Health Information and Quality Authority
Regulation Directorate

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

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

Centre name:	Dungarvan Community Hospital
Centre ID:	OSV-0000594
Centre address:	Springhill, Dungarvan, Waterford.
Telephone number:	058 20900
Email address:	paula.french@hse.ie
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Barbara Murphy
Lead inspector:	Vincent Kearns
Support inspector(s):	Ide Cronin
Type of inspection	Announced
Number of residents on the date of inspection:	73
Number of vacancies on the date of inspection:	43

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.

Please note the definition of the following term used in reports:
responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

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 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:
07 September 2017 08:00	07 September 2017 17:30
08 September 2017 07:30	08 September 2017 15:30

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

Outcome	Our Judgment
Outcome 01: Statement of Purpose	Compliant
Outcome 02: Governance and Management	Compliant
Outcome 03: Information for residents	Substantially Compliant
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Compliant
Outcome 07: Safeguarding and Safety	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	Substantially Compliant
Outcome 12: Safe and Suitable Premises	Non Compliant - Major
Outcome 13: Complaints procedures	Compliant
Outcome 14: End of Life Care	Compliant
Outcome 15: Food and Nutrition	Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Non Compliant - Major
Outcome 17: Residents' clothing and personal property and possessions	Substantially Compliant
Outcome 18: Suitable Staffing	Compliant

Summary of findings from this inspection

This report sets out the findings of a two day announced inspection to inform a decision for the renewal of registration. Unsolicited information of concern had been received by the Health Information and Quality Authority (HIQA) prior to this inspection. These concerns alleged issues in relation to staffing and a poor quality of care provided to residents. However, during the course of this inspection these concerns were not substantiated.

Dungarvan Community Hospital was originally made up of two district hospitals one from the 1900's and the other dating back to famine times. There had been many significant extensions, refurbishments and renovations since then. However, with the exception of St Vincent's unit which was a purpose built 32 bed unit commissioned in November 2009; the overall the design and layout of the premises is largely reflective of a hospital from this period.

Dungarvan Community Hospital is a large center with the dependency levels recorded as follows; 36 residents were assessed as having maximum care needs, 18 residents were considered as having high dependency needs, 13 residents had been assessed as medium dependency and six residents were assessed as having low dependency needs.

The centre is a two-storey building. However, all resident accommodation was on the ground floor and comprised of six separate units, two of which were not occupied on this inspection:
1) St. Michael's Unit: was a 12 Bedded Male unit
2) St. Ann's Unit: was a dementia-specific unit providing accommodation for 10 residents; nine long term beds, one respite bed and day care service to a maximum of three people per day.
3) St. Vincent's Unit: was a 32-bedded unit for male and female residents with three rehabilitation beds, three respite beds and three palliative care beds
4) St. Francis Unit: was a female long-term care unit providing accommodation for 23 residents and it had been refurbished in 2007
5) St. Enda's Unit: was a mixed male and female long-term care unit providing accommodation for 12 residents. However, this unit was not occupied at the time of inspection.
6) Sacred Heart Unit: was a 27-bedded male and female unit comprising 15 beds allocated to rehabilitation, respite and convalescence and 12 beds for long-term care. However, this unit was not occupied at the time of inspection. Inspectors were informed by the provider representative that Sacred Heart Unit was closed at the time of inspection due to insufficient staffing and that St. Enda's Unit had been closed to allow refurbishment works to be completed.

Overall the design and layout of the premises was appropriate to meet most of the needs of residents and was generally in keeping with the center's statement of purpose. There had been significant improvements in the premises since the previous inspection, including a reduction in the number of beds in bedrooms, redecoration and significant refurbishments throughout the center, which are detailed under outcome 12 of this report. However, as has been identified in previous inspection reports; inspectors noted that there were still six-bedded bedrooms that were not suitable to meet the individual or collective needs of residents who lived there. The design and layout of the two six-bedded bedrooms in St Francis unit and four six bedded bedrooms in the Sacred Heart unit were inadequate to protect residents' privacy and potentially compromised residents' dignity. The space between beds in each six-bedded units was limited. This confined bedside space also posed a restriction on movement for staff delivering care at the bedside. The lack of space also reduced the amount of furniture or personal memorabilia that could be accommodated. The provider representative informed inspectors that with the

planned opening of the Sacred Heart unit on the 11 September 2017; all bedrooms in the center would be reduced to a maximum of four beds. The provider representative also stated that the center would be applying for registration renewal of a total of a 104 beds to ensure that there were no more than four residents resided in any of the multi-occupancy bedrooms.

According to the centres' statement of purpose Dungarvan Community Hospital provides general nursing care on a 24 hour basis. The statement of purpose states that the center aims to provide holistic, person centered services for older people. That the service also incorporates adult referrals for respite, rehabilitation, convalescent and palliative care. Pre admission assessment is carried out by a member of the hospital management team to ensure the resident meets the admission criteria for Dungarvan Community Hospital. The centre is located close to all amenities in Dungarvan town including shops, churches and restaurants. On the days of inspection there were 73 residents living in the center. There was plenty of parking provided to the front and rear of the premises. There was suitable paths for residents' use and a number of suitable external areas for residents use.

As part of the inspection process, the inspectors met with residents, staff members, the Clinical Nurse Manager's (CNM's), the Assisted Director's of Nursing (ADON's) the person in charge who is the Director of Nursing (DON) and the provider representative. Inspectors observed practices and reviewed documentation such as policies and procedures, care plans, medication management, staff records and accident/incident logs. Residents told inspectors that they were very happy living in the centre and that they felt safe there. Overall staff spoken to were able to demonstrate good knowledge of the residents' care needs when speaking with inspectors.

There were 17 outcomes reviewed, 10 of which were compliant and two outcomes substantially compliant. However, two outcomes health and social care needs and medication management were deemed moderately non-compliant and two outcomes premises and residents rights and dignity and consultation were judged to be majorly non-compliant. These non-compliances are discussed throughout the report and the action plan at the end of the report identifies where improvements are needed to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Standards for Residential Care Settings for Older People in Ireland.

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 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:
There was a written statement of purpose that described the service that was provided in the center and had most recently been updated in September 2017. The inspectors noted that the services and facilities outlined in the statement of purpose, and the manner in which care was provided, reflected the diverse needs of residents. The statement of purpose contained all of the information required by schedule 1 of the regulations and was reviewed annually.

Judgment:
Compliant

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

Theme:
Governance, Leadership and Management

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

Findings:
On the previous inspection there had been issues identified in relation to inadequate staffing and some of the actions in relation to outstanding premises works had not been

satisfactorily progressed. However, on this inspection, inspectors noted that staffing levels were adequate and most of the actions in relation to outstanding premises improvements had been completed.

The inspectors spoke with staff who were on day and on night duty, CNM's, ADON's, the provider representative and the person in charge. All outlined a clearly defined management structure that was in place. This structure identified who was in charge, who was accountable to whom and the reporting relationships within the organization. Inspectors noted that there was a contemporaneous record on each unit in relation to which manager was on call out of hours. Staff who spoke with inspectors were able to demonstrate good knowledge of this system. There was a copy available of the annual review into the quality and safety of care delivered in the centre as required by regulation. There was a system in place to improve the quality and safety of the service. This included for example, the person in charge supported by other staff undertaking regular audits in the center. These audits were available to inspectors and included, amongst others: falls, hygiene and infection control, health and safety, the quality of life, nutrition and medication. The person in charge outlined how these audits informed the quality and governance within the centre. The person in charge explained how the findings and actions from these audits were also being used to focus areas for improvement in the centre. For example, the data obtained in relation to falls was being actively used to reduce the overall incidence of falls and particularly the level of recurring falls. The provider representative spoke with the person in charge on a daily basis, visited the centre each week and met the person in charge at senior management meetings that were held as required, but at a minimum every second month.

There was evidence of meetings with staff and regular meetings were held with residents. The person in charge also had a responsibility for another center and was supported in her role by two experienced Assistant Directors of Nursing (ADON) and a number of Clinical Nurse Managers (CNM). For example, there was a CNM based on site in each unit and the ADON visited each unit on a daily basis. The ADON's also outlined how they supported the person in charge in her role. For example, each ADON had the lead for a number of areas including health and safety and risk management, medication management and care planning practices. Both ADONs had many years of clinical and managerial experience. Inspectors noted that the person in charge was well known to residents. She informed inspectors that she made getting to know all residents a priority. The person in charge chaired the residents' committee meetings with the most recent recorded as being held on 01 August 2017. From a review of the minutes of these meetings it was clear that issues identified were addressed in a timely manner and that the person in charge was proactive in addressing any concerns or issues raised. Where areas for improvement were identified in the course of this inspection; the person in charge and the provider representative demonstrated a conscientious approach to addressing these issues in a robust manner and displayed a commitment to compliance with the regulations. There was also evidence of good consultation with residents and relatives via resident/relative questionnaires that were provided as part of this registration inspection. Some completed questionnaires did mention for example "that the hospital could do with more staff" and "staff are very busy". However, the overwhelming responses were positive and complementary of staff and the care and support provided. In particular, staff were identified as being very supportive and approachable by respondents to these questionnaires. The provider representative had

also completed a residents satisfaction survey in July 2017. The responses in this survey were mainly positive and complementary of staff and indicated an overall satisfaction with the services provided.

Staff spoken to did identify that staffing had been a significant and stressful issue for them particularly early in the year. Staff told inspectors that a lack of staff became apparent particularly when replacement staff were required. For example, due to unexpected vacancies such as sick leave. However, staff informed inspectors that overall this issue had now been resolved with the recruitment of additional staff and improvements in the number of available staffing resources following the closing of the Sacred Heart unit in May 2017. Inspectors were informed that this unit was due to reopen shortly and some staff spoken to expressed concerns that staffing may again becomes a challenge. These concerns were relayed to the provider representative by inspectors. The provider representative outlined how there had been a successful recruitment campaign completed and stated that there would be sufficient staffing resources for all units in the center. The person in charge and the provider representative acknowledged that staffing had been an issue and outlined the corrective actions that had been taken. They both confirmed that they were on call to assist staff when required and staff spoken to confirmed that this arrangement was in place. This issue was further detailed under outcome 18 of this report.

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:
Samples of residents' contracts of care were viewed by inspectors. Contracts had been signed by the residents/relatives and inspectors found that each contract was clear and gave an outline of the services and responsibilities of the provider to the resident and the fees to be paid. However, in relation to contracts for residents receiving respite care inspectors noted that the section for recording any additional charges were blank in the sample of contracts viewed. In addition, not all contracts of care reviewed contained details of the terms relating to the bedroom to be provided to the resident and the number of other occupants (if any) of that bedroom, "after" the terms, as required by regulation.

A Residents' Guide was also available with copies of both were available in individual

units. The guide included a summary of the services and facilities provided, terms and conditions relating to residence, procedure respecting complaints and the arrangements for visits. This guide was found to meet the requirements of legislation.

Judgment:
Substantially 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 who worked full time and apart from a recent six month break she had been a involved in the governance of the center as DON/person in charge since in 2010. She was an experienced nurse with 31 years experience of nursing care of the older person. The person in charge had responsibility for a second centre which was located across the road. The person in charge outlined how she divided her time between these two centers and how she was supported by two well experienced ADON's and the CNM's on site.

The person in charge was an experienced nurse manager having worked as a staff nurse, CNM 2 and at ADON levels. She was centrally involved in the governance of the centre on a daily basis. Inspectors were satisfied that the person in charge was adequately engaged in the governance, operational management and administration of this centre on a regular and consistent basis. Having significant experience as a nurse she demonstrated a clear knowledge and understanding of the residents needs and person centred care in older people. She was sufficiently knowledgeable of her responsibilities under the regulations. The person in charge was very responsive to the inspection process and engaged proactively and positively with inspectors. For example, a number of improvements had been identified on the first day of inspection such as some minor painting and additional furniture requirements for some residents. However, inspectors noted that the person in charge had remedied these issues before completion of the second day of the inspection. The person in charge had attended various clinical and professional development training courses to keep her skills up-to-date. She had significant experience in dementia care and had commenced training as a dementia champion. She also attended relevant conferences during the year. She was well known to residents and both residents and staff confirmed that she was readily available to provide support. The person in charge confirmed that she maintained an open door policy to residents, their representatives and staff.

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 the center's operating policies and procedures and noted that the centre had policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and these were reviewed and updated at intervals not exceeding three years as required by Regulation 4. The centre-specific policies reflected the care given in the centre and informed staff with regard to up-to-date evidenced best practice or guidelines. There was evidence that there was on-going training to staff on policies and procedures and staff had signed off on these once they had received the training.

The provider representative confirmed that all staff and volunteers in the center had been suitably Garda vetted and inspectors reviewed a sample of staff files and found that they contained all of the information required under Schedule 2 of the Regulations.

Inspectors was satisfied that the records listed in Part 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 were maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. Overall records were seen to be maintained and stored in line with best practice and legislative requirements.

Inspectors viewed the insurance policy and saw that the center was adequately insured against accidents or injury to residents, staff and visitors. Residents' records were reviewed by inspectors who found that they complied with Schedule 3 of the Health Act 2007 (Care and Welfare of Residents in Designated Center's for Older People) Regulations 2013. The records listed in Schedule 4 to be kept in a designated center were all maintained and made available to inspectors.

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

Findings:
Prior to this inspection; unsolicited information of concern had been received by the Health Information and Quality Authority (HIQA). These concerns alleged issues in relation to staffing and a poor quality of care provided to residents. However, during the course of this inspection these concerns were not substantiated.

Inspectors saw that there was positive and respectful interactions between staff and residents and that residents and relatives were comfortable in asserting themselves and bringing any issues of concern to any staff, CNM's, the ADON's or to the person in charge. Residents spoken to articulated clearly that they had full confidence in the staff and expressed their satisfaction in the care being provided. In relation to residents' financial transactions, inspectors spoke informally with residents throughout the inspection and the feedback received from them was positive. Inspectors reviewed the arrangements in place in relation to the maintenance of residents' day to day expenses and the centre managed a small number of residents financial transactions. Inspectors reviewed these systems to safeguard residents' finances which included a review of a sample of residents' records of monies. Inspectors noted that all lodgments and withdrawals were adequately documented or signed for by residents, their representatives and/or two staff. In addition, there were suitable arrangement for a written acknowledgement of the return of the money or valuables and adequate reviewing/auditing of these arrangements. Inspectors noted that a small number of residents had their pension managed by staff in the center. The provider confirmed that in relation to being a pension agent for some residents; the center was in compliance with the requirements of the department of social protection guidelines. Inspectors were informed by staff that residents' financial records were audited both internally and by an external auditor to ensure good financial governance was in place.

Restraints' audits had been completed in each unit in August 2017 using residents care plans and an audit tool. Results from these audits indicated that overall improvements in most units in relation to a reduction in the use of restraints. The person in charge and staff spoken to stated that they were fully committed to providing a restraint free environment. Inspectors noted that there had been a reduction in the level of restrictive practices in use in the centre. The person in charge outlined how the use of low-low beds and bed and chair alarms had help reduce the incidence of restraint. Staff stated that they actively sought to provide alternatives to bedrails whenever possible and this was evidenced from a review of residents care plans.

The person in charge confirmed that there was no active reported, suspected or alleged incident of abuse in the centre. There was evidence that if any allegations of abuse had been reported; such allegations would be recorded, investigated and appropriate action taken and including reported to HIQA and other agencies as required. Inspectors were satisfied that there were policies and procedures in place for the protection of residents. The person in charge was actively engaged in the operation of the centre on a daily basis. There was evidence of good recruitment practices including verification of references and a good level of visitor activity. Inspectors spoke to a number of residents and visitors over the course of the two days and all stated that the staff were very kind and caring. The provider representative confirmed that all staff and volunteers were suitably Garda vetted. The national Health Service Executive (HSE) safeguarding policy was in place for the prevention, detection and management of any protection issues. All staff spoken with confirmed their attendance at elder abuse training and were clear on their responsibilities. Staff outlined for example their on-going "vigilance" and their confidence in the person in charge, the ADON's and/or the CNM's to take appropriate action if and when required.

Inspectors noted that the training matrix recorded that training in dementia care had been provided. There was a policy on responsive behaviours (a term used to describe how persons with dementia represent how their actions, words and gestures are a response to something important to them). Staff to whom inspectors spoke were knowledgeable in suitable de-escalating techniques. Inspectors noted that three residents had been identified as having responsive behaviors. There was evidence that residents who presented with responsive behaviors were reviewed by their General Practitioner (GP) and referred to other professionals for review and follow up as required. Inspectors saw evidence of positive behavioural strategies and staff spoken to outlined suitable practices to prevent responsive behaviours. Care plans reviewed by inspectors for residents exhibiting responsive behaviours and were seen to reflect the positive behavioural strategies proposed including staff using person-centred de-escalation methods. However, from a review of one residents' care plan who was actively displaying responsive behavior's; inspectors noted that their care plan was not adequate to guide staff in providing clinical practice or support. While an initial assessment had been commenced in relation to this residents behavioral triggers, this record had not been suitably updated to reflect on-going changes in the resident's presentation. Therefore this responsive behavior care plan did not adequately provide guidance to staff in the provision of on-going care and support including suitable de-escalating techniques. This issue was actioned under outcome 11 of this report.

Judgment:
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):

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

Findings:
There were appropriate arrangements for investigating and learning from serious incidents/adverse events. These arrangements included for example, the identification of any resident who was at risk of falls and putting in place appropriate measures to minimize and manage such risks. Each serious reportable event (SRE) was suitably recorded and escalated to senior management as per the Health Service Executive (HSE) safety incident management policy January 2017 and reporting protocols. Following any such incident, accident or event, the provider representative and the person in charge along with other staff met at a senior incident management team meeting. Following each SRE these meetings were held to ascertain if there was any learning opportunities or corrective actions that needed to be taken. For example, for residents who had fallen, there were falls risk re-assessments completed after each fall, and care plans were updated accordingly. Suitable governance and supervision systems were in place to monitor residents at risk of falls. Such arrangements were reviewed on an on-going basis. There was a risk register available in the centre and inspectors found that the hazard identification process was adequate. There was an up-to-date risk management policy that addressed the identification and assessment of risks and the controls that were in place including the requirements of the regulation 26(1).

The internal and external premise and grounds of the centre appeared safe and secure, with appropriate locks installed on all interior and exterior doors. The centre had centre specific policies relating to health and safety and the safety statement had been most recently reviewed in June 2017. There was a plan in place for responding to major emergencies likely to cause death, injury, serious disruption to essential services or damage to property. There was a record of incidents and accidents in the centre which recorded slips, trips and falls. The records seen were adequate to ensure arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents. The centre had a detailed infection prevention and control policy in place. Personal protective equipment, such as latex gloves, aprons and hand sanitizers were located throughout the premises. All hand-washing facilities had liquid soap and paper towels available. Staff that were interviewed by inspectors demonstrated knowledge of the correct procedures to be followed in relation to infection prevention and control. Hand hygiene training was on-going and staff demonstrated good hand hygiene practice as observed by inspectors. Arrangements for the disposal of domestic and clinical waste management were appropriate.

Documentation seen indicated that hoists required for moving techniques in resident care were serviced regularly. Care plans contained a current manual handling assessment and plan that referenced the specific equipment required for resident and staff safety. Manual handling practices observed were seen to be in line with current best practice and the training matrix recorded that all staff were trained in manual handling.

Inspectors saw that the fire policies and procedures were centre-specific. The fire safety plan was viewed and found to be comprehensive. There were notices for residents and staff on "what to do in the case of a fire" appropriately placed throughout the premises. Colour-coded floor plans were displayed throughout the centre which identified 'Where

You Are Now' in line with best practice. Fire training had been provided to staff on regular occasions and all staff that had received up-to-date fire training. There was evidence that recent and regular fire drills were taking place in the centre. The most recent fire evacuation drills were recorded in each unit in August 2017. Staff demonstrated an appropriate knowledge and understanding of what to do in the event of fire. Inspectors examined the fire safety register with detailed all services and tests carried out. Inspectors noted that there were records of daily, weekly and monthly fire safety checks being completed in relation to the fire extinguishers, fire exits and fire alarms. Fire fighting and safety equipment had been tested and was up to date including emergency lighting and the fire alarm system. Inspectors noted that one fire exit was temporarily blocked for a maximum period of two weeks while outside works were being completed in one unit. The CNM in this unit outlined to inspectors that the temporary blocking of this fire exit door had been risk assessed and that the HSE fire safety officer had reviewed this temporary arrangement. Controls were in place to mitigate against the residual risks. These controls included additional monitoring and fire safety checks and additional staff assigned to this unit for the duration of these external works. Inspectors requested the provider representative to provide HIQA with further assurances in relation to this arrangement in the event of staff having to evacuate residents from this unit. Detailed personal emergency evacuation plans (PEEPS) were seen to be completed for residents which outlined the assistance they would require in an emergency situation. However, the PEEP records viewed were not adequate as they did not contain adequate details regarding the residents' level of supervision when brought to a place of safety following evacuation.

In one unit' St Vincent's there were two designated outdoor smoking areas however, one of these areas was not adequate as it did not have any fire extinguisher, call bell facility or fire blanket within reasonable proximity to this area in the event of a resident requiring assistance. Residents who were smokers had individual smoking risk assessments in place and all cigarettes and lighters were safely stored by staff. However, these smoking risk assessments required review as they did not quantify the actual level of residual risk associated with the resident smoking and therefore it was unclear as to what level of controls were required to mitigate against such identified risks.

Judgment:
Non Compliant - Moderate

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

Theme:
Safe care and support

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

Findings:
There was a community retail pharmacist who supplied medication and supported the

centre by providing a pharmacist who visited the center each week for six hours to provide medication reviews. Inspectors noted that the most recent review was recorded as being completed in March and April 2017. There had also been medication audits completed in two units in August 2017 and inspectors noted 100% compliance had been achieved. Medication management meetings had been held with the ADON's and the pharmacist; with the most recent meeting recorded in August 2017. Inspectors noted at one of these meetings that there were plans for the pharmacist to provide training to staff commencing in September 2017.

Nursing staff with which inspectors spoke demonstrated adequate knowledge of the general principles and responsibilities of medication management. Medication administration practice was observed by inspectors. Nurses wore red "do not disturb bibs" while administrating medications and inspectors noted that the nursing staff adopted a person-centred approach. For example, when administrating medication staff were observed interacting with each resident in a supportive and consider manner; speaking to residents and eliciting feedback prior to administering medication. Medicines were stored in a locked cupboard, medication trolley or within a locked room only accessible by nursing staff. Medicines requiring refrigeration were stored securely and appropriately. The temperature of the medication refrigerator was noted to be within an acceptable range and the temperature was monitored and recorded daily.

Compliance aids were used by nursing staff to administer medicines. A sample of medication prescription records was reviewed. The practice of transcription was in line with the centre-specific policy and guidance issued by An Bord Altranais agus Cnáimhseachais for all prescriptions seen. However, from a sample of medication administration records examined, inspectors noted that there were gaps in some records. In addition, for medications to be crushed, inspectors noted that not all medications to be crushed had been individually prescribed by the GP.

There were measures in place for the handling and storage of controlled drugs that were accordance with current guidelines and legislation. Nursing staff with whom the inspector spoke demonstrated knowledge of the general principles and responsibilities of medication management. Controlled drugs were recorded as administered in the medication administration records in accordance with guidance issued by An Bord Altranais agus Cnáimhseachais.

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:
Inspectors saw that there was a comprehensive log of all accidents and incidents that took place in the centre. Incidents as described in the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 had been reported in accordance with the requirements of the legislation. There were timely quarterly returns and written notifications were received within three days of accidents and incidents as required.

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:
Unsolicited information of concern had been received by the Health Information and Quality Authority (HIQA) prior to this inspection. These concerns alleged issues in relation to a poor quality of care provided to residents. However, during the course of this inspection these concerns were not substantiated.

Overall inspectors were satisfied that each resident's health and welfare was maintained by a good standard of nursing care and appropriate medical and allied health care. The dependency levels recorded in the centre were as follows; 36 residents were assessed as having maximum care needs, 18 residents were considered as having high dependency needs, 13 residents had been assessed as medium dependency and six residents were assessed as having low dependency needs. The arrangements to meet each resident's assessed needs were set out in an individual care plan. Care plans were found to be person centred and generally reflected the care needs of residents. There was a documented assessment of all activities of daily living, including mobility, nutrition, communication and sleep. There was evidence of a range of assessment tools being used to assess and monitor issues such as falls, pain management, mobilization and risk of pressure ulcer development. Each resident's care plan was kept under formal review as required by the resident's changing needs or circumstances. From the sample of care plans reviewed, all were reviewed no less frequently than at four-monthly intervals. There was evidence that such reviews occurred in consultation with residents and/or their representatives.

It was evident from speaking with staff that they knew the healthcare needs and life history of the residents. On observation of care interventions, staff were seen to anticipate residents' needs in a timely and sensitive manner. Residents were at ease with staff that were assisting them. Residents told inspectors that the staff looked after them very well. Residents and relatives were complementary about the care and support provided by staff. Residents confirmed that they felt that the staff informed them of their health care needs and any changes in their conditions.

There was a low reported incidence of wounds. The inspectors reviewed the management of clinical issues such as wound care and diabetes management and found they were well managed and guided by adequate policies, practices and procedures. Residents to whom inspectors spoke were satisfied with the care and services provided. Residents had access to General Practitioner (GP) services and out-of-hours medical cover was provided. On the morning of the first day of the inspection, the inspector met physiotherapists who were based adjacent to the centre and who outlined physiotherapy supports provided to residents. The person in charge described how the centre received a good level of ongoing support from visiting GP's and allied healthcare professionals including occupational therapists, dieticians and speech and language therapists (SALT). A full range of other services was available on referral including chiropody, dental, optical services and psychiatry of later life services were also available and provided support to some residents. The inspectors reviewed residents' records and found that where residents were referred to these services the results of appointments were recorded in the residents' notes. From the sample of residents' records reviewed inspectors noted that they had been updated to reflect the recommendations of various members of the multidisciplinary team. There had been considerable improvements in the care planning since the last inspection. For example, there was evidence of improved assessments in relation to wound care with person centred wound care plans and care plan reviews provided for all residents. However, as identified on the last inspection, improvements were required in care plan documentation. From a sample of care plans reviewed, care plans were not adequate for the following reasons:
● not all care plans reflected the individual needs of the residents for example, in relation spiritual and psychological needs of some residents
● some of the care plans did not have adequate details of the nursing care to guide practice for example, in two care plans of residents' requiring end of life care there were a number of gaps in the end of life care plan.

Judgment:
Substantially 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:
Dungarvan Community Hospital was originally made up of two district hospitals; one from the 1900's and the other dating back to famine times. There had been many significant extensions, refurbishments and renovations since then. However, with the exception of St Vincent's unit which was a purpose built 32 bed unit commissioned in November 2009; the overall the design and layout of the premises was largely reflective of hospitals from these periods.

On the days of inspection, the centre was generally bright, clean and appeared to be in a reasonably good state of repair. The grounds were well maintained and free from significant hazards which could cause injury. The centre was a two-storey building. However, all resident accommodation was on the ground floor and comprised of six separate units, two of which were unoccupied at the time of this inspection:
1) St Michael's Unit: was a 12 Bedded Male unit
2) St Ann's Unit: was a dementia-specific unit providing accommodation for 10 residents; nine long term beds, one respite bed (block week- rolling system) and day care service to a maximum of three per day
3) St Vincent's Unit: was a 32-bedded unit for male and female residents which included three rehabilitation beds, three respite beds and three palliative care beds
4) St Francis Unit: was a female long-term care unit providing accommodation for 23 residents and it had been refurbished in 2007
5) St Enda's Unit: was a mixed male and female long-term care unit providing accommodation for 12 residents. However, this unit was not occupied at the time of inspection
6) Sacred Heart Units: was a 27-bedded male and female unit comprising 15 beds allocated to rehabilitation, respite and convalescence and 12 beds for long-term care. However, this unit was not occupied at the time of inspection.
Inspectors were informed by the provider representative that Sacred Heart Unit was closed at the time of inspection due to insufficient staffing and that St. Enda's Unit had been closed to allow refurbishment works to be completed. The provider representative also stated that the center would be applying for registration renewal of a total of a 104 beds to ensure that there were no more than four residents residing in any of the multi-occupancy bedrooms.

Since the last registration inspection there had been significant improvements in the premises including the following:

St Michael's Unit:
• complete refurbishment and reduction of 18 bed unit to a 12 bed unit with the rising of partitions in each bedroom area to enhance residents' privacy and dignity and each bedroom had access to shower and toilet facilities
• interior décor of sitting room enhanced to replicate a 'kitchen like' atmosphere

• development of a safe outdoor garden area including a separate fruit garden
• development of private sitting area for residents on the unit.

St Ann's unit:
• enhanced outdoor safe garden
• interior repainted and design of entire unit to replicate 'home like' atmosphere
• reduction of six bedded bedrooms to four bedded bedrooms
• refurbishment of two single bedded rooms with access to shower/ toilet facilities
• installation of a Snozellan room and activation room.

St Vincent's unit:
• some more homely furniture
• there had been the purchase of specialized 'Able Table' to enhance mealtimes for residents in wheelchairs and assisted chairs.
• there had been ongoing repainting of unit, however, some parts required repainting for example some corridor walls had been stained from spray from the hand hygiene gels.

In Francis Unit:
• removal of smoking room in day room to provide a more spacious day/dining room
• refurbishment works to develop safe outdoor garden for residents this was currently under construction with the proposed completion date 24 September 2017
• improved interior décor to day room to enhance to a more homely 'kitchen like' atmosphere
• new replacement curtains in all bedded areas
• the unit had been repainted, however inspectors noted that some areas for example parts of corridors and some bedroom walls required repainting
• there had been the purchase of specialized 'Able Table' to enhance mealtimes for residents in wheelchairs and assisted chairs.
However, on the days of inspection, inspectors noted that there were two occupied six-bedded bedrooms in St. Francis Unit that were not suitable. This was due to the design and layout of these two six-bedded rooms that did not meet the individual or collective needs of residents. For example, the design and layout of these two six-bedded bedrooms were inadequate to protect residents' privacy and potentially compromised residents' dignity. The beds were arranged with three beds against one wall and three beds against the opposite wall. The space between beds in each six-bedded unit was limited. This limited space also posed a restriction on movement for staff delivering care at the bedside. The lack of space also reduced the amount of furniture or personal memorabilia that could be accommodated. The provider representative informed inspectors that with the planned opening of the Sacred Heart unit on the 11 September 2017; all bedrooms in the centre would be reduced to a maximum of four beds. However, in addition the sitting room in St. Francis Unit was still inadequate in size for residents to dine comfortably and appeared crowded at mealtimes. This was confirmed by residents and visitors to whom inspectors spoke.

St Enda's unit:
• elimination of six bedded bedrooms and reduction from a 24 bed unit to 12 bed unit to ensure unit complies with HIQA standards
• complete interior refurbishment including rising of partitions in bed area to ensure

dignity & privacy, upgraded paintwork, curtains and furniture
• refurbishment of new shower room
• installation of new tracking Hoists in all bed areas
• installation of new tracking hoist installed in main bathroom
• refurbishment of safe enclosed outdoor garden for residents
• division partition day/dining room to enhance a more homely atmosphere.
The provider representative informed inspectors that there were plans for this unit to be re-opened in the near future however, this unit was unoccupied on the days of inspection.

Sacred Heart unit:
• entire unit had been repainted
• installation of new tracking hoist in long stay bed units
• installation of new curtains throughout
• introduction of two private sitting areas for residents
• refurbishment of safe enclosed outdoor garden
• upgrade of unit kitchenette including air conditioning.
However, on the days of inspection, inspectors noted that there were four six-bedded bedrooms that were not suitable. This was due to the design and layout of these two six-bedded rooms that did not meet the individual or collective needs of residents in these bedrooms. For example, the design and layout of these two six-bedded bedrooms were inadequate to protect residents' privacy and potentially compromised residents' dignity. The beds were arranged with three beds against one wall and three beds against the opposite wall. The space between beds in each six-bedded unit was limited. This limited space also posed a restriction on movement for staff delivering care at the bedside. The lack of space also reduced the amount of furniture or personal memorabilia that could be accommodated. In addition, inspectors noted that there the showering facilities were inadequate as there was only one communal shower available for residents for this 27 bedded unit. The provider representative informed inspectors that this unit would only open on a incremental basis from Monday 11 September 2017 to allow the following refurbishment works to commence:
• all six-bedded bedrooms would be reduced to 4 bedded rooms
• renovation of all these four bedded bedrooms to include installation of a new shower room into each bedroom
• renovation of 'jack & Jill' style assisted shower room which would then serve as two single bed rooms
• renovation of shower room to the remaining single room on the unit
The provider representative informed inspectors that these proposed works would be completed on or before 31 October 2017.

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 complaints procedure was displayed at the main entrance to the centre and it described how to make a complaint. There were copies of the HSE document "Your Service Your Say" available. The inspectors read a sample of complaints records for 2016 and 2017. The details of each complaint were recorded and the inspectors saw that there was a response to each complaint. The complaint's policy listed details of the nominated complaints officer within the centre which was the person in charge and also included an appeals procedure.

Residents spoken with said they would have no hesitation speaking to any of the staff if they had a concern. The inspectors reviewed the questionnaires recently distributed by the person in charge to residents as part of a quality improvement programme. Many of the returned questionnaires indicated a good level of satisfaction with the service and a positive response to any areas of concern raised. The complaints records recorded whether or not the resident was satisfied following making a complaint as required by regulation.

Judgment:
Compliant

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

Theme:
Person-centred care and support

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

Findings:
There was a suitable and centre specific end of life policy available. Overall there was evidence of a good standard of medical and clinical care provided and the person in charge outline that where required appropriate access to specialist palliative care services was provided. The inspectors found that staff were aware of the policies and processes guiding end of life care in the centre. Staff were able to describe suitable and respectful care practices in relation to end of life care provision and outlined suitable arrangements for meeting residents' needs, including ensuring their spiritual and religious preferences were met. Training in end of life care had been provided for staff. Inspectors noted that families were notified in a timely manner of deterioration in residents' condition and were supported and updated regularly as required. There were

some facilities to support relatives to remain with their loved ones during end-of-life such as small sitting rooms that could be use to enable families remain overnight, if required. There was adequate documentation available in relation to end of life care in the selection of residents' care plans reviewed. However, from this sample of care plans seen inspectors noted a number of sections of the end of life care plans were blank. This issue was addressed and action under outcome 11 of this report.

Judgment:
Compliant

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

Theme:
Person-centred care and support

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

Findings:
Residents were provided with food and drink at times and in quantities adequate for their needs. Assistance was observed and was offered to residents in a discreet, patient and sensitive manner by staff. The dining experience was a social occasion and a number of residents were seen chatting with each other throughout their meal. Staff also used meal times as an opportunity to engage in a meaningful way with residents, particularly with residents to whom they gave assistance. Those residents on modified diets were offered the same choices as people receiving normal diets. A three week rolling menu was in place to offer a variety of meals to residents. Tables in dinning rooms were appropriately set with cutlery condiments and napkins. Residents spoken with agreed that the food provided was always very good and appetising. Overall residents were happy with the food provided in the centre and some residents stated that that "the food was really very good". Food was served from the central kitchen by a team of staff and was well presented. The inspectors spoke with the chef who outlined how he was knowledgeable about residents' dietary needs and preferences. There had been regular meetings with the chef and kitchen staff with the most recent meeting held in June 2017. Inspectors noted that the most recent environmental health officer report dated March 2017 contained a considerable number of recommendations and some actions remain on-going. The chef visited all units regularly to elicit residents' feedback. There was picture enhanced communication system used as required to glean menu choices of some residents.

The chef met with the dietician ounce a month and all kitchen staff had received Hazard Analysis and Critical Control Point (HACCP) training. Modified consistency diets were served appropriately with each element of the meal presented in separate portions on the plate. A list of all special diets required by residents was compiled on foot of the

individual residents' reviews and copies were available in the kitchen.

Drinks such as water, milk, tea and coffee were available. Access to fresh drinking water was available at all times and jugs of water were observed in residents' rooms. Evidence of referral to relevant allied health professional including dietician or speech and language therapists was found and there was a system in place to monitor the intake of residents identified as at risk of malnutrition. The inspectors looked at this system in place to monitor food intake. The system of recording was found to be consistent/detailed enough to enable meaningful analysis as to the adequacy of intake for at risk residents.

Judgment:
Compliant

Outcome 16: Residents' Rights, Dignity and Consultation
Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

Theme:
Person-centred care and support

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

Findings:
Inspectors found that efforts had been taken by staff to ensure the overall resident's privacy and dignity was generally respected. However, this was within the limitations that design and layout of the two occupied six bedded bedrooms in St Francis unit which impacted on residents and has already described under outcome 12 of this report. The inspectors observed staff members knocking on bedroom, toilet and bathroom doors and waiting for permission before entering. Staff interacted with residents in a courteous and friendly manner. Residents spoken to were complimentary about the staff in the centre. Residents and relatives spoken with described the staff as very kind and said they felt safe in the centre and attributed this to staff. Residents clearly stated that they were able to exercise choice regarding how they spent their day. Inspectors observed throughout the inspection that residents were consulted and encouraged to make choices about their daily routine. However, the issue of the unsuitable design and layout of the occupied six-bedded bedrooms to meet the individual or collective needs of residents in St Francis unit also impacted on the privacy and dignity of residents. The inspectors observed that in both of these currently occupied six-bedded bedrooms; residents had various levels of care needs, levels of mobility and a number required support with personal care requirements. Residents and their representatives to whom inspectors spoke with stated that they were happy with the care and support provided

to them or their loved one. A number of residents spoken to in the six-bedded bedrooms stated that they were comfortable in their bedroom and reported that they were able to sleep. This was also confirmed by a review of a sample of residents care plans, medication administration records and from speaking to staff in the unit including the CNM. However, one visitor spoken to stated that "staff were lovely and very caring but the premises is institutional and it is hard to get any privacy when visiting". Inspectors noted that the vast majority of returned resident questionnaires were very positive, particular in their remarks regarding the staff. However, one questionnaire respondent who resided when asked about living in St Francis unit stated "it's noisy. I have very little privacy".

It was evident to inspectors that having six residents with such health and social care needs sharing the same bedrooms inevitably impacted on residents' privacy and potentially on their dignity. Even with the bed screens provided; it was difficult to see how some residents with reduced capacity, mobility or high care needs could undertake personal activities in private. Staff operating hoists could not protect residents' privacy as the screened personal space around the beds was too confined to fully accommodate a hoist. Inevitably some residents were disturbed at night by other residents or by staff providing care during the night. On the days of inspection inspectors noted that due to limited communal space many residents spent long periods in their bedrooms. Some residents appeared to be sleeping on their beds and others receiving visitors, there was very little room for resident to sit by their beds or conduct personal activities or hold conversations in private. Residents did not have adequate space, wardrobes or shelving for personal items or photographs to create a homely environment or to store their personal clothes and possessions. Given the number and considerable needs of the majority of residents in these two six bedded rooms; inspectors formed the view that residents could not comfortably spend much of their day in their bedroom and their privacy and dignity could not be adequately protected. For example, some residents required significant and on-going assistance with maintaining their personal care needs including washing, dressing and toileting needs. However, due to the number of residents and the design and layout of these bedrooms; such assistance inevitably impacted negatively on the privacy and dignity of residents receiving the care and the other residents who also resided in these bedrooms.The provider representatives acknowledged that these bedrooms were not suitable. She stated that remedial action would be taken with the opening of the Sacred Heart unit and that the maximum number of residents in any bedroom in centre would be four. This issue has also been identified and actioned under outcome 12 of this report.

Residents' religious and civil rights were supported. There was a church located in the centre and Mass was celebrated daily with many residents and local people from the community regularly attended these services. Other religious faiths were accommodated including the local Church of Ireland minister who had also visited the centre. There was a small library in the "parlour", which was a sitting room located near St Francis unit and accessible to any residents. Residents had access to a variety of national and local newspapers and magazines to reflect their interests and these were located in easily accessible areas and available to residents daily. Residents also had access to an independent advocacy service and there were records of this advocate actively representing/advocating on behalf of some residents. Inspectors were informed that the quality of interaction schedule (QUIS) observation tool had been used in two units to

systematically observe and record resident and staff interactions as part of a quality improvement initiative. The results from these observations indicated positive connective care of one unit and a more task orientated care provision in the other unit. Staff including management staff outlined to inspectors their plans to improve on these results.

There was a schedule of planned activities displayed at various locations and included trips for example to the greenway and the vintage care run. A social assessment had been completed for each resident and activities were provided which included arts and crafts, bingo, live music, reminiscence therapy, and passive exercise programmes. Each resident's preferences were assessed and this information was used to plan the activity programme. Residents who were confused or who had dementia related conditions were encouraged to participate in activities suitable to meet their needs. A programme of events was displayed and included bingo, music, quizzes, arts and crafts and religious ceremonies. Some residents said they preferred not to take part in the group activities and inspectors saw that their wishes were respected and individual one to one time was scheduled for these residents. Inspectors spoke to the activities coordinator who stated that activities were provided over a seven day period and some activities go on into the evening period such as the men's shed. Residents informed inspectors that there were lots of bus trips happening and that they greatly enjoyed the activities provided. However, from a review of returned resident questionnaires inspectors noted that a number of residents commented that they would like if there was more live music provided in the centre. The inspectors relayed this request to both the person in charge and the provider representative.

There were visitors seen in the centre throughout the inspection and the person in charge outlined that there was always great flexibility afforded to visitors to the center and visiting times were not restricted.

Judgment:
Non Compliant - Major

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):
No actions were required from the previous inspection.

Findings:
There was a centre-specific policy on the management of residents' personal property and possessions that was most recently reviewed in July 2017. From the sample of residents' records reviewed by the inspectors; there were suitable records in place of individual resident's clothing and personal items.

Residents' laundry was well maintained and most laundry including bed sheets and towels was laundered by a off-site laundry provider. The inspectors spoke to laundry staff and noted that there were appropriate arrangements in place for the safe return of residents' personal clothing items.

Residents that inspectors spoke with indicated that they were satisfied with the arrangements in place in relation to the management of residents' personal property. Residents had a secure storage facility in their bedroom for the safekeeping of any personal items or small quantities of monies.

Inspectors noted that some bedrooms had been personalized with individual residents' items, photographs and art work. Most but not all residents had suitable furniture in their bedrooms to store clothing and personal items in their own bedside cabinets and wardrobes. However, a number of bedrooms were not suitable in their design and layout particularly the six bedded bedrooms and this issue has been identified and actioned under outcome 12 of this report.

Judgment:
Substantially Compliant

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

Findings:
Unsolicited information of concern had been received by HIQA prior to this inspection. These concerns alleged issues in relation to inadequate staffing. However, following this inspection these concerns were not substantiated. The provider representative acknowledged that staffing particularly nursing staff, had been a significant challenge early in this year. For example, there had been difficulties in the recruitment of nursing staff. However, the provider had taken a number of actions including the temporary closing of one unit and the recruitment of additional nursing staff. The person in charge, the ADON's, the CNM's and staff to whom inspectors spoke stated that staffing in the centre was now adequate. Confirmation of adequate staffing was also provided by a review of the centres' records including the returned residents' questionnaires, the complaints records, and minutes of staff meetings and staffing rosters. Many staff

acknowledged that the staffing levels were currently good and gave examples of how much time in lieu that had been built up had now been cleared. However, some staff who met with inspectors did express some concern that the planned reopening of the closed unit; may cause staffing to become inadequate again. This concern was relayed to the provider representative who stated that she was confident that with the recruited additional staff she was assured that there would be a sufficient number of staff in the centre.

An actual and planned roster was maintained in the center. Inspectors noted that the person in charge worked full time and was available Monday to Friday. There was also two ADON's available during the week to support the person in charge in her role. In addition, there was a CNM on all units as well as a staff nurse on duty both day and night time. Inspectors spoke to nurses on both day and night duty shifts and attended the handover meeting on the second day of the inspection. Inspectors observed practices and conducted interviews with care staff, the person in charge, both ADON's, the activities coordinator, the chef, staff nurses, CNM's and the provider representative.

Residents spoke very positively about staff and indicated that staff were caring, responsive to their needs and treated them with respect and dignity. Staff demonstrated an understanding of their role and responsibilities to ensure appropriate delegation, competence and supervision in the delivery of person-centred care to residents. Inspectors observed positive interactions between staff and residents over the course of the inspection and found staff to have good knowledge of residents' needs as well as their likes and dislikes.

From speaking to the person in charge, staff, CNM's, ADON's and a review of documentation; staff appeared to be supervised appropriate to their role and responsibilities. Staff appraisals had commenced and were in the process of being rolled out to all staff. Recently recruited staff and a review of a sample of staffing records confirmed that this process was in place. The person in charge discussed staffing issues with inspectors and suitable protocols and records were seen to be in place where any concerns had been identified. There was an education and training programme available to staff. The training matrix indicated that mandatory training was provided and staff had attended training in areas such as manual handling, cardio pulmonary resuscitation (CPR) and elder abuse. In addition, staff had completed mandatory training in responding to and managing behaviours that were challenging or dementia training.

Inspectors reviewed a sample of staff files which included the information required under Schedule 2 of the regulations. Registration details with Bord Altranais agus Cnáimhseachais na hÉireann, or Nursing and Midwifery Board of Ireland for 2017 for nursing staff were seen by the inspector. The provider representative confirmed that all staff and volunteers had been suitably Garda vetted.

Judgment:
Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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Regulation Directorate
Health Information and Quality Authority

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Regulation Directorate

Action Plan

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

Provider's response to inspection report[1]

Centre name:	Dungarvan Community Hospital
Centre ID:	OSV-0000594
Date of inspection:	07/09/2017
Date of response:	12/10/2017

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 03: Information for residents

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
To ensure the agreement referred to in regulation 24 (1) relates to the care and welfare of the resident in the designated centre and includes details of the fees, if any, to be charged for such services including any additional charges to the resident.

1. Action Required:
Under Regulation 24(2)(b) you are required to: Ensure the agreement referred to in

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

regulation 24 (1) relates to the care and welfare of the resident in the designated centre and includes details of the fees, if any, to be charged for such services.

Please state the actions you have taken or are planning to take:
All contracts have been reviewed and appropriate charges have been applied in consultation with residents and/or relatives.

Proposed Timescale: 15/09/2017

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
To agree in writing with each resident, on the admission of that resident to the designated center, the terms on which that resident shall reside in the center including details of the terms relating to the bedroom to be provided to the resident and the number of other occupants (if any) of that bedroom, "after" the terms, as required by regulation.

2. Action Required:
Under Regulation 24(1) you are required to: Agree in writing with each resident, on the admission of that resident to the designated centre, the terms on which that resident shall reside in the centre.

Please state the actions you have taken or are planning to take:
All contracts have been reviewed & amended in consultation with residents and /or families where appropriate.

Proposed Timescale: 15/09/2017

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:
To ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre including suitable smoking risk assessments.

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

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

Risk assessments for residents who smoke have been reviewed to ensure all safety measures have been put in place and same has been included in risk management policy.

Proposed Timescale: 21/09/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
To make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and safe placement of residents including providing details in residents PEEP's regarding the residents' level of supervision when brought to a place of safety following evacuation.

4. Action Required:
Under Regulation 28(2)(iv) you are required to: Make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and safe placement of residents.

Please state the actions you have taken or are planning to take:
All residents PEEP'S have been reviewed & amended to ensure that it details the level of supervision required in the event of fire, where there is a requirement to evacuate the building.

Proposed Timescale: 04/10/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Make adequate arrangements for detecting, containing and extinguishing fires including ensuring that all smoking areas are suitably equipped with accessible fire extinguishers, call bell facility and fire blankets within reasonable proximity to such areas.

5. Action Required:
Under Regulation 28(2)(i) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

Please state the actions you have taken or are planning to take:
All areas have been evaluated / risk assessed & extra fire extinguishers have been installed in areas identified.

Proposed Timescale: 04/10/2017

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:
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 including ensuring complete medication administration records and any medications to be crushed are individually prescribed by the GP.

6. 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:
All medication kardex's have been reviewed to ensure compliance with both the standards & medication management policy. A meeting was held with the GP to reiterate the requirement of adherence to policy in regards to the prescribing of crushed medications.

Proposed Timescale: 28/09/2017

Outcome 11: Health and Social Care Needs

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
To arrange to meet the needs of each resident when these have been assessed in accordance with Regulation 5(2) including the identification of spiritual and psychological needs and provision of comprehensive end of life care plans.

7. Action Required:
Under Regulation 05(1) you are required to: Arrange to meet the needs of each resident when these have been assessed in accordance with Regulation 5(2).

Please state the actions you have taken or are planning to take:
Care plans have been reviewed to ensure that all residents have been assessed to ensure that all spiritual and psychological needs are met. Further end of life care/care planning training is scheduled for staff during October& November 2017.

Proposed Timescale: 30/11/2017

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:
To provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated center including the following:
• some areas of St Vincent's unit required repainting
• the six-bedded bedrooms in St. Francis Unit and Sacred Heart units were not suitable in design and layout to meet residents' needs
• there was inadequate provision of showers in Sacred Heart unit
• the sitting room in St. Francis Unit was inadequate in size for the number of residents in the unit.

8. 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:
There is plan to commence painting of Vincent's unit over a number of months on a phased basis as the areas become available. Since the inspection, the Sacred Heart unit has opened 12 beds and will increase to a maximum capacity of 19 beds in late November 2017. All multi occupancy bedroom accommodation has been reduced to accommodate 4 beds plus the 3 single rooms are also available. There is plan to provide en-suite showers to all 4 bedded areas and work is scheduled to commence mid-October with a completion date of early December 2017. Since the inspection Francis unit has also decreased bed numbers to 19 beds having reduced all multi occupancy bedrooms to 4 beds. A secure safe garden for residents has been developed. The sitting room area has been rearranged to give more space for residents to engage in their activities.

Proposed Timescale: 08/12/2017

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:
Ensure that each resident may undertake personal activities in private including in any of the six bedded bedrooms in the centre.

9. 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:

In the Sacred heart unit the 4 bedded rooms are 59 q.M. Each bed space has curtains/screens around their bed area and a sitting area has been created in the 4 bedded rooms to ensure that residents have privacy and dignity to engage in their personal activities.
In Francis unit the multi occupancy rooms have been reduced to 4 bedded areas which are 49.60Sq.M. There are screens around each bed area and a sitting area has been created to ensure privacy for all residents to engage in personal activities.

Proposed Timescale: 14/09/2017

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:
Not all residents had suitable furniture in their bedrooms to store clothing and personal items.

10. 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 Sacred heart unit and in Francis unit due to decrease in bed numbers in each area there is more space created for residents storage of personal possessions

Proposed Timescale: 14/09/2017