Health Information and Quality Authority
Social Services Inspectorate

Registration Inspection report
Designated Centres under Health Act 2007

Centre name:	Bandon Community Hospital
Centre ID:	0557
Centre address:	Hospital Lane Cloughmacsimon Bandon Cork
Telephone number:	023-8841403
Fax number:	023-8843648
Email address:	Finola.finn@hse.ie
Type of centre:	☐ **Private** ☐ **Voluntary** ☒ **Public**
Registered provider:	Health Service Executive
Person in charge:	Finola Finn
Date of inspection:	24 May 2011 and 25 May 2011
Time inspection took place:	**Day-1 Start:** 09:30 hrs **Completion:** 18:30hrs **Day-2 Start:** 08:30 hrs **Completion:** 15:30hrs
Lead inspector:	Patricia Sheehan
Support inspector(s):	Cathleen Callanan
Type of inspection:	☒ **Registration** ☒ **Announced** ☐ **Unannounced**

About registration

The purpose of regulation is to protect vulnerable people of any age who are receiving residential care services. Regulation gives confidence to the public that people receiving care and support in a designated centre are receiving a good, safe, service. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected.

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.

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.

As part of the registration process, the provider must satisfy the Chief Inspector that s/he is fit to provide the service and that the service is in compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centre for Older People) Regulations 2009 (as amended).

In regulating entry into service provision, the Authority is fulfilling an important duty under section 41 of the Health Act 2007. Part of this regulatory duty is a statutory discretion to refuse registration if the Authority is not satisfied about a provider's fitness to provide services, or the fitness of any other person involved in the management of a centre. The registration process confirms publicly and openly that registered providers are, in the terminology of the law, "fit persons" and are legally permitted to provide that service.

Other elements of the process designed to assess the provider's fitness include, but are not limited to: the information provided in the application to register, the Fit Person self-assessment, the Fit Person interviews, findings from previous inspections and the provider's capacity to implement any actions as a result of inspection.

Following the assessment of these elements, a recommendation will be made by inspectors to the Chief Inspector. Therefore, at the time of writing this report, a decision has not yet been made in relation to the registration of the named service.

The findings of the registration inspection are set out under eighteen outcome statements. These outcomes set out what is expected in designated centres and are based on the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended); the *National Quality Standards for Residential Care Settings for Older People in Ireland*. Resident's comments are found throughout the report.

The registration inspection report is available to residents, relatives, providers and members of the public, and is published on www.hiqa.ie in keeping with the Authority's values of openness and transparency.

About the centre

Location of centre and description of services and premises

The centre is located in the town of Bandon, County Cork. Bandon Community Hospital, established in 1929, is a single-storey building that has had extensive renovations over the years. It provides long-term, respite and palliative care for 23 residents. At the time of inspection there were 22 residents and the person in charge informed inspectors that two of these residents had a diagnosis of dementia.

There are four single rooms, one with en suite containing wash-hand basin, assisted toilet and shower and one with a shared en suite containing wash-hand basin and assisted toilet which can also be accessed from the main corridor. There are two twin-bedded rooms, one of which is accessed through the seven-bedded unit. There is a three-bedded unit, a five-bedded unit with en suite containing wash-hand basin, assisted toilet and assisted shower and a seven-bedded unit with en suite containing wash-hand basin, assisted toilet and assisted shower. There are three communal assisted toilets each with a wash-hand basin, one communal assisted shower room including an assisted toilet and wash-hand basin and a communal assisted bathroom with a wash-hand basin.

Communal accommodation consists of a large room, used both as a sitting room and dining area, and a small room used as a quiet space and for residents to receive visitors in private. Office space, a meeting room, kitchen, a large reception area with comfortable couches and well maintained gardens completes the layout. The gardens are not enclosed.

An adjacent day service is connected to the centre by an adjoining corridor.

Date centre was first established:			1929	
Number of residents on the date of inspection:			22	
Number of vacancies on the date of inspection:			0	
Dependency level of current residents:	**Max**	**High**	**Medium**	**Low**
Number of residents:	14	6	2	0
Gender of residents:			**Male (✓)**	**Female (✓)**
			5	17

Management structure

Bandon Community Hospital is operated by the Health Service Executive (HSE). The Person in Charge is Finola Finn, Director of Nursing and her deputy is Anna Kearney, Clinical Nurse Manager 2. The Director of Nursing reports to Teresa O' Donovan, General Manager for Cork County Community Hospitals in HSE South.
The Person in Charge is supported by the Clinical Nurse Manager 2, a clinical nurse specialist, staff nurses, healthcare assistants, multi task attendants, administrative and ancillary staff.

Summary of compliance with Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

This report set out the findings of a registration inspection, which took place following an application to the Health Information and Quality Authority for registration under Section 48 of the Health Act 2007.

Inspectors met with residents, relatives, and staff members, over the two day inspection. Inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files. Separate fit person interviews were carried out with the provider and the person in charge, both of whom had completed the fit person self-assessment document in advance of the inspection. This was reviewed by inspectors, along with all the information provided in the registration application form and supporting documentation.

Inspectors found substantial compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland.*
There was evidence of effective governance and that residents received a high standard of evidence-based care with good access to allied health services and with an emphasis on improving the quality of life. Staff that inspectors spoke with were knowledgeable about residents' individual health needs, and this was confirmed by the care practices observed. Systems were in place to monitor and develop the quality of care and the quality of life. Residents were facilitated to exercise choice and personal autonomy and their views were sought and listened to. There was an effective complaints management process in place. The feedback received from residents and relatives indicated a high level of satisfaction with the care provided.

Some improvements were required in evening staffing levels, activities for the more dependant residents and the design of the premises, to enhance the findings of good practice. All of the improvements are described under the outcome statements and related actions are set out in the Action Plan under the relevant outcomes.

Section 50 (1) (b) of the Health Act 2007

Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

1. Statement of purpose and quality management

Outcome 1

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.

References:

Regulation 5: Statement of Purpose
Standard 28: Purpose and Function

Inspection findings

A written statement of purpose was available which described the services provided in the centre that reflected the diverse needs of the residents. However, it did not meet all of the requirements of Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

The statement of purpose set out the services and facilities provided in the centre and contained clear strategic objectives for the overall service. Inspectors observed that the centre's capacity to meet the diverse needs of residents, as stated in the statement of purpose, was reflected in practice. In particular inspectors noted the clinical expertise of nurses, a sustained approach to skills training and development, and access to specialist services to ensure a multi disciplinary approach. The statement is kept under review and is made available to residents on request.

The statement did not meet all of the requirements of Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and did not accurately describe the facilities and the admission criteria. The number and size of rooms was not included and currently only 22 beds are available as the three-bedded unit has been reduced to two beds in order to accommodate the needs of one of the residents. The statement did not clearly outline what bedrooms with more than two residents are being used for and the category of residents in them. The exclusion of potential residents who were mobile with dementia from the admission criteria was not clearly stated.

Outcome 2

The quality of care and experience of the residents are monitored and developed on an ongoing basis.

References:

Regulation 35: Review of Quality and Safety of Care and Quality of Life

Standard 30: Quality Assurance and Continuous Improvement

Inspection findings

Systems were in place to monitor and develop the quality of care and quality of life of the residents on a continuous basis.

The centre has retained its accreditation status as a practice development unit for older people through an external source since 2007. Building on this strong foundation, the person in charge has ensured there are regular audits of clinical practice in, for example, care planning, assessing fall risks, medication management, promoting continence and oral care. Examples of quality improvements were an audit of care planning and development of an improved record keeping system and monitoring of medication management practice, in consultation with the contracted pharmacist, with stock management as an identified area for improvement.

Audits of privacy and dignity have also been undertaken and measured against the *National Quality Standards for Residential Care Settings for Older People in Ireland*. This review was informed by residents' views and comments and resulted in, amongst other changes to practice, the introduction of an advocacy system.

Outcome 3
The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

References:
Regulation 39: Complaints Procedures
Standard 6: Complaints

Inspection findings

Inspectors found evidence of good complaints management.

Residents, their relatives and staff reported to inspectors that they had easy access to the person in charge and they could openly report any concerns. There was an up-to-date written complaints policy containing all of the required information, and the process for making a complaint was outlined in the statement of purpose and the Resident's Guide. The procedure for making a complaint was displayed in a prominent place and an inspector discussed modifications to ensure the procedure was user friendly which were made by the person in charge on foot of the discussion.

An inspector read records of written complaints and there was appropriate documentation detailing any complaints, the actions taken, the outcomes and complainants' satisfaction. The recording of verbal complaints and their outcomes was one of the improvements implemented since completing the fit person self assessment.

2. Safeguarding and safety

Outcome 4
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.

References:
Regulation 6: General Welfare and Protection
Standard 8: Protection
Standard 9: The Resident's Finances

Inspection findings

Inspectors reviewed the elder abuse policy which contained contact details for the local designated elder abuse officer. There was evidence that all staff had received elder abuse training. Staff with whom inspectors spoke were able to appropriately describe their responsibilities with regard to reporting an allegation of abuse and the actions to be taken in the event of an allegation of elder abuse.

Where there had been a recent suspicion of elder abuse, which did not involve any staff member, inspectors found from an examination of the records and discussion with the person in charge that the response had been appropriate. Residents with whom inspectors spoke confirmed that they felt safe in the centre.

With regard to the safety of residents' personal belongings, inspectors reviewed the system for the management of personal property and funds and found it to be clear and transparent.

Outcome 5
The health and safety of residents, visitors and staff is promoted and protected.

References:
Regulation 30: Health and Safety
Regulation 31: Risk Management Procedures
Regulation 32: Fire Precautions and Records
Standard 26: Health and Safety
Standard 29: Management Systems

Inspection findings

There was evidence of health and safety practices and the management of risk that promoted the safety of residents, staff and visitors. The risk management policy and risk assessments required some improvements as did the frequency of fire drills.

Examples of practice regarding health and safety and the management of risk that promoted the safety of residents, staff and visitors were:

- a written emergency plan
- a designated health and safety officer and a current health and safety statement that identified hazards and the required controls
- regular environmental and clinical risk assessments were undertaken, findings analyzed and appropriate actions taken. Risks were added to the risk register on a regular basis following incident analysis
- medical and care plan reviews following any fall and serious injury
- review of fire records showed that all fire safety equipment, including the fire alarm and emergency lighting had been serviced at appropriate intervals. records of fire drills were maintained and fire safety and evacuation training for all staff took place on an annual basis.
- records indicated staff had received manual handling training which was confirmed in staff interviews
- the environment was extremely clean and well maintained with safe and appropriate floor covering, hand rails to promote independence and emergency exits were unobstructed
- appropriate sluicing facilities and infection control measures in place and arrangements for the segregation and disposal of waste, including clinical waste. All staff had received training in infection control with an infection control nurse available to give ongoing education and support.
- records indicated that equipment and services were checked and maintained regularly.

The risk management policy did not detail the arrangements that inspectors noted were in place for the recording, investigation and learning from serious incidents involving residents. It did not cover the precautions in place to control the specified risks of unexplained absence of a resident; assault; accidental injury to residents or staff; aggression and violence; and self-harm. It did not address the risks to residents who might develop a cognitive impairment with the potential to wander as there was no secure garden perimeter. As a result the centre was not suitable for people who were mobile with dementia and the person in charge stated that such admissions did not take place. Individual risk assessments had not been completed for those residents who smoked.

There was not written confirmation that all requirements of the statutory fire authority had been complied with, and fire drills were held annually rather than at the recommended 6 monthly intervals.

Outcome 6
Each resident is protected by the designated centres' policies and procedures for medication management.

References:
Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines
Standard 14: Medication Management

Inspection findings

The processes in place for the handling of medicines, including controlled drugs, were safe, secure and in accordance with current guidelines and legislation. Nursing staff demonstrated an understanding of appropriate medication management and adhered to professional guidelines and regulatory requirements.

There was a medication policy with procedures for prescribing, administering, recording and storing of medication. Review of records and observation of practice indicated that these procedures were implemented. Controlled drugs were stored safely and stock levels were recorded at the end of each shift and recorded in a register in keeping with the Misuse of Drugs (Safe Custody) Regulations, 1982. There were appropriate procedures for the handling and disposal for unused and out of date medicines.

3. Health and social care needs

Outcome 7
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied healthcare. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. 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.

References:
Regulation 6: General Welfare and Protection
Regulation 8: Assessment and Care Plan
Regulation 9: Health Care
Regulation 29: Temporary Absence and Discharge of Residents

Standard 3: Consent
Standard 10: Assessment
Standard 11: The Resident's Care Plan
Standard 12: Health Promotion
Standard 13: Healthcare
Standard 15: Medication Monitoring and Review
Standard 17: Autonomy and Independence
Standard 21: Responding to Behaviour that is Challenging

Inspection findings

Inspectors found a high standard of evidence-based care and appropriate medical and allied healthcare access. The arrangements to meet residents' assessed needs were set out in individual care plans, which were drawn up with the involvement of

residents and were subject to review. Opportunities for cognitively impaired and more dependent residents to participate in meaningful activities, appropriate to their abilities and preferences, required improvement.

A sample of medical records were reviewed which confirmed that the health needs and medications of residents were being monitored frequently and on an ongoing basis as there was daily weekday access to one of the five medical officers who were local general practitioners (GPs). An out of hours service provided medical cover at weekends and bank holidays.

Inspectors examined five care plans and found that comprehensive person-centred care plans were in place and regularly reviewed at a minimum of every three months. Each resident had been allocated a nurse who took responsibility for the management of their care and the participation of residents or family members in care planning and review was clearly documented. Residents and relatives spoken to confirmed that they had been involved in the initial assessment and ongoing reviews. Recognised assessment tools with protocols attached to direct care were used to evaluate residents' progress. These included assessments for risk of pressure ulcers, malnutrition, and falls risk and appropriate measures were put in place to manage and prevent risk.

There was evidence that residents had access, with a multi-disciplinary approach, to a range of allied health services such as dietetic, ophthalmology, chiropody, dentistry, speech and language therapy, physiotherapy and occupational therapy. Specialist health services were available in the centre with a direct referral pathway to a consultant geriatrician and psychiatry of old age community team support.

The centres' policy on the use of restraint included a direction to consider all other alternative interventions and the only restraint in use was bedrails. Inspectors found that there was documentation on the reason for the use of bedrails and that other options had been explored before implementing this practice. There was evidence that the use of restraint was subject to assessment and ongoing review with risk assessments undertaken before introducing bedrails. Where there was a lack of clarity about capacity to consent, residents were referred to their GP for a more in-depth assessment than was normally undertaken by the nursing staff. Where a resident exhibited challenging behaviour this was well managed and other residents protected from the adverse effects of such behaviour.

Inspectors found that there were opportunities for engagement in meaningful activity to meet residents' social care needs, based on residents' assessed preferences, interests and capacities. Residents had access to a variety of activities that were organised at the time of inspection by an activities coordinator working 12 hours per week and supported by a number of volunteers. An inspector met the current activities coordinator, reviewed the activity timetable that was displayed in a number of locations , and observed residents engaged in activities such as singing songs, receiving hand massage and exercise. Residents informed inspectors that they were aware of the activities available and that they enjoyed them. Nursing staff, care staff, residents and relatives also confirmed that there were regular activities provided.

Inspectors found that the activity programme was limited in meeting the needs of the more dependent residents who were not able to participate fully in group activity and those with cognitive impairment. While inspectors observed residents with some cognitive impairment being sensitively encouraged to take part in activities and the completion of life stores to aid in communication, there was no evidence of specific therapeutic activities focused on enhancing interaction and communication. The current activities coordinator had not received any specific training regarding how activities might meet the needs of residents with dementia. The person in charge explained that the permanent activities coordinator's unavailability for work at this time had resulted in a replacement part time activities coordinator taking that position.

Outcome 8
Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.

References:
Regulation 14: End of Life Care
Standard 16: End of Life Care

Inspection findings

Caring for residents at end of life was informed by the centres' comprehensive policy on end of life care and relatives confirmed that the policy was implemented in practice.

While no resident was receiving end of life care at the time of inspection, staff described the person-centred care that would be provided, such as a residents' family being facilitated to be with them, and the emphasis on providing appropriate care and comfort to each resident approaching end of life. There was a dedicated en suite room for end of life care. Staff were knowledgeable about the residents' preferred religious practices. Inspectors had an opportunity to speak with two relatives whose (resident) relative's had died in the centre. Both referred to the kindness of staff at the end of life stage and the consideration that had been shown to the family.

There was a comprehensive centre specific written policy available on end of life care that addressed the provision of appropriate care and comfort to meet a resident's physical, emotional, psychological and spiritual needs and consideration of residents' autonomy in regard to wishes and choices. A care pathway to promote best practice for care of the dying had been developed and implemented.

There was evidence of staff training in end of life and palliative care and residents had access to specialist palliative care services via GP referral to support symptom management.

Outcome 9
Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.

References:
Regulation 20: Food and Nutrition
Standard 19: Meals and Mealtimes

Inspection findings

Residents received a nutritious and varied diet that offered choice, and mealtimes were unhurried social occasions that provided opportunities for residents to interact with each other and staff.

Inspectors found that there was a varied diet available and inspectors who met the chef discussed the special dietary requirements of individual residents and saw that information was kept on residents' dietary needs and preferences in the kitchen.

The weight records examined showed that residents' weights were checked on a monthly basis at minimum and nutrition assessments were used to identify residents at risk of malnutrition. Records showed that there was a dietetic review of residents at nutritional risk.

Inspectors observed staff discussing the menu choices for lunch and tea with residents in the day room. Residents were asked whether they would like to sit at a dining table or stay where they were and eat off a side table. An inspector joined residents for lunch and observed that it was an unrushed occasion with appropriate place settings and the food presented in appetising individual portions and was of a high quality. Staff assisted some residents with dining in a respectful manner and used the time as an opportunity for social interaction. Staff members chatted with residents and encouraged discussion amongst them.

Inspectors saw residents being offered a variety of snacks and drinks throughout the day. A water dispenser was available in the day room and jugs of water were at bedside tables. Residents told inspectors that they could have tea or coffee and snacks any time.

4. Respecting and involving residents

Outcome 10
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.

References:
Regulation 28: Contract for the Provision of Services
Standard 1: Information
Standard 7: Contract/Statement of Terms and Conditions

Inspection findings

Contracts were agreed with and provided to residents and set out the overall care and services provided to the residents and the fees charged, including any additional fees charged. Contracts were not sufficiently clear about costs incurred when personal laundry could not taken care of by family.

Outcome 11
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.

References:
Regulation 10: Residents' Rights, Dignity and Consultation
Regulation 11: Communication
Regulation 12: Visits
Standard 2: Consultation and Participation
Standard 4: Privacy and Dignity
Standard 5: Civil, Political and Religious Rights
Standard 17: Autonomy and Independence
Standard 18: Routines and Expectations
Standard 20: Social Contacts

Inspection findings

Inspectors found evidence that residents received dignified and respectful care. Their capacity to exercise person choice and autonomy was maximised and their views were sought and listened to. Privacy and dignity was compromised as result of some multi-occupied rooms.

While residents could influence change as a residents' forum was established, given the high dependency levels and cognitive impairment among the residents, there were limitations on their participation in the organisation of the centre. To overcome this challenge, an advocacy service had been implemented and was effectively used to determine residents' preferences. There were two fully trained advocates available, one of whom spoke with an inspector, and outlined the service and her efforts to facilitate residents on a one to one as well as on a group basis. There was evidence of change having been made – for example in teatimes – as a result of the advocacy service and residents' forum. There was also evidence that residents had been provided with opportunities to provide feedback about the service provided via satisfaction questionnaires that sought specific information regarding, for example, staff attitude and professionalism and satisfaction with care received.

Inspectors observed and were also informed by residents and relatives that the privacy and dignity of residents was respected by staff. For example:

- doors to single and twin-bedded rooms and shower rooms were kept shut while staff were assisting residents
- curtains were pulled around beds in shared bedrooms when personal care was being provided
- the manner in which residents were addressed by staff was appropriate and respectful
- inspectors observed staff taking the time to reassure residents with cognitive impairment, speaking slowly, clearly and sensitively
- a beautician and hairdresser were available to residents.

Inspectors observed that social and family contacts were maintained, as visitors were welcomed at various times of the day and there were no restrictions on these visits. Residents and their relatives confirmed that flexible visiting was usual practice. There was a small room available as a private area for residents to spend time alone and to meet visitors

Inspectors observed that staff promoted residents' independence by encouraging residents to do as much for themselves as possible. Evidence of residents having choice was confirmed by residents who informed inspectors that they themselves decided whether they would get involved in activities, what food they ate and what clothing they wore, what time to get up and go to bed.

Residents, visitors and staff told inspectors that the person in charge was always available and they felt that communication was welcomed and encouraged. Inspectors observed good interactions between staff and residents. Staff were observed chatting freely with residents. Residents stated that they could talk to staff at any time. Relatives were satisfied with information provided by staff about residents' healthcare and general wellbeing.

Inspectors observed that residents had access to televisions, daily newspapers and a portable phone. There was considerable involvement with the local community through volunteers and a 'Friends of the Hospital' group who had been very active in supporting the needs of the residents.

Residents' religious needs were facilitated as inspectors were informed by staff, residents and their relatives that there were religious services held in the day room. Inspectors observed the weekly mass being celebrated during the inspection and other religious denominations were visited by their ministers, as required.

While inspectors noted that staff made every effort to respect and protect the privacy of residents, privacy and dignity was compromised in a number of ways:

- the design and layout of the premises reflects a traditional hospital style with limited single rooms and the majority of accommodation reflecting a ward structure. Therefore the shared facilities were in the form of long narrow wards with little capacity to create any type of domestic environment. The resulting space restrictions did not allow for residents to have a sufficient personally identified space in order to maintain their identity and sense of self. Space to allow for a chair by the bed or to accommodate visitors was also limited.

- doors to multi occupied rooms were kept open so it was not possible for staff to knock first before entering
- in the seven-bedded unit there was only one toilet available for residents.

Outcome 12
Adequate space is provided for residents' personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.

References:
Regulation 7: Residents' Personal Property and Possessions
Regulation 13: Clothing
Standard 4: Privacy and Dignity
Standard 17: Autonomy and Independence

Inspection findings

There were arrangements in place for regular laundering of linen and clothing. As stated in outcome 11, improvements were required to ensure adequate space in multi occupancy rooms.

There was a policy on the management of residents' personal property and possessions which inspectors noted was consistent with the practice. Residents were dressed well and according to their individual choice.

There were arrangements in place for regular laundering of linen through a local laundry service. The arrangements for personal laundry were that this was done by family members and for those residents who did not have a personal contact to do their laundry, this was taken to a local laundry service and they were charged accordingly. Relatives and residents spoken with were satisfied with these arrangements.

Challenges presented by the limitations of a ward structure regarding residents' personal space had been met by notice boards beside each bed to allow for photos to be displayed and wardrobes were allocated to each resident. In addition each resident had their own locker and individual toiletries. However, as stated in outcome 11, improvements were required to ensure sufficient personal space.

5. Suitable staffing

Outcome 13
The designated centre is managed by a suitably qualified and experienced nurse with authority, accountability and responsibility for the provision of the service.

References:
Regulation 15: Person in Charge
Standard 27: Operational Management

Inspection findings

The person in charge was full-time and she was a registered nurse with the required experience and clinical knowledge in the area of nursing of older people. There was evidence that she had a commitment to her own continued professional development and throughout the two days of inspection the person in charge demonstrated very good knowledge of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

Residents, relatives and staff informed inspectors that the person in charge had a daily presence in the centre and she was available to answer any queries or concerns. Inspectors observed evidence of good leadership and a robust management structure to ensure monitoring of practice. The person in charge had kept her clinical knowledge up to date and demonstrated a sufficient knowledge of clinical audit with processes in place for auditing information to identify trends and improve the quality of service and safety of residents.

Throughout the inspection process the person in charge demonstrated competence and a strong commitment to the delivery of person-centred care and to meeting the regulatory requirements and welcomed the opportunity that inspection provided for all within the staff team to review and improve practice.

Outcome 14
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.

References:
Regulation 16: Staffing
Regulation 17: Training and Staff Development
Regulation 18: Recruitment
Regulation 34: Volunteers
Standard 22: Recruitment
Standard 23: Staffing Levels and Qualifications
Standard 24: Training and Supervision

Inspection findings

All staff had access to education and training to meet the needs of residents and were recruited and Garda Síochána vetted in accordance with best recruitment practice. All staff and volunteers were supervised on an appropriate basis. There were not always appropriate staff numbers to meet the assessed needs of residents, and to the size and layout of the centre. Dementia care training was not part of the ongoing training programme.

There was a policy for the recruitment, selection and Garda Síochána vetting of staff and a review of five personnel files found this policy was reflected in practice.

Staff that inspectors spoke with were clear about their areas of responsibility and the reporting structures and supervision arrangements. Staff informed inspectors that copies of both the regulations and the standards had been made available to them and expressed an adequate knowledge of the content. Inspectors saw that policies had been condensed into one sheet descriptions and staff interviewed confirmed that this was a useful aid to familiarize them with policy content. Regular staff meetings were held with minutes of such meetings maintained and staff confirmed that the meetings were regular. Staff facilities were adequate.

There was evidence that the provider and person in charge were committed to staff education and training as records indicated that education and training for all staff was continuous and relevant. Mandatory training in, for example, manual handling and adult protection, was up to date and training records showed the delivery of ongoing training in areas such as basic life support, crisis intervention, hand hygiene, infection control, medication management, dysphasia, communication, wound care, end of life and palliative care. A clinical nurse specialist in gerontology led weekly in house education programmes for staff in, for example, continence management, skin integrity, clinical policies, informed consent and delivered educational projects in areas such as oral care and assessment of older people. Learning was reinforced with follow up questionnaires which inspectors reviewed. The clinical nurse specialist

confirmed that specific dementia care training was not part of the training programme.

Half of the care staff had completed a Further Education and Training Awards Council (FETAC) Level 5 care assistant programme and the person in charge outlined the training plan for the remainder of care staff to be facilitated to complete the qualification.

Inspectors reviewed staffing rotas, spoke with the person in charge and staff and observed the level of staffing. There was an inadequate number of staff on duty to meet the needs of highly dependent residents from 18:00hrs - 19:30hrs. Staffing level inadequacies were confirmed by some relatives who stated in their questionnaires that in their experiences staffing was lower than optimum in the evenings. The person in charge stated that she and her team were not satisfied with the level of staff resources during this time period. An inspector observed that after 18:00hrs the two staff on duty, both of whom were nurses, were extremely busy with one nurse in the office completing documentation and the other checking on residents in the day room and in bedrooms. Two call bells were pushed by residents at either end of the centre, both of whom required the attention of the two nurses. During this time an inspector observed a resident in the day room was experiencing some confusion and distress. Staffing levels increased when a nurse came on duty at 19:30hrs with a subsequent decline again at 23.30hrs when one nurse went off duty. A system for staff off duty to be called upon in the event of emergencies was in operation to augment the minimum staffing of a nurse and care staff during the night.

6. Safe and suitable premises

Outcome 15
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. There is appropriate equipment for use by residents or staff which is maintained in good working order.

References:
Regulation 19: Premises
Standard 25: Physical Environment

The environment was bright, clean and well maintained throughout. Residents told inspectors that the centre offered a comfortable environment. The main communal area had a variety of pleasant furnishings with appropriate seating. The décor was of a high standard and the communal area was bright with a very pleasant view of the surrounding grounds.The centre was not purpose-built and the standard of communal space required improvement as did storage space, the use of signage and the call bell system.

The landscaped unenclosed garden was very well maintained with some appropriate furniture and residents and relatives told inspectors that they enjoyed spending time in the garden during fine weather.

There was a separate kitchen and inspectors observed a plentiful supply of fresh and frozen food.

There was appropriate assistive equipment available such as profiling beds, hoists, pressure relieving mattresses and cushions, wheelchairs and walking frames. The corridors enabled easy accessibility for residents in wheelchairs or those with mobility aids. Hand rails were available to promote independence. Hoists and other equipment had been maintained and service records were up to date.

There were a number of improvements required:

- the communal area was bright and pleasant but was the only space available for a range of activities including dining, religious ceremonies, and activities. Therefore, there was no opportunity for residents to enjoy a separate dining experience
- there was limited storage space for equipment and commodes were routinely stored in bathrooms. On the day of inspection high dependency chairs were stored in the day room
- the call bell system was inadequate in that there are no lights over doors to indicate where the bell has been rung and there was only one panel in the centre of the building to which staff had to refer to identify the source of the call bell. Therefore, staff had to walk a considerable distance to identify the source of the call
- There was an insufficient use of signage to assist in the orientation of residents.

17. Records and documentation to be kept at a designated centre

Outcome 16

The records listed in Part 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) 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 2009 (as amended).

References:

Regulation 21: Provision of Information to Residents
Regulation 22: Maintenance of Records
Regulation 23: Directory of Residents
Regulation 24: Staffing Records
Regulation 25: Medical Records
Regulation 26: Insurance Cover
Regulation 27: Operating Policies and Procedures
Standard 1: Information

Standard 29: Management Systems
Standard 32: Register and Residents' Records

Inspection findings:

**Where "Improvements required" is indicated, full details of actions required are in the Action Plan at the end of the report.*

Resident's Guide

Substantial compliance ☐ Improvements required * ☒

Records in relation to residents (Schedule 3)

Substantial compliance ☒ Improvements required * ☐

General Records (Schedule 4)

Substantial compliance ☒ Improvements required* ☐

Operating Policies and Procedures (Schedule 5)

Substantial compliance ☒ Improvements required* ☐

Directory of Residents

Substantial compliance ☒ Improvements required* ☐

Staffing Records

Substantial compliance ☒ Improvements required* ☐

Medical Records

Substantial compliance ☒ Improvements required* ☐

Insurance Cover

Substantial compliance ☐ Improvements required* ☒

Outcome 17
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

References:
Regulation 36: Notification of Incidents
Standard 29: Management Systems
Standard 30: Quality Assurance and Continuous Improvement
Standard 32: Register and Residents' Records

Inspection findings

An inspector reviewed a record of all incidents that had occurred in the centre and the documentation was comprehensive. All relevant incidents were notified to the Chief Inspector as required.

Outcome 18
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.

References:
Regulation 37: Notification of periods when the Person in Charge is absent from a Designated Centre
Regulation 38: Notification of the procedures and arrangements for periods when the person in charge is absent from a Designated Centre
Standard 27: Operational Management

Inspection findings

There were appropriate arrangements in place for the absence of the person in charge as the deputy director of nursing deputises for the person in charge. Inspectors were informed that there have been no absences of the person in charge for such a length that required notification to the Chief inspector.

Closing the visit

At the close of the inspection visit a feedback meeting was held with the provider, the person in charge, clinical nurse managers and a number of staff members to report on the inspectors' findings, which highlighted both good practice and where improvements were needed.

Acknowledgements

The inspectors wish to acknowledge the cooperation and assistance of the residents, relatives, provider and staff during the inspection.

REPORT COMPILED BY

Patricia Sheehan
Inspector of Social Services
Social Services Inspectorate
Health Information and Quality Authority

3 June 2011

Health Information and Quality Authority
Social Services Inspectorate

Action Plan

Provider's response to inspection report

Centre:	Bandon Community Hospital
Centre ID:	0557
Date of inspection:	24 May 2011
Date of response:	20 July 2011

Requirements

These requirements set out the actions that must be taken to meet the requirements of the Health Act 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care settings for Older People in Ireland*.

Outcome 1: Statement of purpose and quality management

1. The provider is failing to comply with a regulatory requirement in the following respect:

The statement of purpose did not meet all of the requirements of Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and did not accurately describe the facilities and admission criteria.

Action required:

Revise the statement of purpose so that it consists of all matters listed in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and accurately describe the facilities and admission criteria, specifically:

- the number and size of rooms
- the maximum number of residents who can be accommodated
- the use of bedrooms with more than two residents and the category of residents in them
- any exclusion criteria for admissions

Reference: Health Act 2007 Regulation 5: Statement of Purpose Standard 28: Purpose and Function	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The statement of purpose has been amended to include all the above and is attached for your attention.	 20 July 2011

Outcome 5: Health and safety and risk management

2. The provider is failing to comply with a regulatory requirement in the following respect: The risk management policy did not detail the arrangements in place for the recording, investigation and learning from serious incidents and did not cover the precautions in place to control the specified risks of unexplained absence of a resident; assault; accidental injury to residents or staff; aggression and violence; and self-harm. Individual risk assessments had not been completed for those residents who smoked.
Action required: Ensure that the risk management policy covers the arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents.
Action required: Ensure that the risk management policy covers the precautions in place to control the following specified risks: the unexplained absence of a resident; assault; accidental injury to residents or staff; aggression and violence; self-harm and an unsecure garden perimeter
Action required: Ensure that there are individual risk assessments completed for those residents who smoke.
Action required: Provide to the Chief Inspector written confirmation from a competent person that all the requirements of the statutory fire authority have been complied with.
Action required: Ensure, by means of fire drills at six-monthly intervals, that the staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire, including the procedure for saving life.

Reference: Health Act 2007 Regulation 31: Risk Management Procedures Regulation 32: Fire Precautions and Records Standard 26: Health and Safety Standard 29: Management Systems	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: 1. The hospital risk management policy now states how serious incidents are recorded, investigated and the learning outcomes from the incidents. Such learning will be part of staff meeting agendas so that the learning can be disseminated to all staff. 2. The risk policy also includes precautions that are in place to control the specific risk of unexplained absence of a resident, assault, accidential injury to residents or staff, aggression and violence, and self-harm. 3. Individual risk assessments will be completed on any residents who smoke, in the future. 4. As a result of a recent fire safety audit by a fire safety company on behalf of the HSE in Bandon Hospital, works are underway to address the immediate recommendations of this survey in order that the building meets with the fire statutory requirements. 5. At present, all staff receive annual fire safety training, including evacuation drills. HSE Estates department are in discussion with the Health Information and Quality Authority to establish what are the necessary requirements for training to comply with statutory requirements.	31 July 2011 31 July 2011 31 July 2011 31 July 2011

Outcome 7: Health and social care needs

3. The provider is failing to comply with a regulatory requirement in the following respect: There were currently not sufficient opportunities for highly dependent residents and those with cognitive impairment to participate in activities appropriate to his/her interests and capacities.
Action required: Provide opportunities for all residents to participate in activities appropriate to his/her interests and capacities.

Reference: Health Act 2007 Regulation 6: General Welfare and Protection Standard 18: Routines and Expectations	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: At present, there is a weekly activity programme which is determined by the assessed needs/wishes of the residents. This includes one to one sessions with the highly dependent resident, including hand massage, music, chatting and reading the paper, one to one ciunas sessions at the bedside. Ongoing training for staff in the care of the dementia patient will also support residents participation in activities to improve their quality of life.	September 2011

Outcome 10: Contract for the Provision of Services

4. The provider is failing to comply with a regulatory requirement in the following respect: Contracts were not sufficiently clear about costs incurred when personal laundry is not taken care of by family.	
Action required: Ensure contracts are clear about costs incurred when personal laundry is not taken care of by family.	
Reference: Health Act 2007 Regulation 28: Contract for the Provision of Services Standard 1: Information Standard 7: Contract/Statement of Terms and Conditions	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: It has been clarified in the contract, arrangements for personal laundry to include the cost incurred by the resident when no family member can facilitate laundry.	20 July 2011

Outcome 11: Residents' rights, dignity and consultation

5. The provider is failing to comply with a regulatory requirement in the following respect: Privacy and dignity was compromised by the space restrictions of a ward design.
Action required: Review and address the facilitation of sufficient personal space to ensure privacy and dignity for all residents.
Action required: Review the amount of toilets available to residents in multi occupancy rooms.
Reference: Health Act 2007 Regulation 10: Residents' Rights, Dignity and Consultation Standard 4: Privacy and Dignity

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: 1. HSE Estates have drawn up a plan for a six-bedded extension to facilitate sufficient personal space and to ensure privacy and dignity for all residents. While at present, there are two toilets available for ten patients, it is hoped that this extension will also provide additional en suite facilities. This extension has been put on the priority list for HSE South capital expenditure.	31 December 2012

Outcome 14: Suitable staffing

6. The person in charge is failing to comply with a regulatory requirement in the following respect: There were not appropriate staff numbers to meet the assessed needs of residents at all times given the layout of the centre and dementia care training was not part of the ongoing training programme.
Action required: Review staff numbers and provide sufficient staff to meet the assessed needs of residents at all times, and to the size and layout of the centre.
Action required: Provide dementia care training as part of the ongoing training programme.

Reference: Health Act 2007 Regulation 16: Staffing Regulation 17: Training and Staff Development Standard 23: Staffing Levels and Qualifications Standard 24: Training and Supervision	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: 1. Rosters have been amended to allocate a third member of staff to be on duty between 18:00hrs and 19:30hrs. 2. A comprehensive three day Dementia care training has been organised for August/September 2011.	 25 July 2011 August/Sept 2011

Outcome 15: Safe and suitable premises

7. The provider is failing to comply with a regulatory requirement in the following respect: The physical design and layout of the premises did not allow for adequate communal accommodation, sufficient storage and signage and the call bell system was not adequate.
Action required: Provide sufficient communal space to ensure adequate sitting, recreational and dining space.
Action required: Provide adequate storage space for all equipment.
Action required: Improve the adequacy of the call bell system.
Action required: Provide sufficient use of signage to assist in orientation of residents.
Reference: Health Act 2007 Regulation 19: Premises Standard 25: Physical Environment

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: 1. HSE Estates have drawn up a plan for a six-bedded extension to facilitate sufficient personal space and to ensure privacy and dignity for all residents. This extension will include additional sitting and recreational space. It will also provide additional storage space for equipment. This extension has been put on the priority list for HSE South capital expenditure. 2. The call bell system is being upgraded to ensure there will be lights over doors to indicate where the call bell has been rung. 3. Signs are being upgraded in the hospital to assist in the orientation of residents.	31 December 2012 August 2011 August 2011

Outcome 16: Records and documentation to be kept at a designated centre

9. The provider is failing to comply with a regulatory requirement in the following respect: The Resident's Guide was not supplied to each resident and not all of the information for residents reflected the insurance cover against loss and damage to personal property.
Action required: Ensure that a copy of the Resident's Guide is supplied to each resident.
Action required: Ensure that all resident information reflects insurance cover against loss or damage to their property.
Reference: Health Act 2007 Regulation 21: Provision of Information to Residents Regulation 22: Maintenance of Records Regulation 23: Directory of Residents Regulation 24: Staffing Records Regulation 25: Medical Records Regulation 26: Insurance Cover Standard 1: Information

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: A copy of the Resident's Guide is provided to all residents which reflects the insurance cover against loss or damage to their property.	August 2011

Any comments the provider may wish to make:

Provider's response:

None received.

Provider's name: Teresa O'Donovan

Date: 20 July 2011