

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Dunmanway Community Hospital
Centre ID:	OSV-0000599
Centre address:	Dunmanway, Cork.
Telephone number:	023 884 5102
Email address:	berm.power@hse.ie
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Lead inspector:	Caroline Connelly
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	23
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration renewal decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
17 January 2018 10:00	17 January 2018 18:15
18 January 2018 09:00	18 January 2018 16:50

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

Outcome	Our Judgment
Outcome 01: Statement of Purpose	Compliant
Outcome 02: Governance and Management	Compliant
Outcome 03: Information for residents	Compliant
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Substantially Compliant
Outcome 06: Absence of the Person in charge	Compliant
Outcome 07: Safeguarding and Safety	Compliant
Outcome 08: Health and Safety and Risk Management	Compliant
Outcome 09: Medication Management	Compliant
Outcome 11: Health and Social Care Needs	Compliant
Outcome 12: Safe and Suitable Premises	Non Compliant - Major
Outcome 16: Residents' Rights, Dignity and Consultation	Non Compliant - Moderate
Outcome 18: Suitable Staffing	Non Compliant - Moderate

Summary of findings from this inspection

This report sets out the findings of an announced registration renewal inspection. The provider had applied to renew their registration which is due to expire on the 06 June 2018. As part of the inspection the inspector met with the residents, relatives, the person in charge, the Clinical Nurse Manager (CNM2), nurses, multi-task attendants, activities staff, administration staff, the physiotherapist, the speech and language therapist, a General Practitioner (GP), the practice development facilitator and other staff members. The inspector observed practices, the physical environment and reviewed all governance, clinical and operational documentation such as policies, procedures, risk assessments, reports, residents' files and training records to inform this application.

The inspector interacted with the person in charge and CNM throughout the

inspection. The management team displayed knowledge of the standards and regulatory requirements and were found to be committed to providing quality person-centred care to the residents. They were generally proactive in response to the actions required from the previous inspection with the exception of the extension to the premises. The inspector viewed a number of improvements throughout the inspection which are discussed throughout the report.

A large number of quality questionnaires were received from residents and relatives and the inspector spoke to many residents and relatives throughout the inspection. The collective feedback from residents and relatives was one of satisfaction with the service and care provided. Comments from residents included " staff are very nice to me and give me help when I need it ", "I enjoy the activities every day and the food is good". Residents and relatives praised the staff and all stated that they feel their relative is very well looked after. One relative stated that, " a warm welcome is always there from the staff". Relatives were complimentary about their ability to visit and staff being open with information about their relative. Family involvement was encouraged and the inspector saw numerous visitors in and out of the centre during the two day inspection. There was a residents committee which facilitated the residents' voice to be heard and this was run by the external activity staff.

The inspector found that residents' healthcare and nursing needs were met to a very high standard. Residents had easy access to medical, allied health and psychiatry of later life services. Staff interacted with residents in a kind and respectful manner and the inspector found that residents appeared to be very well cared for. Residents could exercise choice in their daily life and were consulted on an ongoing basis. Residents could practice their religious beliefs.

Following the registration inspection in June 2015 the provider had submitted costed time bound plans to HIQA for an extension and substantial renovation to the building so that all bedrooms would be single or twin bedrooms and there would be an increase in communal space for the residents. This was to be completed by 01 April 2017 and the centre was registered with a condition stipulating this. On the previous inspection the building/renovations had not commenced and the centre was found to be in breach of the condition of registration. The provider applied to vary the condition but due to submission of insufficient information this application was refused. Currently the centre has a major non-compliance in premises and there has been no action taken by the provider to expedite the plans despite the breach of the condition saying works would be completed during the current registration cycle.

Premises issues, documentation management and staffing issues continued to require action. These areas and other actions required are detailed in the body of the report, which should be read in conjunction with the action plan at the end of this report. The action plan at the end of the report identifies improvements necessary to ensure compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Standards for Residential Care Settings for Older People in Ireland 2016.

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 staff, residents and relatives at reception. This contained a statement of the designated centre's vision, mission and values. It accurately described the facilities and services available to residents, and the size and layout of the premises.

The statement of purpose included the registration date, expiry date and was updated during the inspection to include the conditions attached by the Chief Inspector to the designated centre's registration under Section 50 of the Health Act 2007 and were found to meet the requirements of legislation.

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 centre was operated by the Health Service Executive (HSE) who was the registered

provider. The provider representative who had responsibility for a number of other centres was available to the management team. The inspector saw that there was a clearly defined management structure in place. The centre was managed by a full time person in charge who was supported in her role by a CNM2. The lines of accountability and authority were clear and all staff were aware of the management structure and were facilitated to communicate regularly with management.

There was evidence of regular meetings between the provider representative and all the persons in charge from the community hospitals in the area. The meetings were a forum for discussion, sharing of ideas and promotion of developments in services and practices. Results of audits and key performance indicators were reviewed and discussed. The person in charge also held regular meetings attended by the CNM and staff.

The inspector saw evidence of the monitoring the quality and safety of care provided to residents. This was through the collection of key clinical quality indicator data including pressure ulcers, falls, the use of psychotropic medications, bed rails, medication management and administration, the assessment of risk, and health and safety. The inspector saw that there were systems in place for monitoring the quality and safety of care provided to residents. These included internal audits and reviews such as falls audits, medication audit and hand hygiene audit took place throughout 2017. Resident surveys had been undertaken in relation to catering and to quality of life further correlation of these surveys was required. There was evidence of consultation with residents and relatives through residents meetings chaired by external activity staff. The inspector noted that issues raised by residents were brought to the attention of the person in charge and items were followed up on subsequent meetings.

The inspector saw that a comprehensive annual review of the quality and safety of care and support in the designated centre had been undertaken by the management team in accordance with the standards for 2016. This review was made available to the inspector and there were a number of recommendations and actions from this review that were actioned. The person in charge said she was currently undertaking the annual review for 2017 which will be made available to residents and relatives when completed.

The management team displayed a good knowledge of the standards and regulatory requirements and were found to be committed to providing quality person-centered care to the residents. They were proactive in response to some of the actions required from the previous inspection and the inspector viewed a number of improvements throughout the inspection which are discussed throughout the report. However the issues and actions in relation to premises remain non-compliant and are discussed under Outcome 12 premises and Outcome 16 Residents rights.

Judgment:
Compliant

Outcome 03: Information for residents

A guide in respect of the centre is available to residents. Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

A Residents' Guide was available which included a summary of the services and facilities provided, terms and conditions relating to residence, procedure respecting complaints and the arrangements for visits. This guide was found to meet the requirements of legislation.

Samples of residents' contracts of care were viewed by the inspector. The inspector found that contracts had been signed by the residents/relatives and found that the contract was clear, user-friendly and generally outlined all of the services and responsibilities of the provider to the resident and the fees to be paid. The contracts had recently been updated to include the bedroom that the resident will occupy and the number of other residents in that bedroom.

Judgment:

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 displayed a good knowledge of the standards and regulatory requirements and was found to be committed to providing quality person-centred care to the residents.

The inspector interacted with the person in charge throughout the inspection process. There was evidence that the person in charge was engaged in the governance, operational management and administration of the centre on a day-to-day basis. The inspector was satisfied that she was a registered nurse, was suitably qualified and had a minimum of three years experience in nursing of the older person within the previous six years, as required by the regulations. She demonstrated a commitment to her own professional development and held a number of post registration qualifications.

Staff, residents and relatives all identified her as the person who had responsibility and accountability for the service and said she was very approachable and were confident that all issues raised would be managed effectively.

Judgment:
Compliant

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

Theme:
Governance, Leadership and Management

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

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

Findings:

The inspector saw that the designated centre had the written operational policies as required by Schedules 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. However a number of these had to be sourced and updated during the inspection. The centre had numerous folders of policies which were centre specific. However there was no specific referencing guide therefore it was difficult to locate a specific policy without going through the numerous folders which would be difficult if looking for guidance in an emergency situation. Although all the other records required were also available during the inspection it was at times difficult to locate specific documentation. The inspector recommended that all records were stored with referencing to ensure they were easily retrievable.

Residents' records were comprehensive and held for a period of not less than seven years. They were stored securely in locked trollies for assessment and care planning documentation and in the office for medical records. Evidence was also seen that the centre was adequately insured against injury to residents and loss or damage to residents' property.

The inspector viewed a sample of staff files and found that the requirements of Schedule 2 had generally been met. The centre had in place HSE Garda Vetting Liaison Officers Garda vetting report confirmation forms for staff. However, this is not a disclosure in accordance with the National Vetting Bureau Act 2012 as required by schedule 2 of the 2013 care and welfare regulations. However a full vetting disclosure

was made available for the four staff members requested by the inspector following the inspection.

Judgment:
Substantially 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 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:
There had been no change of person in charge since the last inspection and the provider was aware of the responsibility to notify HIQA if any absence of over 28 days were to occur.

Suitable deputising arrangements were in place to cover for the absence of the person in charge. The CNM2 was in charge of the centre on a daily basis and when the person in charge is on leave. The inspector met and interacted with the CNM2 throughout the inspection and she demonstrated a good awareness of the legislative requirements and her responsibilities under the Health Act.

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 inspector was satisfied that there were measures in place to safeguard residents and protect them from abuse. The inspector reviewed staff training records and saw

evidence that staff had received up to date mandatory training on detection and prevention of elder abuse and in the safeguarding of vulnerable adults. Staff interviewed were familiar with the policy and knew what to do in the event of an allegation, suspicion or disclosure of abuse, including who to report incidents to. Relatives reported that they felt their residents were very safe in the centre and as they visited on a very regular basis they would notice any changes in their relatives' behaviour. Residents told the inspector that they felt safe in the centre and staff treated them with respect.

The centre maintained day to day expenses for a number of residents and the inspector saw evidence that complete financial records were maintained. The inspector reviewed the systems in place to safeguard resident's finances which included a review of a sample of records of monies handed in for safekeeping. Money was kept in a locked safe in the administration office. Each resident had an individual pouch which contained a book where each lodgement or withdrawal was recorded. All transactions were signed by two staff members and by the resident or relative if appropriate. Receipts were maintained for all purchases and there was a regular system of checks and audits of the monies and receipts. This system was found to be sufficiently robust to protect both the resident and the staff members.

A policy on managing responsive behaviours was in place. The inspector saw training records and most staff confirmed that staff had received training in management of responsive behaviours this was undertaken in 2015 with some staff undertaking the training in 2017. However there were a number of newer staff outstanding this mandatory training which the person in charge said would be provided during 2018. The action for this will be under Outcome 18 Staffing. There was evidence that efforts were made to identify and alleviate the underlying causes of behaviour that posed a challenge. Residents were reviewed by the GP or psychiatrist if required. The records of residents who presented with responsive behaviours were reviewed by the inspector who found that these were managed in a very dignified and person centred way by the staff using effective de-escalation methods. Staff spoken to were very knowledgeable about residents and what worked with them to assist if responsive behaviours were exhibited. They used distraction techniques such as taking the resident out for a walk, singing to and with the resident, talking about their family members, their hobbies and interests. Care plans seen detailed these intervention and charts were maintained identifying triggers, responsive behaviours and actions to take in response.

There was a centre-specific restraint policy which aimed for a restraint free environment and included a direction for staff to consider all other options prior to its use. Since the previous inspection there were comprehensive assessments in place identifying the requirement for restraint and detailing alternatives tried to ensure restraint was the least restrictive alternative. The staff had worked hard to continue the reduction in bedrail usage seen on the previous inspection. Review of use of restraints was on-going and alternatives such as low profiling beds chair and bed alarms that had a dignified alert chime were in use. Regular checks of all residents were being completed and documented. The inspector was satisfied that the center was adhering to best practice guidance in the use of restraint.

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:

The inspector saw that the health and safety and risk management policy was updated to include all the items as listed in the Regulations in relation to specific risks. The emergency plan was also updated to include loss of water and kitchen facilities and was found to be comprehensive for other risks and clearly identified where the residents could be relocated to in the event they could not return to the centre.

There was a current policy in place for infection prevention and control. Advisory signage for best practice hand washing was displayed over hand wash sinks and hand hygiene gel dispensers and the inspector observed that opportunities for hand hygiene were taken by staff. Staff had completed training in infection prevention and control and hand hygiene. Hand hygiene training and audits were undertaken by one of the nursing staff. Gloves and aprons were provided and discussion with multi-task attendant staff indicated that there was a colour coded cleaning system in place for housekeeping and staff were knowledgeable of infection prevention and control practice. The centre was generally bright and clean throughout.

There was a fire procedure in place within the centre. This was displayed throughout the centre in both written and drawing format. The fire drawings reflected the correct fire zones. Records showed that the emergency lighting, fire fighting equipment and the fire detection and alarm system were being serviced at the appropriate times. It is noted that faults with the fire detection and alarm system were recorded in the fire safety register and reported to the appropriate company for service. The inspector noted that the records indicated that exits were being checked.

The inspector found that the needs of residents in the event of a fire were assessed by way of detailed Personal Emergency Evacuation Plans (PEEPs). Fire drill records were available indicating that fire drills were being carried out in the centre as part of the fire safety training for the centre and there was evidence of additional fire drills taking place which were well documented. The inspector was concerned that due to the rural location of the centre and the high dependency needs of residents that two staff at night time is not sufficient for the evacuation of residents in the case of fire. This will be discussed further and actioned under Outcome 18 Staffing. The provider had made necessary arrangements for fire safety training to be provided to staff during 2017 which was confirmed by staff and an up-to-date training matrix. There were no residents who smoked in the centre.

There were arrangements in place to review accidents and incidents within the centre, and residents were regularly assessed for risk of falls. Care plans were in place and following a fall, the risk assessments were revised and care plans were updated to include interventions to mitigate risk of further falls.

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:

There were written operational policies advising on the ordering, prescribing, storing and administration of medicines to residents. There was evidence on the medication prescription sheets of regular review of medications by the medical staff. The inspector observed nurses administering the lunch and morning medications, and this was carried out in line with best practice. Medications were prescribed and disposed of appropriately in line with An Bord Altranais and Cnáimhseachais na hÉireann Guidance to Nurses and Midwives on Medication Management (2007).

There were appropriate procedures for the handling and disposal for unused and out of date medicines and the documenting of same. Medications that required crushing were individually prescribed. As required medications stated the frequency of dose to ensure there was a maximum dose in 24 hours that could not be exceeded. There were appropriate procedures for the handling and disposal for unused and out of date medicines and the documenting of same.

Controlled drugs were stored in accordance with best practice guidelines and nurses were checking the quantity of medications at the start of each shift. The inspector did a count of controlled medications with one of the nursing staff which accorded with the documented records. Photographic identification was in place for all residents as part of their prescription/drug administration record chart. Medication trolleys were securely maintained.

Comprehensive medication audits were undertaken by the pharmacist and there was evidence of actions taken as a result of findings. The pharmacist visited the centre providing medication reviews, stock control, advice and education for staff. Medication errors were recorded and investigated accordingly.

Judgment:

Compliant

Outcome 11: Health and Social Care Needs

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

Theme:

Effective care and support

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

No actions were required from the previous inspection.

Findings:

There was a local GP practice providing medical services to Dunmanway Community Hospital and the GP's attended the centre on a daily basis including Saturday mornings if required. Out-of-hours medical cover was available where necessary but staff reported that due to the daily service from the GP's, it is used infrequently. The inspector met one of the GP's during the inspection and a sample of medical records reviewed confirmed that resident's were reviewed on a very regular basis. Specialist medical services were also available when required. Reviews and on-going medical interventions as well as laboratory results were evidenced. Residents in the centre also had access to psychiatry of older life via a clinic in the town and the psychiatrist also visited the centre to review residents if required. Since the previous inspection a consultant geriatrician had visited the centre and reviewed a number of residents.

The centre provided in house physiotherapy services. Each resident was reviewed on admission and regularly thereafter by the physiotherapist who attended the centre two days per week and provided an exercise class on a Thursday the inspector met the physiotherapist and saw the exercise group take place which was well attended. The dietician visited the centre and reviewed residents routinely. There was evidence that residents had access to other allied healthcare professionals including occupational therapy, speech and language therapy, dental, chiropody and ophthalmology services. The speech and language therapist was also present in the centre during the inspection and the inspector saw the comprehensive service provided to the residents. The dietician and speech and language therapist provided training to staff on nutrition and dysphagia and the inspector saw further training scheduled and planned for the following week. Residents and relatives expressed great satisfaction with the medical care provided and the inspector was satisfied that resident's health care needs were very well met.

On the previous inspection the centre had implement a whole new system of assessment and care planning documentation. On this inspection the inspector saw that

staff were much more familiar with the system and each resident's needs were determined by comprehensive assessment with care plans developed based on identified needs. The assessment process involved the use of a variety of validated tools to assess each resident's risk of deterioration. For example, risk of malnutrition, falls, level of cognitive impairment and pressure related skin injury among others. Pain charts in use reflected appropriate pain management procedures. The inspector reviewed a number of care plans for residents and these were seen to be person centred with evidence of residents and/or their relative's involvement in the development of care plans. Care plans were up to date and were individualised. The inspector saw "key to me" information and support plans that had been completed for residents which included detailed information on resident's likes, dislikes, hobbies and interests. The activity staff completed social care plans were updated in line with residents participation in group or one to one activities. Residents and their families, where appropriate were involved in the care planning process, including end of life care plans which reflected the wishes of residents at end stage of life. A number of plans seen reflected the wishes of the residents and the families to remain in the centre to be cared for and not transferred to the acute hospital. Residents had access to consultant palliative care and the hospice services. Staff had completed professional development training regarding end of life care and palliative care. Care practices observed would suggest that residents would be cared for with the utmost respect at end of life. There was a single room with en-suite facilities and a family room available for palliative care as required. Nursing staff and health care assistants spoken with were familiar with and knowledgeable regarding residents up to date needs.

Residents at risk of developing pressure ulcers had care plans and pressure relieving mattresses and cushions to prevent ulcers developing. Nursing staff advised the inspector that there were no residents with pressure sores or major wounds at the time of inspection. The person in charge was planning to undertake a post registration qualification in wound management.

There were systems in place to ensure residents' nutritional needs were met, and that the residents received adequate hydration. Residents were screened for nutritional risk on admission and reviewed regularly thereafter. Residents' weights were checked on a monthly basis and more frequently if evidence of unintentional weight loss was observed. Residents were provided with a choice of nutritious meals at mealtimes and the inspector saw staff assist residents with eating and drinking and this was undertaken in a discrete and sensitive manner. Residents were complimentary about the food provided. There was an effective system of communication between nursing and catering staff to support residents with special dietary requirements. The inspector saw lists of resident's likes and dislikes and special dietary requirements written in the kitchen. Nursing staff told the inspector that if there was a change in a resident's weight, nursing staff would reassess the resident, and referrals would be made to the dietician and speech and language therapy (SALT). Files reviewed by the inspector confirmed this to be the case. Nutritional supplements were administered as prescribed. All staff were aware of residents who required specialised diets or modified diets and were knowledgeable regarding the recommendations of the dietician and SALT.

Judgment:
Compliant

Outcome 12: Safe and Suitable Premises

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

Theme:

Effective care and support

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

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

Findings:

Dunmanway Community Hospital was established as a residential centre in 1950 and provides long-term, respite, community support and palliative care to older people. The original two-storey building, built alongside the ruins of the workhouse, was modernised between 2007 and 2008 and resident accommodation is now within a ground floor unit. It is registered for the care of 23 residents.

The main entrance opens onto a corridor with bedrooms on the left and reception, offices, nurses' stations, day room, toilets and showers to the right. A treatment room, kitchen, and oratory are attached to the purpose-built unit. Staff facilities, pharmacy store, and a physiotherapy room are located on the first floor. Residents accommodation consists of three four-bedded rooms, three two-bedded rooms, and five single bedrooms. All of these rooms have en suite toilets and showers. In addition, there is a toilet and shower located next to the day room and a bathroom containing an assisted bath.

The external grounds and garden are well maintained and car parking facilities are provided to the front and side of the building. There was an internal courtyard for residents' enjoyment with seating and a staff member had created a beautiful area with potted plants, flowers and shrubs for residents' enjoyment; the external garden was located between the centre and the day centre. A second enclosed garden area had been created at the side of the building which could be seen and accessed from the bedroom areas. Raised flower beds and seating areas were in place for residents and relatives enjoyment along with level pathways for walking. However access doors to the garden were seen to be locked and residents only had access via a staff member. As this is a safe enclosed garden area access should be more freely available to residents who could be outside.

Since the previous inspection the centre had been painted and signage and visual cues were put in place to ensure residents with dementia were enabled to find their way around the centre.

As identified on the previous inspection there was only one communal room and this was used for sitting, dining and recreational activities. The space was inadequate to accommodate all 23 residents. The maximum number of residents that could be seated at the two dining tables at meal time was 10 and this would depend on the types of assisted seating residents were using. The seating area in the communal space apart from dining tables was very limited and could only accommodate six - eight residents. Each bed space had a flat screen television, single wardrobe, bedside locker and some had comfortable seating alongside. There were overhead hoists in all bedrooms. There was a separate bathroom with a specialist bath. Nonetheless, some bed spaces could only accommodate a single wardrobe, and others could not accommodate a comfortable chair alongside their bed, which impeded the privacy and dignity of residents. Private space for visiting was also limited and these issues are all discussed further in outcome 16 Residents Rights Dignity and Consultation.

The inspector saw evidence of the use of assistive devices, for example, hoists, wheelchairs, walking aids, clinical monitoring equipment and specialist seating was provided for residents' use. Up-to-date service records were seen by the inspector for specialist equipment and beds. There was a functioning call-bell system in place. Although the premises was clean, bright and generally well maintained, there were significant limitations within the physical environment which negatively impacted the freedom, choice, privacy, dignity and autonomy of residents and these have been described in detail in the last inspection and a number of previous inspection reports.

Limitations of the premises included:

- 1) there was just one communal room for sitting, dining and recreational space and this was inadequate for 23 residents
- 2) a designated dining room was not available
- 3) there was limited private space for residents to meet their visitors
- 4) equipment storage space was inadequate

Following the registration inspection in June 2015 the provider had submitted costed time bound plans to HIQA for an extension and substantial renovation to the building so that all bedrooms would be single or twin bedrooms and there would be an increase in communal space for the residents. This renovation never took place and there were no updated plans available at the time of the inspection.

Judgment:

Non Compliant - Major

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 centre operated an open visiting policy which was observed throughout the inspection. Numerous visitors were observed throughout both days of inspection where staff members knew the names of visitors and vice versa. Staff took time to talk with family members both when they visited and when they rang to enquire about their relative. Relatives who spoke to the inspector commended staff on how welcoming they were to all visitors and some had tea/coffee with their relative during their visits. They said that if they any concerns they could identify them to the CNM2 or the person in charge and were assured they would be resolved. However the inspector saw that the availability of private space for residents to meet their visitors continued to be an issue. The inspector saw that visitors tended to visit in the day room where there was limited space or in residents bedrooms which did not protect the privacy and dignity of other residents sharing that room. There were areas in the centre which could be used for visiting including a family room off the palliative care suite and a small room on the main area but these did not appear to be routinely used. There was also a conservatory in the old building which again was not generally used. Further development of visiting space is required.

The inspector saw that residents' religious preferences were facilitated through regular visits by clergy from all denominations to the centre. Mass and administration of the sacrament of the sick were held regularly in the centre. There was an oratory in the centre and residents confirmed they enjoyed visiting the oratory for quiet reflection and prayer. However, this was away from the main residential area and residents generally had to be accompanied there by staff.

The inspector saw that the CNM and person in charge knew all the residents well and spoke to them daily. Residents were consulted through the residents committee and through feedback questionnaires. The external activities co-ordinator acted as the residents' advocate and attended the centre twice a week and facilitated residents' meetings every two to three months. The inspector saw minutes of these meetings which a number of residents attended. Issues raised at these meetings were reported back to the person in charge for resolution and followed up on subsequent meetings with updates and progress. Issues discussed were food and menu choices, activities, trips out.

Staff paid particular attention to residents' appearance, dress and personal hygiene and were observed to be caring towards the residents. The hairdresser visited as required and residents were facilitated to avail of the service other residents went down town to their regular hairdresser. Notwithstanding the constraints of the building and lack of day space, the inspector noted that residents received care in a dignified way that respected

them individually. Screening in shared rooms had been extended since the previous inspection to fully enclose the bed area. Staff were observed communicating appropriately with all residents including those who had dementia. Effective communication techniques were documented and evidenced in residents care plans.

There was a varied programme of activities available to residents which included songs, imagination gym, music, sing-songs, chair based exercise, religious activities, gardening and other more individualised activities. Staff members with families had completed the 'Life Story' as part of their reminiscence therapy. The inspector saw a number of group and individual activities being undertaken during the inspection. These included an exercise group, sing-songs, newspaper reading, health promotion and reminiscence. There was a group music session in the day room and the singer engaged the residents. Residents and relatives spoken with gave positive feedback on the activities and often joined in with the groups. The inspector observed that there were specific activity sessions for residents with dementia including one to one sessions. One of the multitask attendants had one day per week allocated to activities and had new and innovative ideas to the activities which residents were very complimentary about.

The person in charge told the inspector about a number of trips out they had taken the residents on including trips to a local show. The inspector saw photographs of these trips and other activities displayed in the centre along with several pieces of residents art displayed throughout the centre. There were also items of interest including posters on the history of the centre displayed adding diversion and interest on the corridors. Since the previous inspection the person in charge had organised for shelving to be put in place in the multi-occupancy rooms to enable residents to display photos and personal items. Some residents had photos and pictures brought in from home displayed but the size and layout of the multi-occupancy rooms did not allow for much personalization of the bed space. Residents had access to private storage space of single wardrobes and bedside lockers to store their possessions and clothing. Since the previous inspection the person in charge had put in place additional wardrobes in the single and some twin rooms which provided much needed storage in these rooms. However the single wardrobes in the multi-occupancy rooms were very small and staff informed inspectors that they sent residents clothing home and only stocked a small number of outfits at time. The inspector found that this did not allow residents full choice around their clothing and did not fully enable them to retain control over their possessions and clothing.

Since the previous inspection there appeared to be more residents using the day room. However the inspector saw that due to the lack of day and dining space a number of residents continued to spend large part of their days beside their beds where they eat all their meals, watched TV and listened to the radio. This did not allow the residents choice. The inspector saw that in one of the four-bedded rooms one resident was watching TV and another resident was listening to the radio which were both on at the same time which was distracting and added to the noise level in the room. Mealtimes in the centre was observed by inspector to require improvement to be more of a social occasion. Although a number of residents attended the day/dining room for their meals this room was too small to accommodate all of the residents and there were only two dining tables seating up to 10 residents. Many residents were seen to eat their meals in their bedrooms by the side of their bed where some residents spent all day, this did not

afford residents real choice in relation to mealtimes.

Judgment:

Non Compliant - Moderate

Outcome 18: Suitable Staffing

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

Theme:

Workforce

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

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

Findings:

Residents and relatives spoke very positively of staff and indicated that staff were caring, responsive to their needs and treated them with respect and dignity. This was seen by the inspector throughout the inspection in the dignified and caring manner in which staff interacted and responded to the residents.

Systems of communication were in place to support staff with providing safe and appropriate care. There were handover meetings each day to ensure good communication and continuity of care from one shift to the next. The inspector saw records of regular staff meetings at which operational and staffing issues were discussed. The inspector saw that staff had available to them copies of the Regulations and standards. In discussions with staff, they confirmed that they were supported to carry out their work by the person in charge. The inspector found staff to be well informed and knowledgeable regarding their roles, responsibilities and the residents' needs and life histories. There was evidence that residents knew staff well and engaged easily with them in personal conversations.

Mandatory training was in place and staff had received training in fire safety, safe moving and handling, safeguarding vulnerable persons and management of responsive behaviours. Other training provided included dementia specific training, infection control, end of life, continence promotion, food and nutrition, hydration and the management of dysphagia. Nursing staff confirmed they had also attended clinical training including venepuncture, care planning, "let me decide" and falls prevention. The inspector saw and staff confirmed that there was a good level of ongoing professional development training and staff were encouraged to attend training and education

sessions. A number of staff that were involved in providing activities had undertaken activity training including sit to stand exercises and imagination gym. However there were a number of staff who did not have responsive behaviour training and new staff also required other mandatory training.

The person in charge confirmed that no staff commenced employment until satisfactory vetting had taken place. Staff files demonstrated that staff appraisals were undertaken on an annual basis and there was evidence of a comprehensive induction programme for new staff.

The inspector saw that the staff numbers and skill mix throughout the day was adequate to meet the needs of residents and hygiene of the centre cognisant of the size and layout of the centre. As identified on the previous inspection there were no dedicated cleaning staff on duty and the role of the multi-task attendant was unclear as they moved from caring to cleaning duties on the one shift. During the two days of inspection the multi-task attend spent the first part of the morning on caring duties, then moved to cleaning. However the inspector saw that the staff member was frequently pulled back to assist with personal care when on cleaning duties. Further segregation of roles was required to ensure consistent care for residents and to allow for more consistency for the purposes of cleaning. On this inspection the person in charge showed the inspector a proposed duty rota where the roles of cleaning caring and catering were separated out. Multitask staff that spoke to the inspector said they looked forward to the separation of the roles and feel it will be more beneficial for resident care. However this separation of the roles had not commenced at the time of the inspection.

Although the centre had a twilight shift until 22.30 or 23.00, the inspector saw there were only two staff rostered for night duty. There was one nurse and one multitask attendant available from 23.00hrs to provide care to the 23 residents residing in the centre many who had maximum or high dependency needs. The Multitask attendant also had to undertake cleaning duties and commence the preparation of breakfast for the residents in the kitchen which was away from the resident area. The inspector found these staffing levels were not safe and required review to ensure adequate care for the residents and to ensure residents could be safely evacuated in the case of fire.

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:

Caroline Connelly
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 report¹

Centre name:	Dunmanway Community Hospital
Centre ID:	OSV-0000599
Date of inspection:	17/01/2018
Date of response:	15/03/2018

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 05: Documentation to be kept at a designated centre

Theme:

Governance, Leadership and Management

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

Some policies and procedures and other records were not stored and maintained in such manner as to be easily accessible.

1. Action Required:

Under Regulation 21(6) you are required to: Maintain the records specified in paragraph (1) in such manner as to be safe and accessible.

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 policies will be streamlined and stored in named folders with the assistance of Susan Daly Clinical Development Co-ordinator.

Proposed Timescale: 31/07/2018

Outcome 12: Safe and Suitable Premises

Theme:

Effective care and support

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

Limitations of the premises included:

- 1) there was just one communal room for sitting, dining and recreational space and this was inadequate for 23 residents
- 2) a designated dining room was not available
- 3) there was limited private space for residents to meet their visitors
- 4) equipment storage space was inadequate

2. 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:

Planning applied for Jan 2018

1 & 2. Building works are due to commence shortly. Planning application has been submitted in February 2018 , with Earliest Construction start October 2018 and Earliest Completion of October 2019 at a cost of €0.2 million .

Revised Schedule of Accommodation issued to Design Team – Revised Stage 2A layout drawings received

1. Recreation room to accommodate up to 23 residents.
2. 2 No. Sitting rooms required. 1 No. Sitting Room to accommodate approx. 2/3rds of the resident population is to be located adjacent to the Dining Room & Recreation Room. No.2 Sitting Room is to accommodate approx. 1/3rd of the resident population.
3. Private room required for residents to receive visitors (not residents room)
4. A Cleaning room required in vicinity of bedrooms. A separate Cleaning room is required for the Kitchen.
5. 2 No Sluice Rooms existing i.e. White Sluice Room and Green Sluice room. White sluice room is to be retained. Convert Green Sluice room to Cleaners room
6. Existing Laundry is satisfactory but clinical wash hand basin to be provided.
7. Laundry Storage Room - Existing arrangement is satisfactory provided door in corridor between the Administration Office and Matrons Office can be opened up.(Currently closed for fire safety reasons)
8. To provide WiFi point in shared bedrooms and single bedrooms, and data outlet at

each bed for phone use only. Note data point at bed existing in most facilities

9. To provide medical oxygen in the 2 no. bedrooms (palliative care)
10. To provide mechanical ventilation and cooling in 2 no bedrooms (palliative).

This will increase communal space. In the meantime meals will be served in two sittings and anybody who likes a quieter environment can use the second sitting room near the main entrance.

In response to the concerns raised by HIQA the HSE has now set out a revised timeframe as above and is committed to completing the works within that timeframe.

- a) HSE is fully committed to completing the scheduled works within the revised time frame. The Planning Application in respect of the development at Dunmanway Community Hospital was lodged in February 2018 with an estimated commencement date of October 2018.
- b) Funding has been secured and has been allocated from the Capital Plan for the completion of the works.
- c) A planning application in respect of the development was submitted in February 2018 (see notice of Application in the Evening Echo dated 01-02-18 attached). Provided there are no requests for further information or appeals in respect of the proposed development, construction shall commence in October 2018 with a possible completion date of October 2019.
- d) Detailed plans for the said works are attached to this document, the additional works to be carried out to the Hospital include a new Recreation room which will accommodate up to 23 residents, 2 new sitting rooms for residents, a private visitors room, 2 sluice rooms and a new cleaning room adjacent to bedrooms. The new build elements of the development are highlighted in pink and the refurbishment works are highlighted in blue.
- e) The HSE has given this development top priority, this is exemplified in that the project design team has begun to seek Tender documents, Fire Certification and Disability Certification prior to obtaining Planning Approval. The project design team have been instructed by the HSE Estates Department to advance this development without delay.
- f) Whilst the HSE are committed to the construction start date as identified above, there are challenges which could arise over which the HSE have little control such as appeals or tendering challenges. The HSE are committed to reporting any such difficulties to HIQA together with any proposed solutions.

Mitigating areas of non-compliance

- a) Restraints of the communal room was highlighted within the report as an issue. This concern is directly addressed within the upcoming development. You will note from the plans that in addition to a new recreational room, there is one new sitting room being built and the current sitting room is also being refurbished. An enhanced dining space is also being developed as part of the development plans. Additional sluice rooms together with equipment and cleaning rooms are also being developed within the plans. These changes will have a significant positive impact on the residents.
- b) The HSE continues to mitigate any areas of non-compliance within the Hospital by way of constantly reviewing and adapting to the needs of the residents. The Hospital's staff are entirely flexible in respect of resident's needs.
- c) Residents are now meeting visitors in a private room adjacent to the palliative care room. This change has the effect of affording residents with additional privacy when

meeting visitors. This area was not previously exploited and highlights the adaptability of both the staff and the Hospital pending the upcoming development.

d)The Hospital has undertaken to remove all redundant equipment and furniture in an effort to create more space within the Hospital. This has had an effect of freeing up previously cluttered areas and providing more space for residents.

e)Consultations now take place with residents and their families in respect of clothing storage. A system to reflect the seasons is now in place ensuring that residents have adequate clothing to hand while also limiting the amount of unnecessary clothing stored at the bedside. This has the effect of providing up more space to residents within the Hospital. Residents are encouraged to select their own clothing in conjunction with staff who facilitate these choices.

f)The Hospital is currently successfully mitigating against the areas of non-compliance due to the physical restrictions of the Hospital. These restrictions shall be addressed by the upcoming development works.

Actions

3& 5 Rest room off Palliative room will be used as private space until then
4.Storage will be addressed with the new plans. In the interim all equipment will be reviewed and equipment not in use will be removed

Proposed Timescale: 31/10/2019

Outcome 16: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

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

The single wardrobes in the multi-occupancy rooms were very small and staff informed inspectors that they sent residents clothing home and only stocked a small number of outfits at time. The inspector found that this did not allow residents full choice around their clothing and did not fully enable them to retain control over their possessions and clothing.

The inspector saw that due to the lack of day and dining space a number of residents continued to spent large part of their days beside their beds where they eat all their meals, watched TV and listened to the radio. This did not allow the residents full choice.

Residents did not have easy access to the outdoor space.

3. Action Required:

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

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

Many of the residents prefer to have meals by their beds .Choice is always offered.
Residents are consulted re: storage of clothing.

Clothing is altered as per seasons on the advice of resident.
Staff are assigned residents and always make sure that the resident has a choice in what they choose to wear.
There is always a full range of clothing available to the resident.
No complaints have been received re: the system we currently have in place and residents have voiced their satisfaction with alternating clothes by season.
Access to the garden is risk assessed and 3 doors onto the enclosed garden will be removed from lock down in consultation with Keaney Medical (suppliers of security system).
Please see Outcome 12 for

Proposed Timescale: 31/03/2018

Outcome 18: Suitable Staffing

Theme:
Workforce

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

The role of the multi-task attendants moving between caring and cleaning on the one shift required review.

Staffing levels at night required review to ensure adequate care for the residents and to ensure residents could be safely evacuated in the case of fire.

4. 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:

New roster in place and to be rolled out .
8.5 hrs MTA have been secured for the cover of the night shift.

Proposed Timescale: Roll out of off duty April 2018

8.5hrs as soon as recruitment can be achieved and employee is garda vetted (expected 6-8 weeks)

Proposed Timescale:

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

There were a number of staff who did not have responsive behaviour training and new

staff also required other mandatory training.

5. 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:

Responsive Behaviour training has been arranged for 21st March 2018

Dementia Training has been arranged for April 2018

Proposed Timescale: 21st March 2018 and April 2018

Proposed Timescale: 30/04/2018