outlined in the 24 hour clock format and shifts were denoted numerically by the number of hours worked. Therefore it was difficult to establish when some shifts commenced and finished. The inspector confirmed through observation the staff rota matched the staffing levels on duty. Annual leave and other planned/unplanned staff absences were covered from within the existing staffing complement.

The inspector reviewed and discussed the staffing levels with the person in charge. There was sufficient nursing staff rostered each day of the week. During the week there are four nurses in addition to a clinical nurse manager and the person in charge. There is a minimum of four nurses rostered each day of the week until 6pm and generally three until 8pm. There are two nurses and a carer rostered for duty each night. The majority of residents are admitted for short-term care and there is a high admission and discharge activity requiring a considerable amount of clinical

care input. There were 76 admission and 68 discharges of residents for the first quarter of 2013. While the inspector concludes the nurse staff complement was satisfactory at the time of inspection, the nursing team were busy overall. The person in charge confirmed in consultation with management she has reduced the number of occupied beds on a short-term basis in the interest of residents safety during peak holiday times in the past. There was separate cleaning and catering staff available and rostered each day of the week.

However, on this visit the inspector was not satisfied by observing practice, reviewing the rota and taking account of the resident profile, adequate care assistant staff levels were not available to meet the needs of residents. While the person in charge had secured some additional care hours, on average there was three care assistant rostered most days to meet the needs of residents. Considering the numbers of residents and their frailty, there were 20 residents with total or maximum care needs the inspector was concerned of the potential to compromise safety. Staff levels did not allow comfortable, flexible routines for residents. The majority of residents required assistance to get up, wash and dress, and retire to bed.

Records were maintained which conveyed that staff had access to ongoing education and a range of training was provided. A range of professional development training was undertaken. This included cardio pulmonary resuscitation (CPR) techniques, hand hygiene and infection control. All staff nurses had completed training in medication management. However, the maintenance of staff training records required review. The documentation provided to the inspector was difficult to review/verify the number of staff who had attended training and assess the suitability of the training content and determine who had provided the training in some cases.

A sample of four staff files were examined to assess the documentation available, in respect of persons employed. All the information required by Schedule 2 of the Regulations was not available in the staff files reviewed. Evidence of Garda Síochana vetting and three references was not available in each of the staff files examined. A record of An Bord Altranais PINs (professional identification numbers) for all registered nurses was maintained.

Closing the visit

At the close of the inspection visit a feedback meeting was held with the person in charge, and the nurse manager to report on the inspectors' findings, which highlighted both good practice and where improvements were needed.

Acknowledgements

The inspectors wish to acknowledge the cooperation and assistance of the residents, relatives, provider and staff during the inspection.

Report compiled by:

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Regulation Directorate
Health Information and Quality Authority

9 May 2013

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 *

Centre Name:	Killybegs Community Hospital
Centre ID:	0620
Date of inspection:	17 April 2013
Date of response:	7 June 3013

Requirements

These requirements set out the actions that must be taken to meet the requirements of the Health Act 2007 as amended, 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*.

Theme: Governance, Leadership and Management

Outcome 4: Records and documentation to be kept at a designated centre

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

The fire register was not bound to secure pages.

The maintenance of staff training records required review. The documentation provided to the inspector was difficult to review/verify the number of staff who had attended training and assess the suitability of the training content and determine who had provided the training in some cases.

Administration sheets were not secured to the prescription charts and were loosely placed in each resident's drug kardex.

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

Action required: Maintain the records listed under Schedule 4 (general records) of the Regulations in a manner so to ensure completeness, accuracy and ease of retrieval.	
Reference: Health Act, 2007 Regulation 22: Maintenance of Records Standard 32: Register and Residents' Records	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The HSE nationally are developing a new version of fire register which will be available for 2014. The current fire register will be maintained in a ring binder until this becomes available. Since the Inspection a new Computerised System for maintaining Staff Training Records has been implemented. Administration sheets are not secured to the Drug Kardex. This is because as the administration sheets are completed they are filed in residents notes. All administration sheets have residents details recorded on them. These are audited monthly.	Completed May 2013 Completed

Theme: Safe care and support

Outcome 6: Safeguarding and safety

The provider is failing to comply with a regulatory requirement in the following respect: Refresher training in adult protection had not been undertaken in line with the time frames outlined in the HSE policy on adult protection.
Action required: Make all necessary arrangements, by training staff or by other measures, aimed at preventing residents being harmed or suffering abuse or being placed at risk of harm or abuse.
Reference: Health Act, 2007 Regulation 6: General Welfare and Protection Standard 8: Protection Standard 9: The Resident's Finances

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: A second Staff Nurse has under gone Train the Trainer Training in Elder abuse on June 14th to support the training programme all staff will have received training by December. A monthly training session will be put in place and all Staff will be trained by October 2013	October 2013

Outcome 7: Health and safety and risk management

The provider is failing to comply with a regulatory requirement in the following respect: Not all staff were retrained in fire safety and evacuation procedures within the required time frame. Not all staff had participated in fire drill practices within the past 12 months to reinforce their annual training. The fire register was not maintained up-to-date. Records were not maintained for all fire alarm tests undertaken. The records could not clearly demonstrate what was checked and how often to ensure all fire equipment was in proper working order. They was no evidence of routine checks to ensure fire exits were unobstructed.
Action required: Provide suitable training for staff in fire prevention.
Action required: Ensure, by means of fire drills and fire practices at suitable intervals, that the staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire, including the procedure for saving life.
Action required: Maintain, in a safe and accessible place, a record of all fire practices which take place at the designated centre.
Action required: Maintain, in a safe and accessible place, a record of all fire alarm tests carried out at the designated centre together with the result of any such test and the action taken to remedy defects.

Reference: Health Act, 2007 Regulation 32: Fire Precautions and Records Standard 26: Health and Safety	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Four fire training sessions have been scheduled, 2 in July, 2 in November this includes evacuation training and use of Fire Extinguishers. In House Evacuation skills have occurred on 2nd and 22nd May and will continue on a monthly basis. The Fire Register is maintained on a daily/weekly/monthly/yearly basis as indicated by the fire register. Hose reels, fire hydrants, Fire Fighting Equipment is maintained as per guidelines. An additional daily check list has been included in the fire register to record when fire exits are checked for obstructions. A nominated person has been allocated to carry out daily checks.	December 2013 Completed Completed

The provider is failing to comply with a regulatory requirement in the following respect: Not all staff had up-to-date moving and handling training as their current certificate of training had expired.	
Action required: Provide training for staff in the moving and handling of residents.	
Reference: Health Act, 2007 Regulation 31: Risk Management Procedures Standard 26: Health and Safety Standard 29: Management Systems	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Since the Inspection 5 additional staff have received in Moving and Handling Training.	October 2013

Four additional Training Dates have been arranged for June July August and September. Those whom certificates have expired will be targeted first. Going forward staff will maintain up to date Moving and Handling Certificates. Further training dates have been requested.	

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

There were no routine checks to review control for existing hazards or to identify potential new hazards through auditing.

There was no documentation of checks on work practices and the premises through regular audits to ensure a pro active response to minimise hazards.

There was limited documenting of identification of potential hazards with controls specified for physical aspects of the building in particular the care environment, communal areas and residents' bedrooms and bathrooms areas.

There was not a specific policy with procedures to guide staff actions in the event of self harm.

Action required:

Put in place a comprehensive written risk management policy and implement this throughout the designated centre.

Action required:

Ensure that the risk management policy covers, but is not limited to, the identification and assessment of risks throughout the designated centre and the precautions in place to control the risks identified.

Action required:

Take all reasonable measures to prevent accidents to any person in the designated centre and in the grounds of the designated centre.

Action required:

Ensure that the risk management policy covers the precautions in place to control the following specified risks, self-harm.

Reference:

Health Act, 2007
Regulation 31: Risk Management Procedures
Standard 26: Health and Safety
Standard 29: Management Systems

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: A risk management policy exists within Killybegs Community Hospital, which includes a Health & Safety Statement, a Risk Register, HACCP Regulations, Quality Risk & Safety Review Group, System of Audit, review of Incidents/ Accidents & Complaints and Infection Control, and Schedule 5 Policies and Procedures. A review of Health & Safety Statement is currently underway. The Risk Management Policy will be reviewed to include a protocol to follow in the event of potential or actual self harm. A checklist has been developed to check routine hazards. Further work is ongoing to produce a monitoring form for clinical risks.	Completed Completed 1st July 2013

The provider is failing to comply with a regulatory requirement in the following respect: The localised health and safety statement was not reviewed and updated regularly.
Action required: Put in place written operational policies and procedures relating to health and safety; including food safety of residents, staff and visitors.
Reference: Health Act, 2007 Regulation 30: Health and Safety Standard26: Health and Safety

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: A comprehensive review of our current Safety Statement took place on 29.05.13. An Action Plan has been developed to implement changes.	Completed

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

There had been no review of the episodes of infection outbreak that had occurred in the recent past. In view of the number of residents impacted the inspector formed the view that a review of these incidents should be completed to ensure that any learning from the management of the outbreaks is identified and circulated to staff as part of good practice in risk management and learning from untoward incidents.

Action required:

Ensure that the risk management policy covers the arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents.

Action required:

Undertake a review of the recent occurrences of noro virus and influenza and provide the Authority's inspectors with a copy of the report.

Reference:

Health Act, 2007
Regulation 31: Risk Management Procedures
Standard 26: Health and Safety
Standard 29: Management Systems
Regulation 31: Risk Management Procedures

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Following each episode of an infectious outbreak a verbal review was conducted between Hospital staff and the Infection Control team. After speaking to the infection control/Public Health team, going forward after each outbreak a review will be conducted and documented. After each recent outbreak the infection control Nurse Specialist was happy that no untoward incident had been responsible for any outbreak. The Registered Provider in consultation with The Public Health Team is undertaking a review of all infectious outbreaks in Donegal Community Hospitals. The risk management policy will be reviewed to cover monitoring of risks on a weekly basis. (appendix 1).	30/09/2013

Outcome 8: Medication management

The provider is failing to comply with a regulatory requirement in the following respect: Controlled drugs were only checked once daily and not at the change of each shift.	
Action required: Put in place appropriate and suitable practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents and ensure that staff are familiar with such policies and procedures.	
Reference: Health Act, 2007 Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines Standard 14: Medication Management	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: All Nursing Staff now check controlled drugs at the end of each shift with one staff from each shift. This was audited in May with 100% compliance.	April 2013

Theme: Effective care and support

Outcome 10: Reviewing and improving the quality and safety of care

The provider is failing to comply with a regulatory requirement in the following respect: While significant data was collected, developing and implementing improvements plans to ensure enhanced outcomes for residents was limited. A system of action taken required to respond to findings was not fully established. There was no audit of infection control outbreaks to inform learning to minimise the risk of possible further events.
Action required: Establish and maintain a system for reviewing the quality and safety of care provided to, and the quality of life of, residents in the designated centre at appropriate intervals.

Reference: Health Act, 2007 Regulation 35: Review of Quality and Safety of Care and Quality of Life Standard 30: Quality Assurance and Continuous Improvement	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Quality and safety issues are reviewed at the local risk management meeting and action plan developed. The Registered Provider in consultation with the Public Health team is undertaking a review of all infectious outbreaks within Donegal Community Hospitals.	 June 2013 30/09/2013

Outcome 11: Health and social care needs

The person in charge is failing to comply with a regulatory requirement in the following respect: Some plans of care were generic in nature. Risk assessments were not updated at the required intervals to inform care plans developed or reviewed. Reviews did not always outline the conclusion or judgment on the care pathway being followed.	
Action required: Keep each resident's care plan under formal review as required by the resident's changing needs or circumstances, as and no less frequent than at three-monthly intervals.	
Action required: Set out each resident's needs in an individual care plan developed and agreed with the resident.	
Reference: Health Act, 2007 Regulation 8: Assessment and Care Plan Standard 3: Consent Standard 10: Assessment Standard 11: The Resident's Care Plan	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**

Provider's response: All Risk assessments are updated within the required time frames. All Care Plans have been reviewed and are individualised and agreed with the resident. Monthly audits are carried out on Nursing Documentation. The audit results and any points highlighted within the audit that require improvement are passed on to Nursing Staff and are part of the action plan. Care plans will be reviewed by CNMI / II on a weekly basis.	Completed Ongoing

The provider is failing to comply with a regulatory requirement in the following respect: There was limited access to speech and language services.
Action required: Facilitate all appropriate health care and support each resident on an individual basis to achieve and enjoy the best possible health.
Reference: Health Act, 2007 Regulation 9: Health Care Standard 13: Healthcare Standard 15: Medication Monitoring and Review

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Having spoken to the Manager of the Speech and Language Department a protocol/Guideline for the appropriate referral of clients will be drawn up and implemented within Killybegs Community Hospital.	01/07/2013

The provider is failing to comply with a regulatory requirement in the following respect: There was limited activity provision while awaiting the post of the activity coordinator to be filled.

Action required: Provide opportunities for each resident to participate in activities appropriate to his/her interests and capacities.	
Reference: Health Act, 2007 Regulation 6: General Welfare and Protection Standard 13: Healthcare Standard 18: Routines and Expectations	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: An activity person has been appointed and is awaiting Garda vetting. An individualised programme of activities will be provided once this appointment is in place. In the mean time residents are accommodated in the Day Hospital Activities programme, and in the ward area.	Completed

The person in charge is failing to comply with a regulatory requirement in the following respect: Many of the restraint care plans were generic and did not outline individual interventions in restraint management well. There was limited evidence of other health professionals involvement in the concluding decision to use bedrails.	
Action required: Put in place appropriate and suitable practices relating to the restraints in accordance with evidence-based practice.	
Reference: Health Act, 2007 Regulation 8: Assessment and Care Plan Regulation 6: General Welfare and Protection Standard 11: The Resident's Care plan	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Restraint/restraint free training for all staff will be completed by the end of the year, care plan reviews will be on a multi-disciplinary basis as required.	December 2013

Outcome 12: Safe and suitable premises

The provider is failing to comply with a regulatory requirement in the following respect: The four-bedded multiple-occupancy rooms were clinical in nature and provided only limited space for residents.
Action required: Ensure the physical design and layout of the premises meets the needs of each resident, having regard to the number and needs of the residents.
Action required: Provide suitable premises for the purpose of achieving the aims and objectives set out in the statement of purpose, and ensure the location of the premises is appropriate to the needs of residents.
Reference: Health Act, 2007 Regulation 19: Premises Standard 25: Physical Environment

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The registered provider and Person in Charge have been in discussion with the Estates Department. A Plan to relocate the residents to one residential area within the hospital is currently being developed. In consultation with Donegal Town Community Hospital.	30/07/2013

Theme: Person-centred care and support

Outcome 13: Complaints procedures

The provider is failing to comply with a regulatory requirement in the following respect: The complaints procedure and noted it did not meet all the requirements of the regulations.
Action required: Make available a nominated person in the designated centre to deal with all complaints.

Action required:

Make a person available, independent to the person nominated in Regulation 39(5), to ensure that all complaints are appropriately responded to and that the person nominated under Regulation 39(5) maintains the records specified under Regulation 39(7).

Action required:

Ensure the complaints procedure contains an independent appeals process, the operation of which is included in the designated centre's policies and procedures.

Reference:

Health Act, 2007
Regulation 39: Complaints Procedures
Standard 6: Complaints

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response:	
The Director of Nursing (person in charge) is the nominated person available within the hospital to deal with complaints this is clearly indicated in the complaints procedures.	Completed
The CNM II from the Day Hospital will monitor complaints within the hospital.	Completed
The complaints policy will be amended to reflect schedule Regulation 39.	July 2013

Theme: Workforce

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

The staff roster was not clear as it did not detail staff positions or their full name. An actual and planned roster was not available.

The rota was not outlined in the 24 hour clock format and shifts were denoted numerically by the number of hours worked. Therefore, it was difficult to establish when some shifts commenced and finished.

Action required:

Maintain a planned and actual staff rota, showing staff on duty at any time during the day and night.

Reference: Health Act, 2007 Regulation 16: Staffing Standard 23: Staffing Levels and Qualifications	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Staff rosters will be amended to reflect the 24 hour clock staff names and grade.	30/06/2013

The provider is failing to comply with a regulatory requirement in the following respect: All the information required by Schedule 2 of the Regulations was not available in the staff files reviewed. Evidence of Garda Síochána vetting and three references were available in each of the staff files examined.
Action required: Put in place recruitment procedures to ensure that no staff members are employed in the designated centre unless they are physically and mentally fit for the purposes of the work which they are to perform.
Reference: Health Act, 2007 Regulation 18: Recruitment Standards 22: Recruitment

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: All Schedule 2 documents have been requested and will be in place by 01.08.2013.	01/082013

The provider is failing to comply with a regulatory requirement in the following respect: Not all nursing staff who complete the restraint risk assessments and care plans were trained on best practice in promoting a restraint free environment.

Action required: Provide staff members with access to education and training on best practice in caring for people with behaviour that challenges and infection control and hand hygiene to enable them to provide care in accordance with contemporary evidence-based practice.	
Reference: Health Act, 2007 Regulation 17: Training and Staff Development Standard 24: Training and Supervision	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: A schedule of training on restraint free environment is in place All staff will be trained by the end of the year.	December 2013

The person in charge is failing to comply with a regulatory requirement in the following respect: On this visit the inspector was not satisfied by observing practice, reviewing the rota and taking account of the resident profile, adequate care assistant staff levels were available to meet the needs of residents.	
Action required: Ensure that the numbers and skill mix of staff are appropriate to the assessed needs of residents, and the size and layout of the designated centre.	
Reference: Health Act, 2007 Regulation 16: Staffing Standard 23: Staffing Levels and Qualifications	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Staffing levels and skill mix are kept under constant review, an escalation policy exists to manage any risks associated with reductions in staffing levels. Two additional care assistant staff have been seconded from the Home Help Service.	