Health Information and Quality Authority
Regulation Directorate

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

Centre name:	Dungarvan Community Hospital
Centre ID:	OSV-0000594
Centre address:	Dungarvan, Waterford.
Telephone number:	058 20900
Email address:	paula.french@hse.ie
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Barbara Murphy
Lead inspector:	Gemma O'Flynn
Support inspector(s):	Ide Cronin
Type of inspection	Unannounced
Number of residents on the date of inspection:	85
Number of vacancies on the date of inspection:	31

About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

▪ Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
▪ Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

▪ to monitor compliance with regulations and standards
▪ to carry out thematic inspections in respect of specific outcomes
▪ following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
▪ arising from a number of events including information affecting the safety or wellbeing of residents.

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.

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

Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
14 February 2017 07:45	14 February 2017 18:10

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

Outcome	Our Judgment
Outcome 02: Governance and Management	Non Compliant - Moderate
Outcome 06: Absence of the Person in charge	Compliant
Outcome 07: Safeguarding and Safety	Non Compliant - Moderate
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 09: Medication Management	Substantially Compliant
Outcome 11: Health and Social Care Needs	Non Compliant - Moderate
Outcome 12: Safe and Suitable Premises	Non Compliant - Moderate
Outcome 16: Residents' Rights, Dignity and Consultation	Compliant
Outcome 18: Suitable Staffing	Non Compliant - Moderate

Summary of findings from this inspection

This report sets out the findings of a one day, unannounced inspection the purpose of which was to monitor ongoing compliance with the regulations. Actions following the previous inspection were also followed up. Of the eight actions resulting from the previous inspection, four had not been fully addressed. These related to hazard identification, documentation and premises.

As part of the inspection process inspectors met with residents, relatives, staff, senior management and the provider nominee. Resident and relatives views were elicited. Practices were observed and documentation was reviewed in four of the five units within the centre.

Prior to the inspection, HIQA had received unsolicited information which expressed concerns regarding staffing issues, activity provision and lack of choice for residents, lack of say for residents in their daily lives. On the day of the inspection, the concern was partially upheld in relation to staffing issues. However, inspectors found evidence of consultation with residents, there was numerous activities on offer on the day of the unannounced inspection which residents from all parts of the centre were seen to attend. Residents and relatives confirmed that they had access to good

care from good staff and that they had choice in how their spent their day. Residents who spoke with inspectors said that they felt safe in the centre and would not be afraid to make a complaint if they had one. At the start of the inspection, the provider and person deputising for the person in charge confirmed that staffing resources were an issue due to staff shortages. Staff who spoke with inspectors were consistent in their reports of staffing shortages. All staff who spoke with inspectors said that management were approachable if they had any concerns and were generally responsive to issues raised.

Premises issues were ongoing and discussed in detail under the relevant outcome in the report. A condition of registration to refurbish St. Endas and St. Anne's by August 2016 was not fully complied with, in that some minor outstanding works were required before the units were suitable for occupation. The provider was requiested to notify HIQA when these works were completed in order to remove the condition of registration.

Areas of non compliance were identified over the course of the inspection and judgments in this regard are set out in the table above and discussed in detail throughout the report and in the associated action plan.

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):
No actions were required from the previous inspection.

Findings:
A condition of registration to refurbish St. Endas and St. Anne's by August 2016 was not fully complied with, in that some minor outstanding works were required before the units were suitable for occupation. This is discussed further under outcome 12.

Overall, inspectors found that there was governance arrangements in place, however, issues pertaining to resources such as staffing required action to ensure that there was adequate contingency plans in place for unexpected short term absences.

Inspectors found that some final works were required before the units were fit for occupation. They requested confirmation from the provider that this work was undertaken in order to remove the condition of registration.

There was a clearly defined management structure in place that identified who was in charge, who was accountable and what the reporting structure was. Staff who spoke with inspectors were able to describe the management system.

At the time of the inspection, the person in charge was on leave and deputising arrangements were in place. The centre was usually staffed with a person in charge who was supported by two assistant directors of nursing. However, the assistant director of nursing who was deputising for the person in charge, was also still required to discharge the role of assistant director of nursing as well as her deputising duties. The other assistant director of nursing post was vacant at the time of the inspection. The provider had made some provisions by appointing two clinical nurse managers to support the assistant director of nursing and the provider nominee also stated that she based herself in the centre two days per week to offer additional support.

Short term staffing resources required review. For example, on the day of inspection, a

member of staff was not available for their shift and this staff member was not replaced on the rota. Inspectors saw evidence that one unit was operating without a full complement of staff and staff were borrowed from another unit thus leaving a deficit on what was a fully staffed unit. The assistant director of nursing confirmed that absent staff members were not always replaced with staff of the same grade, for example, nursing staff absences were often covered by health care assistants. Therefore, the assessed staffing numbers required as per the centre's own roster were not always fulfilled.

The provider nominee confirmed that there were 15.5 vacant nursing posts in the centre. To make allowances for this, the centre had reduced its capacity for admissions and were in the process of reducing this by a further 10 beds to ensure the centre was adequately resourced from a staffing perspective. A 'work to rule' action was in place in the centre since November 2016 due to staff shortages. The 'work to rule' was implemented by staff included not answering phones or completing all administrative work.

Based on the evidence set out above, inspectors formed the judgment that there was inadequate staffing resources available in the centre at all times based on the centre's own assessment of staffing needs and inability to fulfil same at all times.

A management quality system was in place to review key performance indicators. A spreadsheet demonstrated compliance rates in each matter examined over a twelve month period. For example, a medication administration audit showed that compliance had improved from 90 per cent in January 2016 to 97 per cent in December 2016. An audit of nursing care plan showed compliance had improved from 70 per cent at the start of 2016 to 88 per cent at the year end. Inspectors were informed that the 'work to rule' was impacting on the management quality system as monthly data was not being relayed to senior management for analysis and review which meant that the assistant director of nursing was manually retrieving such data.

Inspectors found that the documentation for audits completed could be improved so that it clearly summarised the specific findings of each audit and clearly identified the action plan in place to address areas that required development. For example, upon review of the documentation provided to inspectors, it was not possible to identify trends across the centre or if previously addressed matters recurred throughout the year. This was discussed in detail with the assistant director of nursing before the close of the inspection.

An annual review for 2016 in draft form was given to inspectors, the provider nominee stated that this was awaiting sign off by relevant departments within the organisation. The draft copy contained a review of 2016 including the annual occupancy, interior and exterior improvements, training, incident review and quality improvement plans for the coming year.

There were arrangements in place to consult residents via a monthly residents' meeting forum. A satisfaction survey was kept adjacent to the suggestion boxes on each 'unit', however, the assistant director of nursing stated that these were infrequently completed and did not elicit significant feedback.

Judgment:
Non Compliant - Moderate

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

Theme:
Governance, Leadership and Management

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

Findings:
HIQA had been informed of the absence of the person in charge and deputising arrangements were in place to cover her absence. The person deputising for the person in charge was a senior key member of staff who was able to demonstrate knowledge of the regulations and their associated responsibilities.

Judgment:
Compliant

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

Theme:
Safe care and support

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

Findings:
There was a policy in place for, the prevention, detection and response to abuse. According to the centre's training matrix, 98 per cent of staff had received up to date training, and two per cent were awaiting refresher training. Staff who spoke with inspectors demonstrated on knowledge about the different types of abuse and their responsibilities for reporting any suspicions or witnessing of abuse. All staff who spoke with inspectors said that they would not hesitate to report any concerns in that regard. Residents who spoke with inspectors said that they felt safe in the centre and that the

staff treated them well. Relatives stated that they were satisfied that their loved ones were treated respectfully in the centre and that they were safe there.

The systems to safeguard residents' money were not examined on this inspection.

There was a policy on, and procedures in place, for working with residents who required additional support for responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). The centre had two specific units dedicated to the care of residents with a dementia as well as accommodating residents with a dementia throughout the centre. There was a policy on the management of responsive behaviours. Staff spoken with were familiar with resident's behaviours and could describe particular interventions well to the inspector for individual residents. There was evidence staff had completed training in responsive behaviours. Where residents had specialist care needs there was evidence of links with external services to offer additional expertise. For example, for residents who required additional support to maintain good mental health, there was evidence in care plans of links with the mental health services to review residents and their medication to ensure optimum health.

A policy was in place for physical restraint, this was shown to inspectors in one of the units of the centre and was dated 2011 and therefore required review to meet the regulatory requirement of three yearly reviews. Overall, a restraint free environment was promoted, however, where restraint was in place inspectors found that it was not always in line with national policy nor the centre's own policy. For example, there was no evidence of multi-disciplinary team (MDT) involvement in the decision to implement restraint. Key staff were unaware of the requirement for MDT input and inspectors found gaps in staff knowledge regarding the role of next of kin in the decision to use restraint and regarding the national policy on restraint. Bedrail safety checks and removal schedules were in place. However, an inspector observed that these were not consistently recorded across the different units which impinges on residents' safety. A risk balance assessment tool was completed where restraint was implemented and was accompanied by an appendix that outlined the alternatives to restraint that had been considered. Low-low beds and sensor alarms were available as alternatives to physical restraint.

Judgment:
Non Compliant - Moderate

Outcome 08: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Safe care and support

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

implemented.

Findings:
The centre had policies and procedures relating to health and safety. An up to date health and safety statement was shown to inspectors at the feedback meeting at the close of inspection. The risk management policy included the items set out in the regulations. However, as noted with other policies, it had not been reviewed three yearly, which is a regulatory requirement. There was a plan in place for dealing with emergencies.

Measures were in place to investigate and learn from serious incidents / adverse events involving residents. The provider was awaiting the outcome of an external review of a significant adverse event. The completion date for the investigation was January 2017; however, at the time of the inspection, the provider nominee stated that the completed investigation report would not be available until March 2017. An internal review had taken place in the interim and provisional learning had been identified. The assistant director of nursing said these learning's resulted in additional medication training, training regarding high risk medications and the incident was addressed at ward level. Incident reports were completed and forwarded to management for further analysis and review.

A risk register was maintained, however, the hazard identification process had not identified all relevant issues, such as a number of fire doors being propped open by inappropriate means, for example by the use of chairs or bins. Appropriate identification of hazards was an issue of non compliance in the centre's previous inspection in April 2016.

Satisfactory procedures were in place for the prevention and control of healthcare associate infections. Inspectors spoke with household staff who recounted safe practices in their daily cleaning routines and demonstrated knowledge of what additional measures would be taken if an outbreak of infection were to occur. Although inspectors were satisfied in regards to staff knowledge on the day of inspection, it was not evident that staff were aware that there were specific policies relating to infection control and prevention should they require further guidance, particularly in an outbreak. The trolley being used to transport cleaning supplies, cloths, mops et cetera was seen to be visibly dirty. This was relayed to the provider and assistant director of nursing at the close of the inspection. Infection control practices were an issue identified in the centre's previous inspection in April 2016.

Suitable fire equipment was provided and fire exits were unobstructed. Service records were up to date. Staff were trained and were able to explain what to do in the event of a fire. Fire drill records for May and November 2016 were available for review. These gave good detail of the drill itself, what had gone well and what learnings arose from conducting the drill. Staff who spoke with inspectors discussed the format of the drills and said that they found them very beneficial.

Judgment:
Non Compliant - Moderate

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

Theme:
Safe care and support

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

Findings:
Practices and procedures associated with the ordering, prescribing, and administration of medicines to residents had improved since the previous inspection. There were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents. The requirements from the previous inspection were addressed to ensure all medicines were administered in accordance with the directions of the prescriber.

Medicines were stored securely in the centre in medicine trolleys or within locked storage cupboards. A secure fridge was available to store all medicines and prescribed nutritional supplements that required refrigeration, and temperatures were checked. Controlled drugs were stored securely within a locked cabinet and balances of all controlled drugs were recorded in the controlled drugs register.
Nursing staff checked and documented the balances of all controlled drugs twice daily at the change of shift. The inspector checked a stock balance and found that it was correct. Nursing staff were familiar with the procedure for disposing of unused or out of date medicines.

Medicine prescriptions and administration records were complete in accordance with professional standards in a sample reviewed by an inspector. There were some systems in place within the centre for reviewing and monitoring medication management practices, including medication management audits that reviewed administration records, prescription sheets and storage of medicines within the centre. Inspectors recommended that these audits could be further improved with an input from the pharmacy. While residents' medicines were dispensed as needed, improvement was required to ensure the pharmacy service was facilitated to meet their obligations as required by the regulations. Staff told the inspector that the pharmacist did not routinely come to the different units. This had been identified on the previous inspection also.

Judgment:
Substantially Compliant

Outcome 11: Health and Social Care Needs
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care.

The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

Theme:
Effective care and support

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

Findings:
Overall, inspectors were satisfied that residents had access to medical treatment and the services of allied health.

A general practitioner (GP) visited the centre daily and an out of hours service was available when required. There was allied health professionals available onsite and access to these services was via referral. Records indicated that residents had access to these services such as speech and language therapist or dietitian reviews. A chiropodist was seen to visit the centre over the course of the unannounced inspection.

Efforts were made to deliver care that encouraged the prevention and early detection of ill health such as routine weights and vital sign observations. However, it was not clear what the centre's policy was in regards to the frequency of such checks as depending on the records reviewed in different units, some were undertaken three monthly and some were monthly. Health promotion pamphlets were displayed in high traffic areas.

Resident files were reviewed and demonstrated that comprehensive assessments were carried out at least four monthly. These included assessments such as dependency levels, risk of falls, skin integrity, pain and nutrition. Care plans were in place where specific needs had been identified and inspectors saw that some of these were person centred in their approach, such as a care plan reviewed for a resident requiring end-of-life care.

However, the standard of care plans was inconsistent across different units and required review to ensure that they clearly directed the specific care needs of each individual resident. For example, a care plan for a resident at high risk of falls was generic and didn't adequately direct care interventions such as providing support for anxiety. A care plan to meet the nutritional needs of a resident did not accurately reflect a speech and language therapist's recommendations and gave conflicting guidance regarding the modification of the resident's diet. Instructions for the monitoring of a residents blood sugar levels were inadequate and although records did indicate that levels were checked two monthly, it was not evident that this was based on adequate care instruction in the care plan documentation or on the resident's individual treatment regiment or individual circumstances.

Improvements were required in the involvement of residents and or their next of kin in

the development of care plans. The assistant director of nursing demonstrated an awareness of this and it had been action following the centre's previous inspection.

Records were maintained regarding transfer or discharge of residents from the centre.

Judgment:
Non Compliant - Moderate

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

Theme:
Effective care and support

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

Findings:
The inspectors viewed the accommodation provided for residents in all units of the centre.

Resident accommodation was primarily provided in two-bedded, four-bedded and six-bedded rooms and although efforts had been made to personalise bedroom spaces, an institutional, ward like atmosphere prevailed in many areas.

Since the previous inspections, the provider had undertaken to refurbish St. Ann's Ward and St. Enda's Ward and a condition had been placed on their registration that this be completed by 17th July 2016. A short extension for the completion of works had been applied for by the provider and this was granted up until 29th August 2016. HIQA had since been advised that these works were completed.

Inspectors visited the units to establish that the required refurbishment works were completed to the required standard. They found that some final works were required before the units were fit for occupation. They requested confirmation from the provider that this work was undertaken in order to remove the condition of registration.

Upon inspection of St. Enda's, inspectors observed that the required works had been undertaken. New flooring had been laid and the unit had been freshly painted. Whilst inspectors acknowledge that a significant portion of the works had been completed, additional works were required before residents could move in. For example, bedroom areas were still set up for six beds instead of four. Privacy screening and ceiling hoists

were not in place. A small corridor area required new flooring. Some beds were awaiting overbed lights to be fitted. At the start of the inspection, the provider nominee informed inspectors that St. Enda's ward had not reopened post refurbishment works due to staff shortages.

Inspection of St. Ann's unit evidenced that works had been undertaken and a six bedded ward had been reduced to four. However, there remained two beds within very close proximity of each other and inspectors determined that this impinged on the dignity and privacy of residents. For example, there wasn't sufficient space to sit and relax in the bed space should a resident wish to do so or for family to spend time with their loved one in their bedroom area without intruding on the space of the adjacent bed.

St. Ann's and St. Michael's units were dedicated to providing care to residents with a dementia. Significant efforts had been made to make these areas homely and relaxing. Familiar furniture and homely soft furnishings were used. Signage marking familiar landmarks was situated throughout the centre and relaxing 'scene-scapes' were painted on the walls. St. Ann's ward had recently had a sensory room added to further aid residents to relax.

The sitting and dining room in St Francis's unit was inadequate in size for all residents to dine comfortably if they so wished. St Francis's unit had 23 residents residing there and the sitting and dining room could not accommodate all residents. The provider stated that there were plans in place to reduce the maximum occupancy level from 23 to 20 residents; however, communal space would remain inadequate for 20. There were multi-occupancy rooms comprising six beds on this unit. Inspectors found that this arrangement did not meet the privacy and dignity needs of all residents. For example, inspectors observed residents asleep in their beds, without privacy screening being pulled, whilst residents in adjacent beds sat in close proximity due to space restrictions. Storage on this unit was also an issue with chairs and mobility equipment stored in the corridors.

Other units such as St. Vincent's unit and Sacred Heart Unit provided more spacious surroundings. St. Vincent's ward lacked the homely atmosphere of other parts of the centre. Efforts had been made to personalise bedroom spaces and communal areas throughout the centre as a whole. Resident art work and photographs was displayed. There were bright and spacious areas throughout the centre to meet with family or friends. An activation room was used to hold parties or events.

Grab rails had been fitted in communal areas since the previous inspection.

Judgment:
Non Compliant - Moderate

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:
Staff interactions were observed and were, overall, seen to be respectful, caring and genuine. Residents confirmed that staff treated them well and good conversations were observed between residents and staff. Relatives who spoke with inspectors said that it was like being part of an extended family.

However, some institutionalised practices were observed over the course of the inspection such as inappropriate terminology when referring to residents and or their care interventions. Words such as 'patient' and 'cotsides' were frequently used. Practices such as standing to assist residents who required support to eat their meals were observed and were not addressed by senior staff in the vicinity. This is actioned under outcome 18: staffing. Privacy issues relating to premises are discussed and actioned under outcome 12.

There were arrangements in place to consult residents. Residents' meetings were held monthly and discussed matters such as advocacy, nutrition, maintenance and activities. The centre could accommodate 116 residents, attendance at these meetings ranged between three and thirteen residents. Inspectors noted on reading meeting minutes that residents were reminded to utilise suggestion boxes on each unit, however, the assistant director of nursing stated that use of suggestion boxes was infrequent. A resident who spoke with inspectors said that they did not know what plans were in place for the reopening of a closed ward in which they had resided and said that although they had been consulted in the original move, they would like to be updated on ongoing plans. For those who did not or could not attend, there was no alternative system to formally elicit feedback and update residents, this was discussed with the person in charge.

Residents were facilitated to exercise their civil, political and religious rights. Residents could attend mass in the centre as there was a church on site.The inspectors saw that residents had access to televisions and radios. Newspapers were widely available as observed by inspectors. Life stories were completed for residents as observed by an inspector. There were no restrictions on visitors and residents could meet visitors in private. On the day of inspection visitors were observed spending time with residents in the private spaces available. Voting rights were respected, and the activities coordinator outlined the arrangements in place to inspectors. On the dementia unit the nurse manager showed the inspector the visual aids that were used for residents in relation to voting. Inspectors saw that residents had access to televisions and radios. Newspapers were widely available and the main news topics were discussed each day with residents.

There were opportunities for all residents to participate in activities. There was a structured program of activities in place which was facilitated by two activities

coordinators, seven days per week and up to 20:00hrs four days per week. An inspector spoke with the activity coordinators who confirmed the range of activities in the weekly program and they were well informed. They understood the needs of residents with dementia or responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) and were creative to ensure residents were provided with activities that met their interests and capabilities. With the support of care staff they organised and facilitated a variety of meaningful and interesting activities for residents in the centre over a seven day period such as cinema nights, men's club and music.

Residents were observed to enjoy the group activities and were actively engaged in them. On the day of inspection inspectors observed many residents and relatives enjoying a valentines dance with live music provided. Residents with needs that were better met on a one to one basis were provided with a sensory based activation programme such as reminiscence, reality orientation or music used to enhance communication. The centre had purchased a minibus through local fund raising. An inspector established from speaking with residents and staff that opportunities to maintain personal relationships with family and friends in the wider community was encouraged. Arrangements were provided for residents to attend family occasions and opportunities to socialise and link with the wider community by arranged outings family parties/occasions.

An inspector spoke with a group of residents from different units. All expressed satisfaction with the overall care and services provided. There were notice boards available throughout the centre providing information to residents and visitors. There were details of independent advocacy services that were available to the residents displayed on the notice boards

Judgment:
Compliant

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

Theme:
Workforce

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

Findings:
Inspectors found that a full complement of staff, based on the centre's own assessment of staffing need, was not available at all times.

There was an adequate complement of staff with the required skills and experience rostered to meet the assessed needs of residents at the time of this inspection, taking account of the purpose and size of the designated centre. The staffing complement included nursing, activities coordinators, catering, housekeeping, administration and maintenance staff. However, on the day of inspection, one staff member was unavailable and management were unable to provide cover for the absence. As outlined and actioned under Outcome 2 staff absences were not always replaced with a like for like staff grade and the centre had 15.5 wholetime equivalent (WTE) posts vacant.

There was a clear organisational structure and reporting relationships in place. There were designated clinical nurse manager (CNM) posts of responsibility on the units for the supervision of care and services to residents and the supervision and direction of staff. The inspector saw records of regular meetings between the nurse managers and senior nursing management at which operational and staffing issues were discussed. In discussions with staff, they confirmed that they were supported to carry out their work by the nurse manager and person in charge.

There was a varied programme of training for staff. Records viewed confirmed there was an ongoing program of mandatory training in areas such as safeguarding vulnerable adults, fire safety, infection control and safe moving and handling. The assistant director of nursing confirmed that 98 per cent of staff had received safeguarding training and two per cent were due refresher training. The provider nominee was trained to deliver such training.

Staff also had access to a range of education, including training in specific dementia related courses. Some staff nurses had lead roles for specialist areas that included end of life, hand hygiene, adult protection, dementia care and were responsible for ensuring adherence to good practice standards and training on these topics.

However, inspectors found that additional training was required. As already discussed, under outcome 17, some institutionalised practices were observed over the course of the inspection such as inappropriate terminology when referring to residents and or their care interventions. Words such as 'patient' and 'cotsides' were frequently used. Practices such as standing to assist residents who required support to eat their meals were observed and were not addressed by senior staff in the vicinity.

There was a policy for the recruitment, selection and vetting of staff. This was evidenced by a review of staff files. A sample of staff files reviewed by an inspector contained all matters required by Schedule 2 of the regulations. The nurse deputising for the person in charge confirmed that all staff working in the centre had Garda vetting. A record was maintained of staff nurses' current registration details with the professional body.

An inspector saw that arrangements for supervision and development of staff were in

place. These included induction training, probationary period, an annual appraisal system had commenced, staff meetings and observation of care practice

Judgment:
Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Gemma O'Flynn
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	Dungarvan Community Hospital
Centre ID:	OSV-0000594
Date of inspection:	14/02/2017
Date of response:	09/03/2017

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:
A condition of registration to refurbish St. Endas and St. Anne's by August 2016 was not fully complied with, in that some minor outstanding works were required before the units were suitable for occupation.

1. Action Required:
Under Regulation 4 of the Health Act 2007 (Registration of Designated Centres for

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

Older People) Regulations 2015 you are required to: Provide all documentation prescribed under Regulation 4 of the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015.

Please state the actions you have taken or are planning to take:
Only outstanding works to be complete is the installation of Hoists. Furnishings and deep clean will follow immediately on hoist installation.

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:
Inspectors formed the judgment that there was inadequate staffing resources available in the centre at all times based on the centre's own assessment of staffing needs. For example:

Staff were borrowed from one 'unit' to rectify short staffing on another 'unit'.
Absences were not always covered with a 'like for like' grade of staff.
There were 15.5 vacant nursing posts in the centre.

2. Action Required:
Under Regulation 23(a) you are required to: Ensure the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.

Please state the actions you have taken or are planning to take:
Taking consideration to the staffing issues in the centre, 22 beds have been temporarily closed. This is to ensure that appropriate staffing is available to comply with requirements at each ward level. All vacant posts are approved for filling with National and local recruitment campaigns in place.

Proposed Timescale: 08/03/2017

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:
Where restraint was in place inspectors found that it was not always in line with national policy nor the centres own policy.

For example:
There was no evidence of multi-disciplinary team (MDT) involvement in the decision to

implement restraint.
Key staff were unaware of the requirement for MDT input and inspectors found gaps in knowledge regarding the national policy on restraint and the role of next of kin in the decision to use restraint.
Gaps were noted in safety checklist documentation sampled across different units.

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 training on restraint has commenced to ensure staff adheres to National Policy.
MDT involvement in restraint decisions continue to be applied.
Continued audit in this area on a monthly basis
Restraint bundle to be rolled out in all areas to ensure compliance

Proposed Timescale: 31/03/2017

Outcome 08: Health and Safety and Risk Management

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all hazards in the centre were identified. For example, on the day of inspection a number of fire doors were held open by inappropriate means.

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

Please state the actions you have taken or are planning to take:
All hazard notification have been reviewed and risk assessments completed.
Key part of agenda at Management Team Meetings.

Proposed Timescale: 10/03/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no evidence that the risk management policy had been reviewed on a three yearly basis.

5. Action Required:
Under Regulation 26(1) you are required to: Ensure that the risk management policy set out in Schedule 5 includes all requirements of Regulation 26(1)

Please state the actions you have taken or are planning to take:
Risk management has been reviewed to ensure that all items in Schedule 5 includes all requirements of Regulation 26(1)
Documented evidence of reviews in place.

Proposed Timescale: 06/03/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all staff who spoke with inspectors were aware that there were centre specific policies guiding the management of infection control and prevention practices.
The trolley to transport cleaning supplies was visibly dirty.

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

Please state the actions you have taken or are planning to take:
Further training is to commence for all staff to ensure that they are aware of all procedures pertaining to infection control of healthcare associated infections

Proposed Timescale: 30/03/2017

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:
While residents' medicines were dispensed as needed, improvement was required to ensure the pharmacy service was facilitated to meet their obligations as required by the regulations. Staff told the inspector that the pharmacist did not routinely come to the different units.

7. Action Required:
Under Regulation 29(2) you are required to: Facilitate the pharmacist concerned in meeting his or her obligations to a resident under any relevant legislation or guidance

issued by the Pharmaceutical Society of Ireland.

Please state the actions you have taken or are planning to take:
With immediate effect, the pharmacist will play a more key role in the Multidisciplinary Team at ward level regarding medication management.

Proposed Timescale: 14/03/2017

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:
The standard of care plans was inconsistent across different units and required review to ensure that they clearly directed the specific care needs of each individual resident.

There was insufficient evidence to demonstrate that residents and or their next of kin were involved in the review and development of care plans.

8. 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:
A plan is in place to ensure that the care plan review process makes more provision for the inclusion of residents and families as appropriate.

Proposed Timescale: 31/03/2017

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 refurbishment works on St. Enda's unit were not fully completed.

The layout of the four bedded room in St. Ann's required review as there remained two beds within very close proximity of each other and inspectors determined that this impinged on the dignity and privacy of residents. For example, there wasn't sufficient space to sit and relax in the bed space should a resident wish to do so or for family to spend time with their loved one in their bedroom area without intruding on the space of

the adjacent bed.

The sitting and dining room in St Francis's unit could not accommodate all residents if they so wished to dine / spend time there.

There were multi-occupancy rooms comprising six beds on St. Francis's unit. Inspectors found that this arrangement did not meet the privacy and dignity needs of all residents. For example, inspectors observed residents asleep in their beds, without privacy screening being pulled, whilst residents in adjacent beds sat in close proximity due to space restrictions. Storage on this unit was also an issue with chairs and mobility equipment stored in the corridors.

9. 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:
Reorganisation of beds has taken place in St Ann's Ward to ensure that bed space allow increased privacy to residents.

3 beds have been removed from 6 bedded and 4 bedded area to allow privacy and dignity for residents.

A Plan is in place to remove partition area in sitting room area to create more space for dining area

Proposed Timescale: 20/03/2017

Outcome 18: Suitable Staffing

Theme:
Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
On the day of inspection, one staff member was unavailable and management were unable to provide cover for the absence.
Therefore, inspectors found that a full complement of staff, based on the centre's own assessment of staffing need, was not available at all times.

10. 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:
Taking consideration to the staffing issues in the centre, 22 beds have been temporarily

closed. This is to ensure that appropriate staffing are available to comply with requirements at each ward level. All vacant posts approved for filling with National and local recruitment campaigns in place.

Proposed Timescale: 30/05/2017

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some institutionalised practices were observed over the course of the inspection such as inappropriate terminology when referring to residents and or their care interventions. Words such as 'patient' and 'cotsides' were frequently used.

Practices such as standing to assist residents who required support to eat their meals were observed and were not addressed by senior staff in the vicinity.

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

Please state the actions you have taken or are planning to take:
Further person centred care training is been sourced for all staff to address the main issues above

Proposed Timescale: 30/04/2017