Health Information and Quality Authority
Regulation Directorate

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

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

Centre name:	Midleton Community Hospital
Centre ID:	OSV-0000579
Centre address:	Midleton, Cork.
Telephone number:	021 463 5300
Email address:	midletonch@hse.ie
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Patrick Ryan
Lead inspector:	Mary O'Mahony
Support inspector(s):	Mairead Harrington;
Type of inspection	Unannounced
Number of residents on the date of inspection:	48
Number of vacancies on the date of inspection:	5

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 un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
22 July 2015 09:30	22 July 2015 18:30
23 July 2015 09:30	23 July 2015 15:00

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

Outcome	Our Judgment
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Compliant
Outcome 07: Safeguarding and Safety	Substantially Compliant
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 09: Medication Management	Non Compliant - Moderate
Outcome 10: Notification of Incidents	Compliant
Outcome 11: Health and Social Care Needs	Compliant
Outcome 12: Safe and Suitable Premises	Non Compliant - Major
Outcome 13: Complaints procedures	Non Compliant - Major
Outcome 15: Food and Nutrition	Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Non Compliant - Moderate
Outcome 17: Residents' clothing and personal property and possessions	Non Compliant - Moderate
Outcome 18: Suitable Staffing	Non Compliant - Moderate

Summary of findings from this inspection

This follow up inspection of Midleton Community Hospital was unannounced and took place over two days. The purpose of the inspection was to inform a registration renewal application. The hospital was originally built as a workhouse in 1841, this was now called the 'back hospital'. A newer section of the building, the 'front hospital', was opened in 1937. At the time of inspection it was run by the Health Service Executive (HSE) and provided long-stay, respite and convalescent care to the older population of Midleton and the surrounding area. The hospital was set on a seven acre site and provided a range of services on site including a day centre, physiotherapy, occupational therapy, podiatry, dietician services, public health nursing and a mental health day hospital. The main entrance was through the front hospital where the administration offices were located. The centre has capacity for

53 residents and there were 48 residents in the centre during the inspection. Residents were accommodated between the two buildings which will be described in more detail under outcome 12: Premises. As part of the inspection, inspectors met with the person in charge, management personnel, residents, relatives, nursing staff, kitchen staff and multi-task attendants. Inspectors observed care practices and reviewed documentation such as care plans, medical records, accident and incident records, policies, fire safety records, training records and staff files.

There was evidence of individual resident's needs being met and the staff supported residents to maintain their independence where possible. Inspectors found the premises, fittings and equipment were in good repair overall. However, there were numerous serious and significant issues of non compliance in relation to the design and layout of areas of the premises as regards the legislative requirement to protect and promote the privacy and dignity of residents.

Improvements were required in the areas of: health and safety and risk management: medication management: health and social care needs: safe and suitable premises: complaints procedure: residents' rights dignity and consultation: residents' clothing and personal property and staffing. Following the previous inspection the action plan, concerning premises and the impact of the layout and design on the privacy and dignity of residents, which the provider submitted to the Authority, was not satisfactory. The provider was asked to submit a second revised action plan concerning premises and this was again, unsatisfactory.

There was no evidence presented on this follow up inspection, to indicate that funded, costed, specific, time bound plans were in place, as required by the Authority, for the required alterations. These were required to provide for the privacy and dignity of residents, as regards their accommodation and the storage of their possessions, among other issues. A second action plan was requested following this inspection also, to provide dates for actions to be completed and address any inaccuracies in the previous action plan received. Premises issues remain unresolved at this time, as plans, funding and a timeline for proposed developments were not forthcoming 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 04: Suitable Person in Charge
The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:
Governance, Leadership and Management

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

Findings:
The person in charge was an experienced nurse manager and was actively involved in the day-to-day organisation and management of the service. She was involved in the centre as the acting person in charge since 2007 and was recently appointed to the post in a permanent position. Staff, residents and relatives all identified the person in charge as the person with the overall authority and responsibility for the delivery of care. She was found to be committed to providing person-centred care to residents and was employed full time. She demonstrated good insight into the responsibilities of her role in leading the care and welfare of the residents. She was engaged in continuous professional development including post graduate qualifications in gerontology nursing and health services management.

Judgment:
Compliant

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

Theme:
Governance, Leadership and Management

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

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

Findings:
During this inspection records required under the Regulations were reviewed by inspectors. The records were securely stored and the person in charge assured inspectors that residents had access to their files if required. Inspectors viewed a selection of residents' care plans. There was evidence of input from, and assessments by, allied health professionals. There were centre specific policies which were updated and reviewed when required and these included the policies specified in Schedule 5 of the Regulations.

Fire safety records were seen and were found to have met the requirements of Regulations as regards, training, testing and maintenance of the system. Inspectors viewed a sample of staff files and found that they were maintained in good order. Inspectors were shown the complaints and incidents book. However, inspectors noted that only two complaints were documented in the complaints book since the previous inspection. The person in charge explained that staff use the narrative notes to outline minor complaints. However, during the inspection the person in charge spoke to staff about the complaints policy and stated that all complaints be documented in the complaints book in the future. This failing was addressed under Outcome 13: Complaints procedure.

Training records were maintained in the centre however, gaps in these records indicated that all appropriate training had yet to be provided to staff. This will be addressed under Outcome 18: Staffing: The centre utilised a daily flow chart for recording care given to residents. In addition, narrative nursing notes were now present in all care plans. These were being recorded on a more regular basis since the previous inspection. These were found to be detailed and informative.

Judgment:
Compliant

Outcome 07: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe care and support

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

Findings:

Not all staff had yet been afforded appropriate training.

During this inspection the person in charge stated that staff were made aware, on a regular basis, of the policy on the prevention of elder abuse. She said that she attended staff handover meetings to ensure that she was informed of any issues regarding residents' care and welfare. Residents with whom inspectors spoke said that they felt safe in the centre and that their concerns would be listened to. Staff were able to confirm their understanding of the types of elder abuse. They explained how they would support a resident in this situation. Inspectors viewed the policy for responding to allegations of adult abuse. This policy was comprehensive and provided details in relation to the actions required by staff when responding to an allegation to elder abuse. The person in charge explained to inspectors that a number of elder abuse awareness workshops were held with staff and residents since the previous inspection. Allied health professionals, with expertise in this area, had provided this training. The person in charge informed inspectors that further workshops were scheduled. Inspectors viewed the attendance sheets for staff who had received training to date.

The centre had a policy on behaviour that challenges. Not all staff had yet been afforded specific training to enable them to respond to and manage this behaviour safely. However, inspectors noted that a large number of staff had been afforded this training since the last inspection and further training was seen to be scheduled. Residents with behaviour that challenged were seen to have individualised, supportive care plans in place and staff spoken with were knowledgeable of these. Any residents who were at risk of absconsion, due to the effects of their medical condition, had been provided with 'code alert' bracelets. Corresponding alarm strips were observed to be in place on external exits, as a control, to minimise risks.

Inspectors reviewed the measures that were in place to safeguard residents' money and noted that receipts were obtained and where possible residents' or their representatives' signature had been recorded. Inspectors were informed that the centre was a pension agent for a group of residents and that these records were maintained centrally by the Health Service Executive (HSE). Transactions on these accounts were clear and transparent. Inspectors were informed that the centre had recently been the subject of a satisfactory external financial audit.

Judgment:
Substantially Compliant

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:
Not all hazards in the centre had been identified and controls put in place to minimise the risks since the last inspection.
For example:
Unsecured oxygen cylinders were still stored in an open corridor area and store room, without signage to indicate any associated risks. This was not in line with the guidelines on safe oxygen storage that were outlined in the centre's policy.
A number of oxygen cylinders were stored unsecured, externally, next to the hospital, also without appropriate signage.
Not all windows had been assessed as regards the requirement for restrictors, if any.

During this inspection the fire prevention policy was viewed by inspectors and was found to be detailed and centre-specific. There were signs placed prominently around the centre to alert staff and residents to the procedure to follow in the event of a fire. The emergency lighting was checked and serviced at regular intervals and inspectors viewed these records. Documentation and evidence was also seen which indicated that the fire extinguishers were maintained and serviced as required. Fire training was provided to staff on a number of dates in 2014 and 2015. Regular fire evacuation drills were undertaken since the last inspection. Staff spoken with by inspectors were aware of the procedure to be followed in the event of a fire. There was an evacuation list at the reception area which was updated daily. However, management staff informed inspectors that daily checks of fire doors were not undertaken. Records on these checks were not accessible to inspectors when requested from staff. Management staff informed inspectors that these checks only occurred when senior managers were on duty. this was significant in view of the size and layout of the building

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. The person in charge said that the centre had a health and safety committee which met on three occasions yearly. The centre had the services of a health and safety consultant on site. Hand sanitisers and sinks were present at the entrance to the building, on the corridors and in the staff and resident areas. Inspectors saw that gloves were stored safely. Hoists, wheelchairs, weighing scales, electric beds and mattresses were serviced on a regular basis and these records were seen by inspectors. The centre had an outside smoking area. There were risk assessments noted in the files of residents who smoked. Clinical risk assessments were undertaken for the residents, including falls risk assessment, dependency levels, nutrition, skin integrity, continence, moving and handling and challenging behaviour. Inspectors viewed these in the residents' care plans.

External side and back doors with public access to the physiotherapy area to the centre and to the hospital chapel area had been made secure since the last inspection. There was a risk assessment and controls in place to mitigate risks associated with this. Inspectors also noted that the doors to sluice rooms, a linen room, the room containing the photocopier and the electronic operations control box and kitchenette had been secured since the last inspection.

However, while the risk register had been updated since the last inspection the updated version was not accessible in the centre. The person in charge procured the updated risk assessments from the health and safety consultant during the inspection. Some of the toilets available for residents were unsuitable for residents as a number remained very narrow. In addition, inspectors saw that there were no grab rails in one of these toilets. Furthermore, space in other toilets was restrictive for certain residents. For example, inspectors observed that a screen had to positioned in front of these toilet areas, as the door could not be locked when wheelchair bound residents and residents requiring hoist transfer were using them. This issue was addressed under Outcome 12: Premises. A number of residents had laundry sent home for washing. The management of this laundry had improved since the last inspection and new laundry bags had been procured.

Inspectors observed staff abiding by best practice in infection control with regular hand-washing and the appropriate use of personal protective equipment such as gloves and aprons.

Judgment:
Non Compliant - Moderate

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

Theme:
Safe care and support

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

Findings:
There were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents. The practice of checking, dispensing and recording of the drugs administered was in line with current legislation. The processes in place for the handling of medicines, including controlled drugs, were safe and in line with best practice guidelines. Photographic identification for residents was present. Nurses, spoken with by inspectors, demonstrated a clear understanding of the An Bord Altranais agus Cnaimhseachais na hEireann guidelines on medication management.

Medications which could be crushed were signed by the general practitioner (GP) and the inspectors were informed that transcribing of medications was not carried out in the centre. Medication fridges were in place in the centre and the temperature of these was recorded. The contents were found to be in date and marked with residents' names where appropriate.

Residents were facilitated in their choice of pharmacist. The majority of residents availed of the centre's pharmacist. The pharmacist provided support and expertise on

medication management for nursing staff in the centre and the person in charge said that the pharmacist was responsive and attentive to the needs of the residents in the centre. There was a good general practitioner (GP) service to the centre with residents having a choice of up to seven different GPs available to them. Residents' medications were seen to be reviewed on a regular basis. The centre had a policy on medication errors which required that specific documentation be filled in for medication errors. However, inspectors observed a tablet on the floor in one room during the inspection. This medication was identified and staff informed the GP about this while the inspection was ongoing. Inspector noted that advice from the GP was followed and a medication incident form was completed. In addition, photographic identification was not present on the prescription sheet of three residents.

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

Findings:
A record of all incidents occurring in the centre was being maintained. Notifications of incidents and events were being made to the chief inspector in line with legislation.

Judgment:
Compliant

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

Theme:
Effective care and support

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

Findings:
Residents received a full review of all their medical care by the GPs and their medication was updated as necessary. Residents with whom inspectors spoke expressed satisfaction with the medical care provided to them.

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

There were opportunities for residents to pursue healthy lifestyle choices and recreational activities. There was a wholesome and varied diet available. There was ongoing monitoring of each resident's health status and staff regularly checked residents' weight, blood pressure and blood tests. There was a diverse activity programme in place and residents informed inspectors that they were aware of the activities available. Activities included music, art, church choir, quiz, baking and bingo. One of the residents showed the inspectors her art work which was used to decorate the sitting room in one section. The person in charge informed inspectors that residents' right to refuse treatment was documented and inspectors noted that where a resident refused medication for example, this was documented. Family and friends with whom inspectors spoke were praiseworthy of the staff and the overall care in the centre.

Judgment:
Compliant

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

Theme:
Effective care and support

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

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

- residents in all areas were not provided with adequate personal storage space
- the size and layout of multi-occupancy bedrooms used by residents were not suitable for their needs
- insufficient assisted baths and showers to meet the needs of the residents
- toilets were restrictive for the residents' needs
- dining space was inadequate
- residents were not afforded adequate privacy
- residents could be viewed through glass partitions while in their bedrooms
- the general public passed through bedroom areas to access communal sitting rooms
- residents had to cross to the female side of the ward area to use the bath and to the male area if they wished to use the shower
- a resident residing in the 'palliative care' room or cubicle would have to vacate this area if another resident's condition changed and the room was required to be used for the resident at end of life.

Inspection findings on this inspection:

Inspectors found that there were similar premises failings, as outlined above, on this inspection.
As stated in the introduction, the 'back' hospital was built in 1841 and a newer 'front' hospital was built in in 1937.
In the 'front' hospital the majority of residents' accommodation was provided in shared bedrooms divided by screens and in some areas three, four or seven residents were sharing communal bedrooms. These were referred to as 'wards'. On the ground floor St. Anthony's ward was located to the right of the main entrance and provided accommodation for nine male residents including a seven bedded room and two single rooms. One resident occupied a palliative care area which was vacated if required for the needs of another resident. St. Catherine's ward on the left side provided accommodation for 11 female residents; this included one single room, one twin-bedded room, a palliative care room and a multi-occupancy seven-bedded ward. These wards had a living/dining room at the end of the ward area, two toilets and an assisted bathroom or shower room. A number of these toilet areas were not adequate in size, design or layout to meet the needs of residents. In addition, in a number of these toilets mobile screen had to be used to protect the privacy and dignity of some residents, as the door could not always be closed. A sitting/visitors room had been provided in the front hallway of this building. However, there continued to be serious issues and significant failings with the layout and design of the premises which did not conform to

the requirements for premises in Regulation 17 (1) and Regulation 17 (2). For example, inspectors noted that visitors, residents and staff had to pass by residents, sitting by or lying on their beds, to access the small communal sitting areas. This had a major impact on the privacy and dignity of residents lying in bed or eating meals beside their beds.

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

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

There was an inadequate number of suitable shower and bathing facilities available to meet residents needs. Inspectors noted that there was one shower and one bath available for 26 residents. Staff informed the inspectors that residents requiring a bath had to go to the neighbouring male ward and the same arrangement was in place for the men requiring use of the shower in the female area. In addition some of the toilets were very narrow and could not be used by wheelchair bound residents or those with high dependency needs. This limited the availability of suitable toilet arrangements as there were only four toilets in total for 15 residents with high dependency needs.

The multi occupancy bedroom accommodation, highlighted in previous inspections, continued to be unsuitable in design and layout to ensure the privacy and dignity of residents. The design and layout significantly impacted negatively on residents as they were not able to undertake personal activities in private or meet with visitors in private

in their bedroom area if they so wished. The limited space between residents' beds also impacted negatively on the quality of life of residents and on the storage of personal clothing and belongings in a private manner. For example, to gain access to each of the conservatory living rooms inspectors had to walk through the larger seven bedded rooms. Inspectors noted that there was regular traffic of visitors and staff passing by residents' bed space all day. Inspectors observed that sliding doors had been repaired on one resident's wardrobe since the previous inspection. Inspectors observed that the layout of the large communal bedrooms did not allow for wardrobes to be placed near to residents' beds and some wardrobes were located at the end of the wards in some areas or grouped in the centre of the ward. Personal belongings, clothes, books and toiletries were seen stored on top of some residents' wardrobes. This indicated to inspectors that there was insufficient storage space to accommodate all residents' belongings including personal washbasins and bags of laundry. In addition, mobile hoists were seen stored in residents' bedroom areas. There was access to a sluice room directly off one single bedroom and there was unsecured access from this room to a storage area for commodes and wheelchairs for other residents.

Inspectors observed that the skirting board near the toilet area in St Mary's had been repaired since the previous inspection and the nearby shower room had been decorated. In addition, the upstairs stairwell was now secured with a keypad lock. In addition, a previously unused storage area had been converted into a spacious palliative care room with an adjoining relative's room which included a kitchenette.

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

Judgment:
Non Compliant - Major

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

Theme:
Person-centred care and support

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

implemented.

Findings:
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. The person in charge informed inspectors that she monitored complaints from each area. However, the complaints policy for the centre was not displayed in a prominent area in the centre and the complaints officer and appeals process were not clearly identified. This was addressed by the person in charge during the inspection. Residents spoken with by inspectors stated that they could raise any issue or concern with the person in charge or staff. However, not all complaints were fully and properly recorded, in line with the centre's policy and Regulations. The complaint books were not used to record all complaints. Some complaints books were not available on the units and when found, they were seen to be empty. The person in charge informed inspectors that staff recorded some complaints in the narrative notes in residents' care plans. This was not in line with Regulations which required that details of complaints were to be stored separate from, and in addition to, residents' care plans. Measures were not seen to have been put in place, for improvements in practice, in response to complaints.

The person in charge informed inspectors that she had spoken with staff about the correct use of the complaints log at a staff meeting which took place during the inspection. She stated to inspectors that training would be provided in complaints management and in consistency in documenting concerns, verbal complaints and minor issues.

Judgment:
Non Compliant - Major

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

Theme:
Person-centred care and support

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

Findings:
During this inspection inspectors were shown training records which indicated that staff had attended training in aspects of nutrition, food consistencies and food hygiene. The person in charge informed inspectors that these education sessions were facilitated by a dietician from a nutrition company. Inspectors observed mealtimes including dinner and the evening tea and spoke with residents who said they were happy with the choice and

quality of food on offer. However, a number of dining areas were not adequate to meet the needs of residents as they were restrictive in size and layout. This did not encourage residents to congregate together for the social occasion presented by shared mealtimes. This failing was addressed under Outcome 12: Premises. The conservatory-type sitting rooms were used for residents requiring assistance with their meals. The small dining tables, when in use, were nicely decorated and the crockery and cutlery were of good quality.

The chef showed inspectors her files, which contained relevant information and a record of residents' food preferences. The kitchen was seen to contain a plentiful supplies of fresh, dry and frozen foods. Hand washing facilities were available and plentiful. There was a four weekly menu cycle in place. There was a colour coded and segregated system in place for food preparation. Inspection reports by other organisations were available for viewing in the kitchen. The chef and the kitchen staff were knowledgeable and informed about the specific needs, likes and dislikes of residents.

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

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

Findings:
Not all complaints were properly recorded, advocacy details were not readily accessible.

During this inspection there was evidence that residents were consulted about how the centre was run. Residents' meetings were facilitated on a regular basis. There was evidence that suggestions emanating from these meetings were acted on by the person

in charge. Residents' satisfaction surveys were undertaken. There was a policy on communication for residents in the centre. The centre was located near a busy town and was centrally placed in the community where residents could be apprised of local news. Residents were facilitated to partake in meaningful activities and local events. The person in charge informed the inspectors that residents were facilitated to vote, where possible.

The person in charge spoke with inspectors about how she met with residents and relatives on a daily basis and inspectors noticed that staff engaged with residents and relatives in a dignified and approachable manner throughout the inspection. Inspectors noted that residents received care in a manner which respected their privacy, as much as the environment allowed, with the use of curtains and screens in the multi occupancy rooms. Residents had access to telephones in the centre. Information on local events was provided by the activity personnel, the volunteers and staff members. Inspectors saw information on events advertised on the notice board and heard staff members discussing news events with the residents. Televisions were located in the bedrooms and in the communal rooms. However, because of the layout of the beds in the multi occupancy rooms it was difficult and at times impossible for some residents to see the shared TV because of the need for curtains to be drawn around the beds of other residents. All residents spoken with said that they felt content and they praised the person in charge, the centre and the staff members.

Inspectors observed that visitors were plentiful and those to whom the inspector spoke were very pleased with all aspects of care in the centre. However, visiting times were restricted during meal times and inspectors observed that the conservatory visiting area was not adequate due to the design and layout of the room. For example, when visitors were present it impacted on other residents and also impacted on the privacy of the visitor and that of the resident who was receiving visitors. In addition, information on access to an independent advocacy service was not easily accessible. This was addressed by the person in charge during the inspection.

Judgment:
Non Compliant - Moderate

Outcome 17: Residents' clothing and personal property and possessions Adequate space is provided for residents' personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.

Theme:
Person-centred care and support

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

Findings:
There were outstanding actions from the previous inspection dated 14 May 2013 and 2014:

-The storage space for residents' personal clothing was inadequate overall.
-A sample of residents' clothes seen by inspectors was not marked.

Inspection findings:
Inspectors saw evidence that residents' bedroom areas were personalised where space allowed. There were a number of single rooms and some of the cubicle areas in the multi occupancy rooms were more spacious than others. However, there was inadequate storage space for personal items, as evidenced by the accumulation of these items on top of window sills, lockers and wardrobes. This issue was addressed under Outcome 12: Premises. However, the clothes marking system, which was an outlined as completed in the action plan from the previous inspection, was not applied to all residents' clothing seen by inspectors.

Residents and relatives, spoken with by inspectors, stated that they were happy with the way their clothing and personal belongings were managed. There was no unresolved issue with missing clothing. Inspectors observed that there was an inventory being kept of residents' personal items in residents' care plans.

Judgment:
Non Compliant - Moderate

Outcome 18: Suitable Staffing
There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

Theme:
Workforce

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

Findings:
Not all staff had been afforded mandatory training.

During this inspection the person in charge informed inspectors that a staff development and appraisal system was being undertaken. Staff changing rooms, canteen and shower

area were provided. Staff had received training in the prevention of elder abuse, in moving and handling techniques, in behaviour that challenged and in fire safety. There was a clear management structure and staff on duty were aware of the reporting mechanisms and the line management system. Inspectors reviewed staffing rotas, staffing levels and skill mix.

Inspectors found that there were gaps in the training provided to staff and the clinical nurse manager said that reduced staffing levels had an impact on releasing staff for training. For example, some staff members were yet to be provided with appropriate training in manual handling and in behaviours that challenge. This issue was addressed under Outcome: 7. However, training had been provided to the majority of staff since the previous inspection and clear records were maintained of this. The schedule for forthcoming training was seen by inspectors.

Inspectors viewed the registration details with An Bord Altranais agus Cnaimhseachais na hEireann for nursing staff. Inspectors looked at a sample of staff files and found that they contained the information in relation to matters identified in Schedule 2 of the Health Act 2007 (Care and Welfare Regulations in Designated Centres for Older People) Regulations 2013. The files were kept neatly, easily accessible and stored securely.

Judgment:
Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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Regulation Directorate
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Action Plan

Provider's response to inspection report[1]

Centre name:	Midleton Community Hospital
Centre ID:	OSV-0000579
Date of inspection:	22/07/2015 and 23/07/2015
Date of response:	24/09/2015

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 07: Safeguarding and Safety

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all staff had up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.

1. 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.

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

Please state the actions you have taken or are planning to take:
Staff have been trained in Challenging Behaviour. Further training will be provided to outstanding staff.

Proposed Timescale: 18/12/2015

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 were identified and assessed throughout the designated centre, for example:

Unsecured oxygen cylinders were still stored in an open corridor area and store room, without signage to indicate any associated risks.
A number of oxygen cylinders were stored unsecured, externally, next to the hospital, without appropriate signage also.
Not all windows had been assessed as regards the requirement for restrictors, if any.
Not all toilets had grab rails fitted.

2. 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:
•All oxygen cylinders have been stored securely within the wards, and appropriate signage displayed during inspection in 23rd July 2015
•Ambulance staff notified in view of oxygen cylinders stored externally next to the hospital without appropriate signage. The cylinders will be removed on 24th September 2015.
•All restrictors on the each window were checked following inspection will be re-checked on 24th September 2015.
•All toilets have been measured, grab rails were ordered on 17th September 2015. It will be completed by 29th October 2015.

Proposed Timescale: 29/10/2015

Outcome 09: Medication Management

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all medicinal products were 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.
For example: a medication was found on the floor of one resident's room and not all residents had photographic identification on their files to minimise the risk of administration error.

3. 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:
Incident highlighted to all staff immediately. Pharmacist contacted and is to give talk to staff on a sessional basis re the appropriate use of medicines. All photographic identification has been completed.

Proposed Timescale: 24/10/2015

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:
Inspectors noted that the premises of the designated centre were not appropriate to the number and needs of the residents of that centre.
For example:
-residents in all areas were not provided with adequate dining or personal storage space
-the size and layout of multi-occupancy bedrooms used by residents were not suitable for their needs
-insufficient assisted baths and showers to meet the needs of the residents:
-toilets were restrictive in space for the needs of certain residents.

4. 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:
The HSE is fully committed to addressing all of environmental issues as, identified above. A design team has been appointed & detailed architectural drawings are currently being drawn up to ensure that the facility fully meets the environmental

standards. Funding is in place to bring this process to planning approval stage. Following the announcement last week of €450.00 million funding available for Community Hospitals in Ireland, we are awaiting the allocation of this funding to individual projects. Once this allocation is known, I will forward the details of the funding granted with regard to Midleton Community Hospital.

Proposed Timescale: 30/09/2018

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider had failed to provide premises which conformed to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.
For example:
the layout of bedroom areas did not support the preservation of the privacy and dignity of residents as regards their personal space and the storage and accessible of their personal belongings
-there was access to a sluice room directly off one bedroom and there was unsecured access from this bedroom to a storage area for commodes and wheelchairs for other residents.
-bedroom accommodation in some cases consisted of cubicle style accommodation
-in some cases residents were accommodated in bedroom areas without walls separating them from the public access corridor, a curtain or telescopic screen was in place.
-other residents were accommodated in multi occupancy rooms which had a glass topped partitions separating them from the corridor. This afforded a full view into the bedroom areas of these residents by passing visitors and staff.

5. 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:
•Sluice room directly off one bedroom has been locked with no access to the bedroom.

The HSE is fully committed to addressing all of the privacy & dignity issues, as identified above. A design team has been appointed & detailed architectural drawings are currently being drawn up to ensure that the facility fully meets the environmental standards. Funding is in place to bring this process to planning approval stage.

Proposed Timescale: 30/09/2018

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:
A copy of the complaints procedure was not displayed in a prominent position in the designated centre.

6. Action Required:
Under Regulation 34(1)(b) you are required to: Display a copy of the complaints procedure in a prominent position in the designated centre.

Please state the actions you have taken or are planning to take:
Your Service, Your Say is displayed throughout the hospital in prominent positions. Complaints Procedures was created during inspection and displayed throughout the hospital. (Copy of Complaints Procedures attached).

Proposed Timescale: 23/07/2015

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The nominated person failed to maintain 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 in the complaints log.

7. 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 Triplicate book has been introduced where one copy is sent to the Director of Nursing, one copy is placed in the resident's medical file which is separate to their nursing file and one copy is kept on complaint's book. (Copy of triplicate book attached). This book 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

Proposed Timescale: 15/09/2015

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in

the following respect:
The provider failed to fully and properly record all complaints and the results of any investigations into the matters complained of and any actions taken on foot of a complaint are and ensure such records were in addition to and distinct from a resident's individual care plan.

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

Please state the actions you have taken or are planning to take:
A Triplicate book has been introduced where one copy is sent to the Director of Nursing, one copy is placed in the resident's medical file, separate from the residents' individual care plans, and one copy is kept on complaint's book. (Copy of triplicate book attached). The pages of the complaints book are numbered and can be cross referenced if necessary in the Care plan narrative notes.

Proposed Timescale: 15/09/2015

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure that measures required for improvement in response to a complaint were put in place.

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

Please state the actions you have taken or are planning to take:
A Triplicate book has been introduced where one copy is sent to the Director of Nursing, one copy is placed in the resident's medical file and one copy is kept on complaint's book. (Copy of triplicate book attached). The pages of the complaints book are numbered and can be cross referenced if necessary in the Care plan narrative notes.

Proposed Timescale: 15/09/2015

Theme:
Person-centred care and support

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

The provider failed to nominate a person, other than the person nominated in Regulation 34 (1)(c), to be available in the designated centre to ensure that all complaints were appropriately responded to and that the person nominated under Regulation 34 (1)(c) maintained the records specified under in Regulation 34 (1)(f).

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

Please state the actions you have taken or are planning to take:
The Director of Nursing is the nominated person to deal with complaints. The procedure for complaints is displayed prominently in the centre.

Proposed Timescale: 15/09/2015

Outcome 16: Residents' Rights, Dignity and Consultation

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure that each resident had access to radio, television, newspapers and other media as choice of channel was limited for residents. For example, up to four residents shared a TV, they did not have access to remote controls if required and their view was restricted when curtains were pulled around beds of other residents. In addition, if a resident wished to listen to the radio in the multi occupancy rooms this choice was dependent on whether the TV was on or not.

11. Action Required:
Under Regulation 09(3)(c)(ii) you are required to: Ensure that each resident has access to radio, television, newspapers and other media.

Please state the actions you have taken or are planning to take:
Residents have access to radio, television and newspapers. They have a choice of using the multi-occupancy room or going to a sitting room of their choice in both locations of the hospital. This will be further rectified in the new build.

Proposed Timescale: Ongoing & September 2018

Proposed Timescale: 30/09/2018

Theme:
Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Visits were restricted at meal times and this restriction was required because of the multi occupancy bedroom accommodation and the restriction of space in dining rooms which impacted on the privacy and dignity of all residents.

12. Action Required:
Under Regulation 11(2)(a) you are required to: Ensure that in so far as is reasonably practicable, visits to a resident are not restricted, unless such a visit would, in the opinion of the person in charge, pose a risk to the resident concerned or to another resident, or the resident concerned has requested the restriction of visits.

Please state the actions you have taken or are planning to take:
All signs have been removed to include no visiting restrictions to all residents.

Proposed Timescale: 23/09/2015

Outcome 17: Residents' clothing and personal property and possessions

Theme:
Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The provider failed to provide adequate space for each resident to store and maintain his or her clothes and other personal possessions.

13. 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:
In so far as reasonably possible each individual has access to their possessions. This will be further rectified in the new build.

Proposed Timescale: 30/09/2018

Theme:
Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure that each resident has access to and retained control over his or her personal property and possessions.
for example: lockers and wardrobes were not always located next to residents' beds due to lack of space.

14. Action Required:
Under Regulation 12 you are required to: Ensure that each resident has access to and retains control over his or her personal property, possessions and finances.

Please state the actions you have taken or are planning to take:
In so far as reasonably possible each individual has access to their possessions and finances. The space for lockers & wardrobes will be further rectified in the new build.

Proposed Timescale: Ongoing & September 2018

Proposed Timescale: 30/09/2018

Theme:
Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A sample of residents' clothing seen by inspectors was not marked with the resident's name, to prevent loss or any confusion with clothes. This was relevant in view of the fact that wardrobes were not always located near to individual resident's beds.

15. 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:
Each resident's representative received a letter from Director of Nursing requesting that that each item of clothing was to be clearly marked

Proposed Timescale: 24/09/2015

Outcome 18: Suitable Staffing

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
All staff members were yet to be afforded appropriate training.

16. Action Required:
Under Regulation 16(1)(a) you are required to: Ensure that staff have access to appropriate training.

Please state the actions you have taken or are planning to take:
All staff members are being given the opportunity to improve their professional development, at all levels. All training opportunities are placed on the staff notice board

and in a specific memo folder that all staff have access to.
Proposed Timescale: 18/12/2015