

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Bandon Community Hospital
<b>Centre ID:</b>	OSV-0000557
<b>Centre address:</b>	Hospital Lane, Cloughmacsimon, Bandon, Cork.
<b>Telephone number:</b>	023 884 1403
<b>Email address:</b>	deirdre.carr@hse.ie
<b>Type of centre:</b>	The Health Service Executive
<b>Registered provider:</b>	Health Service Executive
<b>Provider Nominee:</b>	Patrick Ryan
<b>Lead inspector:</b>	Mary O'Mahony
<b>Support inspector(s):</b>	Vincent Kearns: Maria Scally
<b>Type of inspection</b>	Announced
<b>Number of residents on the date of inspection:</b>	21
<b>Number of vacancies on the date of inspection:</b>	1

## 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:
24 February 2015 09:00	24 February 2015 18:30
25 February 2015 08:30	25 February 2015 17:30

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 set out the findings of a registration renewal inspection by the Health Information and Quality Authority (HIQA or the Authority) of Bandon Community Hospital. Inspectors met with residents, relatives and staff members over the two day inspection period. Inspectors observed practices and reviewed documentation such as, residents' care plans, accident and complaints logs, policies and procedures and staff files.

There was evidence of an effective governance structure and that residents received a high standard of evidence-based care with good access to allied health services. Staff with whom inspectors spoke were knowledgeable about residents and this was

confirmed by the care practices observed in the centre. Systems were in place to monitor and augment the quality of care and the quality of life. Residents were facilitated to exercise choice in many aspects of their care and their views were sought and listened to. There was a complaints management process in place. The feedback received from residents and relatives indicated a high level of satisfaction with the care provided.

Inspectors found that the centre was responsive to the Regulations in many of the outcomes required to be inspected and these areas were compliant 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. However, improvements were required in the provision of staff training, complaints management, recording and notifications of allegations of abuse, risk assessments, policy implementation and infection control. There was significant and continued non compliance with the Regulations in relation to the premises. These failings were described in detail under the outcome statements and related actions are set out in the action plan under each outcome.

At the feedback meeting, on day two of the inspection, the provider and person in charge spoke with inspectors about the plans for developing the centre to ensure compliance with the Regulations. Inspectors were informed that costed, time bound, specific and funded plans were available, as required by the Authority, for the centre. A copy of the proposed plan was made available to inspectors. The timing of the commencement of the works on premises and the details on funding will be required in the action plan under outcome 12: Premises. This information and confirmation of funding was made available to the Authority following the inspection. A condition has been attached to the registration of the centre that the proposed works will be completed by November 2016 as specified in the documentation, provided to the Authority.

**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 stated that community involvement was encouraged as an enhancement to the quality of life of residents. Inspectors observed that there was a person centred ethos of care promoted by staff during the inspection. The statement of purpose was made available for residents, visitors and staff. It had been reviewed in November 2014. It contained most of the items listed in Schedule 1 of the Regulations; however, it did not provide clarification as to the extent and type of palliative services provided in the centre. In addition, inspectors noted that clarification was also required as to the arrangements for the admission and on going care of residents with dementia. The statement of purpose also stated that residents could not avail of the services of their personal general practitioner (GP). This was not in compliance with the Regulations. This was addressed under outcome 11: Healthcare needs.

An updated statement of purpose was received by the Authority post inspection.

**Judgment:**

Substantially 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:**

There was a clearly defined management structure in place that identified the lines of authority and accountability in the centre. The person in charge worked full time and was supported in her role by an experienced clinical nurse manager 2 (CNM 2). The person in charge informed inspectors that she held regular meetings with the provider nominee. Interviews were conducted with the CNM 2 and person in charge during the inspection and they demonstrated an ongoing willingness to ensure compliance with the Regulations and to enhance the quality of life of residents. Residents were familiar with the person in charge and inspectors observed that they knew the names of staff members.

Inspectors saw minutes of staff meetings and staff informed inspectors that issues were discussed and actions taken where required. There was evidence of consultation with residents and relatives in the minutes of residents' meetings. Inspectors viewed the results of residents' and relatives' pre inspection questionnaires for this inspection and saw that they were generally praiseworthy of care in the centre.

There were systems in place to assess the quality of life and safety of care. Inspectors viewed audits, completed by the person in charge and staff members, on medication management, health and safety issues and infection control.

**Judgment:**

Compliant

***Outcome 03: Information for residents***

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

**Theme:**

Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

The Resident's Guide was seen by inspectors and this was available to 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 was viewed by inspectors. The contracts were comprehensive and contained the required details under the Regulations such as: the fees to be charged and how the care and welfare of residents would be met. The contracts had recently been updated. Inspectors viewed evidence that residents and their representatives, where appropriate,

had been informed of any changes. There was relevant information available for residents on notice boards, from staff interactions, from visitors, 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 a registered nurse and inspectors saw evidence that she had previous senior management experience. Training records confirmed that she had updated her clinical knowledge and engaged in continuous professional development. She worked full-time in the centre and demonstrated knowledge of the residents and their medical and social needs. She was easily accessible to residents, relatives and staff.

She displayed a comprehensive 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):**

No actions were required from the previous inspection.

**Findings:**

Inspectors reviewed a sample of staff files and found that they contained most of the information required under Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. Other 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 in the centre. Inspectors viewed a selection of residents' care plans. Each care plan outlined the social and medical needs of residents and evidence based tools were used to assess their medical, physical and psychological needs. 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 spoken with by inspectors 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 adopted or implemented correctly, for example, the policy on the procedures to be followed in the event of an allegation of abuse, the policy on complaints and the policy on medication management as outlined under outcome 9: Medication management. In addition all the records required under Schedule 3 of the Regulations as regards medication needs of residents Schedule 3 Part 4 (b). This was addressed under outcome 9 and referred to the maintenance of records of any plan for the administration of, indication for, and effect of PRN (when required) medication for individual residents. Furthermore as regards outcome 9: medication management, not all staff had signed for administering medications as required under Schedule 3 part 4 (d) of the Regulations.

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 testing and maintenance of the system. The staff roster was viewed and it correlated with the staffing levels which the person in charge had outlined.

The person in charge and staff informed inspectors that residents' wishes as regards choice of place of death and refusing certain treatment was not always respected or documented. Inspectors were informed that this was particularly relevant when an on-call GP was on duty at the time when a resident's condition deteriorated. One nurse outlined a situation where she had attempted to advocate at the end of life for a resident's wishes, to stay in the centre. However, the resident was transferred to hospital. Inspectors also spoke with a family group who had experienced a similar situation and they outlined how it had caused them distress. This will be addressed under outcome 14: End of life.

Inspectors were shown an up-to-date complaints and incident book. Most complaints were documented and they were investigated. However, the satisfaction or not of complainants was not always recorded. In addition, inspectors viewed a sample of



complaints recorded which indicated that allegations, which could be construed as allegations of abuse, had been investigated as complaints. These records had not been maintained as per the requirements of Schedule 3 (4) (j). Inspectors found that staff had not implemented 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 and outcome 13: Complaints.

A nursing note of residents' health, condition and treatment was maintained daily in narrative form as required by Regulations and in the guidelines from An Bord Altranais agus Cnaimhseachais na hEireann Recording Clinical Practice Guidance for Nurses and Midwives 2002. However, residents' decisions not to receive or to refuse certain treatments such as cardio-pulmonary resuscitation (CPR), or transfer to hospital were not recorded. 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, Garda vetting clearance was not on file for a staff member. The person in charge informed inspectors following the inspection that files for agency staff are verified by the HSE and are not maintained in the centre unless they have contracts with the hospital.

**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 nominee was aware of the obligation to inform the chief inspector of any absence.

The person in charge was supported in her role by a CNM 2 who displayed a good knowledge of the standards and regulatory requirements in relation to relevant role. Inspectors found that the CNM 2 was appropriately experienced and qualified to act up in the absence of the person in charge.

**Judgment:**

Compliant

***Outcome 07: Safeguarding and Safety***

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

**Theme:**

Safe care and support

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

The person in charge stated that staff were made aware on a regular basis, of the policy on the prevention of elder abuse. She attended staff handover meetings to ensure that she was informed of any issues regarding residents' care and welfare. Staff were able to confirm their understanding of the types of elder abuse. Inspectors viewed the policy for responding to allegations of adult abuse. This policy was comprehensive and provided details in relation to the actions required by staff when responding to an allegation to elder abuse. However, inspectors noted that some allegations of abuse were not investigated as allegation of abuse but were investigated as complaints. Allegations had not been notified to the Authority within the required three day period. This was not in line with the guidelines in the centre's own policy or the 'Trust in Care' (HSE 2005) document which required that a GP would assess the resident and that the person in charge would speak with the resident and consult with other senior management. The policy also stipulated that the event would be notified to the Authority within three days of its occurrence and the names of the resident, the staff member or the relative would be recorded, in line with the Regulations. Furthermore, not all staff were aware of the internal processes and procedures to follow if they saw or suspected an abusive interaction. In addition, staff training records indicated that all staff had not received mandatory training in the prevention and response to elder abuse. These failings were addressed under outcomes 10: Notifications, outcome 13: Complaints.

The centre had a policy on behaviours that challenge. However, all staff had not been afforded the specific training outlined in the policy to enable them to respond to and manage this behaviour safely. Nevertheless, the person in charge informed inspectors that this was planned and showed inspectors a training schedule which confirmed this. Inspectors reviewed the measures that were in place to safeguard residents' money and noted that receipts were retained. Inspectors observed that residents' or their representatives' signatures had been recorded. Inspectors were informed that the centre was a pension agent for a small group of residents and that these records were maintained centrally by the HSE. Transactions on these accounts were maintained in an ordered and transparent manner. Residents' valuables were kept safely and records of

these were shown to inspectors. The administrator informed inspectors that the centre conducted regular financial audits.

**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 centre had a detailed emergency plan in place. It specified the arrangements for the evacuation of residents and identified an external location for the temporary placement of residents. The emergency plan was found to meet the requirements of legislation. The fire prevention policy was viewed by inspectors and was found to be comprehensive and centre-specific. There were signs placed prominently in the centre which outlined the procedure to follow in the event of a fire. The emergency lighting was checked and serviced at regular intervals and inspectors viewed these records. Documentation and evidence was also seen which indicated that fire extinguishers were serviced as required. Fire training was provided to staff on a number of dates. Fire evacuation drills were undertaken on a yearly basis. However, legislation calls for these to be held at regular intervals and inspectors formed the opinion that this was not a suitable interval in view of the design and layout of the centre, not least the narrow doorways and corridors and the dependency levels of residents. Personal evacuation plans were not available for the most dependent residents. Fire drills had not taken place at night time. Staff spoken with by inspectors were aware of the procedure to be followed in the event of a fire. However, not all staff spoken with by inspectors had received updated fire training or fire evacuation drill. The fire alarm and the fire doors were checked regularly and these records were checked by inspectors. Inspectors observed wall mounted heaters in some bedrooms. However, these appeared unsafe as there were brown smoke stains near the vents of the heaters. In addition, there were no carbon monoxide detectors in these rooms. In addition these heaters had not been risk assessed. Nevertheless, the person in charge arranged for these heaters to be removed during the inspection.

Inspectors viewed the record of accidents and incidents. The records indicated that the issues were investigated. The centre had a risk register which was updated when new risks were identified and inspectors were shown the health and safety statement for the centre. This identified the responsibilities of staff in managing risks and promoting health and safety in the centre. The risk management policy was reviewed however, this

did not outline the controls for the risks specified under regulation 26 (1). Nevertheless the person in charge said that regular health and safety audits were carried out and health and safety meetings were facilitated. Hoists, wheelchairs, weighing scales, electric beds and mattresses were serviced on a regular basis and these records were seen by inspectors. The centre had an outside smoking area. There were risk assessments noted in the files of residents who smoked and staff were also obliged to use the outside smoking area as the centre was a non-smoking area. Inspectors observed that an outside boiler room was unlocked and the lock provided was seen to be broken. This unsafe area could potentially be accessed by residents if they were walking outside. However, inspectors noted that this arrangement had not been risk assessed.

Clinical risk assessments were undertaken for residents, including falls risk assessment, dependency levels, nutrition, skin integrity, continence and moving and handling. However, inspectors observed that residents did not have individual risk assessments for absconion risks and behaviours that challenge. In addition, residents who required the use of bedrails had not been assessed as to their suitability for this type of restraint and a restraint log had not been maintained in line with the Regulations. Furthermore, a number of other risks in the centre had been identified or risk assessed. For example, a record of a complaint was seen concerning a resident who had absconded from the centre last year. There was no risk assessment in the identified resident's care plan to put controls in place to prevent this from happening again. While there was a generic risk assessment on absconion in the risk register, inspectors noted that one of the controls listed on the assessment, was the missing persons' policy. However, there was no missing persons policy in the centre.

Inspectors observed that there were numerous unsecured doors in the centre during the inspection. However, these doors had not been risk assessed. The person in charge said that they were all locked at night however, the centre did not have a procedure to check residents during the day to ensure that all residents were accounted for. The person in charge said that there were 12 doors which were unrestricted in the centre and that it was a cost issue to provide alarm alerts on these doors. In addition, a number of windows were also unrestricted. Inspectors observed that oxygen was stored in the centre however, the storage of this had not been highlighted or risk assessed. This was addressed by the person in charge during the inspection. Furthermore, the office door was unsecured on a couple of occasions when inspectors checked. However, inspectors noticed that this door had been risk assessed as requiring to be locked at all times, when staff were not present. On day one of the inspection there was an unlocked cupboard in this office which contained medical supplies including syringes. This cupboard and office were subsequently locked when appropriate.

Inspectors observed staff generally abiding by best practice in infection control with regular hand-washing and the appropriate use of personal protective equipment such as gloves and aprons. However, soiled laundry was kept in the communal bathrooms for various periods of time and the external laundry area had no hand washing facilities. This was addressed in more detail under outcome 12: Safe and suitable premises. In one bedroom nasal oxygen tubing had not been changed since its was last used and was noticed to be soiled and not stored in a protective covering. The oxygen machine and some furniture in that room were dusty. In addition, a sluice room was noticed to

be unlocked and required cleaning. Hand sanitisers and sinks were present at the entrance to the building, on the corridors and in the staff and resident areas. Inspectors saw that gloves were stored safely.

**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:**

There were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents. However, the policy was not adopted and fully implemented as per the findings outlined under this outcome. This will be addressed under outcome 5 and outcome 11. The practice of checking, dispensing and recording of drugs administered, including controlled drugs, was in line with current legislation. Controlled drugs were checked by inspectors and the recording of these drugs was found to be correct. Inspectors had a discussion with the person in charge about the large stock of these drugs in the centre. The person in charge informed inspectors that any unnecessary drugs would be returned to the pharmacy.

Photographic identification for residents was present on the medication sheets. Medication management audits were conducted and the findings were disseminated to staff involved in medication administration. Medication reviews were conducted regularly by the GP and documented in the medical notes. Staff informed inspectors that there was an attentive GP service in the centre. However, residents were not offered a choice of GP or pharmacist as required by the Regulations. The person in charge informed inspectors that the statement of purpose would be amended following the inspection to state that residents would be afforded a choice of pharmacist at their own cost. The pharmacist provided support and education on medication management and staff reported that the pharmacist was responsive and attentive to the needs of the centre. Inspectors met with the pharmacist during the inspection and he explained his system for checking and auditing medications. He was seen to spend time talking with staff and said that he had spoken with residents and was available for consultation with them, when requested. The centre had a policy on medication errors which outlined the process for recording and learning from medication errors.

Medication prescription sheets were transcribed by the GP. Inspectors noted however, that medication in the medication fridge was not labelled for a particular resident. This

medication was sedative in its effect. On the medication trolley inspectors noted that there was an unlabelled bottle of anti seizure medication syrup. In addition, in some cases the maximum dose of PRN (as required) medication was not stated, for example for pain relief and psychotropic medication. This did not conform with the procedures for PRN medications outlined in the centre's medication policy or with An Bord Altranais agus Cnaimhseachais na hEireann Guidelines for Nurses on Medication Management. There was no system for documenting the indications for and the effect of: PRN medications. This was relevant because the medication seen was a psychotropic medication which had been administered to a resident who had a diagnosis of dementia. It was relevant also as inspectors saw evidence that this resident appeared to be drowsy on the following day which could have posed a falls risk. Furthermore, inspectors noted that there were three staff signatures missing from the medication administration record sheets in the sample of documents seen by inspectors. There were no photographs of medications available to aid identification of medications by staff. Nevertheless, there was a recognised medication manual available for staff. Inspectors also observed that there was no space on the medication administration chart to record comments on withholding or refusing medications.

**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:**

There was incident and accident forms maintained for both residents and staff in the centre. The person in charge had notified the Authority of some incidents in line with the requirements under Regulation 31 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 within the required timeframes. However, there had been an incident of an unexplained absence of a resident from the designated centre and this had not been notified to the Authority as required by the Regulations. In addition, inspectors could not find any evidence that an individual risk assessment in relation to this individual had taken place and that an appropriate care plan had been drawn up as a result of this assessment. Observations had not been commenced to minimise the risks of this happening again. Furthermore, as discussed under outcome 8: Health and Safety there was no policy on dealing with missing persons.

There had also been allegations of abuse of residents brought to the attention of the person in charge. These had been investigated as complaints and they had not been

notified to the Authority also as per regulatory requirements within three days of the receipt of the allegation. Allegations of misconduct against staff members had not been notified to the Authority and incidents of the use of restraints, for example, bedrails, had not been notified as per the legislation. These were discussed with the person in charge. Complaints will be addressed in more detail under outcome 13: Complaints.

The centre's policy on the prevention of abuse stated that "The person in charge shall ensure that notice is given to the chief inspector of:

- 1) any occurrence of any allegation suspected or confirmed of abuse and
- 2) any allegation of misconduct by the provider or any person who works in the centre.

**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 viewed a sample of residents' care plans which indicated that residents had timely access to GP services and appropriate treatment and therapies. The centre had the services of a medical director and the group of GPs that worked in this practice. However, residents did not have access to a choice of GP as required under Regulations. This choice was indicated in the updated statement of purpose received after the inspection and the person in charge said that this would be facilitated at a cost to the resident. There was evidence that residents had access to allied health care services and inspectors saw evidence of care plans based on these assessments. Records were maintained of all referrals and follow-up appointments. There was evidence that processes were in place to ensure that when residents were admitted, transferred or discharged, relevant and appropriate information about their care and treatment was shared. The CNM was the designated person responsible for ensuring that reviews of the care plans were undertaken regularly. It was evident that this review was taking place. All staff nurses were involved in the care planning process and were assigned a number of care plans each. These were found to be detailed and contained relevant and interesting information on the holistic needs of residents. Clinical risk assessments were regularly updated and care plan reviews were done in consultation with the resident.

Staff utilised a pink communication sheet to record residents care in narrative form. This was already addressed under outcome 5: Documentation. It was evident that residents had opportunities to participate in activities that were meaningful and purposeful to them and that fulfilled their needs and interests. An alternative activity was arranged for those residents who did not wish to participate in group activities. Residents informed the inspector that they enjoyed the beauty treatments, quiz, ball games, music, exercises and prayers. There was evidence that any concerns regarding weight loss/gain was communicated to, and subsequently addressed by the GP. A copy of residents' speech and language assessment was readily accessible to all staff including kitchen staff. Inspectors saw documentation that residents' vital signs such as blood pressure, were regularly monitored. Where required staff completed a daily record of residents' nutritional and fluid intake/output. There was evidence that residents had a malnutrition universal screening tool (MUST) assessment on admission and it was repeated when care plans were updated.

Inspectors observed the dining experience of residents: The dining tables were nicely decorated with table clothes, flowers and table mats and there was a daily menu card on display on each table. Inspectors saw that there was a monthly menu rotation in operation. Residents stated that they were very happy with the care they received, they enjoyed living in the centre and they liked being in a centre near home. It was evident that residents who experienced dysphagia (difficulty in swallowing) had been assessed by the speech and language therapist and the dietician and care plans had been put in place. The privacy, dignity and confidentiality of all residents were safeguarded as their private information was stored in a safe manner. However, not all residents requiring restraint had been assessed and notifications on the use of restraints had not been notified to HIQA as outlined under outcome 10: Notifications.

Inspectors noted that residents' choice as regards refusing medical treatment was not always respected and this was addressed under outcome 16: Residents' rights, dignity and consultation.

**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 was located in Bandon, County Cork. Bandon Community Hospital, established in 1929, was a single-storey building that had been renovated in the past few years. It provided long-term, respite and palliative care for 22 residents. At the time of inspection there were 21 residents accommodated in the centre. There was one vacant bed. There were four single rooms, one with en suite containing wash-hand basin, assisted toilet and shower and one with a shared en suite containing wash-hand basin and assisted toilet, which could also be accessed from the main corridor. There was three twin bedded rooms, one of which was accessed through the seven-bedded unit. There was a five-bedded unit with en suite containing wash-hand basin, assisted toilet and shower. However, inspectors observed that some areas of the ceilings and the floor covering in the centre required repair and painting. Some of the bedrooms lacked natural light as another building had been erected within the grounds, which was directly outside the windows of a multi-occupancy bedroom. This meant that the room had a dark and dreary appearance and was 'corridor like' in design.

There were three communal assisted toilets each with a wash-hand basin, one communal assisted shower room including an assisted toilet and wash-hand basin. However, there was an issue of concern observed in these shared bathrooms. Inspectors observed that there were soiled laundry bags hanging on a rack for individual residents. This arrangement resulted in an unpleasant smell permeated around the bathrooms which were used by residents and staff assisting them. These laundry bags were collected by residents' representatives for washing. However, the person in charge informed inspectors that they were not collected promptly in some situations. In addition, residents' representatives when collecting these bags were required to enter the communal bathrooms potentially impacting on the privacy and dignity of residents. Furthermore, inspectors discussed with the person in charge the impact this situation had on infection control processes in the centre. The person in charge said that alternative arrangements would be made for the storage of this laundry in the future. Inspectors were also shown the on-site laundry which was used for some laundry tasks. However, the building had no wash hand basin and required painting and renovation to make it suitable as a working environment for staff. Inspectors also observed that one internal bathroom ceiling was stained with mould from condensation. The person in charge said that the washing of bed linen in the centre was outsourced to an external agency.

Tiles outside one sluice room required repair and inspectors noted that one sluice room was unlocked. The sluice required cleaning. Inspectors were informed that because of the layout of the rooms, when residents used commodes they had to be moved through other bedrooms to be emptied in the sluice room. This impacted on the dignity of residents using commodes, residents in these bedrooms and any visitors which might be present.

Communal social space consisted of a large room which served as:

- a sitting and dining room
- a recreational and activities room
- and a place for prayers and spiritual observance.

There was a small room located off the communal room and this was used as a quiet space for residents to receive visitors in private. Office areas consisted of ward office, an office used by the CNM, an office for the person in charge and an administration office located at the reception area of the centre. There was a meeting room, a main kitchen with separate staff changing facilities for the kitchen staff, general staff changing facilities and a staff dining room in the centre. A room previously designated as the office of the person in charge was now a large store room. An external building fitted with an electrical supply and designated for use as a store, was situated in the outer courtyard. This contained some items which required servicing, cleaning and disposal. In general the outdoor space was unsafe. For example there was access to passing traffic, an unsafe surface for residents walking outside, unsafe area of ground next to the aforementioned external shed, which was cordoned off in parts where work was left unfinished.

Inspectors noted that similar to findings on previous inspections, the most recent of which were carried out in October 2013 and May 2014, by the Authority that:

- there was inadequate provision of suitable communal space for residents for the provision of social, cultural and religious activities.
- the centre had one communal room, measuring 65m<sup>2</sup>, to accommodate 22 residents. This room was used as a dining area, a sitting room, activity room, religious ceremonies and the storage of chairs.
- there was little space for wheelchair-bound residents or residents using high dependency chairs to manoeuvre within this room
- the provision of private and communal accommodation for residents remained inadequate
- sitting, recreational and dining space separate to the residents' private accommodation was inadequate
- inadequate provision of storage
- the external grounds and gardens were not suitable for, and safe for use by residents, in that they were unsecured and had unfinished surfaces
- insufficient number of toilets
- one sluice room, located off the five bedded room was not secured in a safe manner.
- some windows were unrestricted
- the storage of commodes in bathrooms further compromised residents' private space
- the residents' bedrooms did not provide sufficient personal space to ensure privacy and dignity. For example, access to a two-bedded room was via a seven-bedded ward. There was a high risk of resident's being disturbed at night due to other occupants in the bedrooms who presented with behaviour that challenges. One resident told inspectors that she was kept awake by residents calling out "mother" at night. This was further developed under outcome 16: Residents rights, dignity and consultation.
- there was insufficient space for a bedside chair for residents' use in the two bedded room, the five bedded ward and the seven bedded ward
- the size and layout of rooms occupied or used by residents were not suitable for their needs.
- some beds were located up against the walls. To attend to a resident, bedside lockers would need to be removed in order to pull the bed out from the wall. Staff spoken with by inspectors stated that bedside chairs were not placed beside beds for two reasons; there was no room for a chair and if one was present staff would need to move the

chair and locker to access both sides of the bed, to attend to the resident.

Inspectors found that overall, the constraints of the design and layout of the building hampered the provision of care to residents and did not provide a suitable environment to enhance their dignity and privacy. Due to the poor design and layout of these multi-occupancy wards which accommodated up to seven 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 curtains around the beds; however, the layout of the premises did not lend itself to the promotion of privacy or dignity for residents. 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 the small two-bedded room inspectors had to pass through the larger seven bedded rooms so there was regular traffic of visitors/staff through the latter. Inspectors also observed that they could see a resident sitting up in the bed having breakfast, from the entrance hall, which was quite a distance from that multi occupancy bed room. There were overhead bed lights but these could not be accessed by residents and in these larger rooms television sets were shared, which limited residents' choice.

Staff informed inspectors that they found it very challenging to attend to residents' toileting and hygiene needs with discretion, as beds were too close together. The screens were very near the beds and it was difficult for staff to assist residents with a wheelchair or commode and maintain residents' privacy behind these screens. Staff said that they would have to get some residents up and out of the multi occupancy rooms so that they could then pull the screen around two beds to afford more space. This unsuitable layout and space constraint limited residents' choices as regards making a decision to have a day in bed or a lie-in in the morning. Inspectors observed that during the in section visitors, who were with a resident who was ill in bed, had no privacy. Nevertheless, inspectors saw that this resident had been moved to a single room while the inspection was in progress. Residents who had to use the commode in the multi-occupancy bedrooms, because of their physical needs, were compromised as regards their dignity. This had an inevitable negative impact on other residents in these rooms. Residents in the two-bedded annexed room had to walk through the seven-bedded ward to access the toilet.

**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. There was a named 'local complaints officer' who was located off-site and the contact details were available in the centre specific complaints policy and in the statement of purpose. 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.

The complaints log was reviewed and inspectors were told that verbal complaints were now being recorded. However, such complaints' had not been recorded prior to 13 October 2014. Some complaints of alleged abusive interactions or of alleged staff misconduct had been recorded as complaints and not investigated using HSE and the centre's policy and procedures. This was addressed under outcome 7: Safeguarding and safety and outcome 10: Notifications.

Residents spoken with by inspectors stated that they could raise any issue or concern with the person in charge or staff. However, there was no record on some occasions of whether or not the complainant was satisfied with the outcome. 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):**

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

**Findings:**

An end-of-life care policy was in place and had been reviewed in June 2013. The policy included the proviso that the resident's wishes and choices concerning end-of-life care were discussed, recorded, implemented and reviewed on a regular basis with the

resident. However, some residents' care plans reviewed by the inspector did not include all this information. This was also discussed under outcome 11: Healthcare needs.

The person in charge stated that residents and visitors were informed when there was a death in the centre and that a remembrance service for deceased residents was held annually and attended by residents, relatives and staff. Documentation was available to inspectors which indicated that an end-of-life development plan had been drawn up in consultation with professionals in the previous two years. A number of initiatives were identified and inspectors noted that most of these initiatives were achieved. These initiatives included that single rooms would be made available when residents were approaching death, and inspectors saw that this happened on day two of the inspection. In addition, sympathy cards were sent to families and a staff member had trained as a facilitator for a recognised end of life programme. There was a new bereavement leaflet for families and handover bags for residents' personal possessions were in use. Training records reviewed by inspectors indicated that staff members had attended training in aspects of caring for residents and relatives at this time.

Religious and cultural practices were facilitated. Residents had the opportunity to attend religious services held in the centre and ministers from a range of religious denominations were attentive to residents. Overnight facilities for relatives were available. Relatives with whom inspectors spoke were complementary of the support from nursing and medical staff and they spoke about the kindness and attention their relative received prior to death. The person in charge informed inspectors that residents had a choice as to their place of death however, it was not clear to inspectors that residents at end of life would always have this choice documented and respected as discussed under outcome 5: Documentation. While there was evidence of ongoing medical review and assessment of the resident and evidence of family/next of kin involvement, it was apparent that records of conversations regarding end-of-life care were not consistent.

There was evidence that each resident received care at the end of his/her life which met his/her physical, emotional, social and spiritual needs. The specialist palliative care team, where appropriate, was involved in residents' end-of-life care and it was evident that recommendations with regard to medication management were followed. Inspectors reviewed a sample of care plans of residents. While inspectors noted that there was some evidence of engagement in consultation regarding spirituality and dying however, not all care plans reviewed reflected this consultation. The person in charge stated that these discussions were on going and that staff were to receive more training on how to initiate this type of conversation. This aspect of the activities of daily living was included in the four-monthly care plan review. An audit on end-of-life care in the centre had been carried out. Inspectors noted letters from family members of residents who had died that were praiseworthy and spoke about the environment and atmosphere which were created by staff in the centre to support the resident, the friends and family. One of these relatives told inspectors, "the place is family, it is home."

**Judgment:**  
Compliant

***Outcome 15: Food and Nutrition***

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

**Theme:**

Person-centred care and support

**Outstanding requirement(s) from previous inspection(s):**

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

**Findings:**

Inspectors saw that the special dietary needs of residents were communicated to the catering staff and placed on a whiteboard in the kitchen. Inspectors met with the chef who confirmed that she received a regular update of the status of residents as regards their nutrition. The chef stated that if a resident did not like what was on the menu, an alternative was available. Menus were displayed in the dining room and were viewed by inspectors. This stated the choice available for lunch and that an 'alternative' was also available. However, the menu did not specify what alternative meal was on offer to residents.

Fresh drinking water was available to residents during the day and inspectors saw jugs of water on the bedside lockers. The centre had an up-to-date policy on food and nutrition signed and read by staff. Most staff had attended training on the use of the malnutrition universal screen tool (MUST). Staff had attended training on dysphagia (difficulty swallowing) and HACCP training (Hazards Analysis and Critical Control Points). A dietician and speech and language therapist (SALT) provided training as required to staff. Inspectors observed mealtimes including breakfast, lunch and afternoon tea. Residents had the option of having their breakfast served in bed. Snacks and drinks were readily available throughout the day.

Inspectors noted that staff levels were adequate to meet the needs of the residents during mealtimes. Residents having their meals in bed or at their bedside were appropriately assisted and received their meal in a timely manner. Staff spoken with by inspectors were very knowledgeable in what to do in the event that a resident experienced difficulty in swallowing or a choking episode. Each resident was seen to be provided with food and drink and in quantities sufficient to their individual needs. Inspectors reviewed records of resident meetings chaired by an independent person and there was evidence that the topic of food was discussed on a regular basis. Suggestions emanating from these meetings were acted on. Inspectors noted that overall, the comments from residents indicated that residents were happy with the food served in the centre. This was confirmed from information in the pre inspection questionnaires and by residents who spoke with inspectors throughout the inspection. The chef met with all residents regarding the menu and food choices. While there was evidence that choice was available to residents for evening tea, the choice available for lunch was not clear. The menu displayed on a white board in the dayroom indicated one choice of main course. While residents confirmed that a staff member came around daily

informing them what was on the menu however, residents' indicated that they were not aware of what the 'alternative' choice entailed.

Medication administration charts reviewed indicated that nutritional supplements prescribed by the GP were administered by nursing staff. Inspectors observed residents having their meals. However, the constraints and lack of space in the room hampered the provision of a social, communal dining experience for residents. Extra chairs were stored in the room and there was little space for wheelchair-bound residents or residents using high dependency chairs. Two dining room tables were available for residents. During inspection, 12 residents availed of this room for lunch. Approximately five residents sat at the dining tables and the remaining residents sat in arm chairs with their meal served on bedside tables. The remaining residents had their meal in bed or at their bedside. Some residents spoken with by the inspector chose to dine at their bedside. However, inspectors noted that there was not sufficient room for all residents to come together for meals.

Residents had good access to medical, dietetic, speech and language and dental services. There was evidence that most residents had a malnutrition universal screening tool (MUST) assessment on admission and every three months onwards. Staff completed a daily record sheet which included the portion of each meal consumed by the resident. Residents' weights were recorded on a three-monthly basis or more often. Documentation indicated that a prompt intervention occurred when a risk was identified including the commencement of food and fluid charts and referral to the dietician and speech and language therapist.

**Judgment:**  
Substantially 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:**  
Residents who spoke with inspectors said that staff addressed them respectfully and they felt that every effort was made by staff to preserve their privacy during times of personal care. However, inspectors found that not all residents had sufficient space and privacy. The size and layout of the multi occupancy rooms meant that there was very

little space between residents' beds. Residents were unable to undertake personal activities or to entertain visitors, in private. There was no room for bedside chairs and residents had to share televisions, as outlined previously. This was disturbing for those residents who were not interested in watching TV but had no option due to the shared occupancy of the rooms. Nevertheless, this arrangement suited some residents. They told inspectors that they were placed next to their friends in the bedroom and as they had similar tastes they enjoyed the sociability of watching programmes together.

Inspectors observed that residents had access to newspapers and radios. There were notice boards available in the premises which provided information, for residents and visitors, about activities and events in the centre as well as in the community. Staff informed inspectors that each resident was afforded choice as regards their daily routine and their daily activities. However, staff also informed inspectors that they had a system for getting residents up in the mornings, in the multi occupancy rooms. This was done to facilitate the easy movement of heavy, cumbersome chairs and commodes where required. This routine was also followed to afford as much privacy and space as possible to residents who required full care. Staff said that when a resident in the neighbouring bed was up and out of the room they could then pull the privacy curtain around both beds. This provided a more spacious environment in which to work with the respective resident.

The person in charge outlined that there were arrangements in place to ensure that each resident's religious and cultural beliefs were respected. Mass was said on a weekly basis and persons of all religious persuasions were facilitated to attend services, if required. Inspectors noted that staff consulted residents in the organisation of the centre and there were records of the minutes of residents' meetings maintained in the centre. Residents who spoke with inspectors outlined that they would feel confident raising issues of concern with staff members and particularly with the person in charge, in whom they expressed their trust.

The list of activities was displayed on the noticeboard and inspectors saw residents participating in various educational and fun tasks, with external facilitators. Residents informed inspectors that the schedule of activities was interesting and tailored to their interests and capabilities. Inspectors spoke with the therapists who said that they attended the centre on three occasions weekly. They were noticed to be familiar with residents' names and with their preferences and abilities. Residents also had access to a hairdresser and various beauty treatments were available when requested. There was a price list of these treatments displayed on the notice board.

Inspectors were informed by staff and residents that they had composed their own charter of rights for the centre. This had been printed and laminated. It was displayed around the centre and in the entrance lobby. Residents expressed to inspectors that they were proud of this achievement. There were CCTV cameras in use in the centre and there were signs to indicate where these were present. This was also supported by policy and procedures. The person in charge was the data controller for the centre and she was found to be knowledgeable about the Data Protection Act and her responsibilities to balance safety with the right to privacy.

Nursing notes from the night staff confirmed residents' previous comments: that some



residents called out repeatedly at night and kept others awake. The needs of residents in the multi occupancy rooms could not be met without disturbing other residents at night time. There was a serious risk also to the dignity of those residents who were incontinent or had dementia and exhibited behaviours that challenged.

There were external independent advocates available to residents or relatives should they wish to obtain help to make a complaint or require assistance to express their views. Inspectors viewed posters for these services on the notice board with contact details available if required. There was a good level of visitor activity throughout the days of inspection with visitors saying they felt welcome to visit. Inspectors met and spoke with a number of visitors who indicated that they had freedom to visit when required. Residents were facilitated to exercise their political rights. The person in charge confirmed that residents who wished to vote were facilitated to do so both externally and within the centre. Residents had access to a portable telephone and their personal mobile phones if they wished to make calls in private. Residents informed inspectors that they received phone calls in the evening from relatives on their personal mobile phones

All residents spoken with said that they felt content and they praised the person in charge, the staff members, the activities personnel, 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:**

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):**

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

**Findings:**

Inspectors observed that there were inventories of residents' personal property in each care plan and these were updated when the resident obtained new personal belongings. These inventories were signed and dated. However, not all residents had sufficient wardrobe space and inspectors noted that in some cases residents were sharing wardrobes due to the space constraints. This also impacted greatly on the privacy and dignity of residents in the following manner: visitors would be able to see private

belongings, including in some cases incontinence wear, of other residents when attending to their relatives' clothes in the shared wardrobes. In addition, residents' wash basins were stored on top of wardrobes in the various rooms due to lack of space and this had the effect of creating a clinical environment, as distinct from a home-like environment. Inspectors also observed that residents could not easily access their personal belongings, as wardrobes were placed at a distance from some beds, due to the constraints of the design and layout of the multi occupancy rooms. The aforementioned laundry management system and storage of residents' soiled laundry was inadequate as addressed under outcome 7: Health and safety and risk management and outcome 12: Premises.

**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):**

No actions were required from the previous inspection.

**Findings:**

Inspectors reviewed a selection of staff files and noted that most of the documents required under Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 were available. There were some documents not available and this was addressed under outcome 5: Documentation. There were sufficient staff with the right skills, qualifications and experience to meet the assessed needs of residents on most days. However, staff informed inspectors that there were times when staff who were absent on sick leave were not replaced which put a strain on the remaining staff. This was not in compliance with Regulation 15 (1). Some 'wards' were busier than others and staff informed inspectors that there were times when staff were not allocated in a fair manner. Inspectors asked the person in charge to risk assess the requirements for observation during staff handover times as all staff attended the report potentially leaving the residents unsupervised albeit for a short period. There was an actual and planned staff rota which indicated that staff nurses were on duty at all times. All staff had access to education and training which enabled them to provide care that reflected contemporary evidence based practice. Inspectors observed evidence of opportunities for further

training advertised in the centre. Staff were knowledgeable about residents and were observed engaging with them in a respectful and kind manner. All members of the nursing staff had up-to-date registration with a relevant professional body which satisfied the requirements of An Bord Altranais, at the time of inspection.

Staff were able to explain the management structure to inspectors and confirmed that copies of both the Regulations and the Standards had been made available to them. Inspectors noted that there was a selection of healthcare reading material and reference books available in the office. However, 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 residents. They explained that there was not enough time for conversing with residents and care was compromised when there was not a full complement of staff. 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, managing and deescalating challenging behaviour and fire drill training, under outcome 7; Safeguarding and Safety and outcome 8: Health and Safety and Risk Management.

**Judgment:**

Non Compliant - Moderate

## Closing the Visit

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

### Acknowledgements

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

### *Report Compiled by:*

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

## Health Information and Quality Authority Regulation Directorate

### Action Plan



### Provider's response to inspection report<sup>1</sup>

<b>Centre name:</b>	Bandon Community Hospital
<b>Centre ID:</b>	OSV-0000557
<b>Date of inspection:</b>	24/02/2015
<b>Date of response:</b>	02/06/2015

### 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 01: Statement of Purpose

**Theme:**

Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The statement of purpose did not outline whether or not emergency admissions were accepted in the centre.

**Action Required:**

Under Regulation 03(1) you are required to: Prepare a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Welfare of

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

Residents in Designated Centres for Older People) Regulations 2013.

**Please state the actions you have taken or are planning to take:**

The Statement of Purpose and Function has been amended to state that emergency admissions are not accepted in Bandon Community Hospital.

**Proposed Timescale:** 31/03/2015

**Outcome 03: Information for residents**

**Theme:**

Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

It was not clear in all contracts of care what services required additional fees as required by the Regulations.

**Action Required:**

Under Regulation 24(2)(d) you are required to: Ensure the agreement referred to in regulation 24 (1) includes details of any other service which the resident may choose to avail of but which is not included in the Nursing Homes Support Scheme or which the resident is not entitled to under any other health entitlement.

**Please state the actions you have taken or are planning to take:**

All future contracts of care will reflect that there are additional fees if residents choose to avail of services such as choice of GP other than the medical officers or pharmacy services other than the hospital pharmacist. Current long term resident has been informed by letter that this is the case. The Statement of Purpose and Function and Hospital Booklet have been amended to reflect this.

**Proposed Timescale:** 31/03/2015

**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:**

Not all policies in the centre were adopted and implemented as per the procedures set out in those policies for example the policy on the prevention on elder abuse, the policy on complaints and the policy on medication management.

**Action Required:**

Under Regulation 04(1) you are required to: Prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.

**Please state the actions you have taken or are planning to take:**

1. A staff meeting was held on 10th March and 14th April during which staff were reminded of their obligation to comply with hospital policies, guidelines and procedures. Minutes of this meeting have been written and are displayed in the staff room.
2. Staff will be required to partake in the auditing of compliance with policies, guidelines and procedures to encourage them to improve compliance. An annual timetable of audits has been written.
3. Annual training is provided on the prevention, detection and reporting of allegations of elder abuse. Members of staff who had not attended these sessions will receive the training by the 30th April, 2015.
4. Staff have been requested to read and sign the complaint flow chart and
5. Staff nurses have been attending training on medication management and completed the HSEland training module in 2014.

**Proposed Timescale:**

- 1 April 17th 2015
- 2 December 31st 2015 and annually thereafter
- 3 Training took place in December 2014 and January, February and April 2015
- 4 June 30th 2015
- 5 November 30th 2105

**Proposed Timescale:** 31/12/2015

**Theme:**

Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

All the records set out in Schedules 2, 3 and 4 were not maintained and were not available for inspection by the chief inspector.

**Examples of these were:**

- employment gaps were not verified for some staff
- a Garda vetting clearance was not on file for a staff member
- residents' decision not to receive or to refuse certain treatments such as cardio-pulmonary resuscitation (CPR) was not recorded
- residents' choice as to place of death was not always documented
- a log of the use of restraint was not maintained in the centre
- records were not maintained re allegations of abuse in the manner set out in Schedule 3, part 4 (j)
- records of medication plans for residents were not maintained as evidenced under outcome 9: medication management, as regards the indication for and effect of PRN medications
- records of all drugs were not signed and dated by the nurse administering the drugs in accordance with professional guidelines

**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.The CVs of all staff have been reviewed. Relevant members of staff have been asked to provide information regarding the gaps in their employment records.
- 2.The member of staff who did not have a copy of her Garda vetting on file had been transferred from another area of service. We have since obtained confirmation of her Garda vetting from the Garda vetting bureau of the HSE.
- 3.Residents who wish to and who are capable have expressed their wishes regarding CPR and place of death and this has been recorded in their care plans. In future staff will be more rigorous in recording the absence of these instructions where residents either do not want to or are not capable of expressing these wishes.
- 4.A daily log of those who use bed rails is now being maintained.
- 5.Allegations of abuse have always been recorded as set out in Schedule 3, part 4 (j). A complaint had been made in the week prior to the announced inspection and the person in charge had not recorded this as an allegation of abuse at the request of the complainant.The person in charge disclosed the complaint to the inspector on the first day of inspection. The person in charge was aware of her obligation to report allegations of abuse to HIQA in writing and did so immediately following the inspection.
- 6.Staff nurses have been reminded of their obligation to record the reason for administering PRN medication and its effectiveness.
- 7.Staff nurses have been reminded of their obligation under An Bord Altranais Medication Management Guidelines to sign for the administration of all medications.

1. All CVs will be updated by the 31st May 2015
2. April 10th 2015
3. May 31st 2015
4. February 27th 2015
5. Allegations of abuse will be reported as they arise
6. April 17th 2015
7. April 17th 2015

**Proposed Timescale:** 31/05/2015

**Outcome 07: Safeguarding and Safety****Theme:**

Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Staff did not have updated knowledge and skills in the management and de-escalation of challenging behaviour.

**Action Required:**

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

**Please state the actions you have taken or are planning to take:**

Training is being arranged for staff in the management of challenging behaviour.

**Proposed Timescale:** 30/09/2015

**Theme:**

Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

All incidents of alleged abusive interactions were not recorded as such and were not investigated in line with the procedures in the centre's policy on the prevention of elder abuse.

**Action Required:**

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

**Please state the actions you have taken or are planning to take:**

The person in charge has taken note of this action and will record any incidents of alleged abuse and investigate them in line with the centre's policy on the prevention of elder abuse.

Proposed Timescale: Compliance with this action will be ongoing

**Proposed Timescale:** 22/04/2015

**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 or updated training in the detection, the prevention of, and the response to, allegations of abuse.

**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:**

Members of staff who did not attend the sessions provided in December 2014 and January 2015 will attend training by the end of April, 2015.



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

### **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:**

Not all hazards in the centre had been identified and risk assessed.

Some examples of this were:

- residents did not have individual risk assessments for absconson risks and challenging behaviour in their files
- residents who required the use of bedrails had not been assessed as to their suitability for this restraint and a restraint log had not been maintained in line with the Regulations.
- there was no policy in the centre on missing persons.
- numerous open doors in the centre had not been risk assessed
- the centre did not have a procedure to check residents during the day to ensure that all residents were accounted for
- some windows were also unrestricted
- oxygen was stored in the centre and the storage of this had not been highlighted and risk assessed
- the office door was open and there was an unlocked cupboard in this office which contained medical supplies including syringes
- there was an unlocked boiler room in the outside area which had a broken lock on the door
- wall mounted heaters had brown heat staining and there were no carbon monoxide detectors in the centre
- a sluice room door was unlocked
- tiles were broken near a sluice room and some floor covering required repair.

**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. Individual Risk assessments have been completed for residents who are at risk of absconson.
2. Individual risk assessments have been completed for residents who display challenging behaviour.
3. All residents who use bedrails have been assessed for their use.
4. A daily log is being maintained of residents who use bed rails.
5. A Missing Person Policy has now been written.
6. A risk assessment of the doors in Bandon Community Hospital has been carried out.
7. A headcount of residents and door check is carried out 4 times daily.

- 8.All windows have been risk assessed and now have restricted opening.
- 9.Oxygen storage has been risk assessed and the number of cylinders reduced to one.
- 10.Signs have been placed on all storage cupboards and office doors reminding staff to keep them locked at all times.
- 11.The boiler room lock has been fixed.
- 12.The wall mounted heaters have been disconnected.
- 13.Keypad locks are being placed on the sluice rooms.
- 14.The tiles and floor covering will be repaired.

**Proposed Timescale:**

1 to 12 have been completed and 13 and 14 will be completed in conjunction with the maintenance department by the 8th May, 2015.

**Proposed Timescale: 08/05/2015**

**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 include the measures and actions in place to control abuse.

**Action Required:**

Under Regulation 26(1)(c)(i) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control abuse.

**Please state the actions you have taken or are planning to take:**

The risk management policy is under review and will include measure and actions in place to control abuse.

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

**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 set out the measures and actions in place to control the unexplained absence of any resident.

**Action Required:**

Under Regulation 26(1)(c)(ii) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the

unexplained absence of any resident.

**Please state the actions you have taken or are planning to take:**

A Missing persons policy has been implemented and will be referenced in the risk management policy.

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

**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 set out the measures and actions in place to control accidental injury to residents, visitors or staff.

**Action Required:**

Under Regulation 26(1)(c)(iii) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control accidental injury to residents, visitors or staff.

**Please state the actions you have taken or are planning to take:**

The risk management policy is under review and will include measure and actions in place to control accidental injury to residents, visitors or staff.

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

**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 set out the measures and actions in place to control aggression and violence.

**Action Required:**

Under Regulation 26(1)(c)(iv) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control aggression and violence.

**Please state the actions you have taken or are planning to take:**

The risk management policy is under review and will include measure and actions in place to control aggression and violence.

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

**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 include the measures and actions in place to control self-harm.

**Action Required:**

Under Regulation 26(1)(c)(v) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control self-harm.

**Please state the actions you have taken or are planning to take:**

The risk management policy is under review and will include measure and actions in place to control self-harm.

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

**Theme:**

Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Infection control was compromised in the following manner:

- soiled laundry was stored for extended periods of time in the communal bathrooms
- there was no hand washing sink in the external laundry
- nasal oxygen tubing was dirty and had not been changed or covered since its last use
- the oxygen machine was dusty as was furniture in that room
- a sluice room required cleaning

**Action Required:**

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

**Please state the actions you have taken or are planning to take:**

1. New individual laundry bins have been purchased and will be stored in an external building.
2. A wash hand basin will be installed in the external laundry.
3. A cleaning schedule has been prepared for the oxygen concentrator.
4. Cleaning schedules are currently being reviewed.

**Proposed Timescale:**

1. April 20th 2015
2. May 15th 2015

3.March 2nd 2015

4.April 30th 2015

**Proposed Timescale:** 15/05/2015

**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 updated fire training and night fire drills had not taken place. Personal fire evacuation plans had not been developed for residents.

**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:**

- 1.Fire drills have been organised for May 2015.
- 2.Personal Fire evacuation plans have been completed for all residents.

**Proposed Timescale:** 31/05/2015

**Theme:**

Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Fire evacuation drills were held at yearly intervals. However, inspectors formed the view that this interval was not suitable, in view of the design and layout of the centre, not least the narrow doorways and corridors and the dependency levels of residents.

**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 will be held every 2 to 3 months.

**Proposed Timescale:** 31/05/2015

## 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 choice of pharmacist was not available to residents as required by Regulations.

**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:**

Residents have been informed that they can choose their pharmacist but that costs will be incurred should they choose a pharmacist other than the pharmacist who supplies the hospital.

**Proposed Timescale:** 10/04/2015

**Theme:**

Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Staff signatures were not present for the administration of all medications which led to inspectors not being able to verify if medications had actually been administered in accordance with the directions of the prescriber of the resident concerned.

**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:**

Staff nurses have been reminded that they are obliged under An Bord Altranais Guidelines to sign for the administration of all medications. Staff who had not recently attended a medication management course did so, commencing in March, 2015.

**Proposed Timescale:** 30/11/2015

## 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:**

The Authority had not been notified of all incidents set out in paragraphs 7(1)(a) to (j) of Schedule 4 within 3 working days of its occurrence.

**Action Required:**

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

**Please state the actions you have taken or are planning to take:**

The person in charge undertakes to inform the chief inspector in writing of any incident set out in paragraphs 7 (1)(a) to (j) of Schedule 4 within 3 working days of the incident.

Proposed Timescale:

February 28th 2015 and ongoing

**Proposed Timescale: 28/02/2015**

**Theme:**

Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

The Authority had not been notified at the end of each quarter in relation to the occurrence of all incidents set out in paragraphs 7(2) (k) to (n) of Schedule 4.

**Action Required:**

Under Regulation 31(3) you are required to: Provide a written report to the Chief Inspector at the end of each quarter in relation to the occurrence of any incident set out in paragraphs 7(2) (k) to (n) of Schedule 4.

**Please state the actions you have taken or are planning to take:**

The person in charge undertakes to inform the authority of all incidents set out in paragraphs 7(2) (k) to (n) of Schedule 4.

Proposed Timescale:

April 30th 2015 and ongoing

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

**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:**

A choice of GP was not available to residents.

**Action Required:**

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

**Please state the actions you have taken or are planning to take:**

Residents have been informed that they can choose their GP but that costs will be incurred should they choose a GP other than the medical officer who attends the hospital..

**Proposed Timescale:** 10/04/2015

**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 of the designated centre was not appropriate to the number and needs of the residents of that centre.

-corridors were narrow and doorways were not wide enough to move residents and beds in an emergency

-multi occupancy bedrooms were not suitable or appropriate for the needs of residents as regards their dignity and privacy, In addition, there was a lack of space available to each resident for a bedside chair, a separate wardrobe and dignified storage of soiled laundry

-laundry facilities were inadequate

-external grounds were unsafe.

**Action Required:**

Under Regulation 17(1) you are required to: Ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.

**Please state the actions you have taken or are planning to take:**

Plans are at an advanced stage for building new accommodation for residents. Twenty one of the twenty five beds planned in the new building will be single rooms with assisted en suite facilities. There will be two two-bedded bedrooms with assisted en suite facilities. Funding has been allocated by the HSE and work on the building should commence in late 2015. Completion is planned for November 2016. A copy of the plans and schedule were given to the inspector at the time of the inspection.

**Proposed Timescale:**

Building works to commence at the end of 2015 with completion of the building works in November 2016



**Proposed Timescale: 30/11/2016**

**Theme:**

Effective care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Premises did not conform to the matters set out under Schedule 6 of the Regulations in the following matters:

- premises were not maintained in good repair both externally and internally
- overhead bed lights were not accessible to residents when in their beds
- not adequate private and communal space for residents
- rooms in the centre were not of a suitable size and layout for the needs of residents
- there was not adequate space and storage facilities for residents
- not all residents had a lockable storage space for personal possessions accessible to them
- external grounds were not safe and suitable for use by residents and they were not safely and properly maintained for this purpose
- there were not sufficient toilets and showers available for use by residents which were located in areas in the centre which were convenient to residents' bedrooms and afforded privacy and dignity in their use
- laundry facilities were not adequate and there was no wash hand basin in the external laundry
- natural lighting was not available to residents in the multi occupancy room where an external building blocked the light into the room
- commodes had to be moved through bedrooms to be emptied

**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:**

Plans are at an advanced stage for building new accommodation for residents. Twenty one of the twenty five beds planned in the new building will be single rooms with assisted en suite facilities. There will be two two-bedded bedrooms with assisted en suite facilities. Funding has been allocated by the HSE and work on the building should commence in late 2015. Completion is planned for November 2016. A copy of the plans and schedule were given to the inspector at the time of the inspection.

A wash hand basin will be added to the external laundry

**Proposed Timescale:**

Building works to commence at the end of 2015 with completion of the building works in November 2016

**Proposed Timescale:** 30/11/2016

### **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 nominated person did not ensure that all complainants were responded to.

The registered provider had not maintained all the records required under Regulation 34 (1) ((f)

The complaints log did not record the satisfaction or not of the complainant in all cases

**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 complaint log is in place and all complaints are responded to.

The details of any investigation into a complaint are being recorded.

The complaints log has been amended to reflect the satisfaction of residents with the resolution of complaints.

**Proposed Timescale:** 27/02/2015

### **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 menu did not specify what the alternative option was for residents if they did not like what was on the menu for lunch.

**Action Required:**

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

**Please state the actions you have taken or are planning to take:**

The alternative choice for residents will be specified in the lunch menu.

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

## 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:

Residents were unable to undertake personal activities in private due to the lack of space in bedrooms and in the multi use communal room, where most residents sat during the day.

### 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:

Plans are at an advanced stage for building new accommodation for residents. Twenty one of the twenty five beds planned in the new building will be single rooms with assisted en suite facilities. There will be two two-bedded bedrooms with assisted en suite facilities. Funding has been allocated by the HSE and work on the building should commence in late 2015. Completion is planned for November 2016.

### Proposed Timescale: 30/11/2016

### Theme:

Person-centred care and support

### The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Residents who had communication difficulties which might be expressed as repetitive calling out were not able to express themselves freely having regard to his or her wellbeing, safety and health and that of other residents in the designated centre. Their placement in the multi occupancy bedrooms impacted on other residents' sleeping pattern and sense of contentment. The lack of a private space for such residents with cognitive impairment compromised their method of communicating their needs.

### Action Required:

Under Regulation 10(1) you are required to: Ensure that each resident, who has communication difficulties may communicate freely, having regard to his or her wellbeing, safety and health and that of other residents in the designated centre.

### Please state the actions you have taken or are planning to take:

Aromatherapy, staff support and other non medical interventions are available for residents. Plans are at an advanced stage for building new accommodation for residents. Twenty one of the twenty five beds planned in the new building will be single rooms with assisted en suite facilities. There will be two two-bedded bedrooms with assisted en suite facilities. Funding has been allocated by the HSE and work on the building should commence in late 2015. Completion is planned for November 2016. A

copy of the plans and schedule were given to the inspector at the time of the inspection.

Proposed Timescale:

Building works to commence at the end of 2015 with completion of the building works in November 2016

**Proposed Timescale:** 30/11/2016

### **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:**

In some cases residents' laundry was not being laundered frequently and was not collected on a regular basis by some relatives or representatives. This impacted negatively on the environment for other residents and presented a risk to infection control in the centre.

**Action Required:**

Under Regulation 12(b) you are required to: Ensure each resident's linen and clothes are laundered regularly and returned to that resident.

**Please state the actions you have taken or are planning to take:**

New individual laundry bins have been purchased and will be stored in an external building. Resident's families have the option of sending soiled linen to a local laundry and they have been informed of this and the costs involved. All efforts are made to communicate the necessity for regular collection of soiled clothes to relatives. Phone calls are made to remind them to collect laundry when required.

**Proposed Timescale:** 20/04/2015

**Theme:**

Person-centred care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Inspectors observed that each resident could not retain control over their clothes, as wardrobes were positioned at a distance from residents' beds, because of lack of space in the rooms.

**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:**

Residents have lockers beside their beds where they can store items they require immediate access to. Every effort is made to ensure residents retain control over their clothes by taking them to their wardrobes to choose their clothes or check on what is in their wardrobe.

Plans are at an advanced stage for building new accommodation for residents. Twenty one of the twenty five beds planned in the new building will be single rooms with assisted en suite facilities. There will be two two-bedded bedrooms with assisted en suite facilities. Funding has been allocated by the HSE and work on the building should commence in late 2015. Completion is planned for November 2016. A copy of the plans and schedule were given to the inspector at the time of the inspection.

**Proposed Timescale:**

Building works to commence at the end of 2015 with completion of the building works in November 2016

**Proposed Timescale: 30/11/2016**

**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 each resident to store and maintain his or her clothes and other personal possessions in the centre as in some situations residents were obliged to share wardrobes due to lack of space in the multi occupancy rooms for individual wardrobes.

**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:**

Plans are at an advanced stage for building new accommodation for residents. Twenty one of the twenty five beds planned in the new building will be single rooms with assisted en suite facilities. There will be two two-bedded bedrooms with assisted en suite facilities. Funding has been allocated by the HSE and work on the building should commence in late 2015. Completion is planned for November 2016. A copy of the plans and schedule were given to the inspector at the time of the inspection

**Proposed Timescale:**

Building works to commence in October 2015 with completion of the building works in November 2016

**Proposed Timescale: 30/11/2016**

**Outcome 18: Suitable Staffing**

**Theme:**  
Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Staff indicated to inspectors that there were times when staff on sick leave were not replaced. This impacted on the care provided to residents and on the remaining staff. There was no staff member allocated to supervise residents during staff handover times. These issues had not been risk assessed.

**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:**

Since the introduction of the new skill mix roster in January, 2015, there has not been an occasion a Health Care Assistant could not be replaced.

A multitask attendant is now present on the corridor during report times and supervises residents while staff receive handover from their colleagues.

A risk assessment of report time and unforeseen staff absences has been carried out.

**Proposed Timescale: 27/02/2015**