

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Clonakilty Community Hospital
Centre ID:	OSV-0000559
Centre address:	Clonakilty, Cork.
Telephone number:	023 88 33 205
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Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Patrick Ryan
Lead inspector:	Breeda Desmond
Support inspector(s):	Mairead Harrington
Type of inspection	Announced
Number of residents on the date of inspection:	127
Number of vacancies on the date of inspection:	10

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.

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 Quality 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:
20 April 2015 10:30	20 April 2015 18:00
21 April 2015 08:30	21 April 2015 19:30

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

Outcome 01: Statement of Purpose
Outcome 02: Governance and Management
Outcome 03: Information for residents
Outcome 04: Suitable Person in Charge
Outcome 05: Documentation to be kept at a designated centre
Outcome 06: Absence of the Person in charge
Outcome 07: Safeguarding and Safety
Outcome 08: Health and Safety and Risk Management
Outcome 09: Medication Management
Outcome 10: Notification of Incidents
Outcome 11: Health and Social Care Needs
Outcome 12: Safe and Suitable Premises
Outcome 13: Complaints procedures
Outcome 14: End of Life Care
Outcome 15: Food and Nutrition
Outcome 16: Residents' Rights, Dignity and Consultation
Outcome 17: Residents' clothing and personal property and possessions
Outcome 18: Suitable Staffing

Summary of findings from this inspection

This report sets out the findings of an announced registration renewal inspection and it was the fifth inspection undertaken by the Authority in Clonakilty Community Hospital. The provider applied to renew their registration which will expire on 24 June 2015. This renewal of registration inspection took place over two days. As part of the inspection the inspectors met with the Person in Charge, recently appointed Designated Provider, Clinical Nurse Managers (CNMs), residents, relatives, and staff members. The inspectors observed practices and reviewed governance, clinical and operational documentation to inform this registration renewal application.

The provider and person in charge displayed knowledge of the standards and regulatory requirements.

Twenty relatives and 32 residents' questionnaires were received and the inspectors spoke with many residents and relatives during the inspection. In general, the collective feedback from residents and relatives was one of satisfaction with the service and care provided. Family involvement was encouraged and this was observed throughout the inspection.

Overall, staff were kind and respectful to residents and demonstrated good knowledge of residents; while this was reflected in residents' assessments it was not reflected in some care plans examined by the inspectors. Residents had access to advocacy services and activities staff provided a variety of social and recreational activities as well as community involvement. Residents were encouraged to exercise choice and their views were sought informally on a daily basis and formally in the residents' committee.

All staff had received training in elder abuse prevention and protection to safeguard residents in their care. Generally staff levels and skill-mix appeared to be adequate to meet the assessed needs of residents, however, inspectors requested that staff levels be reviewed on Crionna ward for twilight hours cognisant of the size and layout of the ward.

While there was some improvement in the private accommodation provided for residents however, overall there were significant limitations within the physical environment which negatively impacted the freedom, choice, privacy, dignity and autonomy of residents along with infection prevention and control risk. In addition, these non compliances were identified in previous inspection reports and will be discussed under Outcome 12 Suitable and Safe Premises.

The inspectors identified other aspects of the service requiring improvement to ensure compliance with the Regulations.

These improvements included:

- 1) review and update some policies to ensure they were centre-specific
- 2) all the policies required in Schedule 1 were not in place
- 3) reviewing and improving the quality and safety of care
- 4) care planning
- 5) privacy and dignity.

The action plan at the end of this report sets out the actions 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 Quality Standards for Residential Care Settings for Older People in Ireland.

Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality 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:

The statement of purpose (SOP) was reviewed and updated in December 2014 to reflect the recent changes to the management structure with the recently appointed designated provider. All items listed in Schedule 1 of the Regulations were detailed in the statement of purpose. Some items required updating and these were remedied before completion of the inspection.

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:

Clinical audits included hand hygiene, falls, care plans, medication management with antibiotic and psychotropic usage, handling and disposal of waste, sharps disposal, ward kitchens and management of resident equipment. A health and safety audit was completed in January 2015 over a five day period with recommendations and action

plans. Results of audits were discussed at ward meeting with staff; a graph was included in the audit results which compared audit results from 2012/2013/2014 which reflected incremental improvements throughout. While some audit reports had responsibilities assigned and timescale detailed however, others did not. An annual review of the quality and safety of care as described in the Regulations was not in place to ensure that such care was in accordance with relevant standards set by the Authority.

Judgment:

Non Compliant - Moderate

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:

Contracts of care were evidenced for residents which detailed the fees to be charged as well as additional fees. Contracts of care for residents were signed and dated by either the resident or their next of kin in line with best practice. They were securely maintained in the administration office.

A residents' guide was available for residents and their relatives. Each resident received a copy of the guide on admission as part of the 'Welcome pack' to Clonakilty Community Hospital. It contained all the items listed in the Regulations.

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 post of the person in charge was full time and held by a registered nurse with the required experience of nursing dependant people. She demonstrated knowledge and understanding of the Regulations and national standards to ensure suitable and safe care. Clear management and accountability structures were in place. The person in charge was engaged in governance, operational management and administration associated with her role and responsibilities. There was evidence that the person in charge had a commitment to her own continued professional development and had completed many courses such as diploma in Health Services Management and a Higher Diploma in Leadership and Management.

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 inspectors were satisfied that the records required in Schedule 2 (staff files), Schedule 3 (residents' records), Regulation 19 (register of residents), Schedule 4 (general records) of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 were maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. However, three polices required in Schedule 5 (operating policies and procedures) were not in place:

- 1) provision of information to residents
- 2) staff training and development
- 3) the creation of, access to, retention of and destruction of records.

The policy on end of life care required updating as it concentrated on the imminent phase of end-of-life care and not the passive phase where residents would have the ability to inform staff of their wishes and preferences when their condition deteriorated and be involved in their plan of care.

Judgment:

Non Compliant - Moderate

Outcome 06: Absence of the Person in charge

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The person in charge was aware of her responsibilities regarding notification to the Authority should the occasion arise. Appropriate deputising arrangements were in place to ensure care and welfare of residents. There were two assistant directors of nursing on day duty and two CNM3s with responsibility for night duty. CNMs 1 and 2 were in place on each ward with responsibility for the day-to-day running of their units. Senior nurses were in place to support the management team also. Residents gave positive feedback to inspectors regarding access to the ward managers to discuss their care and other issues.

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:

Measures were in place to protect residents from being harmed or suffering abuse. There was an up-to-date policy for adult protection which contained the information stipulated in Regulation 31. The policy detailed information regarding procedures for prevention and detection to abuse, however, it did not direct staff on how to take

'appropriate steps to ensure the safety of dependant persons'. Staff had completed training in adult protection and staff spoken with demonstrated their knowledge of protection of residents in their care and actions to be taken if care was untoward. A new interactive adult protection programme was introduced and positive feedback was given regarding this.

The CNMs spoke with residents on a daily basis and also with relatives and supervised staff as part of ensuring the safety of residents. Feedback from residents was positive and many stated they felt 'safe' in the centre. Completed questionnaires stated that 'staff were kind' and they visitors were 'welcome' to visit anytime. There was a resident advocate who attended the centre on a weekly basis; she chaired the residents' meetings which were held every two months. Inspectors noted that issues raised by residents were brought to the attention of the person in charge by the advocate and items were followed up on subsequent meetings. Positive feedback was given to inspectors about the advocacy service provided in the centre.

However, systems relating to maintenance of residents' finances were not sufficiently robust or transparent to ensure the safety of residents or staff, as dual signatures were not in place for all financial transactions. Residents had access to a secure safe within their bedside locker.

There was a checklist sheet to assist staff in the decision-making process in the use of restraint, however, this was not evidenced-based and was subjective. The CNMs reported to the inspectors that an evidenced-based risk assessment for restraint was being implemented in the centre however, it was still in draft form. This was identified in previous inspections so inspectors requested that this be implemented immediately with the associated staff training to ensure effective and appropriate use of bedrails; in conjunction with promotion of a restraint-free environment. Inspectors were given assurances that implementation of the appropriate risk assessments would be expedited.

Judgment:

Non Compliant - Moderate

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

Theme:

Safe care and support

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

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

Findings:

There was a policy labelled "the risk assessment policy", which contained assessment

audits and risk rating template with detailed the identification, assessment of risks with measures and actions in place to control risks identified. In addition there was a safety statement and stand-alone policies regarding self-harm, absconsion, violence and aggression, however, a risk management policy as described in the Regulations was not evidenced.

The health and safety committee met bi-annually and there was a designated health and safety officer in place.

While there was a policy relating to fire management however, it was not labelled as such. There was a policy labelled "the emergency plan", however, this was confusing as it was the local County Council emergency plan for the West Cork area which contained information for reference and context rather than direction for staff regarding protocols and procedures to follow in the event of emergencies; that is a centre-specific emergency plan was not evidenced.

There were guidelines in place for infection prevention and control, however, a centre-specific policy to enhance these guidelines was not available. Advisory signage for best practice hand washing was displayed over some hand-wash sinks; inspectors observed that opportunities for hand hygiene were taken by staff. Staff had completed training in hand hygiene and infection prevention and control. Issues relating to storage of laundry trolleys in residents' bedrooms had been previously highlighted however, it was reported to inspectors that this remained unresolved due to lack of storage space. In addition to this being an infection prevention and control issue, inspectors observed that occasionally these trolleys partially obstructed the emergency escape doors. Furthermore, storage of such equipment in residents' bedrooms was not reflective of the ethos expressed in the Statement of Purpose of respecting residents' dignity. Two other emergency exit doors were observed to be held open by a traffic cone and a chair.

Current relevant fire certification for maintenance and servicing was evidenced. A fire safety register was in place, with daily, weekly and monthly fire safety checks evidenced, in line with best practice guidelines. Staff had completed their mandatory fire training. Fire drills were completed six-monthly and this was evidenced by fire training records reviewed. Fire safety evacuation notices were displayed in a prominent position throughout the centre, however, one emergency escape notice in Sonas ward was inappropriately place over a door which was not an emergency escape route and inspectors requested that this would be remedied immediately and placed over the alternative doors which lead to the emergency exit. Colour-coded floor plans were displayed throughout the centre which identified 'Where You Are Now' in line with best practice.

All staff had completed their mandatory training in moving and handling of residents.

A current insurance policy was demonstrated.

A record was maintained of incidents and accidents. These were reviewed by the CNMs and person in charge and discussed at the health and safety bi-annual meetings. In addition, they were followed up at the daily ward hand-over meetings.

Judgment:

Non Compliant - Moderate

Outcome 09: Medication Management

Each resident is protected by the designated centre's policies and procedures for medication management.

Theme:

Safe care and support

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

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

Findings:

There was a policy in place from the supplying pharmacy with procedures for the supply, prescription and receipt of medications and it was written from the perspective of the pharmacy. It included a statement that a 'prescription for over-the-counter medications was not necessary' which is not in keeping with professional medication management guidelines. An overarching centre-specific medication management policy detailing procedures for safe ordering, prescribing, storing and administration of medicines and handling and disposal of unused or out-of-date medicines was not in place. There were stand-alone policies detailing administration of medications; return of controlled drugs only with no detail for the return of other medications. The protocol for prescribing as required (PRNs) medications was not comprehensive as it did not specify that maximum dosage was required as part of a prescription. A policy on self-medicating was in place however, the risk assessment alluded to in the policy was not evident in the policy. Transcription did not occur in the centre and this was detailed in the policy. Photographic identification was in place for residents as part of their prescription/drug administration record chart, in the sample of prescriptions examined. Controlled drugs were maintained in line with best practice professional guidelines. A new controlled drugs log was in place which enabled appropriate recording of controlled drug administration. Medication trolleys were securely maintained. Medication fridges were in place in each ward and temperatures were recorded.

In the sample of prescriptions reviewed the maximum dosage for PRN medications were not included to mitigate the risk of medication errors; some medications were not signed for by staff administering medications; one medication was written as a regular prescription and the same drug was not discontinued in the PRN prescription leading to a potential risk of over dosage.

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

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

over meetings to mitigate risk of recurrence.

Judgment:

Non Compliant - Moderate

Outcome 10: Notification of Incidents

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

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

Notifications received by the Authority were reviewed upon submission and prior to the inspection. Notifiable incidents and quarterly returns submitted to the Authority were timely and comprehensive. Notification forms were recently upgraded and these were highlighted to the person in charge. Records were maintained of incidents occurring in the centre and were monitored by the person in charge.

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):

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

Findings:

A sample of residents' assessments and care plans were reviewed by inspectors. While residents or their next-of-kin signed for consent for photographs and other clinical interventions however, there was no other documented evidence that they were involved in the planning of care process even though most of the returned

questionnaires stated that they were involved in the care planning process. Residents' assessments demonstrated detailed person-centred information, however, their care plans did not reflect the in-depth knowledge accrued in the assessments or the care observed by inspectors and were based on a medical model of care rather than a holistic social model. Appropriate clinical risk assessments were evidenced to support evidence-based care, for example, specialist falls risk, nutritional risk, positive behavioural support and skin integrity risk assessments.

It was reported to inspectors that sometimes the pre-admission assessment completed on a potential resident were not comprehensive and did not reflect the full health, personal and social care needs of a person intending to become a resident. This was identified as an issue as a resident could be admitted and inappropriately placed in a ward which was not equipped to facilitate someone with complex communication needs (evidence of this was described under Outcome 12). Pre-admission assessments were not conducted by hospital staff but other HSE staff external to the centre.

General practitioners (GPs) from different practices routinely attended the centre with out-of-hours cover when necessary. A sample of medical records reviewed demonstrated that resident's were reviewed on a regular basis. Specialist medical services were also available when required. Reviews and on-going medical interventions as well as laboratory results, were evidenced.

Residents had timely access to dental, optical, psychiatry, occupational therapy, chiropody, dietetic services, physiotherapy, speech and language therapy (SALT) and reports from these referrals and assessments were evidenced in residents' documentation.

Judgment:

Non Compliant - Moderate

Outcome 12: Safe and Suitable Premises

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

Theme:

Effective care and support

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

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

Findings:

This centre was originally built in the 19th century and it had been refurbished and

upgraded with many areas decorated in a homely and cosy fashion. However, there were significant limitations within the physical environment which negatively impacted on the freedom, choice, privacy, dignity and autonomy of residents and these have been described in detail in previous inspection reports.

Issues previously identified on inspections with regards to the limitations of the premises included:

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

There was a dementia-specific unit which accommodated 14 residents and comprised of two single en suite bedrooms, one five-bedded room and a seven-bedded room. However, at the time of inspection there was an extra resident accommodate here due to their complex needs; an extra bed was installed in the sitting room to facilitate this resident. Consequently the communal space was quite limited and while the number of residents accommodated in the centre remained within their registered number, the size and layout of the unit was not adequate to accommodate 15 residents. In addition, the size of the multi-occupancy bedroom with seven beds was inadequate to accommodate seven residents as bedside chairs or wardrobes could not be accommodated alongside some residents' beds; this also significantly compromised the privacy and dignity of residents and was wholly unsuitable to meet their complex needs in relation to dementia care needs.

The centre was generally clean throughout and well maintained. The gardens were attractively laid out, secure and well maintained. A secure garden was available with easy access from the dementia specific unit. Outdoor furniture and fencing here was painted brightly and there was a newly developed walkway for residents to enjoy the garden with raised beds. However, the fencing to the rear of the garden required attention as it was not stable.

The café by the main reception was a pleasant social place for staff, residents and relatives. Feedback from returned questionnaires commented on the value of the cafe.

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

Sluice rooms were inspected and these were quite small in Dochas and An Ghraig; the inspectors observed that while bed pans and urinals were cleaned appropriately however, there was inadequate storage to enable them to be stored in line with best practice guidelines. In addition, the sluice room in Saoirse also contained laundry facilities which is not in keeping with best practice infection prevention and control best practice guidelines.

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

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

Judgment:

Non Compliant - Major

Outcome 13: Complaints procedures

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

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

The complaints policy was displayed prominently at the main reception and throughout the centre. However, the procedure was not displayed as described in the Regulations; the policy was not in an accessible format for easy reading for residents and visitors.

The complaints log was reviewed but whether or not the complainant was satisfied with the outcome was not always recorded. Many of the complaints related to issues pertaining to multi-occupancy bedrooms. The complaints policy did not reflect practice of reporting and recording of complaints in the centre. The CNMs on each unit monitored complaints and endeavoured to resolve issues as soon as they arose.

Recourse to the Chief Inspector was included in the complaints policy and this was identified at the start of inspection and was removed before completion of the inspection.

Judgment:

Substantially Compliant

Outcome 14: End of Life Care

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.

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

There was a policy in place for end-of-life care and this was in date. However, inspectors noted that this policy concentrated on the active stage of end-of-life care and not the preceding time where advanced care planning could be initiated to capture residents' wishes and needs for their care if/when their condition deteriorated. This was actioned under Outcome 5.

Spiritual needs were facilitated with Mass held weekly in the centre; other denominations were facilitated upon request. Residents had access to consultant palliative care and the hospice services. Staff had completed professional development regarding end of life care, palliative care and specialist syringe-driver. Care practices observed would suggest that residents would be cared for with the utmost respect.

Judgment:

Substantially Compliant

Outcome 15: Food and Nutrition

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

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

There was an up-to-date policy in place for food and nutrition which included a

recognised risk assessment and residents care plans contained evidence of regular monitoring of fluid and nutritional status. Following a resident survey and discussion with the resident advocate, a new menu system was introduced which gave a wider choice for residents for their meals. Returned questionnaire reviewed by inspectors demonstrated that while residents were happy with the menu choice, quality and temperature of food however, they expressed dissatisfaction at having their evening meal at 16:00hrs. Feedback stated they were 'not hungry' at that time and 'seldom chose a hot option' because it was too close to dinner time'. This issue was highlighted to the person in charge. Specialist dietary requirements and consistencies were provided and there was lots of evidence of reports from speech and language therapy and dietician to inform residents' care. Residents' weights were documented on a monthly basis or more often if their clinical condition warranted. Residents had access to fresh water and other fluids throughout the day. However, some returned questionnaires reported that sometimes the resident glass of water was not within easy reach when they were in bed and this was highlighted to the person in charge.

Overall, because of very limited space, the dining experience for some residents was significantly curtailed. Residents requiring assistance with their meals were helped appropriately and with respect in a dignified manner.

Judgment:

Non Compliant - Moderate

Outcome 16: Residents' Rights, Dignity and Consultation

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

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

Residents were consulted on a daily basis. The activities co-ordinator offered a choice of group activities as well as one-to-one sessions. Some families and residents had completed a 'Life Story' as part of their reminiscence therapy. A daily activities record detailing the residents' involvement in the activity was maintained. Activities included art therapist, music, bingo, exercises, card playing, gardening, and aromatherapy. Residents' art was displayed in the centre and one resident had won several art competitions in the local town. Relatives spoken with also gave positive feedback regarding communication and involvement with their relative's care and welfare and the ease of access to all staff to discuss matters.

The centre operated an open visiting policy and this open visiting policy was observed throughout the inspection. Completed relatives questionnaires commended staff on how welcoming they were to all visitors. The manner in which residents were addressed by staff was seen by inspectors to be respectful.

The resident advocate facilitated the residents' committee meetings and many residents attended these meetings. Issues raised at these meetings were reported back to the person in charge for resolution and followed up on subsequent meetings with updates and progress.

Judgment:

Compliant

Outcome 17: Residents' clothing and personal property and possessions
Adequate space is provided for residents' personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

There was an up-to-date policy on residents' personal property and possessions. However, due to inaccessibility of wardrobes for many residents it was difficult to see how they retained control over their possessions and clothing.

Judgment:

Non Compliant - Moderate

Outcome 18: Suitable Staffing

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

Theme:

Workforce

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

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

Findings:

There was evidence of staff education programme and staff had attended a range of training, for example, care planning in residential care settings, dysphagia workshop, challenging behaviour, nutritional risk, protection, fire safety, manual handling and lifting, management, hand hygiene, infection prevention and control, and restraint.

A sample of staff files were reviewed and those examined were compliant with the Regulations and contained all the items listed in Schedule 2 of the Regulations. Current registration with regulatory professional bodies was in place for all nurses. Staff files demonstrated that staff appraisals were undertaken. Generally staff levels and skill-mix appeared to be adequate to meet the assessed needs of residents, however, inspectors requested that staff levels be reviewed on Crionna ward for twilight hours cognisant of the size and layout of the ward.

Information relating to persons participating in the management of the centre was not submitted to the Authority as part of their application to re-register and this was highlighted during the inspection.

Judgment:

Substantially Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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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:	Clonakilty Community Hospital
Centre ID:	OSV-0000559
Date of inspection:	20/04/2015
Date of response:	19/05/2015

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non-compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 02: Governance and Management

Theme:

Governance, Leadership and Management

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

An annual review of the quality and safety of care as described in the Regulations was not in place to ensure that such care was in accordance with relevant standards set by the Authority.

Action Required:

Under Regulation 23(d) you are required to: Ensure there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that

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

such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.

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

An annual review of all audits and activity in relation to quality and safety of care will be undertaken which meets the standards set by the authority.

Proposed Timescale: 30/05/2015

Outcome 05: Documentation to be kept at a designated centre

Theme:

Governance, Leadership and Management

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

Three policies required in Schedule 5 (operating policies and procedures) were not in place:

- 1) provision of information to residents
- 2) staff training and development
- 3) the creation of, access to, retention of and destruction of records.

Action Required:

Under Regulation 04(1) you are required to: Prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.

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

Three policies as detailed above will be written, adopted and implemented by staff here in the hospital.

Proposed Timescale: 08/06/2015

Theme:

Governance, Leadership and Management

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

The policy on end of life care required updating as it concentrated on the imminent phase of end-of-life care and not the passive phase where residents would have the ability to inform staff of their wishes and preferences when their condition deteriorated and be involved in their plan of care.

Action Required:

Under Regulation 04(3) you are required to: Review the policies and procedures referred to in regulation 4(1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them

in accordance with best practice.

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

A policy and protocol which includes the passive phase of end of life care, which meets regulation 4(1) will be completed, in conjunction with the implementation of a new care planning documentation (Mid Leinster Care Document).

Proposed Timescale: Policy and Procedure completed by 30th June 2015 and Mid Leinster Care Document completed by 31st October 2015.

Proposed Timescale: 31/10/2015

Theme:

Governance, Leadership and Management

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

There were guidelines in place for infection prevention and control, however, a centre-specific policy to enhance these guidelines was not available.

Action Required:

Under Regulation 04(1) you are required to: Prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.

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

A copy of a centre-specific policy on infection prevention and control will be provided to HIQA.

Proposed Timescale: 11/06/2015

Theme:

Governance, Leadership and Management

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

A risk management policy as described in the Regulations was not evidenced.

Action Required:

Under Regulation 04(1) you are required to: Prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.

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

A risk management policy will be adopted and implemented as detailed in Schedule 5.

Proposed Timescale: 11/06/2015

Theme:

Governance, Leadership and Management

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

While there was a policy relating to fire management, it was not labelled as such.

Action Required:

Under Regulation 04(1) you are required to: Prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.

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

The hospital will write, adopt and implement policies and procedures relating to fire management.

Proposed Timescale: 11/06/2015

Theme:

Governance, Leadership and Management

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

There was a policy in place from the supplying pharmacy with procedures for the supply, prescription and receipt of medications and it was written from the perspective of the pharmacy. It included a statement that a 'prescription for over-the-counter medications was not necessary' which is not in keeping with professional medication management guidelines.

An overarching centre-specific medication management policy detailing procedures for safe ordering, prescribing, storing and administration of medicines and handling and disposal of unused or out-of-date medicines was not in place.

There were stand-alone policies detailing administration of medications; return of controlled drugs only with no detail for the return of other medications; the protocol for prescribing as required (PRNs) medications was not comprehensive as it did not specify that maximum dosage was required as part of a prescription.

A policy on self-medicating was in place, however, the risk assessment alluded to in the policy was not evident in the policy.

Action Required:

Under Regulation 04(1) you are required to: Prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.

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

The hospital will remove from their policy "over the counter medications" as this is not in line with best practice. The hospital will also write, adopt a policy an overarching centre specific medication management policy detailing procedures for safe ordering, prescribing, storing and administration of medicines and handling and disposal of

unused or out-of-date medicines. A risk assessment will be completed for the self medication policy. The PRN Protocol will be updated to include maximum dose as part of the prescription.

Proposed Timescale: 11/06/2015

Theme:

Governance, Leadership and Management

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

The policy relating to protection detailed information regarding procedures for prevention and detection to abuse, however, it did not direct staff on how to take 'appropriate steps to ensure the safety of dependant persons'.

Action Required:

Under Regulation 04(3) you are required to: Review the policies and procedures referred to in regulation 4(1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.

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

A clear procedure showing the steps that staff should take to prevent and detect abuse shall be written, adopted and implemented in the hospital. This will provide direction to staff on the appropriate steps needed to ensure the safety of dependant persons.

Proposed Timescale: 05/06/2015

Theme:

Governance, Leadership and Management

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

Some medications were not signed for by staff administering medications.

Action Required:

Under Regulation 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

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

The hospital has provided two medication management study days for nursing staff since the inspection. Further training on medication management will continue to ensure that staff understands their responsibility in ensuring that all medications which are administered are signed for. Each ward will carry out a 4 monthly audits on all medication administration sheets.

Proposed Timescale: 30/06/2015

Outcome 07: Safeguarding and Safety

Theme:

Safe care and support

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

Systems relating to maintenance of residents' finances were not sufficiently robust or transparent to ensure the safety of residents or staff, as dual signatures were not in place for all financial transactions.

Action Required:

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

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

In relation to the shop there is a requirement for two signatures to be used when handing out small amounts of money to residents. A system of dual signatures will be implemented.

Proposed Timescale: 18/05/2015

Theme:

Safe care and support

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

There was a checklist sheet to assist staff in the decision-making process in the use of restraint, however, this was not evidenced-based and was subjective. The CNMs reported to the inspectors that an evidenced-based risk assessment for restraint was being implemented in the centre but it was still in draft form. This was identified in previous inspections so inspectors requested that this be implemented immediately with the associated staff training to ensure effective and appropriate use of bedrails.

Action Required:

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

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

The hospital has been training staff in the use of a new bed rail assessment. The implementation of the bed rail assessment will be undertaken.

Proposed Timescale: 29/05/2015

Outcome 08: Health and Safety and Risk Management

Theme:

Safe care and support

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

There was a policy labelled the emergency plan, however, this was confusing as it was the local County Council emergency plan for the West Cork area which contained information for reference and context rather than direction for staff regarding protocols and procedures to follow in the event of emergencies.

Action Required:

Under Regulation 26(2) you are required to: Ensure that there is a plan in place for responding to major incidents likely to cause death or injury, serious disruption to essential services or damage to property.

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

A hospital specific emergency plan detailing protocols and procedure for staff to follow in the event of a major incident causing death injury or serious disruption to essential services or damage to property will be written, adopted and implemented. Within this plan there will be clear plan in writing as to how the hospital will respond to major incidents such as incidents which are likely to cause death or injury, serious disruption to essential services or damage to property.

Proposed Timescale: 30/06/2015

Theme:

Safe care and support

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

Sluice rooms were inspected and these were quite small in Dochas and An Ghraig; the inspectors observed that while bed pans and urinals were cleaned appropriately, there was inadequate storage to enable them to be stored in line with best practice guidelines.

The sluice room in Saoirse also contained laundry facilities which is not in keeping with best practice infection prevention and control best practice guidelines.

Action Required:

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

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

The laundry facilities will be removed from the sluice room in keeping with best practice infection prevention and control best practice guidelines.

Proposed Timescale: 30/09/2015

Theme:

Safe care and support

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

Inspectors observed that occasionally laundry trolleys stored in residents' bedrooms partially obstructed the emergency escape doors.

Action Required:

Under Regulation 28(1)(c)(i) you are required to: Make adequate arrangements for maintaining all fire equipment, means of escape, building fabric and building services.

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

Laundry trolleys will only be in the residents bedrooms during the time care is being provided and removed outside of this time. Staff will not leave them situated in front of emergency escape doors when in use.

Proposed Timescale: 18/05/2015

Theme:

Safe care and support

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

One emergency escape notice in Sonas ward was inappropriately placed over a door which was not an emergency escape route.

Action Required:

Under Regulation 28(1)(c)(i) you are required to: Make adequate arrangements for maintaining all fire equipment, means of escape, building fabric and building services.

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

This emergency escape notice will be removed and situated over the correct emergency escape route in the ward.

Proposed Timescale: 10/05/2015

Outcome 11: Health and Social Care Needs

Theme:

Effective care and support

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

While residents or their next-of-kin signed for consent for photographs and other clinical interventions, there was no other documented evidence that they were involved

in the planning of care process even though most of the returned questionnaires stated that they were involved in the care planning process.

Action Required:

Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.

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

A New care plan document will be implemented including clear evidence that the relatives & residents are involved in the planning of care process.

Proposed Timescale: 30/09/2015

Theme:

Effective care and support

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

Residents' assessments demonstrated detailed person-centred information, however, their care plans did not reflect the in-depth knowledge accrued in the assessments or the care observed by inspectors; they were based on a medical model of care rather than a holistic social model.

Action Required:

Under Regulation 05(3) you are required to: Prepare a care plan, based on the assessment referred to in Regulation 5(2), for a resident no later than 48 hours after that resident's admission to the designated centre.

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

To address the above issues, the hospital will implement a new care plan documentation which will encompass the knowledge that the staff have on their residents. This will be based on a holistic social model.

Proposed Timescale: 30/09/2015

Theme:

Effective care and support

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

It was reported to the inspectors that sometimes the pre-admission assessment completed on a potential resident was not comprehensive and did not reflect the full health, personal and social care needs of a person intending to become a resident. This was identified as an issue as a resident could be admitted and inappropriately placed in a ward which was not equipped to facilitate someone with complex communication

needs, (evidence of this was described under Outcome 12). Pre-admission assessments were not conducted by hospital staff but other HSE staff external to the centre.

Action Required:

Under Regulation 05(2) you are required to: Arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to the designated centre.

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

The HSE has a protocol where pre-admission assessments are carried out by a placement co-ordinator. Agreement between the PIC and the placement co-ordinator of criteria for admission will be formulated.

Proposed Timescale: 05/06/2015

Theme:

Effective care and support

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

In the sample of prescriptions reviewed the maximum dosage for PRN medications were not included to mitigate the risk of medication errors; one medication was written as a regular prescription and the same drug was not discontinued in the PRN prescription leading to a potential risk of over dosage.

Action Required:

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

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

The Medical officers who provide cover to the hospital have been informed in writing the maximum dosage must be entered, where appropriate. Nursing staff will ensure that when they are administering the medications that the maximum dosage has been prescribed in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais

Proposed Timescale: 10/05/2015

Outcome 12: Safe and Suitable Premises

Theme:

Effective care and support

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

There were:

- 1) inadequate number of toilets for residents use; one toilet in Sonas was not fit for purpose
- 2) inadequate provision of bathing facilities
- 3) inadequate dining and communal space in Dochas and An Ghraig; most residents in these units continued to be seated near their bed for meals
- 4) multi-occupancy bedrooms; some could not accommodate a bed-side chair or wardrobe alongside residents' beds
- 5) some multi-occupancy bedrooms could only be accessed via other multi-occupancy bedrooms
- 6) some toilet and shower facilities could only be accessed through a series of multi-occupancy bedrooms
- 7) many residents did not have easy access to their wardrobes
- 8) laundry bins were stored in residents bedrooms
- 9) lack of private space for residents to meet their visitors in private if they wished
- 10) lack of private rooms to accommodate residents, especially at end-of-life care.
- 11) the fencing to the rear of the garden required attention as it was not stable.

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:

Points 1, 2, 3, 4, 5, 6, 7, 8 and 10 will be addressed in the new build as per the timelines below.

A design team will be appointed in September 2015 and plans will be completed by, November 2015.

Planning permission will then be applied for, and provided there are no objections, it is anticipated planning will be granted by February 2016.

A tendering process will begin to appoint a suitable construction company, and this process is expected to be completed by September 2016.

We then expect construction to commence in September subject to the appropriate statutory approval and funding for same.

It is expected that the building works will be completed by September 2018.

Point 9 – Every effort is made allow residents to meet their visitors in private if they

wish, a private area is available for private discussion with staff /family /friends, if required. A specific room for this will be addressed in the new build.

Point 11 - The fencing to the rear of the garden was rectified on 07th May 2015.

Proposed Timescale: 01/01/2019

Outcome 13: Complaints procedures

Theme:

Person-centred care and support

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

The complaints log was reviewed but the outcome of whether the complainant was satisfied with the outcome was not always recorded.

Action Required:

Under Regulation 34(1)(f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.

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

A nominated person will maintain a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied

Proposed Timescale: 10/05/2015

Outcome 15: Food and Nutrition

Theme:

Person-centred care and support

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

While residents had access to fresh water and other fluids throughout the day, some returned questionnaires reported that sometimes their glass of water was not within easy reach when they were in bed.

Action Required:

Under Regulation 18(1)(a) you are required to: Provide each resident with access to a safe supply of fresh drinking water at all times.

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

This is monitored daily by the PIC to ensure each resident has access to a safe supply

of fresh drinking water at all times.

Proposed Timescale: 29/05/2015

Theme:

Person-centred care and support

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

Returned questionnaire reviewed by the inspectors demonstrated that while residents were happy with the menu choice, quality and temperature of food, they expressed dissatisfaction at having their evening meal at 16:00hrs; feedback stated they were 'not hungry' at that time and 'seldom chose a hot option' because it was too close to dinner time'.

Action Required:

Under Regulation 18(2) you are required to: Provide meals, refreshments and snacks at all reasonable times.

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

The Residents evening meal will be served at 17.00hrs.

Proposed Timescale: 30/09/2015

Outcome 16: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

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

[The dementia-specific unit accommodated 14 residents and comprised two single en suite bedrooms, one five-bedded room and a seven-bedded room.] The size of the multi-occupancy bedroom with seven beds was inadequate to accommodate seven residents as bedside chairs or wardrobes could not be accommodated alongside some residents' beds; this significantly compromised the privacy and dignity of residents and was wholly unsuitable to meet their complex needs in relation to dementia care needs.

Action Required:

Under Regulation 09(3)(b) you are required to: Ensure that each resident may undertake personal activities in private.

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

The multi occupancy room with 7 beds will be reduced to 6 beds to provide extra space for the remaining residents.

Proposed Timescale: 22/05/2015

Outcome 17: Residents' clothing and personal property and possessions

Theme:

Person-centred care and support

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

Due to inaccessibility of wardrobes for many residents it was difficult to see how they retained control over their possessions and clothing.

Action Required:

Under Regulation 12(a) you are required to: Ensure that each resident uses and retains control over his or her clothes.

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

The hospital will make every attempt provide each resident with a wardrobe where they can have access to it, where this isn't possible, it will be addressed in the new build.

Proposed Timescale: 30/06/2015

Outcome 18: Suitable Staffing

Theme:

Workforce

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

Generally staff levels and skill-mix appeared to be adequate to meet the assessed needs of residents, however, inspectors requested that staff levels be reviewed on Crionna ward for twilight hours cognisant of the size and layout of the ward.

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:

When the ward is at full capacity of 42 beds, management will ensure that an extra support staff will be added into the current workforce between 8pm & 12 midnight.

Proposed Timescale: 30/09/2015