Centre name: Midleton Community Hospital
Centre ID: OSV-0000579

Centre address: Midleton, Cork.
Telephone number: 021 463 5300
Email address: teresa.galvin@hse.ie
Type of centre: The Health Service Executive
Registered provider: Health Service Executive
Provider Nominee: Richard Buckley
Lead inspector: Mary O'Mahony
Support inspector(s): Michelle O'Connor
Type of inspection: Announced
Number of residents on the date of inspection: 51
Number of vacancies on the date of inspection: 2
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 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**

<table>
<thead>
<tr>
<th>From:</th>
<th>To:</th>
</tr>
</thead>
<tbody>
<tr>
<td>28 September 2017 10:00</td>
<td>28 September 2017 18:00</td>
</tr>
<tr>
<td>29 September 2017 08:30</td>
<td>29 September 2017 18:30</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Our Judgment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome 01: Statement of Purpose</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 02: Governance and Management</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 03: Information for residents</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 04: Suitable Person in Charge</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 05: Documentation to be kept at a designated centre</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 06: Absence of the Person in charge</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 07: Safeguarding and Safety</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 08: Health and Safety and Risk Management</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 09: Medication Management</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 10: Notification of Incidents</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 11: Health and Social Care Needs</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 12: Safe and Suitable Premises</td>
<td>Non Compliant - Major</td>
</tr>
<tr>
<td>Outcome 13: Complaints procedures</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 16: Residents’ Rights, Dignity and Consultation</td>
<td>Non Compliant - Major</td>
</tr>
<tr>
<td>Outcome 17: Residents’ clothing and personal property and possessions</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 18: Suitable Staffing</td>
<td>Substantially Compliant</td>
</tr>
</tbody>
</table>

**Summary of findings from this inspection**

This registration renewal inspection of Midleton Community Hospital was announced and took place over two days. The hospital was originally built as a workhouse in 1841: this section was now called the 'back hospital'. A newer section of the building called the 'front hospital' was opened in 1937. At the time of inspection the centre was run by the Health Service Executive (HSE) as a designated centre for the care of older adults. The centre provided long-stay, respite, palliative and convalescent care.

The main entrance hall was located in the front hospital. 51 residents were
accommodated between the two buildings in the centre during the days of inspection with two vacant beds. As part of the inspection inspectors met with the provider, the person in charge, residents, relatives and staff from all areas of care provision. Inspectors observed care practices and reviewed documentation such as pre-inspection HIQA questionnaires, care plans, incident records, policies, fire safety records and staff files.

The findings on inspection were based on the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland, 2016. There was evidence of individual resident’s needs being met and the staff supported residents to maintain their independence where possible. The inspector found the premises, fittings and equipment were in good repair overall. However, there were numerous issues of non compliance in relation to the design and layout of areas of the premises as regards the legislative requirement to protect and promote the privacy and dignity of residents. Improvements were required particularly in the areas of: safe and suitable premises: residents' rights dignity and consultation: residents’ personal property and staffing.

In addition, a condition had been placed by HIQA on the previous registration of the centre which stated that the physical environment must be reconfigured by 2020 to bring the centre into compliance with the 2013 Regulations governing the care and welfare of residents in designated centres. On this inspection inspectors found that planning permission had yet to be applied for in relation to the planned new 50-bedded building on site, which the HSE had proposed. The provider stated that a site on the existing campus had been identified for this building, nevertheless the project was still with the HSE 'estates' team according to an email sent to HIQA following the inspection. A written commitment was received from the provider that the building would be complete and fully compliant with regulations and standards by the end of 2020.
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:**
A detailed statement of purpose was available to both staff and residents at reception and on each ward. It contained a statement of the designated centre’s aims, objectives and ethos of care. It accurately described the facilities and services available to residents, and the size and layout of the premises. It outlined how the centre provided long-term residential care, respite, convalescence, and palliative care.

**Judgment:**
Compliant

**Outcome 02: Governance and Management**

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

**Theme:**
Governance, Leadership and Management

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

**Findings:**
The person in charge was supported by two suitably qualified and knowledgeable clinical nurse managers (CNMs). There were clear lines of authority and accountability in the centre. The provider was available for consultation when required and he attended monthly meetings with the senior management team. He was present on day two of the inspection and was knowledgeable of the service.
An annual review of the quality and safety of care was undertaken as required by regulation. Improvements were instigated as a result of the learning from this review. The person in charge stated that the review was developed in consultation with residents. Customer satisfaction surveys and the minutes of resident and family meetings were incorporated into the review.

The clinical nurse managers spoke with inspectors in relation to clinical audits. Records were seen of a number of these audits. However, inspectors found that a defined audit schedule had not been set up. In addition, there were no dates on a number of audits seen and the actions taken as a result of audit findings had not been documented: for example, in the 'communication audit, the 'gaining consent' audit and in a number of 'medication' audits. Furthermore, the audit system was not comprehensive as regards the inclusion of all key areas to be audited. Inspectors discussed with the person in charge the requirement for comprehensive audit to enable assessment of the area to be audited, the identification of issues to be addressed and the dissemination of learning which a good audit system would support. The person in charge stated that this practice would be improved.

Nevertheless, minutes of team and management meetings including health and safety meetings were detailed and it was apparent that audit was discussed and carried out in some areas. However, there was no documentation to support the audits which were proposed at these meetings. The clinical nurse managers stated that documentation would be developed to provide on-going data on the effectiveness of any improvements in aspects of care or premises brought about as a result of audit findings.

Judgment:
Substantially 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:
A guide to the centre was included in a newly designed ‘Information and Welcome Pack’, which contained useful information leaflets such as ‘Falls Prevention’, ‘The Safe Use of Bedrails’, ‘End of Life Care’ and ‘Your Service, Your Say’. The resident’s guide described the services and facilities available, accommodation type, visiting arrangements and the complaints process. The ‘Information and Welcome Pack’ was distributed to all new and prospective residents and to relatives on request.

Each resident was provided with a written contract on admission, as required under Regulation 24 of the Health Act 2007 (Care and Welfare of Residents in Designated
Centres for Older People) Regulations 2013. However, the accommodation type available to residents was not clearly set out as required under Statutory Instrument No. 293 of 2016. The contract specified which services were covered under the overall fee for the designated centre. These included the provision of care, accommodation, food, lighting, heating and other services deemed appropriate. These additional services extended to activities, access to allied health professionals and newspapers. Pricelists for the provision of an additional in-house hairdressing and podiatry service were displayed throughout the centre.

**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 an experienced nurse. She was involved in the day-to-day organisation and management of the service. Staff, residents and relatives were aware that the person in charge was responsible for the supervision and delivery of care and she was seen to have an in-depth knowledge of residents and their needs. She informed inspectors that she worked full time in the centre and was committed to providing person-centred care to residents. She was found to be aware of the regulations as regards the regulatory duties of the person in charge of a designated centre in leading the care and welfare of residents. She ensured that mandatory training was attended and scheduled. She was engaged in continuous professional development including, attending conferences post-graduate qualifications in gerontological nursing and health services management.

**Judgment:**
Compliant

---

### Outcome 05: Documentation to be kept at a designated centre

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

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

**Findings:**
Inspectors found that the policies required under Schedules 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 were available in the centre to guide the care provision and promote health and safety. These were centre-specific and referenced the latest national policy and guidance. The policies were reviewed every two years, available on all units and signed off as read and understood by staff.

The directory of residents established under Regulation 19 was maintained electronically and contained the required details for both short-stay residents and those receiving continuing care. Inspectors saw that the majority of records required to be maintained under Schedule 2, 3 and 4 of the regulations were available, accurate and easily retrievable.

Evidence was also seen that the centre was adequately insured against injury to residents and loss or damage to residents’ property.

**Judgment:**
Compliant

---

**Outcome 06: Absence of the Person in charge**
*The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/ her absence.*

**Theme:**
Governance, Leadership and Management

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

**Findings:**
The provider was aware of the statutory duty to inform the Chief Inspector of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during her absence. There was a suitably qualified CNM identified from the management staff to deputise in the absence of the person in charge.

**Judgment:**
Compliant

---

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

Theme:
Safe care and support

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

Findings:
The policy on the prevention of elder abuse incorporated the Health Service Executive’s (HSE) Safeguarding Vulnerable Persons at Risk of Abuse Policy & Procedures 2014 and other best evidence-based practice. Inspectors found that measures were in place to protect and safeguard residents. Staff were found to be aware of the procedure to follow if they witnessed, suspected or received an allegation of abuse. Training records reviewed confirmed that staff had received training on recognising and responding to elder abuse. Further training was seen to be scheduled for the weeks following the inspection. Residents told inspectors that they felt safe in the centre. Relatives confirmed with inspectors that staff were kind. Information in the HIQA pre-inspection questionnaires confirmed these statements.

Residents' finances were managed in a careful and detailed manner. Inspectors saw comprehensive records of all transactions on residents’ accounts. Two staff members signed for any cash transaction. Inspectors viewed a sample of these records which were found to be accurate.

A policy which outlined interventions and approaches for residents who exhibited behaviours which were related to the behavioural and psychological symptoms of dementia (BPSD), was clearly set out and guided care planning for relevant residents. A number of staff members spoken with, by inspectors confirmed that training had been provided to them in how to support these residents. The person in charge confirmed that further training had been scheduled in this aspect of care. Psychotropic medication was regularly reviewed by the GP and the pharmacist.

The centre promoted a restraint-free environment. The policy had been updated and was centre-specific. Consent and risk assessments were in place for the use of bedrails and bed/chair/movement sensor alarms. A log of nightly observations related to bedrail use was seen to be maintained. The national policy on restraint use was in operation in the centre.

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):**
No actions were required from the previous inspection.

**Findings:**
Midleton Community Hospital had policies and procedures in place relating to aspects of health and safety. The health and safety statement was dated 13 June 2017. A health and safety committee met monthly to identify and address issues. The emergency response plan contained instructions on how to respond to major incidents or events. The risk management policy included controls for the risks specified in Regulation 26(1). Risks were assessed and prioritised within the risk register. All incidents were recorded using the HSE 'National Incident Report' forms. Arrangements were in place for investigating and learning from any serious incident or adverse event.

Inspectors found suitable fire equipment was available throughout the centre and flammability test reports were seen for bedding and furnishings. Fire evacuation procedures were prominently displayed. Staff stated that they participated in regular fire drills and attended mandatory annual fire training. Staff spoken with by inspectors were familiar with fire safety protocol. The fire alarm system and emergency lighting were serviced at intervals by external contractors and in-house checks were carried out by staff. However, on the day of the inspection some residents' equipment was seen to partially block fire exit doors. This was addressed under Outcome 12: Premises.

Policies and procedures on infection control were consistent with national guidelines including the safe handling and disposal of clinical waste, dealing with spillages, the provision of protective clothing and procedures to prevent cross infection. Alcohol hand-gel and hand-washing facilities were available throughout the centre. An infection prevention and control audit had taken place in March 2017 and found 93% compliance in the area of effective hand hygiene. Inspectors also observed good hand hygiene practices throughout the inspection. This was particularly relevant given the increased risk of cross infection in large multi-occupancy rooms. As a result of these practices infections were controlled to within small groups when they occurred.

**Judgment:**
Compliant

---

**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:**
Inspectors reviewed the policy for medicines management which outlined safe procedures for the administration, recording and disposal of medicines. Staff maintained an accurate and up to date register of controlled drugs. Safe practice in this area was observed. Two nurses checked and recorded the drug stock balance at each shift change. Residents had a choice of GP and staff said that the GPs reviewed each resident's medicine on a three monthly basis. Residents who required medicines to be crushed were seen to have an appropriate prescription in place. Photographic identification for residents was seen on each medicine administration chart. Medicines were stored securely.

Evidence of medication audit was seen by the inspector. Medication errors were recorded in an incident form and reviewed by the Clinical Nurse Managers (CNMs). However, as discussed under Outcome 2 the required actions had no corresponding action set out.

The person in charge, informed inspectors that the pharmacist provided educational sessions for nurses and was available to speak with residents. Medicines were returned to pharmacy when not in use. A record of all medicines, delivered to the centre, was signed by staff and the pharmacist.

**Judgment:**
Compliant

<table>
<thead>
<tr>
<th>Outcome 10: Notification of Incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.</td>
</tr>
</tbody>
</table>

**Theme:**
Safe care and support

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

**Findings:**
A record of all incidents occurring in the designated centre was maintained using the HSE 'National Incident Management' reporting template. All incidents that required notification to the Chief Inspector had been submitted. A record of notifications, including requests for additional information was maintained by the person in charge. A quarterly report was also provided to HIQA to notify the Chief Inspector of regulatory incidents.

**Judgment:**
Compliant

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

Theme:
Effective care and support

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

Findings:
The person in charge outlined the admission process. Efforts were made to ensure that the needs of each resident could be met. Residents were provided with the services of a general practitioner (GP) on admission. The person in charge stated that there was a choice of GP available to residents even though most residents choose the services the HSE doctors.

A sample of care plans for residents were reviewed by inspectors. A physiotherapist located in the centre offered services to both residents and to people in the community. Inspectors observed that since the previous inspection one resident who had requested more frequent physiotherapy had been supported to access an appropriate exercise regime, with the resultant improvement in physical and psychological well-being as stated by the resident. Residents had access to the optician, the podiatrist, the dentist and the occupational therapist, if required. These services were availed of in-house and on an external basis. Clinical assessments, such as, skin integrity, falls, continence, cognitive, pain and nutritional status were seen to be undertaken for each resident. Residents’ right to refuse treatment was documented and brought to the attention of the GP, as required.

Since the previous inspection inspectors found that care plans in relation to dementia care had been developed for relevant residents. The person in charge said that the new care-planning suite of documents was now in use. She stated that it was still a work in progress as there was some new documentation still being considered for inclusion. However, inspectors found that daily narrative notes were not maintained in line with Schedule 3 of the Regulations. These were required to be maintained to enhance communication between staff members and to provide a written narrative record of the on-going attention to care needs and condition of residents.

End of life care wishes had been recorded for a number of residents and training was available to staff. Relatives spoken with stated that staff were very supportive at times of crisis and specialist palliative services were available from the community and hospice care. This area of care was exceptional in the centre. A staff member had hand-crafted a number of end-of-life ‘altars’/display units. These were beautifully finished and contained booklets, prayers and other items for use at this time. In addition, the special palliative room was set aside for residents. This had an adjoining relatives' room,
kitchenette and shower room. Staff had been afforded training in palliative care. Inspectors saw that staff had written person-centred, insightful and caring notes on the outcomes from training and thoughtful narratives about each resident who had died in the centre in the previous year. This documentation demonstrated to inspectors that staff were invested in the lives and deaths of residents in the centre and that residents' experiences really mattered to staff.

Inspectors found that there was a diverse activity programme displayed on notice boards in the centre. This was addressed further under Outcome 16: Residents' rights, dignity and consultation. Family and friends with whom inspectors spoke were praiseworthy of the staff and the care available from all grades of staff including medical staff, pharmacist and activity staff.

Dietary advice and speech and language therapy (SALT) were provided by allied health professionals and from a nutritional company who also offered training to staff. The Malnutrition Universal Screening tool (MUST) was utilised to assess the risk of malnutrition for any resident who had lost weight. Residents' weight was recorded monthly. These was good communication between the dietician, the staff and the kitchen staff. Staff, spoken with by inspectors, were found to be familiar with residents' nutrition needs, special diets, likes and dislikes. A choice of meals were available to residents. Residents were provided with food and drink at times and in quantities adequate to their needs. Jugs of water and juice were available on bedside lockers and snacks were provided throughout the day. A four-weekly menu plan was posted on notice boards. Nutrition care plans and diet sheets were reviewed on a weekly or fortnightly basis by allied health professionals where weight loss indicated a risk. Inspectors observed that one resident liked to go the local shop to buy fresh bread and that he kept this by his bedside. He also had access to a kitchenette to make additional snacks. This was a long standing habit and his choice in this matter was supported by staff.

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:
Actions outstanding since previous inspections dating from 10 March 2010 to January 2017:

- residents in all areas were not provided with adequate dining and communal rooms or personal storage space
- the size and layout of multi-occupancy bedrooms used by residents were not suitable for their needs
- insufficient assisted baths, showers and toilets to meet the needs of residents:

While the finding of major non-compliance on premises was on-going from all previous inspections, inspectors acknowledged the improvements which had been undertaken by staff since the previous inspection:

- a storage room had been converted into a colourful and well-designed activity room for residents. This was decorated with floral murals to represent a garden scene. Residents were seen to utilise this room on a number of occasions during the inspection. It was nicely furnished and had a large roof window. Residents referred to this room as the "garden room" and stated that it was a lovely addition to the centre. Relatives were also seen to sit with residents in this room during activity sessions.
- a new shower room had been developed which meant that female and male residents on one floor in the back building could access a shower without having to go through each others' wards
- all residents in multi-occupancy wards were provided with lockable wardrobes and bedroom lockers
- bed space was personalised for residents in multi-occupancy wards using photographs, flowers and colourful quilts.
- orange blankets were placed on beds where the resident was assessed as being at an increased falls risk
- opaque plastic screening had been applied to the lower sections of the glass 'divider' panels by a staff member to make efforts to enhance privacy screening for residents in each bay area. This was seen to be effective from a visibility point of view
- a new "imagination gym" activity room had been developed in the front building
- a kitchenette had been renovated and painted
- a resident who had been accommodated in a bay facing the nurses office had been moved from that area. The bed had been replaced by a couch and exercise equipment.

However, in conjunction with the significant premises failings found on previous inspection the following findings were observed on this inspection with impacted in a negative manner on the privacy and dignity of residents as well as on their lived experience:

There was an issue with storage space in general:
For example:
- Equipment was seen to partially block fire exit doors including rollators and specialist bed screens which were located next to these doors. Due to the lack of space staff had to constantly remember to tidy them back against the beds.
- Most wardrobes were half-height and were not sufficient to store all residents’ clothing and personal belongings.
- Use of commodes where there were no fixed barrier or wall existed to afford privacy to
a resident: for example, a curtain was in used as a barrier which did not prevent noise, odour or promote the resident's dignity and privacy where other residents shared a sleeping bay or visitors could pass alongside the screening curtain when walking in the hallway adjacent to the curtain. 

- Inner small sitting areas, which could only be accessed through the bedrooms. 
- Distance to toilets from the bedroom areas. 
- Inadequate size of toilets for wheelchair users. 
- Limited number of toilets & bathrooms for hoists having to be moved out from the wall to access both sides for hoist use. 
- Wardrobes all clustered together in the middle of multi-occupancy rooms resulting in residents not having ready access to their personal possessions. 
- Difficult to identify individual wardrobes. 
- Insufficient communal space particularly dining and sitting space: there was a lack of availability of suitable dining rooms which promoted privacy/choice for residents: for example, some dining areas were located in 'hall-like' areas which were accessible to passing visitors, staff or other personnel 
- Visitors were required to walk through bedrooms past other residents in bed to get to communal areas for visits

In the 'front' hospital the majority of residents' accommodation was provided in shared bedrooms 'bays', divided by screens and in some areas three, four or seven residents were sharing communal bedrooms. These were referred to as 'wards'. On the ground floor St. Anthony's ward was located to the right of the main entrance and provided accommodation for nine male residents as follows: a seven-bedded room and two single rooms. St. Catherine's ward on the left side provided accommodation for 11 female residents; this included one single room, one twin-bedded room, a palliative care room and a multi-occupancy seven-bedded ward. However, these wards had a very small living/dining room at the end of the ward area accessible only by walking through residents' bedrooms. Therefore, there continued to be significant issues with the layout and design of the premises which did not conform to the requirements for premises in Regulation 17 (1) and Regulation 17 (2). Premises issues which negatively impacted on the privacy, dignity and choice of residents were further addressed under Outcome 16: Resident, rights, dignity and consultation.

The 'back' hospital was accessed by crossing an external courtyard. This older section was a three-storey building with accommodation provided on the lower two floors. The first floor of this back hospital had a lift installed as well as stairs. St. Mary’s ward provided accommodation for seven female residents on the ground floor. It had a separate living/dining room and a small sitting room between the bedroom areas. A small kitchenette, two toilets and an assisted shower room were available for residents’ use. Upstairs St. Anne’s and St. Ita’s wards accommodated eight and five female residents respectively and St. Joseph’s and St. Patrick’s wards accommodated eight and five male residents respectively. St. Anne’s and St. Ita’s had four toilets between them and an assisted shower room. St. Joseph’s and St. Patrick’s had three toilets and one assisted bathroom and shower room. 

A hairdressing room and a physiotherapy room were available on the ground floor. A chapel was accessible from the ground floor and also from an external entrance door. The external grounds were extensive and provided sufficient car parking. The garden
areas had been renovated through local fund raising efforts. There was a further secure garden area to the left of the front entrance and a new patio area at the back.

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

Some of the toilets were very narrow and could not be used by wheelchair bound residents or those with high dependency needs. This limited the availability of suitable toilet arrangements as there were only four toilets in total for 15 residents with high dependency needs. Toilets were also located a distance from all bed areas which meant that those residents had to be transported along a hallway to access the toilet or shower.

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 most recent version of the complaints procedure was displayed in prominent positions throughout the centre. This correlated with the complaints policy and information contained in the statement of purpose and residents’ guide. The complaints officer was identified as the person in charge. A second nominated person was identified to ensure all complaints were appropriately responded to. The appeals process was clearly outlined. It included the contact details for the Ombudsman, an independent advocate, the HSE’s ‘Your Service, Your Say’ and information on the website healthcomplaints.ie.

A complaints log was maintained on each ward in the centre and staff had been proactive in identifying and recording complaints. All complaints were assessed on a monthly basis and reviewed by a second nominated HSE manager. Most complaints contained details of the specific complaint and whether the complainant was satisfied or not.
However, in some instances the outcome of actions taken, the final outcome of the complaint, dates of follow-up or whether the complainant was satisfied with the outcome was not recorded. For example, a sum of money was reported as missing in January 2017. While the resident stated that the money was not lost but mislaid, the fact that it was eventually found was not recorded. The person in charge assured inspectors that patterns of complaints were dealt with informally, however this learning was not documented or recorded. For example, a number of complaints relating to missing personal items had been made. The response to this had not been documented. However, when asked about the response, the person in charge stated that she had ordered new lockable bedside lockers for residents. The maintenance of records as set out under Regulation 34 would have satisfied inspectors as to the outcome of that particular pattern of complaints.

There continued to be recurrent complaints relating to missing laundry items and noise levels in multi-occupancy rooms.

**Judgment:**
Substantially Compliant

---

**Outcome 16: Residents' Rights, Dignity and Consultation**

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

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

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

**Findings:**
The feedback on the pre-inspection questionnaires from residents and relatives was one of satisfaction with the service and care provided. Family, friends and community involvement was encouraged and relatives with whom the inspector spoke confirmed this. Residents and relatives described staff as "excellent" and "caring". Relatives stated that they felt their residents were safe and that the accessibility of the centre meant that older visitors could easily visit their relatives. In addition, residents had the freedom to go out to the town when necessary. For example, during the inspection nursing staff wheeled a wheelchair-dependent resident to the post office. Staff informed inspectors that the local community had raised funds for many of the recent improvements and that this group continued to fund raise to improve the lives of residents in the centre.

During the previous inspection not all residents had access to regular activity and recreation. On this inspection, inspectors found major improvements in the provision of
activities for residents. A storage room had been converted to an indoor conservatory/ 
garden room’, used for activities and visitors. Staff had been trained to facilitate a form 
of therapy called ‘imagination gym’. The “imagination gym” rooms were used for 
meditation and reminiscence. Each resident had a personal profile ‘My Day, My Way’ 
completed as part of their care plan, which highlighted the resident’s preferred activities. 
An external company provided group and one-to-one sessions on a Thursday and Friday 
and art class was held each Monday. Residents were seen to sing along with musical 
events, hosted by this external activity provider, during the inspection. This group also 
facilitated other activities included art, exercise sessions, newspaper reading, skittles 
and bingo. Resident’s were consulted with and participated in the organisation of the 
centre through resident meetings. These were facilitated by the aforementioned 
company every six weeks. Feedback was reviewed by management and results were 
communicated to residents at subsequent meetings. Posters were observed which 
promoted an external advocacy services for residents and relatives. Suggestion boxes 
were also available on walls in both the front and back buildings.

Inspectors saw evidence that residents' bedroom areas were personalised where space 
allowed. Personal photographs, some ornaments and art work were displayed around 
and near the beds. There were some small single rooms available which were suitable 
for any resident with low dependency needs. However, similar to previous inspection 
report findings living in multi-occupancy bedrooms negatively impacted on the privacy 
and dignity of residents. For example, the use of commodes, lack of walls in some 
bedroom areas, interlinked bedrooms and toilets which were too small for wheelchair 
access. Staff explained to inspectors that they did their best to preserve the privacy and 
dignity of residents within the confines of the restricted bed space available for each 
resident. For example, wardrobes were placed together to form a screen between beds 
in some of the larger shared bedrooms. However, some residents informed inspectors 
that they were kept awake at night when other residents called out. As highlighted on 
all previous inspections the multi-occupancy bedroom accommodation continued to be 
unsuitable in design and layout to ensure the privacy of residents. The design and layout 
also had a significant negative impact on residents as regards undertaking personal 
activities in private or speaking with visitors or doctors in private. The limited space 
together between residents’ beds also impacted negatively on the quality of life of residents for 
example, when attending to residents' intimate care needs especially if a resident was 
incontinent within the shared bedroom. In addition, inspectors had to walk past 
residents who were in bed to access and speak with residents attending activities or 
dining in the small 'conservatory' type living/dining rooms located through and beyond 
these bedrooms. Inspectors noted that there was regular traffic of visitors/staff passing 
by these residents' bed space all day. Personal belongings, clothes and books were seen 
stored on top of a number of residents' wardrobes. This indicated to inspectors that 
there was insufficient storage space to accommodate all residents' belongings, which 
also included personal washbasins and bags of laundry. While lockable bedside lockers 
had been purchased since the previous inspection, the complaints log indicated that 
smaller personal items continued to go missing. This was attributed to the lack of 
storage space as well as the increased risk associated with living in large multi-
occupancy bedrooms with the resultant unrestricted access to personal property items.

Inspectors observed that only a small number of residents ate their meals in the small 
day rooms adjoining the wards in the front and back buildings. This was due to the lack
of space available to residents as the communal dining/sitting areas were too small to accommodate all residents. In addition, residents said that they were used to having their meals by their beds in the multi-occupancy room as that was their normal daily routine. This institutionalised practise was compounded by the fact that dining/sitting rooms were too small and residents were happy to sit by the bed near to their possessions in the shared bedrooms for a large part of their day. On both days of inspection the majority of residents were seen by inspectors to be served their meals and eat them by their beds. Those residents who required assistance with meals were observed to be supported by staff in a discreet and careful manner. Residents also received visitors by their beds while other residents were in bed in the same bedroom.

Residents informed inspectors that they were facilitated to exercise their civil, political and religious rights. Mass was celebrated daily in the hospital chapel and this service could be broadcast to the ward. Residents were kept up dated about current affairs by staff interactions, the daily newspapers, radio and television. Resident’s informed inspectors that they were happy with newly purchased, large screen TV sets, although complaints were received with regard to noise levels, particularly in multi-occupancy cubicles where noise travelled across partitions. Inspectors observed that one resident was located a distance from the TV in one particular four-bedded bedroom bay. However, she could not hear the TV as there were a large group of visitors chatting to a relative in the adjoining bedroom bay. The noise travelled over the partition and this appeared to further confuse the resident who had been diagnosed with dementia.

An open visiting policy was in place at the centre and some space was available for residents to receive visitors in private. Larger groups were sometimes encouraged to use private rooms, so as not to disturb other residents in multi-occupancy rooms. However, this offer was not always taken up according to staff. Residents also had access to a portable private phone to make phone calls. A lap-top computer with internet connection was available to residents and staff stated that there was a plan in place for voluntary secondary school students on work placement in the centre to help residents navigate internet sites and search for issues of personal interest.

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

Findings:
There were outstanding actions from all previous inspections:

- The storage space for residents' personal clothing was inadequate overall.

This inspection findings:
Inspectors noticed that the clothes were stored neatly in the laundry, ready for return to residents. The person in charge advised inspectors that the marking system was in place to enable identification of residents' clothes. Residents and relatives, spoken with by inspectors, stated that they were happy with the way their clothing and personal belongings were managed. Inspectors observed that there was an inventory being kept of residents' personal items in the care plans of residents. These were seen to be signed by the resident or their representative.

However, inspectors observed that wardrobes were very small and the amount of personal property was limited due to this.
There were complaints about missing laundry and personal property items.

**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:**
Based on inspection findings inspectors were generally satisfied that the centre had sufficient staff with appropriate skills, qualifications and experience to meet the assessed needs of residents. However, additional staff to coordinate activities during the afternoon would enhance the lived experience of residents and alleviate pressure placed on staff when other staff took their breaks. For example, similar to findings on previous inspections, inspectors found only one staff member on duty between 14.00 and 15.00 in one ward area, as the second staff member was on an hour long break. This meant that there was only one staff member to attend to the needs of residents, do medications and paperwork as well as meet with any visitor, if required. The staff member stated that she would call a staff member from another ward if she required help attending to residents needs. Similar to findings on a previous inspection residents seemed to spend a long time alone in the afternoon if they were not attending an
activity of receiving a visit at this time. As identified on previous inspections a staff member dedicated to co-ordinating activities would have identified the need for residents to have interaction at times when staffing levels were low. Inspectors found that residents were delighted to speak with inspectors and were stimulated by the company at this time. This finding was particularly significant for those residents sitting by their beds or lying in their beds.

Inspectors viewed evidence that staff were recruited in accordance with good recruitment practice and in accordance with the requirements of Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. Garda vetting clearance for staff in accordance with the National Vetting Bureau Acts 2012 and 2016 was available. All staff nurses had up-to-date registration with An Bord Altranais agus Cnáimhseachas na hÉireann. Volunteers were Garda vetted and supervised appropriate to their level of involvement in the centre.

A programme of induction training had been established for staff. This either took place prior to commencement of employment or as soon as possible thereafter. A buddy system was also used during the first few days to help familiarise new staff with work practices, policies and procedures in the centre. Mandatory staff training was ongoing and included fire training, safeguarding, training in behaviour associated with the behaviour and psychological symptoms of dementia (BPSD) people moving and handling and infection control. Additional training included food hygiene, documentation, palliative care needs, medication management and cardio-pulmonary resuscitation (CPR). However, no official performance appraisal/supervision system was in place to communicate with staff on a one-to-one basis and identify good practice and training goals. The person in charge stated that a programme had been proposed but had not been implemented, as this was still under discussion with staff.

Staff meetings were scheduled on a regular basis. These included management meetings, general staff meetings and multi-task attendant meetings. These provided an opportunity to discuss relevant issues, share experiences and listen to feedback. Minutes of meetings reviewed by inspectors indicated that topics discussed included health and safety, medication errors, fire policy, podiatry, falls management, infection control and complaints.

**Judgment:**
Substantially 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:

Mary O'Mahony
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
**Provider’s response to inspection report**

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Midleton Community Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000579</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>28/09/2017</td>
</tr>
<tr>
<td>Date of response:</td>
<td>01/11/2017</td>
</tr>
</tbody>
</table>

**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:**
A comprehensive audit system had not been established to drive continual improvement and to ensure safety, effectiveness and consistency in care.

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

---

1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Please state the actions you have taken or are planning to take:
The audit system already in place will be modified to ensure a more comprehensive follow-up on findings.

Proposed Timescale: 28/02/2018

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:
The accommodation type available to individual residents was not clearly indicated in the Contract of Care as required under Statutory Instrument No. 293 of 2016.

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:
The specific type of accommodation will be included on all new contracts of care for all future admissions.
The current contracts of care will be amended for existing Residents.

Proposed Timescale: 31/12/2017

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:
A daily nursing note had not been documented for each resident to describe the nursing care afforded to residents in accordance with an .

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

Please state the actions you have taken or are planning to take:
Each resident will have a narrative note recorded on a daily basis commencing immediately.
This practice will be audited on an ongoing basis.
**Proposed Timescale:** 01/11/2017

**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:
- Equipment was seen to partially block fire exit doors including rollators and specialist bed screens which were located next to these doors. Due to the lack of space staff had to constantly remember to tidy them back against the beds.
- Most wardrobes were half-height and were not sufficient to store all residents' clothing and personal belongings.
- Distance to toilets from the bedroom areas.
- Limited number of toilets & bathrooms for hoists having to be moved out from the wall to access both sides for hoist use.
- Wardrobes clustered together in the middle of multi-occupancy rooms resulting in residents not having ready access to their personal possessions.
- Difficult to identify individual wardrobes.
- Insufficient communal space particularly dining and sitting space: there was a lack of availability of suitable dining rooms which promoted privacy for residents: for example, some dining areas were located in 'hall-like' areas which were accessible to passing visitors, staff or other personnel
- Visitors/other residents/inspectors were required to walk through bedrooms residents in bed, some of whom were unwell at the time of inspection, to get to communal areas for visits

4. **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:
Equipment and screens will be stored appropriately and further storage options are being explored.
The layout of the current dining/sitting areas is being reviewed with view to enhancing the privacy within these areas.
The development of the Centre will be advanced as a Public Private Partnership. Site investigations are already complete. The next stage will be the planning of a 50 bedded unit onsite. The sum of €10.3 million has been allocated for this project. It is expected to be complete by December 2020.

Proposed Timescale: December 31st 2017 and end of 2020

**Proposed Timescale:** 31/12/2020

**Theme:**
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The registered provider had failed to ensure that the premises of the designated centre were appropriate to the number and needs of the residents of that centre:
- Use of commodes where there were no fixed barrier or wall existed to afford privacy to a resident: for example, a curtain was in used as a barrier which did not prevent noise, odour or promote the resident's dignity and privacy where other residents shared a sleeping bay or visitors could pass alongside the screening curtain when walking in the hallway.
- Inadequate size of toilets for wheelchair users.

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

Please state the actions you have taken or are planning to take:
The purchase of more mobile screens is underway in order to enhance the privacy of Residents.
We are also exploring the possibility of modifying the dividing partitions in consultation with the estates department.
The development of the Centre will be advanced as a Public Private Partnership. Site investigations are already complete. The next stage will be the planning of a 50 bedded unit onsite. The sum of €10.3 million has been allocated for this project. It is expected to be complete by December 2020

Proposed Timescale: December 31st 2017 and end of 2020

Proposed Timescale: 31/12/2020

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 actions taken, the final outcome of the complaint, dates of follow-up or whether the complainant was satisfied with the outcome was not always recorded.

6. Action Required:
Under Regulation 34(1)(f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.
Please state the actions you have taken or are planning to take:
Complaints and outcomes will be monitored more closely going forward and all outcomes recorded on the form.

**Proposed Timescale:** 01/11/2017

<table>
<thead>
<tr>
<th>Outcome 16: Residents' Rights, Dignity and Consultation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theme:</strong> Person-centred care and support</td>
</tr>
<tr>
<td><strong>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</strong></td>
</tr>
<tr>
<td>- residents did not have a choice of individual TV programmes or radio programme.</td>
</tr>
<tr>
<td>- residents did not have a choice to go to the dining rooms as they were small and not conducive to a social gathering due to lack of space and suitable dining furniture</td>
</tr>
<tr>
<td>- not all residents had a choice of single bedroom accommodation if required</td>
</tr>
<tr>
<td><strong>7. Action Required:</strong></td>
</tr>
<tr>
<td>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.</td>
</tr>
<tr>
<td>Please state the actions you have taken or are planning to take:</td>
</tr>
<tr>
<td>We are currently investigating and about to trial Bluetooth headsets to enable Residents to listen to TV without the need for others to hear if they do not wish to.</td>
</tr>
<tr>
<td>Ultimately the new build will enable Residents to exercise their right to choice.</td>
</tr>
<tr>
<td><strong>Proposed Timescale:</strong> Immediate and by end of 2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Proposed Timescale:</strong> 31/12/2020</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theme:</strong> Person-centred care and support</td>
</tr>
<tr>
<td><strong>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</strong></td>
</tr>
<tr>
<td>Residents were unable to undertake personal activities in private due to the predominance of multi-occupancy bedrooms, lack of communal sitting room/dining room space and the provision of suitable rooms for private visits and other private activity.</td>
</tr>
<tr>
<td><strong>8. Action Required:</strong></td>
</tr>
<tr>
<td>Under Regulation 09(3)(b) you are required to: Ensure that each resident may undertake personal activities in private.</td>
</tr>
<tr>
<td>Please state the actions you have taken or are planning to take:</td>
</tr>
<tr>
<td>We are exploring the option of partitioning off the dining/sitting room areas to enhance</td>
</tr>
</tbody>
</table>
the privacy therein. This will be done in consultation with the estates department.

<table>
<thead>
<tr>
<th>Proposed Timescale: 31/01/2018</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theme:</strong> Person-centred care and support</td>
<td></td>
</tr>
</tbody>
</table>

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Residents were unable to choose personal TV programmes or radio programme.

**9. 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:**
Headsets are soon to be available to trial to enable Residents who choose to listen to TV and radio may do so without impacting on others. Newspapers are available on each unit on a daily basis.

<table>
<thead>
<tr>
<th>Proposed Timescale: 31/01/2018</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theme:</strong> Person-centred care and support</td>
<td></td>
</tr>
</tbody>
</table>

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Suitable communal facilities were not always available for a resident to receive a visitor and a suitable private area which was not the resident’s bedroom was not always available.

**10. 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:**
The use of further available private space is constantly being explored. Currently areas adjacent to the Physiotherapy department and also the lift lobby are being considered for decoration to make these areas more attractive for Residents and their visitors to avail of.

<table>
<thead>
<tr>
<th>Proposed Timescale: 31/03/2018</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outcome 17: Residents' clothing and personal property and possessions</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Theme:</strong> Person-centred care and support</td>
<td></td>
</tr>
</tbody>
</table>
The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Each resident did not have access to or retain control over all his or her personal property and possessions due to the location of wardrobes away from the bedside.

11. **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:**
Where possible Residents’ storage facilities will be placed as close as possible to their bed space.

Proposed Timescale: Ongoing and by end of 2020

<table>
<thead>
<tr>
<th>Proposed Timescale: 31/12/2020</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theme:</strong> Person-centred care and support</td>
</tr>
</tbody>
</table>

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The small size of wardrobes limited the space available to store adequate personal items.
The lack of space in the bedrooms meant that normal size wardrobes were not available to residents.

12. **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:**
More innovative means of storage is always being explored and further lockable storage has been ordered. Ultimately this issue will be fully addressed with the new purpose built unit.

Proposed Timescale: ongoing and by end of 2020

<table>
<thead>
<tr>
<th>Proposed Timescale: 31/12/2020</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outcome 18: Suitable Staffing</strong></td>
</tr>
<tr>
<td><strong>Theme:</strong> Workforce</td>
</tr>
</tbody>
</table>

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
No supervision or appraisal system was in place to formally review staff or identify training goals. A programme had been proposed but had not been implemented.
13. **Action Required:**
Under Regulation 16(1)(b) you are required to: Ensure that staff are appropriately supervised.

**Please state the actions you have taken or are planning to take:**
Steps are currently being taken to introduce an appraisal system. Discussions are currently ongoing with the Human resources department in the local HSE area.

**Proposed Timescale:** 28/02/2018