Health Information and Quality Authority
Regulation Directorate

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

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

Centre name:	Dungarvan Community Hospital
Centre ID:	OSV-0000594
Centre address:	Dungarvan, Waterford.
Telephone number:	058 20900
Email address:	paula.french@hse.ie
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Barbara Murphy
Lead inspector:	Caroline Connelly
Support inspector(s):	Ide Batan;Maria Scally
Type of inspection	Announced
Number of residents on the date of inspection:	102
Number of vacancies on the date of inspection:	14

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

From:	To:
09 December 2014 09:40	09 December 2014 16:30
10 December 2014 09:00	10 December 2014 18:00

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

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

Summary of findings from this inspection

This report sets out the findings of an announced registration inspection of Dungarvan Community Hospital by the Health Information and Quality Authority's Regulation Directorate that took place over two days on 9 December 2014 and 10 December 2014.

As part of the inspection the inspectors met with residents, the provider, person in charge, two Assistant Directors of Nursing (ADON) , the Clinical Nurse Managers (CNM), nurses, relatives and numerous staff members. The inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files.

The centre is currently registered and the registration is due to expire on 1 April 2015 and the provider had applied for renewal of registration.

A number of questionnaires from residents and relatives were returned to the inspector and the inspector spoke to a number of residents and relatives during the inspection. The collective feedback from residents and relatives was one of satisfaction with the service and care provided. Residents and relatives comments are reflected throughout this report.

Overall the inspectors found that the premises posed numerous challenges in the provision of care to due to the lack of private and communal space and facilities for residents. The majority of residents were accommodated in multi-bedded rooms and there was a lack of general storage for personal property and possessions. There were a number of actions required from the previous inspection. A number had been addressed some were completed and some were partially completed. However, there were a number that remained outstanding and the provider continued to be non compliant in these areas such as medication management, inadequate care planning, the management of restraint, the suitability of the premises, staff training and inadequate storage for residents personal property and possessions. There were a number of major non compliances that require immediate attention. These issues are discussed throughout the report.

Actions were required to comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland. These actions are described under each outcome statement and are set out in detail in the Action Plan at the end of this report.
These included improvements in the following areas:

- the premises
- provision of fire training and fire drills
- update risk management policy
- care planning
- end of life planning
- staffing levels
- privacy and dignity
- medication management
- protection of residents finances
- restraint practices
- review of mealtimes
- provision of mandatory training.

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 centre had a comprehensive statement of purpose that accurately described the services provided. It contained all of the information required by Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

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 management team consists of the nominated registered provider, the person in charge and two ADONs who cover two centres. There is a clinical nurse manager 2 (CNM 2) in charge of each of the five units who are responsible for the day to day running of their respective units.
The person in charge held a full time post but is also the person in charge for two other

designated centres, Dunabbey House Dungarvan and St Patrick's Hospital, Waterford. The person in charge stated that she was based in Dungarvan usually for three days each week and spent two days in St Patrick's, Waterford. The inspectors formed the opinion that Dungarvan Community Hospital is a large centre and would benefit from a full time person in charge particularly in light of plans for the renovation of the centre which the person in charge will need to be fully involved in.

The registered provider is based in Waterford; she has responsibility for the operation of HSE services in the Waterford Local Health Office area including management responsibility for Dungarvan Community Hospital and Dunabbey House. She has held this post since July 2012. There was evidence that the provider visits the centre as required. General management meetings, chaired by the provider, were held bi-monthly and attended by the person in charge and all ADONs. The person in charge holds meetings with the ADONS and CNMs and the CNMs in turn hold unit meetings with the unit staff. Minutes of all these meetings were viewed by the inspectors which demonstrated ongoing communication of relevant issues.

There were systems to assess the quality of life and safety of care including committees to consider the review of audits on areas such as activities, pressure sores, falls, hand hygiene and medication. The inspectors viewed audits completed by the ADONs. Data was being collected on a number of key quality indicators such as medication management, accidents and incidents, hygiene, protected mealtime policy and care planning. The audits highlighted a number of issues and action plans were identified; however, the inspectors did not see that improvements were always ongoing following the audit and action plan and as there were ongoing non compliances in relation to areas around medication management, care planning and restraint. There was little evidence of learning from the monitoring/review. Further practice development and change management is required to ensure staff are providing care in accordance with contemporary evidenced-based practice.

Inspectors noted a residents' committee met regularly and minutes of these meetings indicated actions were taken in response to issues identified, such as meals and activities. The inspectors met a relative who sits on the residents committee who was very complimentary about the committee and response received from management to issues and requests made from the committee. Residents had access to advocacy services and nominated advocates had received appropriate training in this area. Advocates met with residents on a regular basis and mechanisms for feedback were in place.

Interviews were conducted with the provider nominee and person in charge and ADONs during the inspection and on previous inspections and they displayed a good knowledge of the standards and regulatory requirements in relation to their relevant roles.

There was appropriate assistive equipment available to meet residents' needs such as electric beds, wheelchairs, hoists and pressure-relieving mattresses. The provider and person in charge outlined the plans to upgrade the premises and to reduce the multi-occupancy accommodation; however, resources had not been identified to date.

Judgment:

Non Compliant - Moderate

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:
A residents' guide was available which included a summary of the services and facilities provided, terms and conditions relating to residence, the procedure respecting complaints and the arrangements for visits. There was also a centre-specific policy on the provision of information to residents.

The inspector also reviewed a sample of residents' contracts of care and noted that contracts were signed and dated by the resident or their representative. The contract set out the services to be provided, and the fee for the provision of care and services. Details of any additional services that may incur an additional charge were included.

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 held a full time post but is also the person in charge for two other designated centres, Dunabbey House Dungarvan and St Patrick's Hospital, Waterford. The person in charge stated that she was based in Dungarvan usually for three days each week and spent two days in St Patrick's, Waterford. The person in charge is a registered nurse and the inspectors saw evidence that she was currently registered with the relevant nursing professional body. She holds a degree in nursing and a diploma in

management. Training records confirmed she had kept her clinical knowledge current showing that she had attended relevant training courses.

The inspectors formed the view that the person in charge was a suitably experienced nurse with the authority, accountability and responsibility for the provision of the service.

She displayed a good knowledge 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.

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

Findings:
The inspector reviewed a sample of staff files and found that they contained the information required under Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Records relating to inspections by other authorities were maintained in the centre and the inspector viewed documentation relating to food safety.

The directory of residents in the centre was found not to contain all details as required by Schedule 3 of the Regulations for all residents. Items missing for some residents included:
• Marital status of the resident
• address and telephone number of the resident's general practitioner
• the date on which the resident was discharged from the designated centre
• if the resident is transferred to another designated centre or to a hospital, the name of the designated centre

or hospital and the date on which the resident is transferred
• if the resident died at the designated centre, the date, time and cause of death.

The designated centre had 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. However a number of policies required review and the medication management policy, though centre-specific, did not outline the procedure for the prescription, administration and review of PRN medications. There were numerous versions of various policies and it was difficult to establish which was the current and up to date version. This practice could lead to errors as staff need to follow the up to date policy. Overall the records were found not to be maintained in a way to ensure ease of retrieval.

The centre was adequately insured against accident or injury and insurance cover complied with the all the requirements of the Regulations.

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 had been no period of 28 days or more when the person in charge was absent from the centre and the provider demonstrated that were aware of the obligation to inform the Chief Inspector if there is any proposed absence.

The person in charge is supported in her role by two assistant directors of nursing, who are also involved in the management of one other designated centre. There is a clinical nurse manager 2 (CNM 2) in charge of each of the five units and are responsible for the day to day running of their respective units.

The ADONS were interviewed by the inspectors and were found to be experienced nurses with managerial experience. The ADONS will act up in the absence of the person in charge as they have done in the past. The inspectors were satisfied that they demonstrated an awareness of their responsibilities in being in charge of the centre under the legislation.

The person in charge and assistant directors of nursing are on call out-of-hours should a

need for their assistance arise.

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

Findings:
Inspectors found that there were measures in place to protect residents from suffering harm or abuse. There was a generic HSE policy on the prevention, detection and response to elder abuse which had additional centre specific guidelines. Staff interviewed by the inspector demonstrated a good understanding of elder abuse and were clear about their responsibility to report any concerns or incidents in relation to the protection of a resident. The inspectors saw that elder abuse detection and prevention training was ongoing and training records showed that 90 percent of staff had received update elder training but the other 10 percent of staff needed training as required by legislation.

There was evidence that previous allegations of abuse had been recorded investigated and managed appropriately by the staff and management team.

Records of residents' finances and invoicing for care were maintained in accordance with HSE policy and best practice guidelines which were also the subject of regular external audit. However, it was identified that the records maintained of money and valuables handed in by a resident/relative for safekeeping at the ward level in one unit was not sufficiently robust. Money was stored in a locked cupboard but transactions were not signed and witnessed by resident/relative second staff member. This practice did not safeguard residents' finances and the inspector found a discrepancy of €20 in one resident's money handed in for safe keeping with no evidence of the money having been returned to the resident or where that money went to.

There was a policy on challenging behaviour. St Anne's unit is a dementia specific unit and the CNM in charge of the unit is a Clinical Nurse Specialist (CNS) in dementia care. The inspectors saw evidence of positive behavioural strategies and practices implemented to prevent behaviours that challenged. The CNS told the inspector that she

regularly reviewed residents on all units and particularly residents who presented with any behaviour that challenged. She advised on treatment and behavioural plans. The CNS confirmed that she provided training to staff on behaviours that challenge, medication management and monitoring and is available for advice and support.

The inspectors saw that bedrails were currently being used for a large number of residents in the centre, some who have requested them for their comfort others were used for restraint purposes. The inspector saw that assessments for the use of bedrails were being completed on some residents and some alternatives had been tried. These assessments were reviewed on a regular basis and there was evidence that residents were being checked and these checks were documented. However, for some residents there was no evidence of assessment for the use of bedrails and there was also no evidence of consideration of the least restrictive alternatives to bedrail usage. Residents' consent to treatment forms were viewed by the inspectors and were found to require review as relatives and next of kin had signed consent forms, which do not have any legal standing. Best practice would advocate the discussion of the requirement for restraint with the next of kin but not the signing of the consent which can only be completed by the resident.

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

Findings:
The fire policies and procedures were centre-specific. The fire safety plan was viewed by the inspector and found to be very comprehensive. There were notices for residents and staff on "what to do in the case of a fire" throughout the building. The inspector viewed records which showed that fire training was provided to staff on various dates in 2014; however, although a very high percentage of staff had received training, there were still a number outstanding who had not completed this mandatory training. There was no evidence of a fire drill having taken place in one of the units. There was evidence of a contract in place for the maintenance of fire safety equipment and stickers on a sample of fire safety equipment viewed by inspectors indicated that maintenance was most recently carried out in March 2014. Certification was available to show that the fire alarm system was last checked in August 2014. Staff interviewed demonstrated an appropriate knowledge and understanding of what to do in the event of fire and that fire drills were being held on a regular basis last fire drill was undertaken in one unit on 8

December 2014. There was a fire safety register in each of the units with records of checks verifying that means of escape were free from obstruction these were completed on a weekly basis as scheduled. Emergency exits were seen to be free of obstruction on the days of inspection.

There was a centre-specific health and safety statement in place dated 2014. There was also a risk management policy and a register of risks, detailing the precautions in place to control them. Arrangements were in place for investigating and learning from serious/adverse events involving residents. However, the risk management policy did not meet the requirements of legislation as it did not have the measures in place to control the following specified risks

- the unexplained absence of a resident
- accidental injury to residents, visitors or staff
- aggression and violence.

Accidents and incidents were recorded on incident forms and were submitted to the HSE clinical incident reporting system (STARSWeb) and there was evidence of action in response to individual incidents. There was a regional health and safety committee and one of the ADONs had specific responsibility for health and safety.

There were reasonable measures in place to prevent accidents such as safe floor covering, grab rails in toilets and hand rails on corridors.

The emergency plan had been updated since the last inspection and it now a centre-specific emergency plan that take into account all emergency situations and where residents could be relocated to in the event of being unable to return to the centre.

Clinical risk assessments are undertaken including falls risk assessment, assessments for dependency, continence, moving and handling.

The provider has contracts in place for the regular servicing of all equipment and the inspectors viewed records of all equipment serviced.

The environment was observed to be clean both and personal protective equipment, such as gloves and aprons, and hand sanitizers were located throughout the premises. All hand-washing facilities had liquid soap and paper towels available. There were policies in place on infection prevention and control and staff that were interviewed demonstrated knowledge of the correct procedures to be followed.

The inspectors viewed training records which showed that 10 percent of staff had not received current training in moving and handling. There were a number of different hoists available in the centre. These hoists were serviced on a regular basis as required by legislation and records of same were seen by the inspector. The inspector observed staff assisting residents using the hoists which was completed in a safe manner following best practice guidelines.

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

Findings:
The inspectors observed nurses administering the medications, and this was carried out in line with An Bord Altranais agus Cnáimhseachais na hÉireann Guidelines 2007.

There was evidence of good practice and evidence that staff on a daily basis endeavoured to implement procedures for the safe management of medications.

The medication management policy, though centre-specific, did not outline the procedure for the prescription, administration and review of PRN medications. This was an action from the previous inspection and the provider and person in charge continued to be non compliant in this area. The action for this is covered under documentation in outcome 5.

Medications were generally stored and disposed of appropriately in line with An Bord Altranais agus Cnáimhseachais na hÉireann Guidance to Nurses and Midwives on Medication Management (2007). Medication Management practices were subjected to audit, but based on a sample of prescriptions reviewed the inspector saw and staff agreed that:

· the dosage and maximum dosage of all medications prescribed on a PRN basis was not stated.
• Crushed medications were not consistently prescribed by the medical officer as is required by legislation.

There was a GP's signature for each medication prescribed and discontinued. Each resident's medication regime was routinely reviewed and prescribed on a quarterly basis by the medical officer. The prescription sheets were designed so that they had to be renewed every 12 weeks.

The supply, distribution and control of scheduled controlled drugs was checked and correct according to the register and in line with legislation. Nurses were checking the quantity of medications at the start of each shift. The nurses spoken to displayed a good knowledge of medications and the procedure outlined for administration.

Procedures were in place for the recording and monitoring of medication errors.

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 designated centre was maintained and, where required, notified to the Chief Inspector. Quarterly notifications had been submitted to the Authority as required and within the appropriate timeframe.

Judgment:
Compliant

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

Findings:
The centre had sufficient GP cover and an out of hours service was also provided. Residents were seen by a GP within 24 hours of admission. Records confirmed that residents had timely access to GP services were reviewed regularly which included regular medication reviews.

Residents had access to a range of other health and social care services. Records were maintained of referrals and follow-up appointments. The centre had just employed the services of a dietician one day per week and the inspector met and spoke to the

dietician during the inspection who confirmed she had commenced reviews of the residents' individual dietary plans. Chiropody services were provided in the centre as required. There was a physiotherapy unit located in the centre and physiotherapy was available for assessment and the implementation of treatment plans. Occupational health and speech and language therapy were available through community services on site. Consultant geriatrician services were provided from consultants based in Waterford University Hospital. There was also evidence that residents had access to the local mental health services and other specialist services in Waterford University Hospital.

Staff members spoken with by inspectors were knowledgeable of resident's individual needs and based on observations of inspectors, residents were treated with dignity and respect. However, improvements were required in relation to care planning and the delivery of evidence-based nursing practice such as in the management of restraint as discussed earlier and wound care. These issues were also identified on the previous inspection. A small number of residents had wounds and on one unit there was no evidence of the ongoing scientific assessment and measurement of the wound and wound bed. Therefore there was no ongoing evidence of improvement or deterioration of the wound.

Residents had regular nursing assessments using evidence-based tools for issues such as falls prevention, dependency level, pressure sore risk and nutrition. However, care plans were not developed for a significant number of residents based on the results of these assessments to support the provision of consistent, high quality, evidence-based care. The care plans also did not address the topic of spirituality and dying in line with residents' emotional, psychological and physical needs. In one unit, although assessments were ongoing and issues identified there was no plan of care in place to plan and direct care for any of these residents. This was particularly relevant with residents who suffered from dementia and behaviours that challenged as many residents were unable to express their needs and requirements and the care plan was essential to identify strategies specific to that resident to provide care in accordance with their needs and routines. Care planning was identified as non compliant on the last inspection and remains a major non compliance on this inspection.

Documentation in place indicating that information about residents was provided and received when they were absent or returned from another care setting, home or hospital.

Judgment:
Non Compliant - Major

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:
The centre is a two-storey building. However, all resident accommodation is on the ground floor and comprises five separate units:

- Vincent's Unit is a 32-bedded unit for male and female residents comprising eight beds allocated for acute general practitioner (GP) admissions, eight beds for respite care, three beds designated for young chronic sick, three beds for palliative care and 10 beds for short-term convalescence
- Sacred Heart Unit is a 27-bedded male and female unit comprising 15 beds allocated to rehabilitation, respite and convalescence and 12 beds for long-term care
- Ann's Unit is a dementia-specific unit providing accommodation for 10 residents incorporating nine long-term care residents and one respite resident. The unit also provides day care services from Monday to Friday for a maximum of three residents each week
- Francis Unit is a female long-term care unit providing accommodation for 23 residents
- Enda's Unit is a mixed male and female long-term care unit providing accommodation for 24 residents.

On the days of inspection the centre was bright, clean and appeared to be in a reasonably good state of repair. The grounds were well maintained and free from significant hazards which could cause injury. However the inspectors found that the premises posed numerous difficulties in the provision of care due to the lack of private and communal space and facilities for residents. The inspectors found that the centre required a number of actions to ensure it met the requirements of legislation.

The corridor leading to the units from the main entrance was wide allowing easy access for residents in wheelchairs and those people using walking frames. However, the corridor leading to Ann's Unit from the main entrance was narrow in places.

Resident accommodation was primarily provided in two-bedded, four-bedded and six-bedded rooms. The significant number of multi-occupancy rooms impacts on the privacy and dignity of residents and means that most residents have limited scope for personalising spaces and limited facilities to secure personal belongings. In particular, Enda's Unit has a number of six-bedded "bays" that open directly onto a corridor and the proximity of the beds to each other does not support privacy and dignity for residents and does not allow for adequate storage of residents' personal belongings, including clothing, which are instead stored in a central store room.

In Ann's Unit, which is the dementia-specific unit, there was one six-bedded room and one four-bedded room, both of which were sparsely furnished they had been redecorated since the last inspection and some personalisation of the bed space had

taken place but the environment prevented full personalisation.

There were no separate dining rooms in Enda's Unit, Francis Unit and Sacred Heart Unit and residents' meals were served in the sitting rooms. While the sitting room in Sacred Heart was sufficient in size for a designated dining area, the sitting rooms in both Enda's and Francis were inadequate in size for residents to dine comfortably and appeared crowded at mealtimes.

A number of mobile electronic hoists were stored on corridors outside residents' rooms while the batteries were recharged. Wheelchairs and commodes were also being stored along corridors. All of the above issues were identified on the last and previous inspections and were identified as major non compliances.

The provider and person in charge showed the inspectors plans for the renovation and upgrade of the premises however no funding has been identified to date for the provision of this upgrade work.

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

Findings:
A centre-specific complaints policy was in place dated 30 August 2014 which identified the person in charge as the nominated complaints officer and also provided information on an independent appeals process and referral to the office of the Ombudsman. The complaints procedure was summarised in both the statement of purpose and the resident's guide. Information for residents and visitors on how to make a complaint was clearly on display at the centre. Information was also available on the rights of residents and visitors and providing the contact details of advocacy agencies. Two designated advocates were available at the centre who met with residents on a regular basis; a mechanism was also in place for the provision of feedback from these meetings.

The centre referenced the Health Service Executive (HSE) national complaint document "Your Service Your Say" to support its procedures. Residents spoken with stated that they understood the process for raising concerns and were satisfied with service at the centre and did not have any issues or complaints. When asked, residents regularly

identified the person in charge as the appropriate responsible person to go to with complaints. The person in charge stated that as issues were identified they were addressed on an on-going basis. The inspector reviewed the complaint log on different units and verified that generally where complaints had been recorded appropriate actions were taken and records of improvements implemented were maintained. However, on one unit the CNM told the inspector that she had received a complaint a number of weeks ago that she had failed to document into the complaint log therefore there was no evidence of the complaint or whether the complaint was satisfied with the outcome.

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:
The inspector reviewed the self-assessment questionnaire and the overall self-assessment of compliance with Regulation 14 and Standard 16 End of Life Care. The person in charge had assessed the centre as being non-compliant: minor and outlined specific actions to ensure compliance.
These actions included:
• review of the end of life policy
• end of life care planning to be introduced to all units
• commencement of an end of life committee
• staff training in relation to end of life.

The inspectors viewed that the end of life policy had been reviewed and was found to be comprehensive. The inspector observed that the policy guided staff in assessing a resident's needs should their health deteriorate rapidly including regular review by the general practitioner (GP). The Health Service Executive (HSE) palliative care team offers guidance as required in respect of appropriate management of illness. There was evidence in resident's notes of involvement of the palliative care team with referral and reviews seen by the inspector in resident's files.

A number of staff had completed further education in palliative care and end of life care and they plan to roll out further training for all staff over the next number of months. Training records showed that 30 care staff had undertaken end of life training as part of their Further Education and Training Awards Council (FETAC) level 5. Staff who spoke to

the inspector demonstrated knowledge of how to provide good end of life care. However, as the centre offers dedicated palliative care beds there were no staff trained to higher diploma level in palliative care which would assist in ensuring palliative care was being provided in accordance with contemporary evidenced based practice. The person in charge said they have encouraged staff to undertake the course but no staff had expressed interest to date.

In St Vincent's unit there are three single bedrooms which are dedicated palliative care rooms and have en suite shower, toilet and wash-hand basin facilities. One of the rooms has an adjoining room for visitors who are facilitated to stay overnight if required which has a table and chairs and facilities to prepare drinks and snacks. However in the other units there are very limited single rooms available for end of life care as the majority of accommodation is provided in multi occupancy bedrooms, therefore residents may not be able to be offered private accommodation at end stage of life.

Religious needs were facilitated for residents of a Roman Catholic faith with mass taking place in the hospital church daily. There is also a video link service to each unit of all services in the church. Residents are visited by the local priests who provide pastoral care. Residents from other religious denominations were visited by their ministers as required.

The inspector reviewed a sample of care plans and found that there was some evidence of engagement and consultation regarding spirituality and dying in some plans but not in others. Some residents had an end of life assessment completed, some were quiet detailed specifying their wish to remain in the centre and not be transferred to the acute hospital if their condition deteriorated, funeral and burial arrangements, others had limited or no detail. The inspectors saw that although some assessments had been commenced the care plans did not address the topic of spirituality and dying in line with residents' emotional, psychological and physical needs. The nursing staff said it was a new process and they were only getting familiar with talking to the residents about end of life and were aware that it required to be developed further and were aware that care plans would need to be implemented. The whole documentation and care planning in relation to end of life care requires review as plans of care were seen not to direct the care to be delivered and this is auctioned under outcome 11.

There was evidence in residents' medical notes of regular medical and medication reviews by the GPs with visits increasing towards end of life as required.

A remembrance event had taken place in November 2014. A bereavement leaflet for relatives 'The Bereavement Journey' had been developed. The leaflet offered practical information on what to do following a death, information on how to access bereavement/counselling services and how to register a death.

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

Findings:
The inspector reviewed the person in charges self assessment and the overall assessment of compliance with regulation 20 and standard 19. The person in charge assessed the centre as compliant however the inspectors did not concurred with this assessment due to mealtimes being served too early and lack of dining space for all residents.

There was an up to date policy on food and nutrition which was found to be comprehensive. The inspector observed that food and hydration needs were assessed on admission using the malnutrition universal screening tool (MUST) and this was repeated on a three-monthly basis or more frequently if required. The inspector observed mealtimes including breakfast, mid morning and afternoon refreshments lunch and tea time. The inspectors found that mealtimes were generally too early. The inspectors observing lunch in one unit commencing as early as 12.00hrs, tea time was 16.30hrs and although drinks and snacks may be served later, the next full meal was not until breakfast the next morning. Residents had identified via surveys that they would like the mealtimes to be later and the provider and person in charge agreed that mealtimes need to be later but no change has been undertaken to date. Mealtimes required review to be available at times suitable to residents.

The food was cooked in the main kitchen and transported to each unit in a heated trolley. The food was seen to be nutritious and residents stated they had choice and adequate portions. The inspectors spoke with the chef who was relatively new to his post and had made numerous changes to the menu and particularly to the modified diets adding variety and fortification as required. He met with residents and elicited residents views via the residents committee. There was a good menu cycle. the kitchen staff told inspectors that the dietary needs of residents were conveyed by nursing staff to the kitchen staff. The inspectors saw specialist diets and residents requirement documented on a board in the centres kitchen. Residents informed the inspectors that the food was good and that they always had a choice and if they did not like what was on the menu they could request something else.

Many residents required assistance and the inspector observed that this assistance was provided in an appropriate manner. The inspectors noted that staffing levels were adequate to supervise meal times based on observation and staff rosters.
The inspector observed that residents had access to drinking water at all times. Jugs of drinking water and glasses were present by the bedsides of residents.

There was a policy on nutrition and the centre had just employed the services of a dietician one day per week who was commencing the assessment and nutritional planning for residents. The Inspector viewed a number of residents' care plans and observed that the weight of each resident was taken regularly and that the Malnutrition Universal Screening tool (MUST) was completed. There was evidence of appropriate referrals to dietetic services and speech and language services as required. The inspectors noted that the dietician had only recently taken up her post in the centre. However, there was no evidence available that the menus and nutritional content of the food met the dietary needs of residents as prescribed by healthcare or dietetic staff, based on nutritional assessments in accordance with the individual care plans of residents. The inspectors observed that there were a number of the residents taking nutritional supplements. These were appropriately prescribed by the general practitioner (GP). The inspector saw in residents' care plans that residents were seen by their GP on a regular basis and there was evidence that residents saw the dentist as required.

In all of the units dining tables were appropriately and attractively set however the inspectors observed that mealtimes were not social occasions for some residents as in a number of units there were not enough dining facilities available for residents use and a number of residents had their meals in or by their beds in their bedrooms. As previously described many of the bedrooms were multi occupancy rooms which did not afford residents any space or dignity during mealtimes. These residents were not offered the choice to move to a different area for their meals as is required by legislation. The action for this is under outcome 12 premises.

The kitchen was clean. There was a food safety management system in place and there was no evidence of non-compliance with the requirements of food safety authorities. Kitchen staff had received food handling training, and were knowledgeable of their role and responsibilities.

Judgment:
Non Compliant - Moderate

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:
Residents who spoke to the inspector said that staff addressed them respectfully and that screening curtains were used in shared rooms when personal care was being delivered. However, the inspector found that residents did not have sufficient space and privacy. The size and layout of the multi-occupancy rooms meant that there was very little space between some of the residents' beds. Residents were unable to undertake personal activities in private. The inspectors observed that some residents were trying to rest while another resident was talking beside them.

There was a good level of visitor activity throughout the days of inspection with visitors saying they generally felt welcome to visit. Residents had access to the church for prayer services or quiet reflection. Accommodation was available to receive visitors both communally and in private in some units but in others there were not private space for visiting.

The centre was suitably resourced with adequate daily entertainment and leisure facilities such TV, radio, newspapers and magazines. A dedicated activities co-ordinator was available to the centre that initiated and supervised a range of activities and outings. During the inspection there were numerous Christmas activities ongoing such as decoration making and Christmas cake icing which the inspectors saw residents participating in and enjoying. A residents' forum was held regularly and minutes indicated that residents were also involved in some of the programmes initiated by the centre. For example, the activities co-ordinator was driving an initiative to purchase a wheelchair accessible vehicle and residents had been actively involved in the fundraising process. As previously discussed, there were two residents advocates available for residents to bring issues forward if required.

Judgment:
Non Compliant - Moderate

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 was a policy for the management of residents' accounts and personal property. A sample of residents' records indicated that records of residents' property was created on admission. Residents' clothing is appropriately labelled and sent externally to be

laundered.

As stated in Outcome 12, due to multi-occupancy rooms there was insufficient space for all residents to store their own clothes and these were stored centrally in each unit.

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:
Based on their observations and a review of the staff roster, inspectors were not satisfied that staffing levels and skill-mix were adequate to meet the needs of the residents and other factors such as the layout of the building and the specifics of each unit. The management of the roster was devolved to each unit manager and each staff member had their roster planned for a full 12 month period. There was a registered nurse on duty at all times on each unit and a designated nurse in charge of the centre for out-of-hours. Staffing levels in the morning met the needs of the residents. However staffing levels decreased from 17.00hrs onwards in all units and most units operated with one nurse and one care staff from 20.00hrs and earlier in many units. The night nurse had to do the night time medication round and therefore this left only one member of staff to give out evening drinks and assist residents to bed and with other personal care needs. The inspectors found that these staffing levels were not adequate to ensure the nurse administered the medications safely without interruption and to ensure residents had a choice in bedtimes. The inspectors observed and were told by staff that the majority of residents were in bed before the night staff came on duty at 20.00hrs.

There was a clear organisational structure and reporting relationships in place. There were designated CNM posts of responsibility on each unit for the supervision of care and services to residents and the supervision and direction of staff. The inspector saw records of regular meetings between these post holders and senior nursing management

at which operational and staffing issues were discussed. The inspector saw that staff had available to them copies of the regulations and standards.

Inspectors observed appropriate interactions between staff and residents and they observed staff chatting easily with residents. Residents and relatives told the inspector that staff were very kind and caring.

There was a recently written policy for the recruitment, selection and Garda Síochána vetting of staff. The current registration details were maintained for all nursing staff. The inspectors viewed a sample of staff personnel files. These files were found to contain all the documentation required under Schedule 2.

Staff told inspectors that copies of the regulations and the standards had been made available to them and that these were also discussed at staff meetings. The inspector viewed minutes of staff meetings and saw that issues covered by the legislation and standards were on the agendas.

The scope of and individual staff attendance at staff training, as identified at the last inspection continued to require review and monitoring. This is to ensure that each staff member attained and maintained the required skills and competencies to allow them to meet the needs of the residents in line with contemporary evidence-based practice. A staff training matrix was in place and the inspector saw, based on the records reviewed, that staff had completed recent education and training such as health and safety, the safe management of sharps, sharps, nutrition and the older person, person-centred care, basic life support and end of life care. However, the training records also indicated that while training including mandatory training was facilitated by the provider, not 100 per cent of staff had attended mandatory training such as manual handling, elder abuse and fire training within the required mandatory timeframes. Training records did not demonstrate that staff had attended recent training on the use of physical restraint and wound care as previously outlined in the report as areas requiring improvement to ensure they provided care in accordance with contemporary evidenced-based practice. Higher education in palliative care would be of benefit for staff when the hospital is providing dedicated palliative care beds this was specified by inspectors in line with the findings as discussed in Outcome 14.

Agency staff were employed in response to staffing contingencies and the inspector saw that service agreements were in place with the respective agencies.

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:

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Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	Dungarvan Community Hospital
Centre ID:	OSV-0000594
Date of inspection:	09/12/2014
Date of response:	19/01/2015

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 02: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The audits undertaken highlighted a number of issues to be addressed and action plans were identified, however the inspectors did not see that improvements were always ongoing following the audit and action plan and this was evidenced by ongoing non compliances in relation to areas around medication management, care planning and restraint. There was little evidence of learning from the monitoring/review.

Action Required:

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

Under Regulation 23(c) you are required to: Put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

Please state the actions you have taken or are planning to take:
The person in charge has now to complete monthly template for the registered provider of all systems to ensure that there is safe appropriate consistent and effective monitoring taking place.This will ensure that audits action plans are been evaluated and that all policies are been reviewed in timely manner.

Proposed Timescale: 30/01/2015

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:
A number of policies required review and updating and the medication management policy did not outline the procedure for the prescription, administration and review of PRN medications. This was an action from the previous inspection and the provider and person in charge continued to be non compliant in this area.

Action Required:
Under Regulation 04(3) you are required to: Review the policies and procedures referred to in regulation 4(1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.

Please state the actions you have taken or are planning to take:
Medication management policy has been reviewed and updated plan in place to roll out policy to all staff including General Practitioners.

Proposed Timescale: 12/01/2015

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The directory of residents in the centre was found not to contain all details as required by Schedule 3 of the Regulations for all residents. Items missing for some residents included:
• Marital status of the resident
• address and telephone number of the resident's general practitioner
• the date on which the resident was discharged from the designated centre

• if the resident is transferred to another designated centre or to a hospital, the name of the designated centre
or hospital and the date on which the resident is transferred
• if the resident died at the designated centre, the date, time and cause of death.

Action Required:
Under Regulation 19(3) you are required to: Ensure the directory includes the information specified in paragraph (3) of Schedule 3.

Please state the actions you have taken or are planning to take:
Template has been put in place to ensure compliance and audit will be conducted to evaluate the same.

Proposed Timescale: 15/01/2015

Outcome 07: Safeguarding and Safety

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no evidence of assessment for the use of bed rails on some residents and there was also no evidence of consideration of least restrictive alternatives to bed rail usage.
Residents consent to treatment forms required review as relatives and next of kin had signing consent forms, which do not have any legal standing.

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:
The restraint free policy to be rolled out inducing new consent/ consultation form and also to ensure all assessment are carried out correctly and documented

Proposed Timescale: 30/01/2015

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Training records showed that 90 percent of staff had received update elder training but the other 10 percent of staff needed training 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:
Training in Ongoing and Remaining 10% will have Completed Training by end of January 2015

Proposed Timescale: 31/01/2015

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
It was identified that the records maintained of money and valuables handed in by a resident/relative for safekeeping at the ward level in one unit was not sufficiently robust. Money was stored in a locked cupboard but transactions were not signed and witnessed by resident/relative second staff member. This practice did not safeguard resident's finances and the inspector found a discrepancy of €20 in one resident's money handed in for safe keeping with no evidence of the money having been returned to the resident or where that money went to.

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

Please state the actions you have taken or are planning to take:
Policy is in place and education has been given to staff in handling money

Proposed Timescale: 23/12/2014

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:
the risk management policy did not meet the requirements of legislation as it did not have the measures in place to control the following specified risks
- the unexplained absence of a resident
- accidental injury to residents, visitors or staff
- aggression and violence

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:
Risk management policy in place and plan to roll out the same to staff

Proposed Timescale: 19/01/2015

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were a number of staff outstanding mandatory fire 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 training takes place on regularly and plan in place to ensure all staff trained

Proposed Timescale: 19/01/2015

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no evidence of fire drills in one of the units

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 take place on regular basis

Proposed Timescale: 19/01/2015

Outcome 09: Medication Management

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Based on a sample of prescriptions reviewed the inspector saw and staff agreed that:

· the dosage and maximum dosage of all medications prescribed on a PRN basis was not stated.
• crushed medications were not consistently prescribed by the medical officer as is required by legislation.

Action Required:
Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.

Please state the actions you have taken or are planning to take:
Medication management policy has been reviewed and updated medication committee has been set up and plan in place to roll out policy to all staff and general practitioners

Meeting set up to meet with all general Practitioners to ensure compliance with Regulations

Proposed Timescale: 26/01/2015

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:
Care plans were not developed for a significant number of residents and therefore there was no plan of care in place to plan and direct care for any of these residents. This was particularly relevant with residents who suffered from dementia and behaviours that challenged as many residents were unable to express their needs and requirements and the care plan were essential to identify strategies specific to that resident to provide care in accordance with their needs and routines. Care planning was identified as non compliant on the last inspection and remains a major non compliance on this inspection.

Action Required:
Under Regulation 05(3) you are required to: Prepare a care plan, based on the assessment referred to in Regulation 5(2), for a resident no later than 48 hours after that resident's admission to the designated centre.

Please state the actions you have taken or are planning to take:
All care plans are been reviewed and updated and plan to carry out monthly audits for 3 months in each ward.
Education re documentation to be put in place for all staff .

Proposed Timescale: 19/01/2015

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The assessment of wounds was not in accordance with evidenced based practice. On one unit there was no evidence of the ongoing scientific assessment and measurement of the wound and wound bed. Therefore there was no ongoing evidence of improvement or deterioration of the wound.

Action Required:
Under Regulation 06(1) you are required to: Having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care for a resident, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais.

Please state the actions you have taken or are planning to take:
Evidenced based education on wound assessment is to be rolled out to staff to ensure high standard of evidence based nursing care is carried out

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 premises posed numerous difficulties in the provision of care due to the lack of private and communal space and facilities for residents. The inspectors found that the centre required a large number of actions to ensure it met the requirements of legislation.

The corridor leading to Ann's unit from the main entrance was narrow in places.

Resident accommodation was primarily provided in two-bedded, four-bedded and six-bedded rooms. The significant number of multi-occupancy rooms impacts on the privacy and dignity of residents and means that most residents have limited scope for

personalising spaces and limited facilities to secure personal belongings. In particular, Enda's Unit has a number of six-bedded "bays" that open directly onto a corridor and the proximity of the beds to each other does not support privacy and dignity for residents and does not allow for adequate storage of residents' personal belongings, including clothing, which are instead stored in a central store room.

There were no separate dining rooms in Enda's Unit, Francis Unit and Sacred Heart Unit and residents' meals were served in the sitting rooms. While the sitting room in Sacred Heart was sufficient in size for a designated dining area, the sitting rooms in both Enda's and Francis were inadequate in size for residents to dine comfortably and appeared crowded at mealtimes.

A number of mobile electronic hoists were stored on corridors outside residents' rooms while the batteries were recharged. Wheelchairs and commodes were also being stored along corridors.
All of the above issues were identified on the last and previous inspections and were identified as major non compliances.

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:
Estate management submit plans to conform with Schedule 6

Proposed Timescale: 30/01/2015

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:
The inspector was informed that a complaint that had been made had not been recorded in the complaint log therefore there was no record of the complaint and whether there was or was not a satisfactory outcome from same.

Action Required:
Under Regulation 34(2) you are required to: Fully and properly record all complaints and the results of any investigations into the matters complained of and any actions taken on foot of a complaint are and ensure such records are in addition to and distinct from a resident's individual care plan.

Please state the actions you have taken or are planning to take:
Staff have been educated in the documenting of complaints and actions and evaluation of the same

Proposed Timescale: 19/12/2014

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:
There are very limited single rooms available for end of life care as the majority of accommodation is provided in multi occupancy bedrooms, therefore residents may not be able to be offered private accommodation at end stage of life.
The care plans did not address the topic of spirituality and dying in line with residents' emotional, psychological and physical needs so therefore did not direct the care to be provided.

Action Required:
Under Regulation 13(1)(a) you are required to: Provide appropriate care and comfort to a resident approaching end of life, which addresses the physical, emotional, social, psychological and spiritual needs of the resident concerned.

Please state the actions you have taken or are planning to take:
Education in End life care planning is been rolled out to all staff to ensure that there is compliance with Regulation 13 (1) (a) .
There has been Number of staff have enrolled in European Certificate in Palliative care and "What Matters To Me" course has been introduced to hospital .

Proposed Timescale: 30/01/2015

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 inspectors noted that there was no evidence available that the menus and nutritional content of the food met the dietary needs of residents as prescribed by healthcare or dietetic staff, based on nutritional assessments in accordance with the individual care plans of residents.

Action Required:
Under Regulation 18(1)(c)(iii) you are required to: Provide each resident with adequate quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietetic staff, based on nutritional assessment in accordance with the individual care plan of the resident concerned.

Please state the actions you have taken or are planning to take:
Consultation has taken place with Chef and Dietician menu review has commenced with Nutritional content to be included on all menus

Proposed Timescale: 26/01/2015

Theme:
Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Meal times were too early with Lunch served as early as 12md and tea at 4.30. resident's had identified that meal times were too early.

Action Required:
Under Regulation 18(2) you are required to: Provide meals, refreshments and snacks at all reasonable times.

Please state the actions you have taken or are planning to take:
Plan to change meal times to ensure that all meals are at reasonable times is been introduced

Proposed Timescale: 19/01/2015

Outcome 16: Residents' Rights, Dignity and Consultation

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The inspector found that residents did not have sufficient space and privacy. The size and layout of the multi occupancy rooms meant that there was very little space between some of the residents' beds. Residents were unable to undertake personal activities in private. The inspectors observed that some residents were trying to rest while another resident was talking beside them.

Action Required:
Under Regulation 09(3)(b) you are required to: Ensure that each resident may undertake personal activities in private.

Please state the actions you have taken or are planning to take:
Estate management to submit plans

Plans to commence refurbishment of St Michaels Ward are been finalised and work should commence at end of March 2015

Proposed Timescale: 30/01/2015

Theme:
Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
In some units there was not private space for visiting.

Action Required:
Under Regulation 11(2)(b) you are required to: Make suitable communal facilities available for a resident to receive a visitor and a suitable private area which is not the resident's room, if required.

Please state the actions you have taken or are planning to take:
Estate management to submit plans

Plans to commence refurbishment of St Michaels Ward are been finalised and work should commence at end of March 2015

Proposed Timescale: 30/01/2015

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:
Due to multi-occupancy rooms there was insufficient space for all residents to store their own clothes and these were stored centrally.
Therefore residents did not have easy access to their clothing and belongings.

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:
Estate management to submit plans

Plans to commence refurbishment of St Michaels Ward are been finalised and work should commence at end of March 2015

Proposed Timescale: 30/01/2015

Outcome 18: Suitable Staffing
Theme: Workforce **The Registered Provider is failing to comply with a regulatory requirement in the following respect:** Staffing levels decreased from 17.00hrs onwards in all units and most units operated with one nurse and one care staff from 20.00 and earlier in many units. The night nurse had to do the night time medication round and therefore this left only one member of staff to give out evening drinks and assist residents to bed and with other personal care needs. The inspectors found that these staffing levels were not adequate to ensure the nurse administered the medications safely without interruption and to ensure residents had a choice in bedtimes. . **Action Required:** Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre. **Please state the actions you have taken or are planning to take:** Roster review has commenced to ensure correct skill mix at all times of the day Roster change to commence immediately
Proposed Timescale: 19/01/2015
Theme: Workforce **The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:** 100 per cent of staff had not attended mandatory training such as manual handling, elder abuse and fire training within the required mandatory time frames. Training records did not demonstrate that staff had attended recent training on the use of physical restraint, end of life and wound care to ensure they provided care in accordance with contemporary evidenced based practice. **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:** Training continues to ensure all staff are trained appropriately
Proposed Timescale: 19/01/2015