### Health Information and Quality Authority Regulation Directorate

#### Compliance Monitoring Inspection report

**Designated Centres under Health Act 2007, as amended**

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Midleton Community Hospital</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000579</td>
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<tr>
<td>Centre address:</td>
<td>Midleton, Cork.</td>
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<tr>
<td>Telephone number:</td>
<td>021 463 5300</td>
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<tr>
<td>Email address:</td>
<td><a href="mailto:midletonch@hse.ie">midletonch@hse.ie</a></td>
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<tr>
<td>Type of centre:</td>
<td>The Health Service Executive</td>
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<tr>
<td>Registered provider:</td>
<td>Health Service Executive</td>
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<tr>
<td>Provider Nominee:</td>
<td>Patrick Ryan</td>
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<tr>
<td>Lead inspector:</td>
<td>Mary O'Mahony</td>
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<tr>
<td>Support inspector(s):</td>
<td>Vincent Kearns</td>
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<tr>
<td>Type of inspection:</td>
<td>Announced</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>52</td>
</tr>
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<td>Number of vacancies on the date of inspection:</td>
<td>1</td>
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About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration renewal decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times
From: To:
02 October 2014 09:00 02 October 2014 19:00
03 October 2014 08:30 03 October 2014 18:30

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

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Summary of findings from this inspection
This registration renewal inspection of Midleton Community Hospital was announced and took place over two days. The hospital was originally built as a workhouse in 1841, this was now called the 'back hospital'. A newer section of the building, the 'front hospital', was opened in 1937. Both buildings were run as a district hospital by the Sisters of Mercy from that date. At the time of inspection it was run by the Health Service Executive (HSE) and provided long-stay, respite and convalescent care to the older population of Midleton and the surrounding area. The hospital was set on a seven acre site and provided a range of services on site including a day centre, physiotherapy, occupational therapy, podiatry, dietician services, public health nursing and a mental health day hospital. The main entrance was through the...
front hospital where the administration offices were located. The centre was initially registered to cater for 66 residents. This number had been reduced to 53 residents in an effort to provide for enhanced privacy and dignity of residents. Residents were accommodated between the two buildings which will be described in more detail under outcome 12: Premises. As part of the inspection, inspectors met with the person in charge, management personnel, residents, relatives, nursing staff, kitchen staff and multi-task attendants. Inspectors observed care practices and reviewed documentation such as care plans, medical records, accident and incident records, policies, fire safety records, training records and staff files.

The findings of the inspection are set out under 18 outcome statements. These outcomes are based on the requirements of 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. The person in charge was in her post since 2007. She was found to be an experienced nurse manager who was involved in the day-to-day running of the centre and was found to be easily accessible to residents, relatives and staff. There was evidence of individual resident's needs being met and the staff supported residents to maintain their independence where possible. The inspector found the premises, fittings and equipment were in good repair overall. However, there were numerous issues of non compliance in relation to the design and layout of areas of the premises as regards the legislative requirement to protect and promote the privacy and dignity of residents. The feedback on the pre-inspection questionnaires from residents and relatives was one of satisfaction with the service and care provided. Family, friends and community involvement was encouraged and relatives, with whom the inspector spoke, confirmed this.

Improvements were required in the areas of safeguarding and safety: health and safety and risk management: medication management: notification of incidents: health and social care needs: safe and suitable premises: complaints procedure: residents' rights dignity and consultation: residents' clothing and personal property and staffing. The initial action plan, concerning premises and the impact of the layout and design on the privacy and dignity of residents, which the provider submitted to the Authority, was not satisfactory. The provider was asked to submit a revised action plan concerning premises and this was also unsatisfactory.
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 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

**Outcome 01: Statement of Purpose**
There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

**Theme:**
Governance, Leadership and Management

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

**Findings:**
The statement of purpose and function information booklet was viewed by inspectors. It described the service and facilities provided in the centre. It contained the information required in Schedule 1 of the Regulations and also outlined the aims, objectives and ethos of the centre. The statement of purpose was found to be comprehensive and it met the requirements of legislation. It was available for all visitors and residents in the reception area of the centre.

**Judgment:**
Compliant

**Outcome 02: Governance and Management**
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.

**Theme:**
Governance, Leadership and Management

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

**Findings:**
The quality of care of residents was monitored and developed on an ongoing basis. Effective management systems were seen to be in place in the centre during the inspection. The person in charge assured inspectors that there were sufficient resources in place to ensure the delivery of safe and quality care to the residents with the present skill mix and staffing levels. The person in charge was supported by two experienced
clinical nurse managers (CNMs). There were clear lines of authority and accountability. There were daily care handover meetings and all grades of staff were included in these. Inspectors saw evidence of staff meetings and saw that any issues arising were addressed. Improvements were seen to have occurred as a result of the learning from the outcome of audits. The person in charge informed inspectors that she is expanding her audits to other relevant areas which she had identified.

There was evidence of consultation with residents and their relatives. Inspectors spoke with residents who said that there were residents' meetings held in the centre. Relatives spoke with inspectors about the fact that staff frequently consult with them if there was a change in the status of the resident or if any accident happened. Relatives and residents were familiar with the person in charge and with her role and were able to identify her by name to inspectors. Inspectors viewed the details of residents' surveys, the minutes of residents' meetings and the pre inspection questionnaires for this inspection. These indicated a person-centred approach to the care and quality of life of the residents.

**Judgment:**
Compliant

**Outcome 03: Information for residents**
A guide in respect of the centre is available to residents. Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

**Theme:**
Governance, Leadership and Management

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

**Findings:**
The Resident's Guide was seen by inspectors and this was available to all residents. It was placed prominently in the hallway of the centre and was easily accessible. Contracts of care had been implemented for residents and a sample of these contracts was viewed by inspectors. The contracts were comprehensive and contained the required details under the Regulations such as: the fees to be charged and how the care and welfare of residents would be met. The contracts had recently been updated to include the cost of additional services. There was relevant information available for residents on notice boards and in newsletters in the centre.

**Judgment:**
Compliant

**Outcome 04: Suitable Person in Charge**
The designated centre is managed by a suitably qualified and experienced person with
authority, accountability and responsibility for the provision of the service.

Theme:
Governance, Leadership and Management

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

Findings:
The person in charge was an experienced nurse manager and was actively involved in the day-to-day organisation and management of the service. Staff, residents and relatives all identified the person in charge as the person with the overall authority and responsibility for the delivery of care. She was found to be committed to providing person-centred care to residents and was employed full time. She demonstrated good insight into the responsibilities of her role in leading the care and welfare of the residents. She was engaged in continuous professional development including post graduate qualifications in gerontology nursing and health services management.

Judgment:
Compliant

Outcome 05: Documentation to be kept at a designated centre
The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:
Governance, Leadership and Management

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

Findings:
Records required under the Regulations were maintained in the centre. The records were securely stored and the person in charge assured inspectors that residents had access to their files if necessary. Records of inspections by other bodies were maintained. Inspectors viewed a selection of residents’ care plans. Each care plan outlined the social and medical needs of the resident and recognised tools were used to assess the medical, physical and psychological needs of residents. There was evidence of input from, and assessments by, allied health professionals, where necessary. Inspectors found that the care plans contained information about residents' holistic needs and there was evidence that the plans were individualised. There were centre
specific policies which were updated and reviewed when required and these included the policies specified in Schedule 5 of the Regulations. Staff demonstrated an understanding of these and inspectors viewed a signature sheet for staff to sign when the policies were read. However, inspectors noted that not all the policies were implemented for example, the policy on used or out of date medications, the procedures to be followed in the event of an allegation of abuse and the policy on complaints.

The centre was adequately insured against injury to residents according to the insurance certificate viewed by inspectors. Fire safety records were seen and were found to have met the requirements of the regulations as regards, training, testing and maintenance of the system. Inspectors viewed a sample of staff files and found that they were maintained in good order. There was a policy for volunteers in the centre and guidelines were set out for the parameters of the role and the responsibilities attached. However, inspectors noted that this document was not signed by the volunteer, in the personnel file seen. This was addressed under outcome 18: Staffing. The staff roster was viewed and inspectors saw that it correlated with the staffing levels which the person in charge had outlined. Inspectors viewed the directory of residents. Records for this were stored in separate files but were amalgamated for ease of retrieval while inspectors were on the premises. Documentation was seen by inspectors which indicated that residents' right to refuse treatment was documented, where this occurred and there were records available to indicate that discussions were held with residents and their representatives about CPR (Cardio-Pulmonary-Resuscitation). Inspectors were shown an up-to-date complaints and incident book. Complaints were documented in the complaints book and they were investigated. However, inspectors viewed a sample of complaints recorded which indicated that allegations, which could be construed as allegations of abuse, had been investigated under the complaints policy and had not followed the procedures set out in the centre's policy on the prevention of elder abuse. In addition, the Authority had not been notified of these allegations, within the specified timeframe, as set out in legislation. Nevertheless, the required documentation was forwarded to the Authority following inspection. These failings will be addressed under outcome 7: Safeguarding and Safety and outcome 10: Notifications.

Training records were maintained in the centre however, these were not up to date and did not indicate that all appropriate training had been provided to staff. This will be addressed under outcome 18: Staffing: The centre utilised a daily flow chart for recording care given to residents. However, inspectors noted that this was not fully completed for a resident with a specific medical condition. In some instances there were nursing notes recorded of health conditions and medical treatment given on a supporting 'communication' sheet. Inspectors noted however, that in a sample of files checked there were extended gaps in recording, in one case a period of four months had elapsed since an additional nursing note was written in this 'communication' sheet for a resident. This system of recording health conditions and medical care did not comply with the requirement of Regulation 21, Schedule 3, 4 (c) of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 or with the guidelines as set out in An Bord Altranais agus Cnaimhseachais na hEireann "Recording Clinical Practice Guidance for Nurses and Midwives" 2002.

Judgment:
Non Compliant - Moderate
### Outcome 06: Absence of the Person in charge

The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.

**Theme:**
Governance, Leadership and Management

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

**Findings:**
There were suitable arrangements in place for the management of the designated centre in the absence of the person in charge for more than 28 days.

The person in charge worked full time and was supported in her role by two experienced clinical nurse managers (CNMs). The CNMs covered for the person in charge in her absence.

**Judgment:**
Compliant

### Outcome 07: Safeguarding and Safety

Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

**Theme:**
Safe care and support

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

**Findings:**
The person in charge stated that staff were made aware, on a regular basis, of the policy on the prevention of elder abuse. She attended staff handover meetings to ensure that she was informed of any issues regarding residents’ care and welfare. She informed inspectors that she would speak with residents and relatives each day. During the inspection, inspectors observed the person in charge interacting and supporting residents and relatives. Residents with whom inspectors spoke said that they felt safe in the centre and that their concerns would be listened to. Staff were able to confirm their understanding of the types of elder abuse. They explained how they would support a resident in this situation. Inspectors viewed the policy for responding to allegations of
adult abuse. This policy was comprehensive and provided details in relation to the actions required by staff when responding to an allegation to elder abuse. However, inspectors noted that three allegations of abuse were not investigated as such but were recorded and investigated as complaints. This was not in line with the guidelines in the centre's own policy or the 'Trust in Care' (HSE 2005) document. In addition, staff training records indicated that all staff had not received updated mandatory training in the prevention and response to elder abuse. A sample of records seen indicated that some staff did not have training since 2010 and others since 2011. Nevertheless, following the inspection the person in charge confirmed that three staff members were to undertake a ‘train the trainer’ course to ensure that this training would be delivered in-house.

The centre had a policy on behaviour that challenges. However, staff had not been afforded the specific training outlined in the policy to enable them to respond to and manage this behaviour safely. Inspectors reviewed the measures that were in place to safeguard residents’ money and noted that receipts were obtained and where possible residents' or their representatives’ signature had been recorded. Inspectors were informed that the centre was a pension agent for a group of residents and that these records were maintained centrally by the HSE. Transactions on these accounts were clear and transparent. Residents’ valuables were in safekeeping and accurate records of these were seen by inspectors. The administrator informed inspectors that the centre had recently been the subject of a successful external financial audit.

**Judgment:**
Non Compliant - Major

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**Outcome 08: Health and Safety and Risk Management**
The health and safety of residents, visitors and staff is promoted and protected.

**Theme:**
Safe care and support

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

**Findings:**
Action were not satisfactorily implemented since previous inspection:

Inspectors formed the opinion that there were not sufficient controls in place to supervise access to the centre from the numerous open fire doors affording access for the general public to the centre.

The centre had a comprehensive emergency plan in place which detailed the actions to be taken by staff in the event of emergency situation. It specified the arrangements for the evacuation of residents and identified an external location for the temporary
The emergency plan was found to meet the requirements of legislation. The fire prevention policy was viewed by inspectors and was found to be detailed and centre-specific. There were signs placed prominently around the centre to alert staff and residents to the procedure to follow in the event of a fire. The emergency lighting was checked and serviced at regular intervals and inspectors viewed these records. Documentation and evidence was also seen which indicated that the fire extinguishers were maintained and serviced as required. Fire training was provided to staff on a number of dates in 2013 and 2014. Regular fire evacuation drills were undertaken. Staff spoken with by inspectors were aware of the procedure to be followed in the event of a fire. However, not all staff had completed fire drill training over the two years 2013 and 2014 and inspectors noted that in the records seen for 2014 only 3 staff had attended the fire evacuation drill. Inspectors saw the records for fire equipment training and noted that approximately 27 staff had attended this training in 2014. There was an evacuation list at the reception area which was updated daily. The fire alarm and the fire doors were checked regularly and these records were checked by inspectors.

Inspectors viewed the record of accidents and incidents. The records indicated that the issues were investigated. The centre had a risk register which was updated when new risks were identified and inspectors were shown the health and safety statement for the centre. This identified the responsibilities of staff in managing risks and promoting health and safety in the centre. The risk management policy was reviewed and this outlined the controls for the risks specified under regulation 26 (1). The person in charge said that the centre had a health and safety committee which met on three occasions yearly. The centre had the services of a health and safety consultant and the person in charge said that a recent audit had shown that the centre had 100% compliance. Hand sanitisers and sinks were present at the entrance to the building, on the corridors and in the staff and resident areas. Inspectors saw that gloves were stored safely. Hoists, wheelchairs, weighing scales, electric beds and mattresses were serviced on a regular basis and these records were seen by inspectors. The centre had an outside smoking area. There were risk assessments noted in the files of residents who smoked and staff were also obliged to use the outside smoking area as the centre was a non-smoking area. Clinical risk assessments were undertaken for the residents, including falls risk assessment, dependency levels, nutrition, skin integrity, continence, moving and handling and challenging behaviour. Inspectors viewed these in the residents' care plans. However, inspectors observed that not all the risks in the centre had been identified and risk assessed. There were open external side and back doors for the general public to gain access to the centre, to the physiotherapy and to the hospital chapel. There was a risk assessment seen and controls in place to mitigate the risks associated with this. However, inspectors formed the opinion that there were too many open entrance doors to the centre to enable suitable supervision of access. This issue required further review/risk assessment. This was addressed under outcome 12: Premises. In addition, unrestricted window openings, the use of the lift, the unlocked doorways at the entrance to stairways and hot radiators in one section of the building were among the risks which had not been assessed. Inspectors also noted that the sluice rooms, an unused room where there was an open door to the external area, the room containing the photocopier and the electronic operations control box and the kitchenette, were unsecured and open access to these rooms had not been risk assessed. Inspectors noted that staff handbags were stored in an unlocked linen room.
Inspectors noted that water in the shower and taps was cold when checked and the staff told inspectors that there is a long standing problem with the boiler which required frequent repair. A staff member informed inspectors that he had difficulty with the water temperature that morning and residents could not use the shower. Inspectors observed that oxygen was stored in unlocked cupboards and in one instance two cylinders were stored in the hallway. This was not in line with the guidelines on safe oxygen storage which was outlined in the centre's policy.

Some of the toilets available for residents were very narrow and inspectors saw that there were no grab rails in one of these toilets. A number of residents had laundry sent home for washing. However, the management of this laundry was not adequate to ensure residents' dignity as it was seen stored in blue plastic bags beside residents' beds and on window sills in multi occupancy bed rooms. This was addressed under outcome 12: Premises.

Inspectors observed staff abiding by best practice in infection control with regular hand-washing and the appropriate use of personal protective equipment such as gloves and aprons. However, water in the hand washing sink in one section was cold when checked, even though it had been running for an extended period. The inspectors observed that care staff were multi-task attendants and were seen to be cleaning floors, helping residents with meals and carrying out other care and cleaning duties in the centre. The centre was seen to be visibly clean but in one situation a staff member had to stay back for two hours beyond her working day to clean one of the kitchenettes. Staff spoken with by inspectors said that they felt that they did not have enough time to spend with residents during the day because of the nature of their duties. Inspectors noted that there was a complaint in the complaints book where a resident had said she had waited too long for the toilet. This had been addressed.

Inspectors observed a number of issues that potentially compromised the prevention of cross contamination including; the storage rack for washed bedpans had been placed on the floor of a sluice room and there were three 'kidney dishes' stored on the window sill in the sluice room. The person in charge explained to inspectors that the storage rack had been taken down from the wall to facilitate redecorating. In addition, inspectors noted that laundry trolleys and commodes were stored in the bathrooms and the inspectors found scissors, a comb which was labelled 'MRSA' and disposable razors in a basket in one bathroom. A hoist and a cleaning trolley were stored in the shower room.

**Judgment:**
Non Compliant - Moderate

**Outcome 09: Medication Management**
*Each resident is protected by the designated centre’s policies and procedures for medication management.*

**Theme:**
Safe care and support
Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
There were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents. The practice of checking, dispensing and recording of the drugs administered was in line with current legislation. The processes in place for the handling of medicines, including controlled drugs, were safe and in line with best practice guidelines. Photographic identification for residents was present. The nurses, spoken with by inspectors, demonstrated a clear understanding of the An Bord Altranais agus Cnaimhseachais na hÉireann guidelines on medication management. However, some drugs which were no longer in use were kept on the medication trolley and these were not dated or labelled with a resident's name. Some medications were kept in bottles which did not have an expiry date attached. Inspectors observed that the policy for unused or out of date medicines was not signed or dated. Medication management audit was not carried out for medication management in the centre nevertheless, there was an audit of controlled drugs management practices. Medications which could be crushed were signed by the general practitioner (GP) and the inspectors were informed that transcribing of medications was not carried out in the centre. Medication fridges were in place in the centre and the temperature of these was recorded. The contents were found to be in date and marked with residents’ names where appropriate.

The pharmacist provided support and expertise on medication management for nursing staff in the centre and the person in charge said that the pharmacist was responsive and attentive to the needs of the residents in the centre. However, residents were not afforded a choice of pharmacist or GP as required by the regulations. There was a good GP service to the centre and all residents automatically came under this 'medical officer's' care on admission. However, this practice was not in line with Regulation 6 (2) (a) of the Health Act 2007 (Care and Welfare of residents in Designated Centres for Older People) Regulations 2013 which requires that residents are offered a choice of GP. This will be addressed under outcome 11: Health and Social Care Needs. Residents' medications were seen to be reviewed on a regular basis. The centre had a policy on medication errors which required that specific documentation be filled in for medication errors. However, the inspectors noted that a medication error was recorded in the complaints book and the aforementioned form was not used.

Judgment:
Non Compliant - Moderate

Outcome 10: Notification of Incidents
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:
Safe care and support
Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
A record of all incidents occurring in the centre was being maintained. However, notifications as regards allegation of abuse were not being made to the Chief inspector in line with the requirements of the regulations. Nevertheless, the person in charge sent the required notification forms to the Authority following the inspection.

Judgment:
Non Compliant - Major

Theme:
Effective care and support

Outcome 11: Health and Social Care Needs
Each resident’s wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident’s assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

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

Findings:
Residents were provided with the services of a GP on admission however, Regulation 6 (2) (a) requires that the resident shall be offered a "medical practitioner chosen by or acceptable to that resident" and inspectors noted that this choice was not facilitated by the centre. Inspectors viewed a complaint from one resident who wished to access their personal GP at one stage. Residents received a full review of all their medical care and their medication was updated as necessary. Residents with whom inspectors spoke expressed satisfaction with the medical care provided to them. The person in charge outlined the assessment process for the residents coming to the centre.

There was a well equipped physiotherapy room and a physiotherapist was employed by the HSE to offer services to both residents and to people in the community. Residents were happy with the service and felt that it supported them to remain independent. A podiatry service was available also and residents had access to the optician, the dentist and the occupational therapist if required. These services were availed of in house and on an external basis. Dietary advice and speech and language therapy (SALT) were provided by allied health professionals and from a nutritional company who also offered training to staff. Inspectors viewed the training records of staff and saw that staff had training in nutrition, dysphagia (difficulty in swallowing) and modified diets. Inspectors viewed a number of residents' care plans which detailed residents' needs and choices. Inspectors observed that care was seen to be delivered to residents in accordance with their care plan. The care plans were reviewed on a four monthly basis as required by
the regulations and there was documented evidence of residents' involvement in the care planning process. Residents' had access to their personal file if required. Guidelines from the national policy on restraint were followed in the implementation of restraint when necessary and inspectors observed that consent forms had been signed by residents and their representatives. There was evidence that staff were liaising with the relevant medical teams for advice and assessment on a regular basis, if there were issues which needed a particular input as required under Regulation 6 (2) (c). The medical officer informed the inspectors that a geriatrician attended the centre every six weeks. Residents were also facilitated to attend consultant or other appointments.

There were opportunities for residents to pursue healthy lifestyle choices and recreational activities. There was a wholesome and varied diet available. There was ongoing monitoring of each resident’s health status and staff regularly checked residents' weight, blood pressure and blood tests. There was a diverse activity programme in place and residents informed inspectors that they were aware of the activities available. Inspectors saw this programme displayed on the notice boards in the centre and observed the activity coordinator leading and encouraging the residents. Work experience students from local schools were facilitated in the centre and these students were seen to chat with residents and to provide music entertainment on the day of inspection. A visiting music group provided a concert of traditional songs and music. Residents were seen to sing along and dance to the music. Other activities included art, church choir, quiz, baking and bingo. The centre had plans to become involved in positive ageing week. One of the residents showed the inspectors her art work which was used to decorate the sitting room in one ward. The person in charge informed inspectors that residents' right to refuse treatment was documented and inspectors noted that where a resident refused medication for example, this was documented. Family and friends with whom inspectors spoke were praiseworthy of the staff and the overall care in the centre.

Judgment:
Non Compliant - Moderate

Outcome 12: Safe and Suitable Premises
The location, design and layout of the centre is suitable for its stated purpose and meets residents’ individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:
Effective care and support

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

Findings:
Actions outstanding since previous inspections dating from 10 March 2010 to 14 May 2013

- Residents in all areas were not provided with adequate dining or personal storage space
- The size and layout of multi-occupancy bedrooms used by residents were not suitable for their needs
- Insufficient assisted baths and showers to meet the needs of the residents:

Previous Response from Provider:

“The HSE nationally and in the South are completing detailed plans in relation to existing buildings to achieve compliance with the environmental standards required. These plans consider the options of refurbishment, extension or full replacement of these facilities. This work is nearing completion for all facilities and a detailed plan is being drawn up for Midleton Community Hospital. This will then be assessed against the number of public beds that are required to be retained in an area based on trends in demand for service and will form part of an overall plan for HSE South. This plan and the overall funding requirement for the HSE will then be put forward for discussion with The Department of Health and ultimately for consideration by The Minister for Health”.

Inspection findings on this inspection:
As stated in the introduction, the ‘back’ hospital was built in 1841 and a new ‘front’ hospital was built in in 1937.
In the ‘front’ hospital the majority of residents' accommodation was provided in shared bedrooms divided by screens and in some areas three, four or seven residents were sharing communal bedrooms. These were referred to as ‘wards’. On the ground floor St. Anthony’s ward was located to the right of the main entrance and provided accommodation for nine male residents including a seven bedded room and two single rooms. One resident occupied a palliative care area which was vacated if required for the needs of another resident. St. Catherine’s ward on the left side provided accommodation for 11 female residents; this included one single room, one twin-bedded room, a palliative care room and a multi-occupancy seven-bedded ward. These wards had a living/dining room at the end of the ward area, two toilets and an assisted bathroom or shower room. A new sitting/visitors room had been provided in the front hallway of this building. However, there continued to be significant issues with the layout and design of the premises which did not conform to the requirements for premises in Regulation 17 (1) and Regulation 17 (2). For example, inspectors noted that visitors, residents and staff had to pass by residents, sitting by or lying on their beds, to gain access to sitting areas. Inspectors noted that one respite resident was sitting behind a curtained area in one of the multi occupancy bedrooms, with visitors. The resident had specific needs and the layout was not conducive to promoting privacy and dignity for this resident.

The ‘back’ hospital was accessed by crossing an external courtyard. This older section was a three-storey building with accommodation provided on the lower two floors. The first floor of this back hospital had a lift installed as well as stairways. St. Mary’s ward was on the ground floor and this provided accommodation for seven female residents. It had a separate living/dining room and a small sitting room between the bedroom areas.
Also a small kitchenette, two toilets and an assisted shower room were available for residents’ use. Upstairs St. Anne’s and St. Ita’s wards accommodated eight and five female residents respectively and St. Joseph’s and St. Patrick’s wards accommodated eight and five male residents respectively. St. Anne’s and St. Ita’s had four toilets between them and an assisted shower room. St. Joseph’s and St. Patrick’s had four toilets and one assisted bathroom for residents' use. A visitors’ room was available on the second floor located in the hallway outside the ward area, near the lift. A hairdressing room and a physiotherapy room were available on the ground floor. A chapel was accessible from the ground floor and also from an external entrance door. Mass took place daily and it was available to residents and the local community. The external grounds were extensive and provided sufficient car parking. The garden areas had been renovated through local fund raising efforts and there was outdoor seating provided as well as cultivated garden areas and gazebos for the residents’ use. There were two outdoor smoking shelters available for staff and residents. There was a further secure garden area to the left of the front entrance and a new patio area at the back.

A number of residents ate their meals next to their beds while other residents used individual bed tables in the living room for their meals. There were also some small dining tables in the living rooms. However, inspectors noted the dining space in each of the living rooms was inadequate; for example there was generally only one small table available with seating for only four to six residents. Consequently, this lack of space did not afford a choice for residents to sit at the dining table. Also the large chairs which were required to accommodate residents' needs could not be positioned at the dining table.

There were inadequate shower and baths available. Inspectors noted that there was one shower and one bath available for 26 residents. Staff informed the inspectors that residents requiring a bath had to go to the neighbouring male ward and the same arrangement was in place for the men requiring use of the shower in the female area. In addition some of the toilets were very narrow and could not be used by wheelchair bound residents or those with high dependency needs. This limited the availability of suitable toilet arrangements as there were only four toilets in total for 15 residents with high dependency needs. In addition, this issue had been recorded in the complaint log in relation to a resident being left waiting to use the toilet and a further complaint was made in relation to the fact that there were too few wheelchair accessible toilets.

The multi occupancy bedroom accommodation, highlighted in previous inspections, continued to be unsuitable in design and layout to ensure the privacy of residents. The design and layout significantly impacted negatively on residents as they were not able to undertake personal activities in private or meet with visitors in private in their bedroom area. The limited space between residents’ beds also impacted negatively on the quality of life of residents and on the storage of personal clothing and belongings in a private manner. For example, to gain access to each of the conservatory living rooms inspectors had to walk through the larger seven bedded rooms. Inspectors noted that there was regular traffic of visitors/staff/volunteers/musicians passing by residents' bed space all day. In addition, the sliding doors were missing from one resident's wardrobe and this impinged on the privacy and dignity of this resident as his personal medical devices and toiletry requirements could easily be seen. Furthermore, when inspectors were talking to a nurse in an office area it was noted that another resident's bed was located just
outside the open office door. Inspectors formed the view that the location of this bed negatively impacted on this resident by significantly compromising his privacy and dignity. Inspectors also observed that the layout of the large communal bedrooms did not allow for wardrobes to be placed near to residents’ beds and some wardrobes were located at the end of the wards in some areas. Personal belongings, clothes, books and toiletries were seen stored on top of residents' wardrobes. This indicated to inspectors that there was insufficient storage space to accommodate all residents' belongings including personal washbasins and bags of laundry. In addition, a mobile hoist was seen stored in one resident's cubicle.

Inspectors noted that the skirting board near the toilet area in St Mary's was in need of repair and the shower room required redecorating. The person in charge stated that repairs were underway in this section. One kitchenette needed re-painting and tile sealant around the kitchen sink required renewal. The hallway upstairs led on to a stairwell that had unsecured door access. In one area a small gate had been placed at the bottom of a stairs however, inspectors noted that this was unlocked during the inspection and required to be suitably risk assessed.

On day one of the inspection inspectors found numerous unsecured fire exit doors that afforded unsupervised access to and exit from the building. The person in charge assured inspectors that these doors were checked and locked at 19.00 at night. However, she informed the inspectors that there was no system/records available for staff to ensure such checks had been conducted. For example, one unsecured door led to a stairwell and inspectors noted that the control in place to prevent unauthorised access was a 'staff only' sign. The person in charge informed inspectors that the time for locking these doors would be brought forward in view of the seasonal change. On the second day of inspection most of these doors were seen to be secured.

Inspectors noted that the statement of purpose outlined measurements for bedroom and communal areas which fell short of the recommended space per person for existing centres outlined in Standard 23.31 and 25.40 of the National Quality Standards for Residential Care Settings for Older People in Ireland 2009. In some situations the bedroom and communal areas available were up to two square meters short of the recommended space. Inspectors noted that since the first inspection of this centre in March 2010; previous plans, submissions and correspondence to the Authority in relation complying with the regulations had yet to be fully implemented. Nevertheless, the person in charge informed inspectors that a detailed plan would be forthcoming.

Judgment:
Non Compliant - Major

Outcome 13: Complaints procedures
The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:
Person-centred care and support
Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
The centre had an up-to-date policy and procedure for the management of complaints. The HSE complaints procedure 'Your Service, Your Say' was displayed and a copy was included in the Resident's Guide. It was referenced in each resident's contract of care. However, this was not prominently displayed around the centre and the person in charge addressed this on inspection. Residents were aware of how to make a complaint and that the person in charge was the complaints officer. The person in charge informed inspectors that she monitored the complaints from each area. She was identified as the nominated person to deal with complaints and to ensure that all complaints were appropriately responded to. Residents spoken with by the inspectors stated that they could raise any issue or concern with the person in charge or staff. Not all complaints were fully and properly recorded however, in line with the centre's policy. The forms identified in the complaints policy were not used and there was no record on some occasions on whether or not the complainant was satisfied with the outcome. The log was used to record a medication error on one occasion and allegations of alleged abuse on other occasions as outlined under outcome 7 and outcome 10. The record did not specify the measures put in place for improvements in practice in response to complaints.

Judgment:
Non Compliant - Minor

Outcome 14: End of Life Care
Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.

Theme:
Person-centred care and support

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

Findings:
Inspectors viewed next of kin questionnaires which had been sent out from the Authority as part of a national thematic inspection programme, which focused on end of life care and nutrition. Overall, the relatives who submitted the questionnaires were satisfied with the care given at the end of life. However, one person felt that they would have liked to have been allowed stay overnight with their relative at an earlier stage and another person stated that they felt that they would have liked someone to sit with the dying person towards the end of life. Staff shortages were mentioned by relatives as impacting on the time spent with residents. Care plans, viewed by inspectors in relation to end-of-life care, indicated that residents' wishes, as to their preferred place of care at this time were being documented. It was evident that residents' representatives were
involved in the care plan. Staff, spoken with by inspectors, were aware of information about individual resident's wishes. Inspectors noted that arrangements were in place to ensure that residents' choices were respected. If cardio-pulmonary resuscitation was to be undertaken for a resident this was seen to be documented.

The centre had a policy on end of life care which indicated that every effort was made to ensure that residents received care at the end of life which respected their right to autonomy and dignity. There was evidence that residents had access to palliative care services and staff members spoken with by inspectors had palliative care training done. The person in charge informed inspectors that the centre had the use of a syringe driver and that staff were trained in its use. All religious and cultural practices were facilitated. There was a daily religious service in the chapel in the centre. Family and friends could be facilitated to be with the resident at the end of life and accommodation was available for relatives if necessary. Residents of all religious denominations would receive end-of-life care appropriate to their beliefs, and the inspectors noted that the centre had a copy of the HSE multicultural guide on end of life practices, for reference.

**Judgment:**
Compliant

**Outcome 15: Food and Nutrition**
*Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.*

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

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

**Findings:**
Inspectors viewed the policies on food and nutrition and found that they were in line with best practice guidelines in this aspect of care. There was a fresh supply of drinking water available throughout the day. Inspectors were shown training records which indicated that staff had attended training in aspects of nutrition, food consistencies and food hygiene. The person in charge informed inspectors that these education sessions were facilitated by a dietician from a nutrition company. Inspectors observed mealtimes including dinner and the evening tea and spoke with residents who said they were very happy with the meals on offer. There was a menu card on each floor and residents had a choice of two meals at each sitting. Residents on diabetic and coeliac diets were accommodated. The dining areas were small and this did not encourage residents to congregate together for the social occasion presented by shared mealtimes. This failing was addressed under outcome 12: Premises. The conservatory-type sitting rooms were used for residents requiring assistance with their meals. The small dining tables when in use, were nicely decorated and the crockery and cutlery were of good quality.
Inspectors reviewed records of resident meetings. It was evident that issues raised by residents, as regards to food, were addressed. Inspectors spoke with the chef who said that she regularly met with the person in charge and the dietician to discuss the residents’ dietary needs and food fortification if required. The chef showed inspectors her files, which contained relevant information and a record of residents’ food preferences. The kitchen was seen to contain a plentiful supplies of fresh, dry and frozen foods. Hand washing facilities were available and plentiful. There was a four weekly menu cycle in place. There was a colour coded and segregated system in place for food preparation. Inspection reports by other organisations were available for viewing in the kitchen. The chef and the kitchen staff were knowledgeable and informed about the specific needs, likes and dislikes of residents.

Residents with diabetes had their blood sugar levels recorded by staff and they were seen to have individual glucometers to measure this. Staff were observed supporting residents with their meals in a careful and attentive way. They were able to tell the inspectors how they would cope with a resident who had swallowing difficulties or a choking episode. Some residents were seen to have individualised seating arrangements depending on their assessed needs. A sample of medication administration charts reviewed by the inspectors indicated that nutritional supplements were prescribed by the GP and that they had been administered by staff.

**Judgment:**
Non Compliant - Minor

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

Residents are consulted with and participate in the organisation of the centre. Each resident’s privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

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

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

**Findings:**
There was evidence that residents were consulted about how the centre was run. Residents' meetings were facilitated on a regular basis. There was evidence that suggestions emanating from these meetings were acted on by the person in charge. Residents' satisfaction surveys were undertaken. There was a policy on communication for residents in the centre. The centre was located near a busy town and was centrally placed in the community where residents could be apprised of local news. Residents were facilitated to partake in meaningful activities and local events. The person in charge informed the inspectors that residents were facilitated to vote, where possible.
The person in charge spoke with inspectors about how she met with residents and relatives on a daily basis and inspectors noticed that staff engaged with residents and relatives in a dignified and approachable manner throughout the inspection. Inspectors noted that residents received care in a manner which respected their privacy, as much as the environment allowed, with the use of curtains and screens in the multi occupancy rooms. Residents had access to telephones in the centre. Televisions were located in the bedrooms and in the communal rooms. However, because of the layout of the beds in multi occupancy rooms it was difficult for some residents to see the TV in the shared cubicles because of the need for the curtains to be drawn around the beds of other residents. Information on local events was provided by the activity personnel, the volunteers and staff members. Inspectors saw information on events advertised on the notice board and heard staff members discussing national events with the residents. Residents with whom inspectors spoke were aware of recent world events and conversed about their life and experiences in the centre.

All residents spoken with said that they felt content and they praised the person in charge, the centre and the staff members. Inspectors observed that visitors were plentiful and those to whom the inspector spoke were very pleased with all aspects of care in the centre. However, inspectors noticed a possible breach of the right to privacy of the residents by an individual using camera recording equipment within the bedroom areas. These findings reflect the findings under outcome 12: Premises: as regards lack of privacy due to the design and layout of the premises. Actions have already been issued under outcome 12. The person in charge addressed this when it was pointed out by inspectors and she placed a sign at all entrances prohibiting any photography without residents’ permission or that of the person in charge. This was to also ensure compliance in the centre with the Data Protection Act 1988 and 2003.

**Judgment:**
Non Compliant - Moderate

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

*Adequate space is provided for residents’ personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.*

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

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

**Findings:**
There were outstanding actions from the previous inspection dated 14 May 2013:

- The storage space for residents’ personal clothing was inadequate overall:
The providers response was:

"The HSE nationally and in the South are completing detailed plans in relation to existing buildings to achieve compliance with the environmental standards required. These plans consider the options of refurbishment, extension or full replacement of these facilities. This work is nearing completion for all facilities and a detailed plan is being drawn up for Midleton Community Hospital. This will then be assessed against the number of public beds that are required to be retained in an area based on trends in demand for service and will form part of an overall plan for HSE South. This plan and the overall funding requirement for the HSE will then be put forward for discussion with The Department of Health and ultimately for consideration by The Minister for Health."

Inspection findings:
Inspectors saw evidence that residents' bedroom areas were personalised where space allowed. There were some single rooms and some of the cubicle areas in the multi occupancy rooms were more spacious than others. However, as outlined previously there was inadequate storage space for personal items as evidenced by the accumulation of these items on top of window sills, lockers and wardrobes. This was addressed under outcome 12: Premises. The protocol in place for managing residents’ clothing was effective from the point of view of having a knowledgeable laundry staff member however, residents' clothes were not labelled. The laundry staff member informed inspectors that an 'identification button' was in use previously but this machine was not seen by inspectors and was not in use at the time of inspection. Inspectors noticed that the clothes were stored neatly in the laundry, ready for return to residents. The person in charge advised inspectors that the marking system will be recommenced to enable identification of residents' clothes.

Residents and relatives, spoken with by inspectors, stated that they were happy with the way their clothing and personal belongings were managed. There was no unresolved issue with missing clothing. Inspectors observed that there was an inventory being kept of residents' personal items in the residents’ care plans. These were seen to be signed by the resident or their representative. Inspectors noted that there were unmarked, unclaimed clothing in the linen presses and the person in charge said these were belonging to deceased residents. The person in charge said these would be removed and stored elsewhere.

Judgment:
Non Compliant - Minor

Outcome 18: Suitable Staffing
There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.
Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
Residents and relatives informed inspectors that staff were responsive and treated them with respect and dignity. A staff development and appraisal system was being undertaken for all staff. Staff changing rooms, canteen and shower area were provided. There was an effective induction system in place for new staff and training in policies and procedures was ongoing. Most of the staff had received training in the prevention of elder abuse, in moving and handling techniques in the prevention of elder abuse and in fire safety. However, some staff members with whom inspectors spoke did not have the mandatory training update in fire safety and in elder abuse as outlined in the actions under outcome 7 and outcome 8. A member of the kitchen staff informed inspectors that she had not received manual handling training for three years.

There was a clear management structure and staff on duty were aware of the reporting mechanisms and the line management system. Staff demonstrated a clear understanding of their role and responsibilities which ensured appropriate delegation and supervision in the delivery of person-centred care to residents. Inspectors spoke with staff members from all areas of the care setting during the two day inspection and they were clear as to their responsibilities and duties. Inspectors reviewed staffing rotas, staffing levels and skill mix. However, the person in charge informed inspectors that staffing levels had been reduced in recent times. She was satisfied with the current skill mix but felt that any further reduction would have a negative impact on the care of residents. Staff meeting notes viewed by inspectors contained concerns about staffing levels and some of the relatives' questionnaires, received by the Authority, prior to the inspection, highlighted this issue also.

Inspectors found that there were gaps in the training provided to staff and the clinical nurse manager said that the reduced staffing levels had an impact on releasing staff for training. A number of the multi-task attendants had completed Further Education Training Awards Council (FETAC) level 5 courses in older adult care and the person in charge told inspectors that other staff would also do this training. The human resource officer showed inspectors the registration details with An Bord Altranais agus Cnaimheacht na hEireann for nursing staff and these were found to be up to date. Inspectors looked at a sample of staff files and found that they contained the regulatory information in relation to matters identified in Schedule 2 of the Health Act 2007 (Care and Welfare Regulations in Designated Centres for Older People) Regulations 2013. The files were kept neatly, easily accessible and stored securely. However, the file of a volunteer in the centre did not contain a signed document setting out the roles and responsibilities of a volunteer as required by the Regulations.

Judgment:
Non Compliant - Moderate
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:

Mary O'Mahony
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
### Provider’s response to inspection report

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<td>OSV-0000579</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>02/10/2014</td>
</tr>
<tr>
<td>Date of response:</td>
<td>16/01/2015</td>
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### Requirements

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

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

### Outcome 05: Documentation to be kept at a designated centre

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The centre’s policy on the prevention of abuse was not implemented in practice as regards the investigation of allegations which may have arisen as complaints initially. Documentation in the appendix of the centre's complaints policy was not utilised in practice. The policy on the disposal of used and out of date medication was not signed or was not implemented in practice.

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Action Required:
Under Regulation 04(1) you are required to: Prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.

Please state the actions you have taken or are planning to take:
All staff are to be provided with training to recognise and respond to allegations of elder abuse. Further education will be given regarding the complaints policy (Your Service Your Say) and the Elder Abuse Policy. The Trust in Care policy and sign off sheet has been distributed to all staff to read and this has been discussed at staff meetings.

Staff will be required to sign off on the Disposal of Used and Out of Date Medication. A designated area for unused medicines has been put in place and the Pharmacy Department has been made aware of the importance of ensuring that all medications have an expiry date label. The pharmacy staff will sign off on all medications returned.

Proposed Timescale: 28/02/2015

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The records required under Schedule 2, 3 and 4 of the Regulations were not maintained as required by legislation. Nursing notes for resident’s were not maintained in line with the Regulations or the professional guidelines on recording clinical practice.

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:
Nurses are assigned individual care plans; the daily flow chart is recorded throughout the day by staff and all ADL’s are recorded on this. Daily documentation on resident’s care takes place every day and night. If there are any changes and any problem with any resident, this is recorded immediately, action taken and care given as appropriate. Staff have received training on care planning and importance of documentation.

Proposed Timescale: 16/01/2015

Outcome 07: Safeguarding and Safety

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff in the centre had not been provided with appropriate training as outlined in the policy on behaviour that challenges which would enable staff to develop the knowledge and skills to respond to and manage this behaviour.

**Action Required:**
Under Regulation 07(1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.

**Please state the actions you have taken or are planning to take:**
Training is to be provided re Challenging Behaviour Training, within the timescale below.

**Proposed Timescale:** 27/03/2015
**Theme:**
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
All staff in the centre had not had up-to-date training in the detection, prevention and response to abuse as required by legislation.

**Action Required:**
Under Regulation 08(2) you are required to: Ensure staff are trained in the detection and prevention of and responses to abuse.

**Please state the actions you have taken or are planning to take:**
All staff are receiving training in Trust in Care as part of the training to recognise and respond to allegations of elder abuse. Staff are aware of what to do if an allegation of abuse is made to them and the person in charge/CNM2 has made sure there is a policy of no tolerance to any form of abuse in the centre.

**Proposed Timescale:** 16/01/2015
**Theme:**
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Allegations of abuse in the centre were not investigated as such but were investigated as complaints. This contravened the safeguarding measures outlined in the ‘Trust in Care’ document and the guidelines in the centre's policy on responding to allegations of abuse.

**Action Required:**
Under Regulation 08(3) you are required to: Investigate any incident or allegation of
abuse.

Please state the actions you have taken or are planning to take:
Staff have been made aware and given opportunities for open discussion where question and answer education sessions have taken place. The importance between a complaint and an allegation of abuse has been clearly clarified to all members of staff on how to respond to any of these issues. The dignity at work policy has been distributed to all staff members and they have been made aware of the importance of this policy. The PIC strongly advocates that each member of staff respects one another in a dignified and respectful way at all times.

Proposed Timescale: 16/01/2015

Outcome 08: Health and Safety and Risk Management

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Window openings, the use of the lift, the unlocked doorways at the entrance to stairways and hot radiators in one section of the building had not been risk assessed in line with the centre's policy.

Sluice rooms, an unused store room, the room containing the photocopier and the electronic operations control box and the kitchenette, were unsecured and not risk assessed in line with the centre's policy.

Staff handbags were stored in an unlocked room and this practice was not assessed for risks attached.

Oxygen was stored in unlocked cupboards and in one instance two cylinders were stored in the hallway.

Action Required:
Under Regulation 26(1)(a) you are required to: Ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.

Please state the actions you have taken or are planning to take:
Windows – Maintenance Department have checked and fit the windows with restrictors (Complete)

Lift – A risk assessment on the use of the lift has been carried out by the Fire & Safety Officer. A Policy on the use of the lift has been completed. (Complete)

Doors – The Fire and Safety Officer and Maintenance Officer have assessed the doors
leading to the stairways and appropriate locks connected to the fire alarm system will be put in situ. (13/02/2015)

Radiators – The Fire and Safety Officer and Maintenance Officer have assessed the radiators and those that need to be covered have been prioritised to protect and safeguard residents. A risk assessment will be carried out by the relevant personnel. (13/02/2015)

Sluice Rooms, Photocopying Room and Store Room - All sluice rooms, photocopying room and store room have been fitted with key pads and staff have been instructed on an ongoing basis on the importance of maintaining a safe environment. Staff have been allocated personal lockers and have been requested to store their bags in the locker rooms or in a safe location in the nurses office. (Complete)

Oxygen is now being stored in a secure location. (Complete)

**Proposed Timescale:** 13/02/2015

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The storage rack for washed bedpans was placed on the floor of a sluice room and there were three 'kidney dishes' stored on the window sill in the sluice room. Commodes and the cleaning trolley were stored in the bathroom and shower room.

Unlabelled scissors, a comb which was labelled 'MRSA' and unlabelled disposable razors were seen in a basket in one bathroom.

Water in the shower, bath and some hand wash basins was cold, when checked, posing an infection control risk.

Clothes for washing were stored in blue plastic bags next to the residents' beds.

Washcloths were seen on the side of wash basins which were stored on the window sills next to the beds of some residents.

**Action Required:**
Under Regulation 27 you are required to: Ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.

**Please state the actions you have taken or are planning to take:**
The storage rack has been removed from the sluice room (Complete)

Staff have been requested to store utensils appropriately. The cleaning trolleys are now stored in the store room. The shower chairs are now stored in the shower rooms.
There have been ongoing talks with the maintenance department regarding the plumbing and improving the supply of hot water to the wards. The boiler has been examined and serviced by appropriate personnel.

Laundry for the residents will continue to be stored beside the beds in a more discreet manner i.e. appropriate laundry bags that have been purchased for each resident.

All lockers are fitted with a rail to store wash cloths. Staff have been instructed to store wash basins and wash cloths appropriately in a person centred manner that is respectful and dignified for each resident.

**Proposed Timescale:** 16/01/2015

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
All staff had not received updated fire safety training and fire drill training.

**Action Required:**
Under Regulation 28(1)(d) you are required to: Make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.

Please state the actions you have taken or are planning to take:
Fire safety and fire drill training has taken place.

**Proposed Timescale:** 16/01/2015

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Fire drills were not carried out at intervals which ensured that all staff were familiar with the fire evacuation procedures for the centre.

**Action Required:**
Under Regulation 28(1)(e) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and residents are aware of the procedure to be followed in the case of fire.
Please state the actions you have taken or are planning to take:
Fire evacuation training taking place on 20 January 2015.

**Proposed Timescale:** 20/01/2015

### Outcome 09: Medication Management

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
On admission to the centre the residents were not afforded a choice of pharmacist.

**Action Required:**
Under Regulation 29(1) you are required to: Make available to the resident a pharmacist of the resident’s choice or who is acceptable to the resident.

Please state the actions you have taken or are planning to take:
Choice of Pharmacist – Pharmacy Supplies are provided to the hospital by the Owenacurra Pharmacy through an interim contract. Residents may attend another pharmacy, at their own cost.

**Proposed Timescale:** 16/01/2015

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Out of date and unused medicines were not segregated from other products, were not disposed of in line with guidelines and legislation and were not stored securely to ensure that the medication could no longer be used as a medicinal product.

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

Please state the actions you have taken or are planning to take:
A designated area for unused medicines has been put in place and the Pharmacy Dept has been made aware of the importance of ensuring that all medications have an expiry date label. The pharmacy staff will sign off on all medications returned.
Proposed Timescale: 16/01/2015

Outcome 10: Notification of Incidents

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Three incidents of alleged abuse were not notified to the chief inspector within three days of occurrence.

Action Required:
Under Regulation 31(1) you are required to: Give notice to the chief inspector in writing of the occurrence of any incident set out in paragraphs 7(1)(a) to (j) of Schedule 4 within 3 working days of its occurrence.

Please state the actions you have taken or are planning to take:
This policy will be adhered to forthwith; HIQA will be notified of all incidents of alleged abuse, as per HIQA requirements and regulatory requirements.

Proposed Timescale: 16/01/2015

Outcome 11: Health and Social Care Needs

Theme:
Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The residents in the centre were not offered a choice of GP on admission.

Action Required:
Under Regulation 06(2)(a) you are required to: Make available to a resident a medical practitioner chosen by or acceptable to that resident.

Please state the actions you have taken or are planning to take:
The HSE has two medical officers that attends Midleton Community Hospital, and adheres to their contract, at all times. Residents may access other GP’s, at their own cost.

Proposed Timescale: 16/01/2015
Outcome 12: Safe and Suitable Premises

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<th>Theme: Effective care and support</th>
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The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The premises were not appropriate to the number and needs of the residents and did not conform to the issues set out in Schedule 6 of the regulations, for example:
- The dining space in each area of the living rooms was small and consisted of a small dining table with seating for four to six residents.
- There were insufficient shower and baths available to afford choice, access to which did not impinge on the privacy and dignity of residents.
- Some of the toilets were very narrow and could not be used by wheelchair bound residents. This limited the availability of suitable toilet arrangements as there were four toilets in all for the use of 15 residents, two of which were too narrow to enable assistance to be given if required.
- In one area the sliding doors were missing from a wardrobe and this had consequences for protecting the privacy and dignity of the resident involved. Personal medical devices and toiletry needs were on view.
- It was noted that a resident's bed was located just outside the open office door of one area. This resident was nursed in bed on most days and therefore had limited privacy.
- Some resident's beds were located at the edge of cubicles and there was no place for private activity, as required by regulations.
- The layout of the large open communal rooms did not allow for wardrobes to be placed near to residents' beds and they were placed at the end of the wards in some areas. Personal belongings, clothes, books and toiletries were stored on top of the wardrobes, which appeared small.
- A hoist was seen stored in one resident's cubicle.
- The skirting area outside St Mary's toilet area was in need of repair and the shower room in that area was accessed down a narrow hallway. The shower room required redecorating and the person in charge told inspectors that repairs were underway in this section.
- One kitchenette needed re-painting and the tile sealant around the kitchen sink required renewal.
- The upstairs hallways led on to stairways which had unsecured, unassessed door access.
- There were numerous unlocked fire exit doors afforded unsupervised access to and exit from the building.
- The statement of purpose outlined measurements for bedroom and communal areas which fell far short of the recommended space per person for existing centres outlined in Standard 23.31 and 25.40 of the National Quality Standards for Residential Care Settings for Older People in Ireland 2009.

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:
Action 1: The HSE and HIQA work closely together on the implementation of all standards for our residents in our older person facilities. As regards our infrastructural standard, the HSE is in the process of drawing up plans for each hospital & costings these plans. The Department have committed to work closely with us on implementation, but obviously this is finance dependent and we are currently awaiting a response from the Department on when extra Capital funding will be made available, to complete this work. We will continue to closely liaise with HIQA nationally on this issue, and we will advise local inspectors of any updates available to us.

Sliding Doors – Doors reviewed by the Maintenance Dept – to be complete by 31/01/2015.

Residents bed – Every effort is made to ensure privacy, will be rectified as per action 1 above.

The hoist has been removed from the area specified above, with immediate effect.

Skirting area – St. Mary’s toilet, fully repaired with immediate effect.

Shower in St Mary’s Ward – The ceiling has been painted in the shower room - Complete

Kitchen – painting and repairs have been carried out at per report. Complete

Outside doors – the number of outside doors will be restricted with emergency access only. Maintenance and Fire and Safety Officer have assessed this. (09/01/2015). Final works will be complete by 01/03/2015)

Proposed Timescale: 01/03/2015

Outcome 13: Complaints procedures

Theme: Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were some documentation gaps evident in the records of complaints. The records of complaints in the centre did not state the learning that had occurred as a result of complaints and the satisfaction or otherwise of the complainant was not recorded on occasions.

Action Required:
Under Regulation 34(1)(h) you are required to: Put in place any measures required for improvement in response to a complaint.

Please state the actions you have taken or are planning to take:
The complaints procedure has been updated. New recording methods have been put in
place. All complaints are now dealt with appropriately under the complaints policy, Your Service Your Say, and the outcomes are recorded.

**Proposed Timescale:** 16/01/2015

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**Outcome 15: Food and Nutrition**

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

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The lack of availability of space to dine at the dining tables did not afford adequate choice to the residents.

**Action Required:**
Under Regulation 18(1)(b) you are required to: Offer choice to each resident at mealtimes.

**Please state the actions you have taken or are planning to take:**
Residents are always given a choice of where they would like to dine. There is a dining room available to the residents if they so wish to dine there. However, if residents prefer to dine in their own personal space, this is their choice, and this is respected by all staff.

**Proposed Timescale:** 16/01/2015

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

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The inspectors noted that staff had complained at staff meetings of not having enough staff on duty to help at mealtimes.

**Action Required:**
Under Regulation 18(3) you are required to: Ensure that an adequate number of staff are available to assist residents at meals and when other refreshments are served.

**Please state the actions you have taken or are planning to take:**
Review of rosters has taken place. Alterations have been made to staff rosters to ensure extra staff are available to assist residents at meal times. Meals time will be addressed and changed accordingly.

**Proposed Timescale:** 17/02/2015
**Outcome 17: Residents' clothing and personal property and possessions**

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

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**  
Residents' clothes were not individually marked to ensure correct identification of personal items of clothing.

**Action Required:**  
Under Regulation 12(a) you are required to: Ensure that each resident uses and retains control over his or her clothes.

**Please state the actions you have taken or are planning to take:**  
All residents' clothes are now individually marked to ensure correct identification of personal items of clothing. Families are reminded to label new clothes and this is their responsibility. A letter has been sent to each representative.

**Proposed Timescale:**  16/01/2015

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**Outcome 18: Suitable Staffing**

**Theme:**  
Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**  
Not all staff had appropriate training such as manual handling training and all mandatory training had not been attended to.

**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 are afforded Manual Handling training but unfortunately do not always attend even though Management have informed them that this is mandatory training. This is each person's responsibility and if they do not attend in the future, appropriate actions will be taken by Management.

**Proposed Timescale:**  16/01/2015

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**in the following respect:**
The file of a volunteer in the centre did not contain a signed document setting out the roles and responsibilities for the job.

**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 volunteer job description is now complete.

**Proposed Timescale: 10/10/2014**