<table>
<thead>
<tr>
<th><strong>Centre name:</strong></th>
<th>Macroom Community Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Centre ID:</strong></td>
<td>OSV-0000578</td>
</tr>
<tr>
<td><strong>Centre address:</strong></td>
<td>Macroom, Cork.</td>
</tr>
<tr>
<td><strong>Telephone number:</strong></td>
<td>026 20 600</td>
</tr>
<tr>
<td><strong>Email address:</strong></td>
<td><a href="mailto:macroomch@hse.ie">macroomch@hse.ie</a></td>
</tr>
<tr>
<td><strong>Type of centre:</strong></td>
<td>The Health Service Executive</td>
</tr>
<tr>
<td><strong>Registered provider:</strong></td>
<td>Health Service Executive</td>
</tr>
<tr>
<td><strong>Provider Nominee:</strong></td>
<td>Patrick Ryan</td>
</tr>
<tr>
<td><strong>Lead inspector:</strong></td>
<td>Mary O'Mahony</td>
</tr>
<tr>
<td><strong>Support inspector(s):</strong></td>
<td>Vincent Kearns</td>
</tr>
<tr>
<td><strong>Type of inspection</strong></td>
<td>Announced</td>
</tr>
<tr>
<td><strong>Number of residents on the date of inspection:</strong></td>
<td>36</td>
</tr>
<tr>
<td><strong>Number of vacancies on the date of inspection:</strong></td>
<td>2</td>
</tr>
</tbody>
</table>
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, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 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

<table>
<thead>
<tr>
<th>From:</th>
<th>To:</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 November 2014 08:00</td>
<td>12 November 2014 18:30</td>
</tr>
<tr>
<td>13 November 2014 08:00</td>
<td>13 November 2014 16:30</td>
</tr>
</tbody>
</table>

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

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

Summary of findings from this inspection

This registration renewal inspection by the Health Information and Quality Authority (HIQA or the Authority) of Macroom Community Hospital was announced and took place over two days. The hospital was originally built as a workhouse in the 1800's but following a fire it was rebuilt in the 1930's. At the time of inspection it was run by the Health Service Executive (HSE) and provided long-stay and respite care to the older population of Macroom and the surrounding area. The hospital was situated on a six acre site and provided a range of services on site including a day care for mental health services and an ambulance base. As part of the inspection, inspectors met with the person in charge, administration personnel, residents, relatives, nursing staff, the activity coordinator, kitchen staff and multi-task attendants. Inspectors
observed care practices and reviewed documentation such as care plans, medical records, complaints log, policies, fire safety records, training records and staff files.

There was evidence of individual resident's needs being met and the staff supported residents to maintain their independence where possible. Inspectors found the premises, fittings and equipment were in good repair overall. 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.

A number of improvements were required to comply with 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. These improvements included the following: safeguarding and safety: health and safety and risk management: medication management: notification of incidents: documentation: complaints procedure: personal property and staffing.

In particular there continued to be significant failings as regards compliance with the regulations on premises which was highlighted during previous inspections, the most recent of which was undertaken on 6 November 2013.

The first action plan received by the Authority to address the premises failings was unsatisfactory. The centre was asked to re-submit the action plan. However, the second action plan remained unsatisfactory as there were no specific, costed and funded, time bound plans submitted to the Authority, which would address the premises failings, in the centre.

| Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National 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 the residents was monitored and developed on an ongoing basis. Effective management systems were seen to be in place in the centre on the day of 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 an experienced clinical nurse manager (CNM). There were clear lines of authority and accountability. There were daily care handover meetings and all grades of staff were included in these. Inspectors were present for the morning handover meeting and noted that all staff participated. 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 showed inspectors her audit system and copies of recent audits in areas such as: nutritional needs and infection control. Inspectors were also informed that the master dissertation theses recently completed by the person in charge and another senior staff member had informed improvements in practice. Examples of this were, the setting up of a men's group and new care practices in the prevention of pressure sores.

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. Relatives and residents were familiar with the person in charge. Inspectors viewed the details of residents’ surveys, the minutes of residents’ meetings and results of the pre inspection questionnaires for this inspection. These indicated that a person-centred approach to the care and quality of life of the residents was fostered in the centre.
### 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 residents and visitors. 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 were viewed by the inspectors. One contract had yet to be returned to the centre for a resident who had recently been admitted. 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. There was relevant information available for residents on notice boards, from staff interactions, from radio and television and also in local newsletters which were seen 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. She had been appointed to her post since the previous inspection. 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. She showed the inspectors her recently completed dissertation thesis on the prevalence of pressure ulcers in residential care settings in Ireland.

A thesis on social experiences of male residents in a nursing home setting was undertaken by the senior staff nurse. The person in charge had initiated improvements in practice as a result of these studies.

**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. This was confirmed with inspectors by residents and their representatives. 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. 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 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. 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 which contained the required information. The person in charge undertook to amalgamate the written record and the computerised records to aid accessibility of all the required data.

Documentation was seen by inspectors which indicated that residents’ right to refuse treatment was documented, where this occurred. However, there were no records maintained in the care plans to indicate that discussions were held with residents and their representatives about CPR (Cardio-Pulmonary-Resuscitation) or other end of life wishes. The person in charge said that discussions on end of life wishes had not yet been initiated but in the event of a medical need the general practitioner (GP) would record decisions in the medical notes.

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 as complaints and staff had not followed the procedures set out in the policy on the prevention of elder abuse. In addition, the Authority had not been notified of these allegations, within the specified time-frame, as set out in legislation. These failings will be addressed under outcome 7: Safeguarding and Safety and outcome 10: Notifications.

Training records were maintained in the centre however, the records 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. There were some additional nursing notes recorded of health conditions and medical treatment given but not all care plans had a daily nursing note recorded. In addition, some care plans were noted to be out of date. This will be addressed under outcome 11: Health and Social Care Needs.

Staff files were reviewed and while most of the required information was held in the centre inspectors noted that employment gaps were not verified for some staff. In addition an agency staff member did not have file available and a Garda vetting clearance was not on file for that staff member. A recent alleged complaint against this staff member had not been documented. This will be addressed under outcome 13: Complaints Procedures.

**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 an experienced clinical nurse manager (CNM). The CNM 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:**
Inspectors reviewed the centre's policy on the prevention of adult abuse and found it to contain procedures for the prevention, detection and response to abuse. Staff had received training in understanding adult abuse. Staff members informed inspectors that the training generally involved the viewing of a HSE DVD on 'Recognising and Responding to Abuse in Residential Settings'. This DVD was of 40 minutes duration. However, not all staff spoken with by inspectors were aware of the procedure in implementing the centre's policy on responding to suspicions, allegations and disclosures of abuse. In addition, the reporting and investigation of allegations was not robust and
inspectors formed the opinion that the training in this area was not sufficient in duration or content. Nevertheless, residents with whom inspectors spoke stated that they felt safe in the centre and spoke positively about the care they received from staff.

In a sample of care plans seen by inspectors it was noted that some residents had exhibited episodes of behaviours which challenge, as a symptom of their medical or psychological condition. However, staff with whom inspectors spoke did not have training in this aspect of care and some staff were in need of a refresher course. One staff member said "it was a long time ago" since she had completed the training. In addition, residents who were wearing a 'code alert', and others who had episodes of 'behaviours which challenge' did not have a plan of care to guide staff in appropriate interventions. Where lap belts, bed-rails and code alerts were in use for residents there was not sufficient evidence of multidisciplinary (MDT) assessments, in some cases, in line with best practice as outlined in the National Policy on Restraint.

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.

Inspectors noted that there were a number of visitors who assisted their relative/friend during lunch time and it was evident that visitors attended the centre frequently. The person in charge and the CNM were present in the centre all day and regularly met residents and visitors. Inspectors observed staff engaging with residents in a respectful and kind manner. Staff were observed knocking on bathroom doors prior to entering and utilising the screens available in the bedroom areas. Staff were noted to be interacting with residents and visitors in a sensitive and caring way.

Judgment:
Non Compliant - Major

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

**Findings:**
The centre had an up-to-date health and safety statement and inspectors noted that fire safety checks were conducted and all fire door exits were seen to be unobstructed. The fire policies and procedures viewed by inspectors were centre-specific and there was a
fire safety plan in place. Inspectors noted that there were records of staff having completed fire training and evacuation drills. However, staff had not participated in fire drills since October 2013. There were adequate precautions against the risk of fire and suitable policies in relation to residents who smoke. However, there was no risk assessment for one resident who smoked and no system to observe his smoking practices. He was seen by inspectors smoking outside an open fire exit door at the back of the hospital and there was no ash tray to be seen in the vicinity.

Inspectors noted that the centre was clean and well maintained and the cleaning processes outlined by staff to inspectors were in keeping with best practice. The equipment used for cleaning was suitably colour coded and stored to prevent cross-infection. There was a waste disposal contract in place and there were measures in place to control and prevent infection. The person in charge informed inspectors that arrangements for the segregation and disposal of waste, including clinical waste were in place. Inspectors observed staff abiding by best practice in relation to infection control, with regular hand washing and the appropriate use of personal protective equipment such as latex gloves and plastic aprons. There were adequate supplies of gloves and disposable plastic aprons and inspectors saw staff using alcohol hand gels which were available throughout the centre.

There was evidence that staff were trained in the moving and handling of residents. Inspectors observed staff using equipment to aid the transfer of residents in an appropriate manner. Overhead hoists were in use in the multi-occupancy bedrooms and the staff informed inspectors that these had been funded by the local community. However, staff told inspectors that one of these hoist, in the Barra ward, often broke down when in use. However, the potential risks to residents and staff posed by this hoist had not been assessed. This hoist was repaired while inspectors were on the premises. In addition, there were other risks on the premises which had not been assessed. For example, there were large unrestricted openings on the windows at the back of the hospital in the visitors' room and bathroom. These were seen to be open in the late evening by inspectors. The fire exit doors which led directly into the bedrooms were opened on many occasions during the inspection and some residents could be viewed lying in their beds by passing visitors and motorists. Inspectors noted that the risk to residents' privacy and dignity of this arrangement had not been assessed. The risk to residents' privacy and dignity also required assessment in relation to a number of missing bed-screens and lack of personal space for residents due to the size, design and layout of the multi occupancy rooms. In addition, the door to the external cleaning equipment store was seen to be unsecured and this was accessible to the public through an open door in the fenced off storage area. The centre used the services of agency staff and these staff were not afforded a suitable induction to the centre. This was a particular concern to inspectors in regards to their lack of understanding of the fire procedures and precautions for the centre.

Inspectors reviewed the risk management policy and the risk register. There were risk assessment forms completed and inspectors noted that the impact of staff shortages and the lack of continuity due to the employment of agency staff had been assessed.

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

**Findings:**
There was a centre-specific medication policy signed and dated as reviewed by the person in charge in September 2013. This policy detailed the procedures for safe ordering, prescribing, storing and administration of medicines and handling and disposal of unused or out-of-date medicines. Photographic identification for residents was in place. Inspectors noted that a copy of Bord Altranais agus Cnáimhseachais na hÉireann medication guidelines was available. The medication trolleys were stored securely in the treatment room and the medication keys were held by the staff nurse. Nursing staff to whom inspectors spoke demonstrated an understanding of appropriate medication management and adherence to professional guidelines and regulatory requirements. The medication fridge which was located in the treatment room was maintained at the appropriate temperature and there were suitable records available in relation to this. Controlled drugs were stored safely within a locked cupboard also in the treatment room. Stock levels of controlled drugs were counted at the end of each shift and recorded in a register, in line with best practice.

There was evidence that residents’ medication charts were reviewed at least three monthly by the residents’ GP. Four staff from the centre, including the person in charge, were trained as nurse prescriber’s. The person in charge informed inspectors that residents were not afforded a choice of pharmacist. She said that there was a service level HSE agreement with one pharmacist. However, this practice was not in line with Regulation 29 (1) which states that "a pharmacist of a resident's choice or who is acceptable to the resident is available to the resident".

**Judgment:**
Non Compliant - Minor
### 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.

**Judgment:**
Non Compliant - Major

### Outcome 11: Health and Social Care Needs

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

**Theme:**
Effective care and support

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

**Findings:**
Inspectors noted that residents had access to regular general practitioner (GP) services and allied healthcare services including physiotherapy, dental, speech and language therapy, dietician, occupational therapy, optician and chiropodist services. The person in charge informed inspectors that the GPs and the pharmacist were attentive to the residents in the centre. The person in charge also attended regular multidisciplinary community team meetings. Residents and their representatives spoken with by inspectors confirmed that there was good access to medical care both inside and outside the centre. Geriatricians facilitated out patient clinics in the centre, at intervals, to review residents' healthcare needs.

There were a number of centre-specific policies in relation to the care and welfare of
residents including policies on wound care, clinical observations and nutrition. Inspectors noted that residents' weights were monitored and recorded monthly. The centre had a comprehensive care planning process in place for each resident. Inspectors reviewed a selection of care plans and noted that detailed information pertinent to each resident was included. There was evidence that the care plans were reviewed at least every four months and generally reflected any change in residents' treatment. However, there were some gaps noted in the maintenance of care plan documentation. For example inspectors noted that some care plans were out of date or no longer relevant, due to the changed needs of residents. There were daily flow sheets that recorded if residents had, for example, mobilised, if personal care was provided, and their dietary intake. From the selection of care plans reviewed however, a daily nursing note had not been completed, and signed and dated by the nurse on duty, in accordance with relevant professional guidelines. The flow chart system 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 Cnaímhseachais na hÉireann "Recording Clinical Practice Guidance for Nurses and Midwives" 2002. This issue was addressed under outcome 5: Documentation.

In relation to restraint practices, inspectors observed that where bed-rails were in use their application followed an appropriate assessment. Care plans of residents using bed-rails specified that their use was subject to assessment and on-going review. Inspectors noted that there were monitoring checks for the observation of residents while bed-rails were in use. However, there was a lack of multidisciplinary input noted in the assessment of residents requiring lap belts and 'code alerts'. This issue was addressed under outcome 7: Safeguarding and Safety.

Judgment:
Non Compliant - Minor

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:
Macroom Community Hospital dated back to the 1930s when it was first opened to
provide long-term care services for older adults. Inspectors noted that the premises were clean and were regularly maintained with a good standard of décor. Efforts had been made to create an atmosphere of comfort through the use of suitable fittings and furniture and there was evidence that renovations had been carried out to improve the ambience. Toilet doors in each area had been painted different colours to aid residents in identifying their function. There was a spacious multi-purpose sitting room which had large conservatory type windows providing plenty of natural light. This room was used for a number of functions including activities, music, TV and dining. There was also an impressive oratory which was used for religious services and for residents who wished to meet relatives in private. Staff informed inspectors that this extension had been funded by the local community. However, the following actions from previous inspections were still outstanding:

To provide bedroom space and appropriate use of communal space having regard to privacy and dignity of the residents.

To provide adequate sluicing, laundry and storage facilities.

To ensure adequate private accommodation is provided for residents.

To ensure suitable provision for storage of personal belongings in the designated centre.

To ensure that the external grounds are suitable for, and safe to use by residents.

To provide residents with privacy to the extent that each resident is able to undertake personal activities in private by ensuring that there are adequate bathroom and toilet facilities.

In response to the actions contained in the action plan from the previous inspection dated 6 November 2013 the provider had stated:

"Given the changes in Older Peoples population in all HSE areas there is a need to maintain the current number of residential beds for Older People, including the number of public beds, along with a requirement to increase the bed numbers in areas such as Cork City and its environs. The HSE nationally and in the South have completed accommodation layout plans in relation to existing buildings to achieve compliance with the environmental standards required. A detailed plan for all hospitals has been drawn up. These plans consider the options of refurbishment, extension or full replacement and require significant Capital investment. This plan and the overall funding requirement for the HSE has been forwarded to the Department of Health for consideration and any future development is dependant on funding becoming available. A prioritisation process based on capital investment becoming available is on going between the HSE and the Department of Health to ensure that both requirements for additional capacity and compliance with HIQA standards are met. The completion date of the works is dependent on available funding and this has been discussed at Corporate level between the HSE and HIQA."

However, as stated in previous reports, the physical design and layout continued to be unsuitable and remained predominately institutional in physical design and appearance.
consistent with the layout and style of that era. Inspectors noted that since the last inspection the following outstanding issues in relation to the premises had remained unchanged:

- The bedrooms consisted of ward type accommodation and there continued to be inadequate bedroom space or private accommodation to ensure privacy and dignity for residents:

  The multi-occupancy bedroom accommodation consisted of three eleven-bedded wards which were divided into an eight-bedded wards and a three-bedded small annexed wards, a seven-bedded ward and one single-bedded room. One of the eleven-bedded wards 'Barra' was occupied by male residents. Due to the design and layout of these multi-occupancy wards which accommodated up to eight residents, there was inadequate private accommodation for residents to ensure that their privacy and dignity was met, on a daily basis. The design and layout of these wards significantly impacted negatively on residents as they were not able to undertake personal activities in private or meet with visitors in private. Inspectors noted that the staff made every effort to protect the privacy and dignity of residents through the use of fixed telescopic screens; however, the layout of the premises did not lend itself to the promotion of privacy or dignity for residents. In some areas screens were broken or missing and there was a portable screen in use where screens were missing. The limited space between individual residents' beds also impacted on the quality of life of residents and storage of personal clothing, possessions and belongings. Furthermore, to gain access to each of the small three-bedded anterooms; inspectors had to pass through the larger eight bedded rooms so there was regular traffic of visitors/staff through the latter. There were overhead bed lights but these could not be accessed by residents and the televisions sets were shared which limited residents' choice.

- There were inadequate bathroom and toilet facilities to promote and protect the privacy and dignity of residents.

  Staff informed inspectors that they found it very challenging to attend to residents' toileting needs with discretion, as beds were too close together. The screens were fixed next to the beds and it was difficult for staff to assist residents with a wheelchair or commode and maintain residents' privacy behind these screens. Some residents had to use the commode in the multi-occupancy bedroom because of their physical needs. Residents in the three-bedded annexed rooms had to walk down through the eight bedded rooms so there was regular traffic of visitors/staff through the latter. There were two toilets for each 11 bedded multi-occupancy room. There was one bath available for the 38 residents and two showers, which were difficult to access for some residents.

- There was inadequate sluicing, laundry and storage facilities:

  The laundry room continued to be unsuitable as it was a combined sluice/laundry facility and storage area for vacuum cleaners. This arrangement necessitated that dirty and clean laundry were handled in the same room, that commodes were also cleaned in this room and the bed pan washer was also located in this small area. The bedpan washer was very small considering the amount of commodes that were in use. There was no
wash-hand basin, soap or drying facility for staff to wash their hands in the sluice/laundry room. In addition, the cleaning store which contained a variety of cleaning materials and chemicals had to be accessed by going through this laundry/sluice room and therefore posed further cross-contamination risks. Commodes were unsuitably stored outside in a perspex-covered yard area. It had been raining on the day of inspection and due to the low outside temperature the commodes were wet and very cold to touch for residents use.

-There was inadequate suitable provision of storage for residents, for equipment and for belongings:

There continued to be very limited space for personal belongings and there were no individual locked areas for residents to keep their valuables. Many residents only had access to a small bedside locker and limited access to communal storage press for storing their personal belongings. Residents' bags were on the floor in some areas and clothes and other belongings were placed on radiators. For some residents, access to these bedside lockers was impeded, due to the proximity of the privacy bed-screens beside each of the multi-occupancy beds. Inspectors observed that residents displayed minimal personal effects and it was clear that they had limited choice or opportunity to do so due to the lack of space. Staff had made attempts to personalise the wall area over each bed with photographs for some residents. However, most residents had no wardrobes and their possessions were stored in large plastic containers. Inspectors opened a cupboard at the end of one ward and saw 11 such boxes stored there with a resident's name on each box. Staff informed inspectors that relatives oblige them by limiting the clothes that they bring in due to the lack of storage space. Staff also said that they wash the clothes regularly because of the limited choice and space available to residents. There continued to be inadequate storage space available for the storage of equipment such as hoists, wheelchairs and walking frames and inspectors saw that equipment was stored in the residents' assisted bathroom, bedrooms, oratory and shower rooms.

-Unsafe external grounds for use by residents:

There were many services provided on the grounds of the centre such as a day care centre and the dental hospital. There was some garden seating to the front of the building and car parking spaces provided in a number of locations to the front and side of the premises. At the rear of the centre there was a patio area which had been developed through local fund-raising. This area contained shrubs, planted trees and sections of lawn surrounded by an old walled boundary. However, this attractive outside garden area continued to be unsuitable for residents to access independently, as they were required to cross a service road which surrounded the hospital, to get to this unsecured garden area. The person in charge said that two new traffic ramps had been installed in an attempt to slow passing traffic.

Inspectors noted that a resident had become quite upset one evening when he could not get into his bed due to being obstructed by the screen which was drawn around the adjoining bed. Another complaint was seen from a relative who said she could not visit her relative without the resident in the next bed reaching out to touch her due to the proximity of the beds.
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, the policy did not contain the name of a nominated person, as specified under Regulation 34 (3), other than the complaints officer to ensure that all complaints were responded to and properly recorded. Residents were aware of how to make a complaint and they knew that the person in charge was the complaints officer. The person in charge informed inspectors that she monitored the complaints from each area.

Residents spoken with by inspectors stated that they could raise any issue or concern with the person in charge or staff. However, not all complaints were fully and properly recorded in line with the centre's policy. Furthermore, there was no record on some occasions of whether or not the complainant was satisfied with the outcome. In addition, inspectors noted that the complaints log was used to record allegations of alleged abuse, as complaints, as already addressed under outcome 7. Some complaints were not recorded for example, there was the aforementioned complaint by a resident who was unhappy at not being able to get into his bed. A further complaint against a staff member made by two residents was recorded in a care plan, however, it had not been recorded in the complaints log. In addition, the records seen by inspectors did not specify the measures put in place for improvements in practice in response to all complaints.

Judgment:
Non Compliant - Moderate
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. Staff shortages were mentioned by relatives as impacting on the time spent with residents. However, care plans, viewed by inspectors did not contain end of life care plans. In addition, staff to whom the inspector spoke to were not aware of residents' wishes as regards cardio-pulmonary resuscitation (CPR) as discussions on end of life wishes had not been initiated. The GP recorded this in the medical notes if the issue arose as part of a medical review. The person in charge informed inspectors that she had arranged a series of training courses with recognised experts and that she intended to get advice and training for staff on how to respond to and record advanced care wishes.

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 a syringe driver and that staff were trained in using this. All religious and cultural practices were facilitated. There was a daily religious service in the chapel which was broadcast on the bedroom TVs. There was a yearly commemoration mass held for deceased residents. Family and friends were invited to attend this service. They were facilitated to be with the resident at the end of life also and accommodation was available for relatives if necessary. Residents of all religious denominations received end-of-life care appropriate to their beliefs, and inspectors noted that the centre had a copy of the HSE multicultural guide on end of life care, for reference.

Judgment:
Non Compliant - Moderate
### 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. There was a fresh supply of drinking water and juices 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 told 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 board in the dining room and residents had a choice of two meals at each sitting. Residents on diabetic and coeliac diets were accommodated. There were four large tables in the communal sitting room and residents were seen seated around these at mealtimes. The social occasion presented by shared mealtimes was appreciated by residents who were seen by inspectors to be engaging in conversation with each other. The dining tables were nicely decorated and the crockery and cutlery were of good quality. Fresh flowers were brought in daily by the activity nurse who said that residents helped to arrange these for the tables. Some of the residents had their meals by the beds and staff were seen to assist some people when necessary.

Inspectors reviewed records of resident meetings. It was evident that issues raised by residents, as regards to food, were addressed. Inspectors spoke with the agency chef who was temporarily working replacing the chef in the centre. She was supported by a staff member who was familiar with residents' needs. The chef showed inspectors the kitchen 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. 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.

Residents with diabetes had their blood sugar levels recorded by staff and that were seen using individual glucometers to measure each residents' blood sugar levels. Staff were observed supporting residents with their meals in a careful and attentive way. They were able to tell 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 inspectors indicated that nutritional supplements were prescribed by the GP and that they had been administered by staff.

Judgment:
Compliant

**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 every six months and inspectors saw that a meeting was held on the second day of inspection. There was evidence that suggestions emanating from these meetings were acted on by the person in charge. Residents’ and relatives’ satisfaction surveys were undertaken. There was a policy on communication for residents in the centre. The centre was located on the outskirts of a busy town and was centrally placed in the community where residents could be apprised of local events. Residents were facilitated to partake in meaningful activities and local events. The person in charge informed 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 observed 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 not possible for each resident to choose a favourite programme, as they shared two large TVs on opposite walls of the room. In addition, it was difficult for individual residents to watch/hear the TV programme or to listen to an individual radio programme within the multi-occupancy bedrooms. This was addressed in under outcome 12: Safe and Suitable Premises. The person in charge told inspectors that there were plans in place to provide wireless headphones for residents.
who were interested.

Information on local events was provided by the activity nurse. Inspectors spoke with this staff member who showed inspectors the programmes of activities for residents, such as, sonas, chair based exercises, singing, art, gardening, reminiscence and outings to the pantomime and the local garden centres. Inspectors observed one activity session and it was very apparent that residents were happy, engaged and interested in the programme on offer. The activity nurse explained how she provided individual therapy to residents who did not attend the group sessions and this consisted of hand massage and passive exercises. The physiotherapist liaised regularly with her to risk assess the programme and to guide the individual sessions. Inspectors saw detailed notes of the activity sessions and there was evidence of a person centred, individualised approach in the terminology used. There was information on upcoming events advertised on the notice board and inspectors heard staff members discussing books, family and 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 staff members, the activities nurse, the food and the facilities. Inspectors observed that visitors were plentiful and those with whom inspectors spoke were very pleased with all aspects of care in the centre. However, there were some visitors and staff who felt that space was very limited for residents, for their clothes, for their personal belongings as well as for private conversations.

Judgment:
Compliant

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

Findings:
There continued to be very limited and inadequate space for personal belongings and there were no individual locked areas for residents to keep their valuables. Most residents had a small bedside locker and limited access to communal storage areas for storing and maintaining control over their own clothes and belongings. This was required under Regulation 12. In addition issues of storage for personal possessions and clothing had been highlighted in detail under Outcome 12. The person in charge informed inspectors that residents' personal clothing was laundered by staff in the
centre and that bed linen was outsourced to a contract laundry service provider. Inspectors noted there was a centre-specific policy in relation to the management of residents' personal property, which had been reviewed by the person in charge in January 2013. This policy required staff to record residents' personal property on admission and ensure that such records were kept up-to-date. A sample of these records was seen by inspectors.

Judgment:
Non Compliant - Moderate

**Outcome 18: Suitable Staffing**

There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

Theme:
Workforce

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

Findings:
Actions not satisfactorily implemented following the previous inspection:
- There were gaps in the employment records of some staff members which had not been accounted for.

Staff were able to articulate to inspectors the management structure and reporting relationships and confirmed that copies of both the Regulations and the Standards had been made available to them. There was a new person in charge since the previous inspection but as she had worked in the centre before her appointment the staff were familiar with her. Inspectors noted that there was a selection of healthcare reading materials and reference books available in an office as well as copies of both the Regulations and the Standards. A number of staff with whom inspectors spoke said that there were times when staff on sick leave were not replaced and this impacted negatively on providing person centred care to the residents. They explained that there was not enough time for conversing with residents and care was compromised due to the other tasks, such as laundry and cleaning. On other occasions agency staff were employed but this meant that there were inconsistent staff on duty who may not always be as familiar with the residents' needs and preferences.

Inspectors viewed the training records for staff. Staff spoken with by inspectors were
familiar with the training programme and confirmed with inspectors that training was available to them. However, inspectors addressed some failings in training, on the prevention of elder abuse, the lack of challenging behaviour training and fire drill training, under outcome 7; Safeguarding and Safety and outcome 8: Health and Safety and Risk Management.

Inspectors reviewed a selection of staff files and noted from these files that most of the documents as required under Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 were available. However, from the sample of staff files reviewed not all files contained a full employment history, together with a satisfactory history of any gaps in employment. This failing was addressed under outcome 5: Documentation to be kept at a designated centre.

Judgment: Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Mary O’Mahony
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider’s response to inspection report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Macroom Community Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000578</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>12/11/2014 and 13/11/2014</td>
</tr>
<tr>
<td>Date of response:</td>
<td>20/02/2015</td>
</tr>
</tbody>
</table>

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 failed to maintain all the records required under Schedule 2,3 and 4 of the Regulations for example: records of all complaints, records and notifications of alleged abusive interactions, a daily nursing note was not maintained, records of residents' decision not to receive certain medical such as CPR and a full employment history for all staff including any gaps in employment were not maintained.

1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
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:
1. A separate recording template for complaints and allegations of abuse in place.
2. A daily nursing narrative now recorded in all care plans.
3. Advanced care directives being further developed with GP, Geriatrician, Residents input ongoing.
4. Gap in employment history addressed.

Proposed Timescale: 30/04/2015

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:
Not all staff had up to date knowledge and skills to respond to and manage and de-escalate behaviours that challenge.

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 being organised with Planning and Development on challenging behaviour.

Proposed Timescale: 30/06/2015

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Multi disciplinary input had not been sought when planning interventions such as the use of lap belts, bedrails or 'code alerts' for individual residents, in line with best practice as outlined in the Department of Health National Policy on Restraint.

Action Required:
Under Regulation 07(3) you are required to: Ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.
Please state the actions you have taken or are planning to take:
Risk assessment and Plan of Care implemented for all residents using bed rails and code alerts in line with national policy has commenced.

**Proposed Timescale:** 30/04/2015

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Incidents and allegations of abuse were not investigated under the centre's policy on the prevention of abuse but were instead investigated as complaints.

**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:
Allegations of alleged abuse will be separately recorded and investigated.

**Proposed Timescale:** 20/02/2015

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Not all staff had received training in relation to the detection, prevention and response to abuse in such a manner as to be able to respond to inspectors questions on the protocol to follow in the centre, as outlined in the centre’s policy.

**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:
Elder abuse training is being organised for all staff on site. Train the trainer course is being sourced. Education on notifications of elder abuse commenced and ongoing.

**Proposed Timescale:** 30/06/2015

**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:
All risks in the centre had not been identified and assessed for example:
- A resident who smoked
- A broken ceiling hoist
- Lack of fire safety awareness for agency staff
- Lack of space and storage for residents
- Residents' bedroom doors opening out to the public road
- Open, unrestricted windows in some areas
- Unlocked chemical/cleaning store.

**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:
1. Risk assessment for residents who smoke in place – no smokers currently.
3. Fire Safety awareness on induction.
4. To be addressed in upgrading plans.
5. Fire doors kept closed at all times – staff informed of same.
6. Restricted window openings on all windows completed.
7. Locked at all times

**Proposed Timescale:** 20/02/2015

**Theme:**
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Fire drills were not facilitated regularly in the centre and all staff on duty during the inspection were aware of the procedure to be followed in the event of a fire.

**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 drills to be undertaken by Fire & Safety Officer.

**Proposed Timescale:** Commenced – April 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:**
A pharmacist of the residents' choice had not been made available in the centre.

**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:**
The centre has a medical officer assigned to the centre. However, residents can choose a GP of their choice at their own cost. This choice is now reflected in the centre’s Statement of Purpose.

**Proposed Timescale:** 12/03/2015

**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:**
Incidents of allegations of possible abusive interactions were not notified to the Chief Inspector within three days as required by the regulations.

**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:**
Notifications of any incident of alleged abuse will be sent to the Chief Inspector within 3 working days. Staff will be educated to the above standard.

**Proposed Timescale:** Completed & ongoing
### 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:**
Some care plans were noted to be out of date or no longer relevant due to the changed needs of residents for example: there was no plan to support a resident who no longer smoked and mobility needs of another resident had changed.

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

**Please state the actions you have taken or are planning to take:**
All care plans updated 3 monthly and revised accordingly in consultation with Resident and family. Key nurse named to patients care plans.

**Proposed Timescale:** 20/02/2015

---

### Outcome 12: Safe and Suitable Premises

**Theme:**
Effective care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The provider was failing to provide appropriate bedroom space and appropriate use of communal space having regard to privacy and dignity of the residents.

The provider was failing to provide adequate sluicing, laundry and storage facilities to support best practice in cross infection control.

The provider was failing to ensure adequate private accommodation is provided for residents.

There was a lack of suitable provision for storage in the designated centre for residents possessions and equipment.

The external grounds were not suitable for or safe to use by residents.

Residents lack privacy to the extent that each resident is unable to undertake personal activities in private by ensuring that there were inadequate bathroom and toilet facilities.
Residents did not have access to an individual call system by their beds.
There was no lockable storage space provided for residents.

**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:**
A design team will be appointed, and plans will be completed by, 30th June 2015.
Planning permission will then be applied for, and provided there are no objections, it is anticipated planning will be granted by October 2015.
A tendering process will begin to appoint a suitable construction company, and this process is expected to be completed by December 2015.
We then expect construction to commence in Jan/Feb 2016, subject to the appropriate statutory approval and funding for same.
It is expected that the building works will be completed by Feb 2018.
Call bells are located beside each bed, accessible to each resident.
Lockers to be purchased, as space allows.

**Proposed Timescale:** Ongoing & March 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 was no record on some occasions on whether or not the complainant was satisfied with the outcome.
- The complaints log was used to record allegations of alleged abuse as complaints, as outlined under outcome 7.
- Some complaints were not recorded such as, a complaint by a resident who was unhappy at not being able to get into his bed and a complaint against a staff member made by two residents.
- The records seen did not specify the measures put in place for improvements in practice in response to complaints.

**Action Required:**
Under Regulation 34(1)(f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.
Please state the actions you have taken or are planning to take:
A record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the complainant was satisfied has commenced. The complaint log is now used solely for complaints only. All staff have been educated on the appropriate recording of complaints.

**Proposed Timescale:** 20/02/2015

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

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The complaints policy did not provide details of the independent nominated person required under Regulation 34 (3) who would ensure that all complaints were appropriately responded to and that there were suitable records maintained.

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

**Please state the actions you have taken or are planning to take:**
The nominated person is identified on all hardback copies of HSE Your Service Your Say throughout the unit.

**Proposed Timescale:** 20/02/2015

**Outcome 14: End of Life Care**

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

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The advanced care wishes and preferences of residents had not been recorded or ascertained.

**Action Required:**
Under Regulation 13(1)(d) you are required to: Where the resident approaching end of life indicates a preference as to his or her location (for example a preference to return home or for a private room), facilitate such preference in so far as is reasonably practicable.

**Please state the actions you have taken or are planning to take:**
Resident’s preferences are now recorded in their end of life care plan, as is practicable.
**Proposed Timescale: 20/02/2015**

### 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 had no control over the management of their own clothes and could not access them.

**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:**  
Lockable units to be purchased, as space allows. Maintenance Dept to fit locks to remaining units and will change the walled units to wardrobe/shelves to accommodate the shortfall. The linen room will be changed to facilitate a walk in wardrobe facility. This will allow residents to have control over the management of their clothes.

**Proposed Timescale: 30/04/2015**

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

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**  
There was inadequate space for residents to store and maintain their own clothes.

**Action Required:**  
Under Regulation 12(c) you are required to: Provide adequate space for each resident to store and maintain his or her clothes and other personal possessions.

**Please state the actions you have taken or are planning to take:**  
Lockable units to be purchased, as space allows, Maintenance Dept to fit locks to remaining units and will change the walled units to wardrobe/shelves to accommodate the shortfall. The linen room will be changed to facilitate a walk in wardrobe facility.

**Proposed Timescale: 20/02/2015**