**Centre name:** Clonakilty Community Hospital  
**Centre ID:** OSV-0000559  
**Centre address:** Clonakilty, Cork.  
**Telephone number:** 023 88 33 205  
**Email address:** carol.mccann@hse.ie  
**Type of centre:** The Health Service Executive  
**Registered provider:** Health Service Executive  
**Provider Nominee:** Patrick Ryan  
**Lead inspector:** Caroline Connelly  
**Support inspector(s):** Breeda Desmond  
**Type of inspection** Unannounced  
**Number of residents on the date of inspection:** 103  
**Number of vacancies on the date of inspection:** 26
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).
This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times
From: 08 March 2017 10:15 09 March 2017 08:45
To: 08 March 2017 18:15 09 March 2017 18:20

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

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Summary of findings from this inspection
This inspection of Clonakility Community Hospital, by the Health Information and Quality Authority (HIQA), was unannounced and took place over two days. The centre was registered to accommodate the needs of 129 residents and there were 103 residents residing there on the days of the inspection. The centre is operated by the Health Service Executive (HSE) and is located on the outskirts of Clonakility town and comprises of five separate units. This inspection report sets out the findings of a monitoring inspection. As part of the inspection inspectors met with residents, relatives, the person in charge, the Assistant Director of Nursing (ADON), Clinical Nurse Managers (CNM), nurses, activity staff and numerous staff members. Inspectors observed care practices and reviewed all governance, clinical and operational documentation including nursing and medical records, accidents and
incidents, complaints and staff related records. Inspectors also followed up on the actions required from the previous inspection.

Inspectors found that residents' healthcare and nursing needs were met to a good standard. Residents had easy access to medical, allied health and psychiatry of later life services. Most of the allied health staff and psychiatry of later life services were on site. Staff interacted with residents in a kind and respectful manner and inspectors found that residents appeared to be very well cared for. Residents and relatives were spoken with throughout the inspection. The feedback received from them was generally positive and indicated that they were satisfied with the staff and care provided. However a number of residents did tell the inspectors that they found residing in the multi occupancy rooms difficult. This was due to the lack of privacy and increased noise levels disturbing them during the day and the night.

Overall the inspectors saw there had been a number of improvements in the premises since the previous inspection. A number of six bedded bays were reduced to five bedded bays and en-suite facilities were included. Dining rooms were now in place in all of the units. There were lovely enclosed garden areas and safe places for residents to walk and enjoy the outdoor space. However the centre still consisted mainly of large multi-occupancy rooms and similar to findings on previous inspections the premises did not meet the individual and collective needs of residents in terms of their privacy, personal space, access to communal space and adequate and accessible sanitary facilities. This had a significant negative impact on the quality of life of residents who resided in the centre.

The inspectors saw that on four out of the five units a large number of the residents spent long periods of the day in their bedrooms, either in bed or on a chair at their bedside. Many did attend the dining rooms for meals and for some activities but returned to their bedrooms immediately following same. The inspectors visited every unit in the centre at 18.00 hours on the first evening of the inspection and found that the majority of residents in the centre were either in bed or sat beside their bed with the exception of Saoirse unit where the majority of the residents were sitting in the day room accompanied by staff participating and very much enjoying a sing song. On this unit there was a day room with an open fire assisting in the provision of a homely atmosphere for the residents who resided there. The inspectors concluded that on the other units as a consequence of the prevalence of mainly large multi-occupancy rooms, lack of day rooms and the fact that residents spent most of the day by their beds, the centre appeared institutionalised and hospital-like. Reduced staffing levels in the evening also were seen to contribute to the number of residents going back to bed in the late afternoon prior to a large number of the staff finishing at 17.30. These practices did not fit in with person-centred care as identified in the centres statement of purpose and function, nor did it promote the privacy and dignity of the residents on the units which were open to visitors for the evening. All these issues will be discussed throughout the report.

Inspectors also found that the governance and management of the service required review as the provider nominee had recently been replaced on an interim basis due to restructuring of roles and responsibilities within the (HSE). HIQA received correspondance that the previous provider nominee had returned to their substantive
post on 01 February 2017. This information had also not been communicated to the
person in charge who reported having difficulty in getting access to the provider
nominee.

Inspectors saw that a number of the actions required from the previous inspection
had been addressed as outlined above improvements were seen in the premises.
Assessment and care planning documentation had been totally reviewed and
updated and there was evidence of resident and relative involvement in the care
planning process. Improvements were seen in the provision of activities and the
inspectors spoke to a number of staff providing activities and saw group and one to
one activities taking place throughout the two day inspection. Policies and procedure
updates required on the previous inspections were generally implemented, an annual
review of the quality and safety of care was undertaken. Food and nutrition was fully
reviewed and numerous changes were made to the provision of a more social dining
experience and to the way food was prepared and served. Appropriate assessments
tools were used in the assessment for restraint usage.

On this inspection inspectors also found that a number of the actions required from
the previous inspection were not completed but progress was evident towards their
completion. Other actions remained non-compliant. Inspectors had identified the
need for improvement in the management of residents’ finances and this remained
ongoing. Changes to the complaints policy were not fully implemented. These areas
and other actions required are detailed in the body of the report, which should be
read in conjunction with the action plan at the end of this report. The action plan at
the end of the report identifies improvements necessary to ensure compliance with
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 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):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
The centre was operated by the Health Service Executive (HSE) who was the registered provider. However there appeared to be some confusion as to who was the person representing the HSE as provider nominee for the centre. The nominated provider had recently been replaced on an interim basis due to restructuring of roles and responsibilities within the (HSE). HIQA received notification that the previous provider nominee had returned to their substantive post on 01 February 2017. This information had also not been communicated to the person in charge who reported having difficulty in getting access to the provider nominee. The provider nominee did not attend the feedback session at the end of the inspection. The person in charge was in a full time role in the centre and was supported on a daily basis by two assistant directors of nursing (ADONs) and a team of clinical nurse managers (CNMs).

The management team displayed knowledge of the regulatory requirements. They were proactive in response to a number of actions required from previous inspections and inspectors viewed a number of substantial improvements throughout the centre. However, as previously identified other actions required further action and a number of actions remained non-compliant. The provider had given assurances that a new build premises was to replace the existing building to ensure compliance with the standards and the regulations and to ensure it met the privacy and dignity needs of the residents. The time frame for completion furnished to HIQA and therefore a current condition of the registration of the centre is by 2020. However the person in charge confirmed that there had been no movement on this and there were no proposed plans to date.

Inspectors saw evidence of the collection of key clinical quality indicators data including pressure ulcers, falls, the use of psychotropic medications, bed rails, medication management and administration, the assessment of risk and health and safety. Inspectors saw that there were systems in place for monitoring the quality and safety of
care provided to residents. These included internal audits and reviews such as falls audits, nursing documentation audit, infection control audit, hand hygiene and health and safety audit. These audits had taken place in 2016 and the nurse responsible for completing a number of the audits told inspectors these were to be repeated in 2017 and were ongoing. Audit outcomes and any corrective actions were documented and had resulted in changes to practices particularly around falls and bedrail usage. As a result of the inspection findings audits on quality of life and privacy and dignity of residents would be required to promote improvements in those areas.

There was evidence of consultation with residents and relatives through residents meetings chaired by external resident advocates and relative meetings on each unit in March 2016. Inspectors noted that issues raised by residents were brought to the attention of the person in charge by the advocate and items were followed up on subsequent meetings. The person in charge told the inspectors that a comprehensive survey had been undertaken in 2016 however this was not available for inspectors to review and it did not form part of the annual review. However inspectors saw the survey planned to take place in March 2017 which was seen to be comprehensive and relevant to residents needs. Inspectors saw minutes of resident’s committee meetings and evidence that individual residents were consulted. On the previous inspection there was a requirement for an annual review which was not in place. On this inspection the inspectors saw that a comprehensive annual review of the quality and safety of care and support in the designated centre had been undertaken by the management team in accordance with the standards. This review was made available to the inspectors and there were a number of recommendations and actions from this review that are currently being actioned. However there was no evidence of resident relative consultation and this had been made available to residents and relatives as required by the legislation.

**Judgment:**
Non Compliant - Moderate

**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 inspectors interacted with the person in charge throughout the inspection process. There was evidence that the person in charge was engaged in the governance, operational management and administration of the centre on a day-to-day basis. Inspectors were satisfied that she was a registered nurse, was suitably qualified and had
a minimum of three years experience in nursing of the older person within the previous six years, as required by the regulations.

She had extensive managerial experience and had been the person in charge of the centre for 14 years. There was evidence that the person in charge had a commitment to her own continued professional development and had completed many courses such as diploma in Health Services Management and a Higher Diploma in Leadership and Management. Staff, residents and relatives all identified her as the person who had responsibility and accountability for the service.

**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:**
Residents' records were reviewed by the inspector who found that they complied with Schedule 3 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. The records listed in Schedule 4 to be kept in a designated centre were all maintained and made available to the inspector.

On the previous inspection a number of policies and procedures required review. On this inspection inspectors saw that centre had recently updated and implemented 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 and these are reviewed and updated at intervals not exceeding three years as required by Regulation 4.

The person in charge informed inspectors that all staff had Garda vetting and no staff commenced employment until satisfactory Gardaí vetting, references and all the requirements of schedule 2 of the regulations had been attained. Inspectors reviewed a sample of staff files and found that they contained all of the information required under Schedule 2 of the Regulations.
The inspectors were satisfied that the records listed in 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. There was a room in the administration area dedicated to staff and other files which were maintained in a very complete and organised manner. Overall records were seen to be maintained and stored in line with best practice and legislative requirements with the exception of the storage of residents records which were insecurely stored at the end of residents beds will be discussed further in outcome 11 health care needs.

Judgment:
Compliant

**Outcome 07: Safeguarding and Safety**

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

**Theme:**
Safe care and support

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

**Findings:**
Inspectors found that there were measures in place to protect residents from suffering harm or abuse. Staff interviewed demonstrated a good understanding of safeguarding and elder abuse prevention and were clear about their responsibility to report any concerns or incidents in relation to the protection of a resident. The inspector saw that elder abuse training had been provided to staff and that the centre was now implementing the new HSE protecting vulnerable adults' policy and safeguarding training following the new policy was now on-going on a very regular basis in-house and training records confirmed that staff had received this mandatory training. However the hairdresser and activity staff confirmed to inspectors that they had not received prevention of elder abuse training and were not fully aware of the reporting mechanisms if they ever witnessed abuse. There was evidence that allegations of abuse were recorded, investigated, referred to the safeguarding team as appropriate, reported to HIQA and all appropriate measures were taken to protect residents. This was in line with the centres policy and legislative requirements. Residents indicated that they could speak to the CNM or any member of staff if they had any concerns and confirmed that they felt safe and were well looked after in the centre.

On the previous inspection inspectors found that the systems in place for the management of residents finances was not sufficiently robust to protect residents or
staff as dual signatures were not in place for all financial transactions. On this inspection
the person in charge told the inspectors that they did not manage any residents’ monies
as residents had safes ad keys in their bedside lockers. However inspector saw and staff
confirmed that they did hold monies in safekeeping for a number of residents and this
was to enable them to buy toiletries and other items from the mobile shop service. The
mobile shop was a lovely service run by a care assistant with the assistance of
administration staff. However the staff member had monies for residents and was
providing them with goods which were all documented but there was no record of any
signatures for these transactions and no evidence of any checks or audits of monies or
records. This system was not sufficiently robust to protect the staff member or the
resident and a more robust system is required with double signatures on all transactions
is required with immediate effect.

Inspector reviewed the policies on meeting the needs of residents presenting with
responsive behaviour and restraint use. The policy on behaviours that challenged
outlined guidance and directions to staff as to how they should respond and strategies
for dealing with behaviours that challenged. The policy on restraint was based on the
national policy and included clear directions on the use of restrictive procedures
including risk assessment and ensuring that the least restrictive intervention was used
for the shortest period possible. On the previous inspection inspectors identified that
there was a checklist sheet, to assist staff in the decision-making process in the use of
restraint, however, this was not evidenced-based and was subjective. On this inspection
an evidenced-based risk assessment for restraint had being implemented in the centre.
Inspectors reviewed a sample of files of residents using bedrails and found that risk
assessments detailing alternatives tried and considered as well as care plans guiding
care were documented. Regular checks of all residents were being completed and
documented. The ADON informed the inspectors that there were 72 residents out of the
103 current residents using bedrails at the time of the inspection. Inspectors found this
was a very large percentage of bedrail usage and required that this is reviewed to
promote a reduction in the use of bedrails. Although there were some alternatives such
as low profiling beds, crash mats and bed alarms in use for some residents these need
to be further explored and promoted to aim towards a restraint free environment.

Inspectors reviewed a sample of files of residents presenting with responsive behaviours
and noted that comprehensive care plans were in place to guide staff in addition to
behavioural support plans. There was evidence of regular involvement of psychiatric
services including specialist nurse review and review by the psychiatrist as required.
There had been a reduction in the use of chemical restraint and a full review is
undertaken when as required anti-psychotic or sedating medications are used.

Many staff spoken with and training records reviewed indicated that staff had attended
training on dementia care and in dealing with responsive behaviours. The CNMs spoke
with residents on a daily basis and also with relatives and supervised staff as part of
ensuring the safety of residents. Feedback from residents was positive and many stated
they felt ‘safe’ in the centre. There was a resident advocate who attended the centre on
a weekly basis. Positive feedback was given to inspectors about the advocacy service
provided in the centre.

Judgment:
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:
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 building. Colour-coded floor plans were displayed throughout the centre which identified ‘Where You Are Now’ in line with best practice. Staff demonstrated an appropriate knowledge and understanding of what to do in the event of fire. Inspectors saw that fire training was provided to staff and that staff had up to date fire training. Records showed that fire drills were undertaken regularly with different staff in attendance the actions taken and outcome of the fire drill was documented and an evaluation form completed. Inspectors examined the fire safety register with details of all services and tests carried out. All fire door exits were unobstructed and fire fighting and safety equipment had been tested in October 2016 and the emergency lighting and fire alarm was last tested in January 2017. Detailed Personal Emergency Evacuation plans (PEEPs) were seen to be completed for residents outlining the assistance they would require in an emergency situation.

Accidents and incidents were recorded on incident forms and were submitted to the person in charge and there was evidence of action in response to individual incidents. These were also reviewed and discussed at the health and safety bi-annual meetings. In addition, they were followed up at the daily ward hand-over meetings. There were reasonable measures in place to prevent accidents such grab-rails in toilets and handrails on corridors. There was a centre-specific emergency plan that took into account all emergency situations. Clinical risk assessments were undertaken, including falls risk assessment, assessments for dependency, assessments for malnutrition and assessments for pressure ulcer formation. The provider has contracts in place for the regular servicing of all equipment and inspectors viewed records of equipment serviced which were all up-to-date.

On this inspection the environment was observed to be clean and generally well decorated throughout. Personal protective equipment, such as gloves, aprons and hand sanitizers were located throughout the premises. All hand-washing facilities had liquid soap and paper towels available. There were policies in place on infection prevention and control and staff that were interviewed demonstrated knowledge of the correct procedures to be followed. Hand hygiene training was on-going and staff demonstrated
good hand hygiene practice as observed by the inspectors. Arrangements for the disposal of domestic and clinical waste management were appropriate. Infection control training was ongoing and provided to staff on a regular basis. However on a number of units there were no dedicated cleaning staff. The multitask attendant was going from providing personal care to residents in the morning to cleaning for the remainder of the day which did not fit in with best practice around infection control and to ensure consistent care for residents. This is further discussed and action required outlined under outcome 18 Staffing.

The health and safety of residents, visitors and staff were promoted and protected. The health and safety committee met bi-annually and there was a designated health and safety officer in place. The health and safety statement seen by the inspectors was centre-specific and up-to-date. The risk management policy as set out in Schedule 5 was updated since the last inspection to ensure it included all the requirements of Regulation 26(1) The policy covered, the identification and assessment of risks and the precautions in place to control the risks identified. It included the measures and actions in place to control the following specified risks, 1) abuse, 2) the unexplained absence of a resident, 3) accidental injury to residents or staff, 4) aggression and violence, and 5) self-harm and therefore was found to meet the requirements of legislation. The risk register was up to date and it identified and outlined the management of clinical and environmental risks. Corrective action reports were completed for any deviation and risks identified.

Records viewed by the inspector indicated that staff had received up to date moving and handling training. Hoists were serviced on a regular basis as required by legislation and records of same were seen by the inspector.

Staff training records confirmed staff had completed their mandatory training in moving and handling of residents.

A current insurance policy was demonstrated.

**Judgment:**
Compliant

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**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:**
The centre-specific policies on medication management were made available to inspectors and had been updated since the previous inspection. The policies included the ordering, receipt, administration, storage and disposal of medicines. The policies
were comprehensive and evidence based. The policies were made available to nursing staff who demonstrated adequate knowledge of this document. Medicines for residents were supplied by a community pharmacy.

Medicines were stored in a locked cupboard or medication trolley. Medications requiring refrigeration were stored securely and appropriately. The temperature of the medication refrigerator was noted to be within an acceptable range; the temperature was monitored and recorded daily. Controlled drugs were stored in accordance to best practice guidelines and nurses were checking the quantity of medications at the start of each shift. The inspector did a count of controlled medications with the nurse which accorded with the documented records.

Medication administration was observed and the inspectors found that the nursing staff generally did adhere to professional guidance issued by An Bord Altranais agus Cnáimhseachais and adopted a person-centred approach. However inspectors saw that on one unit medications were not being administered at the times prescribed or within the guidelines for safe administration in that a medication prescribed for 10am was being administered at 11.45. In the sample of medication prescriptions charts reviewed inspectors saw that nurses were administering medications in a crushed format when they were not all prescribed in a crushed format by the GP. Inspectors also found that one medication was prescribed as a regular prescription four times per day which was the maximum dose. However, the same drug was also prescribed in the PRN prescription leading to a potential risk of over dosage. In one chart nurses signatures showed that a resident received 5 doses of one gram of paracetamol in 24 hours where 4 grams is the accepted maximum dose in 24 hours.

Medication audits were evidenced which included a detailed questionnaire completed for each ward. A report was compiled which included a graph with year-on-year statistics for each question per ward demonstrating incremental improvements. A separate external audit was completed by the supplying pharmacist.

Medication errors and near misses were recorded and monitored by the CNM 2 on each ward. The CNM 2 reported to the inspectors that these were discussed at ward hand-over meetings to mitigate risk of recurrence.

Judgment:
Non Compliant - Moderate

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:
There was evidence of timely access to health care services facilitated for all residents. Four different General Practitioner (GP) practices acted as medical officers provided medical services to the centre and an on-call medical service was available in the evenings and out of hours and this was confirmed by residents. A sample of medical records reviewed demonstrated that resident’s were reviewed on a regular basis. Specialist medical services were also available when required. Reviews and on-going medical interventions as well as laboratory results, were evidenced. There were policies in place to ensure that relevant information was shared between providers and services for when the resident was admitted to, transferred or discharged from the centre. On the previous inspection inspectors found that pre-admission assessments completed on a potential resident were not comprehensive and did not reflect the full health, personal and social care needs of a person intending to become a resident. This was identified as an issue as a resident could be admitted and inappropriately placed in a ward which was not equipped to facilitate their needs pre-admission assessments were not conducted by hospital staff but other HSE staff external to the centre. On this inspection the ADON and CNMs confirmed that this had much improved and they were using a new system to ensure they had far greater and more comprehensive information on all residents prior to admission to ensure appropriate placement in the centre and CNMs would be able to prepare for the needs of the resident being admitted.

All referrals and appointments were recorded and blood tests were completed as per the GPs instructions. Nurses had received training in venepuncture and regularly took blood in the centre. A physiotherapist was present in the centre and referral could be made by nurses or medical officer as required. The inspector also saw that residents had access to podiatry, dental, optical, dietetic and speech & language services as required. Residents in the centre also had access to the specialist mental health of later life services. The psychiatrist was based on the grounds of the centre and was available to review and follow up residents with mental health needs and residents who displayed behavioural symptoms of dementia. Treatment plans were put in place, which were followed through by the staff in the centre. Follow-up to consultations were completed as required. Residents and relative’s expressed satisfaction with the medical care provided.

Since the last inspection the centre had implement a whole new system of assessment and care planning documentation. Inspectors saw that residents had a comprehensive nursing assessment completed on admission. The assessment process involved the use of a variety of validated tools to assess each resident’s risk of deterioration. For example, risk of malnutrition, falls, level of cognitive impairment and pressure related skin injury among others. Pain charts in use reflected appropriate pain management procedures. Inspectors reviewed care plans for residents and these were seen to be person centred with evidence of residents and/or their relatives involvement in the development of care plans. Care plans were easy to follow and were individualised. The inspector saw "key to me" information and support plans that had been completed for
residents which included detailed information on residents likes, dislikes, hobbies and interests. Although inspectors saw that the assessment tools were reviewed and updated on a four monthly basis there was no evidence that the care plans were reviewed as a result of the updating of assessment as required by legislation. The assessment and care plans were maintained in large folders and were kept at the end of each resident's bed. The inspectors found that this did not protect the privacy of the residents as confidential information was stored in these files and was available to visitors/ neighbours/ other residents sharing the room to pick up and read. The staff confirmed that they had ordered lockable trolleys to store the folders to protect the privacy of the residents and to provide secure storage for the records.

Good wound care management was evident in the centre and there was evidence that wound care was evidence based. Inspectors saw that attention was given to promoting continence and assessments were completed to ensure correct use of continence products. Inspectors observed that residents appeared to be well cared for, which was further reflected in residents’ comments that their daily personal care needs were well met.

**Judgment:**
Substantially Compliant

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**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:**
Clonakilty Community Hospital is located on the outskirts of Clonakility town and comprised of two buildings which date back to the 1800’s. Resident accommodation is spread across five units and the centre is registered to provide long term, respite, palliative and dementia care for 129 residents. The five units comprised of:

- Saoirse, the dementia specific unit, comprises of two single rooms with en suite assisted showers, toilets and hand basins and two large multi-occupancy rooms. There is a homely dining/day room and a second homely sitting room, further communal space was provided in an open area set out like a street which included comfortable seating and a dining table.
- AnGraig has one single bedroom and four multi-occupancy bedrooms with five beds
Dochas has six multi-occupancy rooms with five beds each with full en-suite facilities, there is also a single room used for end of life care.

Crionna has nine multi-occupancy rooms some six bedded and some four bedded with full en-suite facilities

Sonas consists of multi-occupancy rooms varying from seven bedded rooms down to three bedded rooms.

All of the units now have their own dining rooms but not all have a sitting room/lounge. On some units there continued to be not enough dining space to accommodate all residents. There is a café, shop, chapel and enclosed gardens with extensive car parking.

The centre had been refurbished and upgraded since the previous inspection and the eight bedded-rooms in Docus unit had now been reduced to five bedded rooms with full en-suite facilities. Dining rooms had been added to units and some doors had been widened to ensure better access. A number of areas were redecorated and were seen to be decorated in a homely and cosy fashion. However, there remained significant limitations within the physical environment which negatively impacted on the freedom, choice, privacy, dignity and autonomy of residents and these have been described in detail in previous inspection reports. Similar to findings on all previous inspections the design and layout of parts of the premises did not conform to the matters listed in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

The design and layout did not meet the individual and collective needs of residents for space, storage and privacy. This will be addressed further under Outcome 16: Residents’ privacy, dignity and consultation. The person in charge stated that arrangements were in place to address the premises failings with the work proposed to be completed in 2020. However, plans had yet to be drawn up for the proposed new 100 bedded centre.

Issues previously identified on inspections with regards to the limitations of the premises that remained issues on this inspection included:

1) inadequate number of toilets for residents use, for example, there was just one usable toilet in the female section of Sonas for 10 residents as the second toilet was not fit for purpose because it was so small when a resident used the facility the door could not be closed

2) inadequate provision of bathing facilities

3) inadequate communal space in Dochas and An Ghraig; most residents in these units continued to be seated near their beds for large parts of the day.

4) multi-occupancy bedrooms; some could not accommodate a bed-side chair or wardrobe alongside residents’ beds

5) some multi-occupancy bedrooms and single rooms could only be accessed via other multi-occupancy bedrooms

6) some toilet and shower facilities could only be accessed through a series of multi-occupancy bedrooms

7) many residents did not have easy access to their wardrobes

8) equipment stored in bedrooms

9) lack of private space for residents to meet their visitors in private if they wished

10) lack of private rooms to accommodate residents, especially at end-of-life care.
The centre was generally clean throughout and well maintained. The gardens were attractively laid out, secure and well maintained. A secure garden was available with easy access from the dementia specific unit. Outdoor furniture and fencing here was painted brightly and there was a newly developed walkway for residents to enjoy the garden with raised beds. The café by the main reception was a pleasant social place for staff, residents and relatives. Feedback from residents and relatives commented on the value of the café.

A number of rooms both on the ground floor of the main building and the first floor of Sonas unit were used as meeting rooms for both HSE staff and visiting groups. A hairdressing service was available on site as was a physiotherapy service and a day centre. The day centre was not generally used by residents in long term care but was utilised by residents receiving respite care.

The centre had closed-circuit television cameras (CCTV) and there was a policy in place to support its use. All cameras were in public areas. There was a sign to inform residents, staff and visitors that CCTV was in operation.

Inspectors saw evidence of the use of assistive devices, for example, hoists, wheelchairs, walking aids, clinical monitoring equipment and specialist seating provided for residents’ use. There was a functioning call-bell system in place.

**Judgment:**
Non Compliant - Major

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**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 complaints policy was displayed prominently at the main reception and throughout the centre and had been updated since the last inspection. However, the policy document continued to have recourse to the chief inspector which does not meet the requirements of legislation. Throughout the inspection it was clear that residents were familiar with members of staff and management. It was apparent to inspectors that residents would find staff easy to approach with any concerns or complaints and residents confirmed this to be the case.Staff interviewed conveyed an understanding of the process involved in receiving and handling a complaint.
Inspectors viewed the complaints log that was maintained on each unit. They contained details of complaints, the investigation of each complaint and the outcome of the investigation. Records did not detail whether or not the complainant was satisfied with the outcome of the complaint. Many of the complaints related to issues pertaining to multi-occupancy bedrooms, noise levels and issues with televisions which will be discussed further in outcome 16 Residents Rights Dignity and Consultation. A number of complaints also were in relation to lost clothing which will be discussed under outcome 17 Residents Clothing and Possessions. There was evidence that the CNMs on each unit monitored complaints and endeavoured to resolve issues as soon as they arose.

**Judgment:**
Non Compliant - Moderate

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**Outcome 15: Food and Nutrition**

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

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

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

**Findings:**
There was an up-to-date policy in place for food and nutrition which included a recognised risk assessment and residents care plans contained evidence of regular monitoring of fluid and nutritional status. There had been substantial improvements in the overall provision of food and nutrition since the previous inspection. The person in charge explained how they had implemented a colour coded menu system to indicate food consistency. A new tray system of serving meals in the kitchen was implemented consistent with residents' menu choices and food consistency required. Residents spoken to all expressed satisfaction with the food and choices available to them.

Since the last inspection and following a survey by residents, tea-time had been moved forward from 16.00hrs to 16.45hrs as residents expressed that 16.00hrs was too early. Residents stated it was much better later. However the inspectors saw that tea-time was starting on some of the units earlier than the agreed 16.45hrs and inspectors required that the person in charge kept this under review to ensure meal times met the needs and choices of the residents. Tables on some units were attractively set and trays were no longer placed on tables. The dining experience was more of a social occasion than on previous inspections.

Inspectors saw that on most of the units the majority of residents were coming to the dining rooms for their lunch, there was less residents at tea-time. Some of the dining
rooms were seen to be homely and kitchen like. However on some units there continued to not enough dining space to facilitate all the residents living there and this will was actioned under outcome 12 Premises.

Specialist dietary requirements and consistencies were provided and there was lots of evidence of reports from speech and language therapy and dietician to inform residents’ care. Residents’ weights were documented on a monthly basis or more often if their clinical condition warranted. Residents had access to fresh water and other fluids throughout the day. Residents requiring assistance with their meals were helped appropriately and with respect in a dignified manner.

**Judgment:**
Compliant

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**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:**
Numerous visitors were observed throughout both days of inspection where staff members knew the names of visitors and vice versa. Feedback from relatives was that staff took time to talk with family members both when they visited and when they rang to enquire about their relative. Visitors told the inspectors that they were always made welcome and said that if they any concerns they could identify them to the staff and were assured they would be resolved. The centre operated an open visiting policy and this open visiting policy was observed throughout the inspection. Relatives commended staff on how welcoming they were to all visitors. However the inspectors saw that many visitors visited residents in the multi-occupancy bedrooms as there were limited private or communal rooms for visiting. These visiting arrangements did not promote or protect the dignity of the residents in the other beds who may require personal care or be trying to sleep/rest watch television while visitors were in their bedroom.

The manner in which residents were addressed by staff was seen by inspectors to be respectful. Inspectors heard staff addressing residents by their preferred names and speaking in a clear, respectful and courteous manner. Staff paid particular attention to residents’ appearance, dress and personal hygiene and were observed to be very caring towards the residents.
Inspectors observed that religious beliefs were facilitated as there was a chapel attached to the building. Mass was held very regularly, which residents could attend if they wished and it was also televised so they could watch from their rooms. Residents also had access to ministers from other religious denominations as required. Residents and relatives confirmed that the spiritual and religious needs of residents were very well met.

Residents were consulted through the residents committee and through feedback questionnaires. The resident advocate facilitated the residents’ committee meetings and many residents attended these meetings. Issues raised at these meetings were reported back to the person in charge for resolution and followed up on subsequent meetings with updates and progress. The inspectors queried the frequency of these meetings. The person in charge said some of minutes of meetings were not available at the time of the inspection and the person in charge was to forward them to the inspectors following the inspection. The inspector had not received these at the time of the report.

Inspectors saw a variety of activities ongoing during the two days of inspection. Residents were offered a choice of group activities as well as one-to-one sessions. Some families and residents had completed a ‘Life Story’ as part of their reminiscence therapy. A daily activities record detailing the residents’ involvement in the activity was maintained. Activities included art therapy, music, bingo, exercises, card playing, gardening, and aromatherapy. Residents’ art was displayed in the centre and one resident had won several art competitions in the local town. Inspectors met a number of activity staff who were providing individual and group activities and also a number of musicians who played the harp and guitar for the residents. However due to lack of space attendance at group activities was not always possible for all residents and a number were seen to remain by their beds. It was also unclear to inspectors who was co-ordinating the activities programme.

Inspectors saw that although televisions were provided to residents in the multi-occupancy bedrooms, the position of some of these televisions required review some were positioned too high. Others were positioned in close proximity to other residents televisions, therefore as seen by inspectors when two or more televisions were on at the same time in the multi-occupancy rooms it was very distracting and residents and staff said the noise level was too much. Inspectors saw in the complaints log that there had been a number of complaints made in relation to televisions and noise levels in relation to same. Particularly in relation to some residents having their televisions on too loud. Inspectors also saw in the complaints book that a number of residents did not have access to television for eight days over the Christmas period and although this was rectified, a delay of eight days was unacceptable. A number of residents told inspectors that overall the noise level in the multi-occupancy bedrooms was disturbing and upsetting especially if a fellow resident was disturbed and shouting. One resident described how she would love a single room as her sleep was regularly disturbed by other residents and staff attending to them at night in the multi-occupancy rooms. Other residents and a staff member stated that residents find the multi-occupancy rooms very disturbing because of some residents calling out, the use of hoists and visitors in and out.
Inspectors saw that although staff promoted residents privacy and dignity as best as they could in the multi-occupancy rooms. Inspectors also saw that in some of the units the screens used did not fully encircle the bed area therefore gaps were seen which did not protect the residents’ dignity. Staff said they had other mobile screens they could use in addition and inspectors requested that these were used at all times. The inspectors saw that on four out of the five units a large number of the residents spent a long periods of the day in their bedrooms, either in bed or on a chair at their bedside. As residents sat by their own bedside and not close enough to engage in conversation with the resident in the bed next to them this meant that some residents had few opportunities to meet, interact and engage with each other on a social basis. Many did attend the dining rooms for meals and for some activities but returned to their bedrooms immediately following same. The inspectors visited every unit in the centre at 18.00 hours on the first evening of the inspection and found that the majority of residents in the centre were either in bed or sat beside their bed with the exception of Saoirse unit where the majority of the residents were sitting in the day room accompanied by staff participating and very much enjoying a sing song. On this unit there was a day room with an open fire assisting in the provision of a homely atmosphere for the residents who resided there. The inspectors concluded that on the other units as a consequence of the prevalence of mainly large multi-occupancy rooms, lack of day rooms and the fact that residents spent most of the day by their beds, the centre appeared institutionalised and hospital-like. Reduced staffing levels in the evening also were seen to contribute to the number of residents going back to bed in the late afternoon prior to a large number of the staff finishing at 17.30. The inspectors felt this did not offer a full choice of bedtimes to the residents. These practices did not fit in with person-centred care nor did it promote the privacy and dignity of the residents on the units which were open to visitors for the evening.

**Judgment:**
Non Compliant - Major

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**Outcome 17: Residents’ clothing and personal property and possessions**

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

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

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

**Findings:**
There was an up-to-date policy on residents’ personal property and possessions. The majority of residents were accommodated in multi-bedded rooms which afforded little space, privacy or room for personal storage. These rooms were generally not
personalised. In many cases, lockers and wardrobes were quite small and did not accommodate sufficient clothing to allow residents to exercise choice. In a number of the rooms the wardrobes were stored away from residents' bedsides therefore they were inaccessible for residents which made it difficult for them to retain control over their possessions and clothing.

Laundry in the centre is outsourced with bedding and towels going to one laundry service and personal linen going to a different service. There were a number of complaints in the complaints log in relation to missing clothing. The person in charge had highlighted it to staff to be vigilant and separate laundry trolleys and bags were available, however this continues to be an issue and further controls are required.

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

Findings:
Inspectors observed warm and appropriate interactions between staff and residents and they observed staff chatting easily with residents. Residents and relatives spoke very positively of staff and indicated that staff were caring, responsive to their needs and treated them with respect and dignity. This was seen by the inspectors throughout the inspection in the dignified and caring manner in which staff interacted and responded to the residents.

Inspectors viewed the staff training and education records. An overall training matrix was in place and individual records were maintained. Mandatory training was in place and training records confirmed that staff had received up to date training in fire safety, safe moving and handling, safeguarding vulnerable persons and training in responsive behaviours. Other training provided included, care planning, dementia specific training, infection control, end of life, syringe driver training, care planning, dysphagia and medication management. A lot of training was provided on site by external and internal trainers. Training facilities were available in house which including fully equipped
conference and training rooms. The inspectors saw that other training courses had been booked and were scheduled for the coming months. Staff confirmed that they were facilitated and encouraged to attend training and through their staff appraisals were able to highlight their training needs.

Inspectors reviewed a sample of staff files which included all the information required under Schedule 2 of the Regulations. Registration details with An Bord Altranais for 2017 for nursing staff were seen by inspectors. The person in charge confirmed Garda vetting was in place for all staff and no staff commenced employment until this was in place.

Systems of communication were in place to support staff with providing safe and appropriate care. There were handover meetings each day to ensure good communication and continuity of care from one shift to the next. Inspectors saw records of staff meetings at which operational and staffing issues were discussed. The inspector saw that staff had available to them copies of the regulations and standards. Inspectors found staff to be well informed and knowledgeable regarding their roles and responsibilities. However from talking to staff and reviewing the duty rota there was evidence that staff were frequently moved from unit to unit with some staff on different units each shift they worked in a week. The duty rota was completed centrally by the night staff with the CNM’s on the units not having control over the allocation of their staff or skill mix. This practice is not good for continuity of care. It also did not allow for allocation of nurses to act as key workers for a set group of residents, ensuring all of the residents’ needs were documented and set out in their care plans to direct their care.

As discussed under outcome 8 Health and safety. There were no dedicated cleaning staff on a number of smaller units and the role of the multi-task attendant was unclear as they moved from caring to cleaning to catering duties. Further segregation of roles is required to ensure consistent care for residents and to allow for more consistency for the purposes of cleaning and catering.

Staffing levels in the evening required review as Inspectors found that staffing levels decreased from 17.30hrs onwards in all units and two units operated with one nurse and two care staff until 20.00hrs and then to one nurse and one care staff for the evening and night. The night nurse had to do the night time medication round and therefore this left only one member of staff to give out evening drinks and assist residents to bed and with other personal care needs. The inspectors found that these staffing levels were not adequate to ensure the nurse administered the medications safely without interruption and to ensure residents had a choice in bedtimes. These practices did not fit in with person-centred care as the inspectors formed the opinion which was confirmed by staff that most residents were assisted back to bed before staffing levels decreased. This also did not promote the privacy and dignity of the residents on the units. These units were open to visitors for the evening where visitors visited by residents bedsides while other residents tried to sleep or watch television. The person in charge and staff confirmed that staffing levels in the evening had increased on Saoirse unit. This was the unit where the inspectors found the best outcomes for residents as residents were up and about in the day room, enjoying the company of the staff and each other and participating in a sing song.

Judgment:
Non Compliant - Major
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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Action Plan

Provider’s response to inspection report

Centre name: Clonakilty Community Hospital
Centre ID: OSV-0000559
Date of inspection: 08/03/2017
Date of response: 13/04/2017

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 02: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The inspectors were concerned that the current management structure did not clearly identify the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision. This was evidenced by lack of notification to the centre of who the interim provider nominee was and also lack of official notification of this to HIQA. No progress to date on plans for the reconfiguration of the building to ensure the privacy and dignity of residents is protected.

1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
1. **Action Required:**
Under Regulation 23(b) you are required to: Put in place a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

**Please state the actions you have taken or are planning to take:**
Mr. Richard Buckley has been nominated as the interim provider nominee while the position of General Manager is vacant.

**Proposed Timescale:** 30/04/2017

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The annual review was not prepared in consultation with residents and their families and was not made available to them as required by the regulations.

2. **Action Required:**
Under Regulation 23(e) you are required to: Prepare the review referred to in regulation 23(1)(d) in consultation with residents and their families.

**Please state the actions you have taken or are planning to take:**
Going forward the annual review will include a consultation process with residents and their families and will be made available to them, when completed.


**Proposed Timescale:**

**Outcome 07: Safeguarding and Safety**

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was a very high usage of bedrails in the centre that required review

3. **Action Required:**
Under Regulation 07(3) you are required to: Ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.

**Please state the actions you have taken or are planning to take:**
Further review of the bed rail usage will be undertaken in each unit.

**Proposed Timescale:** 30/04/2017  
**Theme:** Safe care and support  

The Registered Provider is failing to comply with a regulatory requirement in the following respect:  
The activity staff and hairdressing staff had not received training on detection and prevention of abuse and were unsure of the reporting mechanisms in place.

4. **Action Required:**  
Under Regulation 08(2) you are required to: Ensure staff are trained in the detection and prevention of and responses to abuse.

Please state the actions you have taken or are planning to take:  
All activity staff and hairdresser will be provided with safeguarding training on 24th May 2017.

**Proposed Timescale:** 24/04/2017  
**Theme:** Safe care and support  

The Registered Provider is failing to comply with a regulatory requirement in the following respect:  
The systems in place to safeguard residents finances handed in for safekeeping was not sufficiently robust.

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

Please state the actions you have taken or are planning to take:  
A new system will be implemented where the resident will sign a docket for the items that they buy from the ‘shop’; they, or their families will be invoiced on a monthly basis.

**Proposed Timescale:** 03/04/2017  

**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:
Medications were not always being administered as prescribed:
Inspectors saw that on one unit medications were not being administered at the times prescribed or within the guidelines for safe administration in that a medication prescribed for 10am was being administered at 11.45.
In the sample of medication prescriptions charts reviewed inspectors saw that nurses were administering medications in a crushed format when they were not all prescribed in a crushed format by the GP.
Inspectors also found that one medication was prescribed as a regular prescription four times per day which was the maximum dose however, the same drug was also prescribed in the PRN prescription leading to a potential risk of over dosage. In one chart nurses signatures showed that a resident received 5 doses of one gram of paracetamol in 24 hours where 4 grams is the accepted maximum dose in 24 hours.

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:
Nursing staff have been reminded that all medications are administered at the time they are prescribed or as close to this time within the guidelines for safe administration of medicine. Only medications that are prescribed to be ‘crushed’ may be given in a crushed format or alternative suspension prescribed. Staff informed to be vigilant and ensure that medications are given as prescribed and that they take note of maximum dose allowed in 24 hours. Nursing staff attend medication management training – next training is on 26th April 2017.

Proposed Timescale: 13/04/2017

Outcome 11: Health and Social Care Needs

Theme:
Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Although inspectors saw that the assessment tools were reviewed and updated on a four monthly basis there was no evidence that the care plans were reviewed as a result of the updating of assessment as required by legislation

7. Action Required:
Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident’s family.
Please state the actions you have taken or are planning to take:
Nursing staff have been reminded of the requirement to document in the ‘Ongoing evaluation’ section of the care plan once a review is completed. Nursing staff attend Care Planning study days.

Proposed Timescale: 03/04/2017

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:
The premises did not conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre. There were no plans evident for the commencement of the new building that is to be in place by 2020.

Issues identified included:
1) inadequate number of toilets for residents use, for example, there was just one usable toilet in the female section of Sonas for 10 residents as the second toilet was not fit for purpose because it was so small when a resident used the facility the door could not be closed
2) inadequate provision of bathing facilities
3) inadequate communal space in Dochas and An Ghraig; most residents in these units continued to be seated near their beds for large parts of the day.
4) multi-occupancy bedrooms; some could not accommodate a bed-side chair or wardrobe alongside residents’ beds
5) some multi-occupancy bedrooms and single rooms could only be accessed via other multi-occupancy bedrooms
6) some toilet and shower facilities could only be accessed through a series of multi-occupancy bedrooms
7) many residents did not have easy access to their wardrobes
8) equipment stored in bedrooms
9) lack of private space for residents to meet their visitors in private if they wished
10) lack of private rooms to accommodate residents, especially at end-of-life care.

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:
A design team will be appointed shortly and plans developed for the Hospital. These plans will comply with the requirements of the recently issued new 2016 HIQA standards (as published 3rd May 2016) and the amendment to the Regulation (S.I. No. 293 of 2016).
The environment will be assessed, and any interim measures identified to improve the privacy and dignity of the residents will be pursued, pending funding.
Outcome 13: Complaints procedures

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The outcome of the complaint was not documented on all complaints

9. Action Required:
Under Regulation 34(1)(g) you are required to: Inform the complainant promptly of the outcome of their complaint and details of the appeals process.

Please state the actions you have taken or are planning to take:
A new complaints log book will be ordered to contain a section for the complainant to sign as to whether they are satisfied or not with the outcome. Until then the complainant will sign the ‘Actions & Outcomes’ box, staff have been informed of this change.

Proposed Timescale: 03/04/2017

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The complaint policy document continued to have recourse to the chief inspector which does not meet the requirements of legislation
Whether the resident was satisfied with the outcome of the complaint was not documented.

10. Action Required:
Under Regulation 34(1) you are required to: Provide an accessible and effective complaints procedure which includes an appeals procedure.

Please state the actions you have taken or are planning to take:
Residents Complaints Policy has been amended to remove section in relation to Chief Inspector and added the requirement to record whether the complainant is satisfied or not. Complaints procedure displayed throughout hospital has also been updated.
Proposed Timescale: 03/04/2017

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:
Residents were limited in their choice of television programme, in their choice of bedtimes due to the fact that staffing was reduced at night time and in their choice of the type of bedroom they would like to be accommodated in. In addition, residents were limited in their choice of sitting area during the day. As there was not enough dining space on all units those residents did not always have choice in dining areas.

11. **Action Required:**
Under Regulation 09(3)(a) you are required to: Ensure that each resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.

Please state the actions you have taken or are planning to take:
There are a number of areas on each unit and throughout the hospital that residents can choose from to sit and socialise with others and visitors. All staff will be reminded to inform residents and visitors that these areas are available. Residents have access to all national television channels. If a resident chooses not to go to bed at a particular time, this will be accommodated in so far as is reasonably possible so as not to interfere with the rights of other residents. At present we are limited with space to provide or offer single occupancy bedrooms or larger dining areas until the hospital is re-built/re-furbished.

Proposed Timescale: 31/12/2020

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Due to the large number of multi-occupancy rooms, and screening that did not fully encircle the bed area in a number of the units residents were not able to undertake personal activities in private.

12. **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:
Screening is available to encircle all bed areas. Staff reminded to use screens appropriately to provide privacy to residents.
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents did not always have access to television due to the positioning of the televisions and also inspectors saw in the complaints book that a number of residents did not have access to television for eight days over the Christmas period.

13. 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:
A resident was admitted over the Christmas period and the television in her room was not working due to problems with the cabling going to the television. There was alternative provision to the resident in the day room across from the ward.

Proposed Timescale: 13/04/2017

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Inspectors saw that many visitors visited residents in the multi-occupancy bedrooms, as there were limited private or communal rooms for visiting. These visiting arrangements did not promote or protect the dignity of the residents in the other beds, who may require personal care or be trying to sleep/rest, watch television while visitors were in their bedroom.

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

Please state the actions you have taken or are planning to take:
At present we are limited with space until the hospital is re-built/re-furbished. We have provided areas within the hospital for private spaces for visitors. Residents have a preference to have visitors around their bed space.
### 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 majority of residents were accommodated in multi-bedded rooms which afforded little space, privacy or room for personal storage. These rooms were generally not personalised. In many cases, lockers and wardrobes were quite small and did not accommodate sufficient clothing to allow residents to exercise choice. In a number of the rooms the wardrobes were stored away from residents' bedsides therefore they were inaccessible for residents which made it difficult for them to retain control over their possessions and clothing.

15. **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:**
Efforts have been made to have residents' wardrobes beside their bed but in some areas of the hospital this is not possible due to the lack of space in the ward. Proposed Timescale: Interim works 30/04/2018, and completed project December 2020.

<table>
<thead>
<tr>
<th>Proposed Timescale: 31/12/2020</th>
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<tbody>
<tr>
<td><strong>Theme:</strong> Person-centred care and support</td>
</tr>
<tr>
<td><strong>The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:</strong> Laundry in the centre is outsourced with bedding and towels going to one laundry service and personal linen going to a different service. There were a number of complaints in the complaints log in relation to missing clothing. The person in charge had highlighted it to staff to be vigilant and separate laundry trollies and bags were available, however this continues to be an issue and further controls are required.</td>
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<tr>
<td><strong>16. Action Required:</strong> Under Regulation 12(b) you are required to: Ensure each resident's linen and clothes are laundered regularly and returned to that resident.</td>
</tr>
<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong> We provide a 6 day service where residents' laundry is picked up and returned to residents within a 24 hour period. Having reviewed the issues– the first is where respite or new residents have been admitted and the clothing is not marked. Secondly, we have changed the colour of clear laundry bags to a different colour for sheets and for clothing to reduce the risk of clothing getting lost.</td>
</tr>
</tbody>
</table>
### Outcome 18: Suitable Staffing

**Theme:**
Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were a number of issues around staffing and skill mix that required review and action.
Staffing levels in the evening required review as Inspectors found that staffing levels decreased from 17.30hrs onwards in all units. These practices did not fit in with person-centred care.
Staffing levels in the evening times required action to ensure there were enough staff for nurses to safely administer medications without interruption and to ensure choice of bedtimes was available to residents
The role of the multi-task attendants moving between caring and cleaning on the one shift required review as did the requirement for dedicated cleaning staff for all units. The frequent movement of staff to different units did not facilitate continuity of care.

#### 17. Action Required:
Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

**Please state the actions you have taken or are planning to take:**
Request to new GM for increase in staffing levels from 17.30 hrs – 20.00 hours in three units and an increase of staffing in An Ghraig unit from 20.00 – 00.00 hrs to ensure administration of medications without interruption and to ensure choice of bedtimes for residents.

Request from GM an increase of domestic staffing to do cleaning only in the An Ghraig, Sonas and Saiorse units.

On each unit there are core staff members, whilst there is flexibility required from some staff to accommodate leave throughout the units, continuity of staff is accommodated where possible.

Staffing and Skill mix will be reviewed to ensure adequate staffing levels available at all times to ensure safe practice, and to provide a person centred care approach. A review of roles will be conducted, with a view to segregation of roles, to ensure adequate numbers of staff allocated to caring and cleaning within the Hospital.

**Proposed Timescale:** 01/06/2017