<table>
<thead>
<tr>
<th><strong>Centre name:</strong></th>
<th>Dunmanway Community Hospital</th>
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</thead>
<tbody>
<tr>
<td><strong>Centre ID:</strong></td>
<td>OSV-0000599</td>
</tr>
<tr>
<td><strong>Centre address:</strong></td>
<td>Dunmanway, Cork.</td>
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<tr>
<td><strong>Telephone number:</strong></td>
<td>023 8845102</td>
</tr>
<tr>
<td><strong>Email address:</strong></td>
<td><a href="mailto:catherine.white3@hse.ie">catherine.white3@hse.ie</a></td>
</tr>
<tr>
<td><strong>Type of centre:</strong></td>
<td>The Health Service Executive</td>
</tr>
<tr>
<td><strong>Registered provider:</strong></td>
<td>Health Service Executive</td>
</tr>
<tr>
<td><strong>Provider Nominee:</strong></td>
<td>Patrick Ryan</td>
</tr>
<tr>
<td><strong>Lead inspector:</strong></td>
<td>Breeda Desmond</td>
</tr>
<tr>
<td><strong>Support inspector(s):</strong></td>
<td>None</td>
</tr>
<tr>
<td><strong>Type of inspection</strong></td>
<td>Announced</td>
</tr>
<tr>
<td><strong>Number of residents on the date of inspection:</strong></td>
<td>22</td>
</tr>
<tr>
<td><strong>Number of vacancies on the date of inspection:</strong></td>
<td>1</td>
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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 decision. This monitoring inspection was announced and took place over 2 day(s).

**The inspection took place over the following dates and times**

From: 03 June 2015 09:30  
04 June 2015 08:00

To: 03 June 2015 18:00  
04 June 2015 16:30

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

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Our Judgment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome 01: Statement of Purpose</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 02: Governance and Management</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 03: Information for residents</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 04: Suitable Person in Charge</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 05: Documentation to be kept at a designated centre</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 06: Absence of the Person in charge</td>
<td>Compliant</td>
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<tr>
<td>Outcome 07: Safeguarding and Safety</td>
<td>Non Compliant - Moderate</td>
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<tr>
<td>Outcome 08: Health and Safety and Risk Management</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 09: Medication Management</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 10: Notification of Incidents</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 11: Health and Social Care Needs</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 12: Safe and Suitable Premises</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 13: Complaints procedures</td>
<td>Compliant</td>
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<tr>
<td>Outcome 14: End of Life Care</td>
<td>Substantially Compliant</td>
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<tr>
<td>Outcome 15: Food and Nutrition</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 16: Residents’ Rights, Dignity and Consultation</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 17: Residents’ clothing and personal property and possessions</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 18: Suitable Staffing</td>
<td>Substantially Compliant</td>
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**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 the Health Services Executive (HSE) Dunmanway Community Hospital. The provider applied to renew their registration which will expire on 6 June 2015. This renewal of registration inspection took place over two days. As part of the inspection the inspector met with the Person in Charge, the Provider nominee, Clinical Nurse Manager (CNM 2),
residents, relatives, and staff members. The inspector observed practices and reviewed governance, clinical and operational documentation to inform this registration renewal application.

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

A number of questionnaires were received and the inspector spoke with many residents and relatives during the inspection. The collective feedback from residents and relatives was one of satisfaction for the 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, however, this was not always reflected in care plans examined by the inspector. While formal residents’ meetings were convened every two months there was little evidence that residents were consulted with and participated in the organisation of the centre.

Staff levels and skill-mix were adequate to meet the assessed needs of residents. However, it was difficult to determine if all staff had up-to-date mandatory training from the files reviewed.

While the premises was clean, bright and appeared well maintained, overall, there were limitations within the physical environment which negatively impacted the freedom, choice, privacy, dignity and autonomy of residents; these were identified in previous inspection reports and will be discussed under Outcome 12 Suitable and Safe Premises.

A compliant fire safety certificate was submitted as part of the registration documentation.

The inspector identified aspects of the service requiring improvement to enhance the areas of good practice evidenced on inspection. These improvements included:

1) several policies were not comprehensive and/or out-of-date
2) notifications of restraint to the Authority were not submitted
3) aspects of medication management documentation were not comprehensive
4) a system to review and monitor the quality and safety of care and the quality of life of residents was not in place
5) staff files did not contain all the items listed in Schedule 2
6) routine fire safety checks were not documented
7) maintenance of residents notes did not ensure completeness, accuracy or ease of retrieval
8) privacy and dignity issues relating to multi-occupancy bedrooms and notices displayed
9) premises:

lack of storage space
inadequate dining room to accommodate all residents
inadequate communal space to accommodate all residents
lack of private space to facilitate visitors
one sluice room was inadequate.

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 June 2015 to ensure compliance with the Regulations. The statement of purpose did not include consultation and development of the care plan with the resident and/or their relative as described in the Regulations and this was amended on the day of inspection. All items listed in Schedule 1 of the Regulations were detailed in the statement of purpose. Services and facilities were described.

**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:**
An annual review of the quality and safety of care and quality of life in consultation with residents and their families to ensure that such care was in accordance with the national Standards was not in place, consequently, improvements as a result of the learning from
such a monitoring review could not occur. That is, the quality of life for residents was not evaluated to determine outcomes for residents regarding their quality of life in the centre. A food and nutrition survey and privacy and dignity survey were completed in 2010 with residents however, further surveys or audits regarding quality of life had not been undertaken since then.

Examples of clinical audits completed routinely were hand hygiene, medication management, clinical risk assessments for residents, equipment; non-clinical audits included environmental hygiene. Actions were demonstrated following audits to remedy issues and responsibilities were assigned to appropriate staff.

**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 maintained by administration staff. The contracts detailed 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. 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 was currently studying for her Masters degree in nursing.

The person in charge was supported in her role for by the CNM 2 as well as senior staff nurses.

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

Findings:
The inspector was satisfied that the records required in Regulation 19 (Directory of Residents), Regulation 21 (provision of information to residents), Regulation 25 (medical 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.

While the centre-specific policies relating to Schedule 5 (operating policies and procedures) were in place some were out-of-date; others were not comprehensive and did not reference current publications, for example, the adult protection policy did not reference the new HSE policy 'Safeguarding Vulnerable Persons at Risk of Abuse 2014'.
The admissions policy for example did not include pre or post admission assessment, care planning, resident and family involvement or consent. Other policies were discussed under relevant outcomes in this report.

All the requirements listed in Schedule 2 (staff files) were not in place in the sample of staff files reviewed.

Schedule 3 (residents’ records) were maintained in three separate locations, that is, the resident’s prescription and bedrail restraint risk assessment was located at the end of residents’ beds, the resident’s care plan was in a folder at the nurses’ station and clinical risk assessments were located in medical notes securely maintained in the CNM2 office, consequently, their completeness and ease of retrieval could not be assured.

**Judgment:**
Non Compliant - Moderate

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**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 designated provider and person in charge were aware of their responsibilities regarding notification to the Authority should the occasion arise. The CNM 2 deputised for the person in charge. Senior nurses were in place to support the management team also.

**Judgment:**
Compliant

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**Outcome 07: Safeguarding and Safety**

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

**Theme:**
Safe care and support
Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
It was reported to the inspector that staff had completed training in adult protection, however, it was unclear from the records reviewed if all staff had up-to-date training. Staff spoken with demonstrated their knowledge of protection of residents in their care and actions to be taken if care was untoward. Residents stated that they could discuss anything with any member of staff. Completed questionnaires stated that 'staff were always kind and great craic'.

While the policy for protection was dated January 2015, it was not up-to-date as previously described in Outcome 5. Nonetheless, the new HSE policy titled 'Safeguarding Vulnerable Persons at Risk of Abuse 2014' was evidenced, however, it was not clear if any staff member had read or was aware of the policy.

While some staff had completed training on behaviour that was challenging, all staff had not. While there was a policy to inform management of behaviours that challenge, it was not comprehensive and it did not include up-to-date research based information to inform practice. The incident forms completed for episodes relating to residents with behaviours that challenge demonstrated good insight into assessments of antecedents to the behaviours and positive interventions to prevent or alleviate behaviours. However, this information was not evidenced in residents’ care plans or outlined in the policy. Nonetheless, the inspector observed several occasions where staff intervention demonstrated appropriate and kind interventions with residents who became anxious and agitated.

There was a policy in place for restraint which referred to a bedrail risk assessment however, this was not included in the policy. There was evidence that alternatives to bedrails were used, for example, some residents had low-low beds to minimise risk.

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):
No actions were required from the previous inspection.

Findings:
There was a safety statement, however, when this was reviewed it was the health,
safety and risk management policy which contained the safety statement, but this was titled the safety policy. Details on the identification, assessment of risks with measures and actions in place to control risks identified were contained within the folder titled the ‘department safety statement’. The emergency plan was available with alternative accommodation detailed, should the need arise.

There was a policy in place for infection prevention and control. Advisory signage for best practice hand washing was displayed over some hand-wash sinks. There were hand hygiene gel/foam dispensers available throughout the centre. Advisory signage for best practice use of hand hygiene gels was displayed and the inspector observed that opportunities for hand hygiene were taken by staff. Staff had completed training in hand hygiene.

There were two sluice rooms, one small room and one large. Both had separate hand wash facilities in addition to sluicing sinks, however, appropriate storage racks for urinals and bedpans was not available in the smaller sluice room and inadequate to accommodate the continence equipment in the second sluice room.

Current relevant fire certification for maintenance and servicing was evidenced. Comprehensive fire safety evacuation notices were displayed in prominent positions throughout the centre. A fire safety register was in place for daily, weekly and monthly fire safety checks; while some checks were recorded, several were not evidenced. The inspector could not determine from the records demonstrated if all staff had completed their mandatory fire training.

The policy relating to smoking was not comprehensive as it did not include a risk assessment of residents wishing to smoke; in addition safety precautions including fire safety precautions were not included in the policy even though fire safety equipment was evidenced in the smoking room.

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 with appropriate interventions and reporting evidenced. Notifications submitted to the Authority correlated with accident and incident records. The policy relating to incident reporting and investigation was inadequate as it did not direct staff in the appropriate actions and procedures to follow.

Laundry was segregated at source and staff demonstrated best practice regarding safe handling of unclean laundry with the use of alginate bags were appropriate.

Work-flows described by the chef were in compliance with best practice. The kitchen was inspected. Advisory signage indicating designated areas for preparation of different foods to ensure safe food preparation practices and mitigate risk of cross contamination was not in place. There were two sinks in the meat preparation area and both had paper towel dispensers, however, advisory signage for their purpose (food preparation or hand washing) was not in place in line with best practice guidelines. Defrosting recording sheets were evidenced however these were not comprehensively completed to mitigate the associated risks. The hand-wash sink in the cooking area of the kitchen was part of
the work top and not separate from it; the inspector asked that this be reviewed as it posed a risk of contamination of food if used when food was being prepared or plated.

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

**Findings:**
An over-arching centre-specific medication management policy was not in place. There was a policy titled 'drug administration' which detailed procedures for safe ordering, prescribing, storing and administration of medicines and handling and disposal of unused or out-of-date medicines that was in place. However, it did not state whether transcription occurred in the centre.

Photographic identification was in place for residents as part of their prescription/drug administration record chart to mitigate risk, as described in best practice professional guidelines. Controlled drugs were maintained in line with best practice professional guidelines. Medication trolleys were securely maintained. The medication fridge was located in the secure CNM2 office. Medications were discontinued in line with best practice.

A sample of prescriptions/drug administration records were examined and while nurse signed following administration of medication however, sometimes administration records were blank. One resident was prescribed pain medication one – two daily and while most nurses documented the dosage given, others did not; in addition after care was not always recorded.

Medication errors and near misses were recorded and monitored by the CNM 2 to mitigate risk of recurrence. Medication audits were completed regularly and the attending pharmacist facilitated education sessions for staff including topics such as management of asthma, antibiotics, constipation in the dependant adult and diabetes.

**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 however, notifications regarding restraint were not included in the quarterly returns. Records were maintained of incidents occurring in the centre and these were monitored by the person in charge.

**Judgment:**
Non Compliant - Moderate

### Outcome 11: Health and Social Care Needs

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

**Theme:**
Effective care and support

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

**Findings:**
A sample of residents’ assessments and care plans were reviewed by the inspector. There was little evidence that residents and/or relatives were involved in care planning. While some care plans had resident-specific information to direct person-centred care, others did not. Risk assessments were not always completed in accordance with the Regulations, for example, one resident’s moving and handling risk assessment was last completed in 08/10/14. Another resident’s care plans stated ‘as above’, directing the reader to the risk assessment; consequently, the resident did not have a plan of care for those activities of daily living. One person admitted for respite care did not have their moving and handling risk assessment updated on this admission; neither was there a plan of care for their nutritional needs. There was evidence that residents signed for consent for photographs as part of their care planning and medication management.
There was a medical officer assigned to Dunmanway Community Hospital and the doctor attended the centre on a daily basis. Out-of-hours medical cover was available 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. Each resident was reviewed on admission and regularly thereafter by the physiotherapist. The dietician visited the centre and reviewed residents routinely.

Residents had access to psychiatry, geriatrician, dental, optical, chiropody, speech and language therapy (SALT) and community palliative care.

A falls team was in place which comprised the person in charge, CNM2, physiotherapist and staff members and meetings were held quarterly. Minutes reviewed demonstrated that each resident was discussed regarding slips/trips/falls episodes and safety measures were put in place to mitigate the risk. For example, residents’ footwear was a significant factor identified and each resident had their footwear reviewed and upgraded.

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:
While the premises was clean, bright and appeared well maintained, there were significant limitations within the physical environment which negatively impacted the freedom, choice, privacy, dignity and autonomy of residents and these have been described in detail in previous inspection reports.

Limitations of the premises included:
1) there was just one communal room for sitting, dining and recreational space and this
was inadequate for 23 residents
2) a designated dining room was not available
3) there was limited private space for residents to meet their visitors
4) equipment storage space was totally inadequate
5) one sluice room was very small and did not have appropriate storage equipment for
urinals and bedpans, the second sluice room did not have adequate storage equipment
6) there were three four-bedded rooms.

The communal room for sitting, dining and recreational space was inadequate to
accommodate all 23 residents. The maximum number of residents that could be seated
at the two dining tables at meal time was 12 and this would depend on the types of
assisted seating residents were using; three-to-four residents had their lunch in the
seating space and the remainder had their meals by their bedside. The only private
space for residents to meet their visitors was part of the palliative care suite; if this was
being used for palliative care purposes then there would be no space available for
residents to meet their relatives in private. The seating area in the communal space was
very limited and could only accommodate six - eight residents.

Each bed space had a flat screen television, single wardrobe, bedside locker and some
had comfortable seating alongside. There were overhead hoists in all bedrooms; all
bedroom had full en suite facilities; bedrooms had patio doors to the outside. There was
a separate bathroom with a specialist bath. Nonetheless, some bed spaces could only
accommodate a single wardrobe, and others could not accommodate a comfortable
chair alongside their bed, which impeded the privacy and dignity of residents.

Closed-circuit television cameras (CCTV) were in public areas. There was a sign to
inform residents, staff and visitors that CCTV was in operation. While there was a policy
in place it was not comprehensive to support the use of CCTV. The inspector requested
that the internal CCTV at the main entrance be re-directed to the entrance and main
reception only to ensure the privacy and dignity and freedom of residents.

The inspector saw evidence of the use of assistive devices, for example, hoists,
wheelchairs, walking aids, clinical monitoring equipment and specialist seating was
provided for residents’ use. There was a functioning call-bell system in place. There was
an internal courtyard for residents’ enjoyment with seating and a staff member had
created a beautiful area with potted plants, flowers and shrubs for residents’ enjoyment;
the external garden was located between the centre and the day centre.

**Judgment:**
Non Compliant - Moderate

**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 procedure was displayed prominently at main reception, as required in the Regulations. The complaints policy contained most of the details listed in the Regulations; the nominated person other than the person nominated in Regulation 34 (1) (c) was not identified. The complaints’ log was reviewed and while most complaints were recorded in line with the Regulations, the outcome of whether the complainant was satisfied or not, was not always recorded due to limitations of the form; the form was amended to enable the outcome to be recorded. The person in charge monitored complaints and endeavoured to resolve issues as soon as they arose.

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

Findings:
There was a policy in place for end-of-life care and this was in date. There was an end-of-life recourse folder from an external service provider which outlined that centre-specific information be included as part of the information however, this was not evidenced. End of life care plans reviewed stated that the families were aware of residents’ wishes.

Spiritual needs were facilitated with Mass held weekly in the centre; other denominations visited the centre regularly. There was a prayer room with seating for residents however, this was not easily accessible for residents and there was no signage directing residents to the prayer room.

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. Some residents were receiving palliative care and care practices observed demonstrated that residents were 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 a policy in place for food and nutrition that included a recognised food and nutrition risk assessment, monitoring and documentation of nutritional status. Catering staff discussed nutritional needs including specialist diets with the inspector and demonstrated their knowledge regarding specialist diets and consistency for residents. Staff had completed training in modified consistency food preparation. Residents’ weights were documented on a monthly basis or more often if their clinical condition warranted; dietary intake was recorded when necessary and residents were prescribed supplements when their condition necessitated. Residents had access to fresh water and other fluids throughout the day.

Residents had choice at each mealtime and residents spoken with gave positive feedback regarding the quality of their food. The inspector observed breakfast, mid morning, lunch and tea times. Residents requiring assistance with their meals were helped appropriately and with respect in a dignified manner. Residents were asked individually, their preferences and quantities and meals were well presented and served in a calm and pleasant atmosphere.

Overall, because of very limited space in the day room and lack of a designated dining room, the dining experience for residents was significantly curtailed.

#### Judgment:
Compliant
Outcome 16: Residents’ Rights, Dignity and Consultation
Residents are consulted with and participate in the organisation of the centre. Each resident’s privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

Theme:
Person-centred care and support

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

Findings:
Notwithstanding the constraints of the building and the layout of the wards, the inspector noted that residents received care in a dignified way.

The centre operated an open visiting policy which was observed throughout the inspection. Completed relatives questionnaires commended staff on how welcoming they were to visitors.

The external activities co-ordinator acted as the residents’ advocate and attended the centre on a weekly basis and facilitated residents’ meetings every two months. The programme of activities included art therapy, music, massage, exercises and one-to-one sessions. Residents were facilitated to vote in the recent elections. However, there was insufficient evidence to determine that the programme of activities was developed following consultation with residents to ensure activities available were in accordance with their interests and capacities. In addition, there was no evidence to suggest that feedback was actively sought from residents on an on-going basis on the services provided to enable them to maximise their independence, make informed decisions or exercise personal autonomy and choice.

Residents stated they enjoyed the art classes and there were several pieces of art displayed throughout the centre. The art teacher held an art exhibition in the town and sent an invitation to the person in charge to invite residents to attend however, residents were not consulted about this and consequently no one attended.

There was a large notice board on the main corridor which contained information relevant to staff and not residents, for example, hazard identification, bodily fluid exposure, healthcare risk and non-risk waste. However, this notice board was not in keeping with the vision and mission espoused in their statement of purpose regarding respecting residents dignity.

Judgment:
Non Compliant - Moderate
**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 a centre-specific policy on residents’ personal property and possessions. A resident property list was completed on admission and at regular intervals thereafter and this record was evidenced as part of care plan documentation. Residents had access to private storage space of single wardrobes and bedside lockers to enable them to retain control over their possessions and clothing.

Residents’ finances were securely maintained in the CNM 2 office.

**Judgment:**
Compliant

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**Outcome 18: Suitable Staffing**

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

**Theme:**
Workforce

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

**Findings:**
There was evidence of staff education and staff had attended training, for example, end-of-life care, nutrition, food consistencies, food safety, eating drinking and swallowing disorders, specialist clinical equipment hand hygiene, infection prevention and control, and challenging behaviour.
A sample of staff files were reviewed however, those examined did not contain all the items listed in Schedule 2. Current registration with regulatory professional bodies was in place for all nurses. Staff training records were maintained however, it was difficult to determine if all staff had completed their mandatory training as described throughout the report.

**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:**

Breeda Desmond  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority
Provider’s response to inspection report

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<tr>
<th>Centre name:</th>
<th>Dunmanway Community Hospital</th>
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<tr>
<td>Centre ID:</td>
<td>OSV-0000599</td>
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<tr>
<td>Date of inspection:</td>
<td>03/06/2015</td>
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<tr>
<td>Date of response:</td>
<td>16/09/2015</td>
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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 and quality of life in consultation with residents and their families to ensure that such care was in accordance with the National Standards was not in place, consequently, improvements as a result of the learning from such a monitoring review could not occur.

1. Action Required:
Under Regulation 23(d) you are required to: Ensure there is an annual review of the

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
quality and safety of care delivered to residents in the designated centre to ensure that 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:**
A full review of audits and surveys that residents can participate in will be carried out. From consultation with resident’s/ families/ senior management and other HSE residential care facilities a template for an annual review of quality of life and safety issues from the resident’s perspective will be developed. This will be incorporated into the service as an annual review year end.

Proposed Timescale: First Annual Review by 31/12/2015

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### 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:**
While the centre-specific policies relating to Schedule 5 (operating policies and procedures) were in place, some were out-of-date; others were not comprehensive and did not reference current publications.

**2. 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:**
All policies will be reviewed to ensure they are comprehensive and within date as indicated in the inspection report.

**Proposed Timescale:** 01/10/2015

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**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
An over-arching centre-specific medication management policy was not in place.

**3. 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:
All policies will be reviewed to ensure they are comprehensive and within date as indicated in the inspection report.

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<td><strong>Theme:</strong> Governance, Leadership and Management</td>
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The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The policy relating to closed-circuit television cameras (CCTV) was not comprehensive and did not inform practice.

**4. 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:
This policy will be reviewed as above.

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The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was an end-of-life recourse folder from an external service provider which outlined that centre-specific information be included as part of the information, however, this was not evidenced.

**5. 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:
Centre-specific information has been included in the end-of-life resource folder.

| Proposed Timescale: 16/09/2015 |
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 to inform management of behaviours that challenge, it was not comprehensive and it did not include up-to-date research based information to inform practice for example, assessments of antecedents to the behaviours and positive interventions to prevent or alleviate such behaviours.

6. 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:
This policy will be reviewed as above.

Proposed Timescale: 01/10/2015

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
While the policy for protection was dated January 2015, it was not up-to-date. While the new HSE policy titled ‘Safeguarding Vulnerable Persons at Risk of Abuse 2014’ was evidenced, it was not clear if any staff member had read or was aware of the policy.

7. 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:
This policy will be reviewed as above. The HSE policy ‘Safeguarding Vulnerable Persons at Risk of Abuse 2014’ will be incorporated into the new review for sign off by staff members

Proposed Timescale: 01/10/2015

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
All the requirements listed in Schedule 2 (staff files) were not in place in the sample of
8. **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:**
Every effort will be made to ensure all the requirements listed in Schedule 2 (Staff files) are in place.

**Proposed Timescale:** 01/10/2015

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**Outcome 07: Safeguarding and Safety**

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
While some staff had completed training on behaviour that was challenging, all staff had not.

9. **Action Required:**
Under Regulation 07(1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.

**Please state the actions you have taken or are planning to take:**
Up to date training on behaviour that challenges was provided for Staff in June 2015. A second session will be organised to facilitate remaining staff that were on duty that day.

**Proposed Timescale:** 01/10/2015

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**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
It was reported to the inspector that staff had completed training in adult protection, however, it was unclear from the records demonstrated if all staff had up-to-date training.

10. **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:**
All our staff have received up to date training in adult protection. This is demonstrated in our records. However, a spreadsheet of mandatory training is now being developed to ensure that such information is more easily observable and retrievable.

**Proposed Timescale:** 01/09/2015  
**Theme:** Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:  
While the new HSE policy titled ‘Safeguarding Vulnerable Persons at Risk of Abuse 2014’ was evidenced, it was not clear if any staff member had read or was aware of the policy.

11. **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:  
This policy will be incorporated into the adult protection policy as above for staff sign off.

**Proposed Timescale:** 01/10/2015

**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:  
The policy relating to incident reporting and investigation was inadequate as it did not direct staff in the appropriate actions and procedures to follow.

12. **Action Required:**  
Under Regulation 26(1)(d) you are required to: Ensure that the risk management policy set out in Schedule 5 includes arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents.

Please state the actions you have taken or are planning to take:  
This policy will be incorporated into the adult protection policy as above for staff sign off.

**Proposed Timescale:** 01/10/2015

**Theme:** Safe care and support
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were two sluice rooms, one small room and one large. Both had separate hand wash facilities in addition to sluicing sinks, however, appropriate storage racks for urinals and bedpans was not available in the smaller sluice room and inadequate to accommodate the continence equipment in the second sluice room.

13. 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:
A new sluice room is being provided for in the New Development Plan for Dunmanway Community Hospital. Extra storage space for urinal, bedpans and equipment will be incorporated into the new design.

Proposed Timescale: no date submitted by provider

Proposed Timescale:
Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Advisory signage indicating designated areas for preparation of different foods to ensure safe food preparation practices and mitigate risk of cross contamination was not in place.

14. 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:
Signage as indicated on the day of inspection is now in place.

Proposed Timescale: 16/09/2015
Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were two sinks in the meat preparation area and both had paper towel dispensers, however, advisory signage for their purpose (food preparation or hand
washing) was not in place in line with best practice guidelines.

15. **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:**
Advisory Signage is now in place.

**Proposed Timescale:** 16/09/2015

**Theme:**
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Defrosting recording sheets were evidenced however these were not comprehensively completed to mitigate the associated risks.

16. **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:**
New defrosting record sheets have been put in place which are easier to understand.

**Proposed Timescale:** 16/09/2015

**Theme:**
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The hand-wash sink in the cooking area of the kitchen was part of the work top and not separate from it; the inspector asked that this be reviewed as it posed a risk of contamination of food if used when food was being prepared or plated.

17. **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:**
Steel panel to separate the two areas requested from maintenance department.
Proposed Timescale: 01/08/2015

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The inspector could not determine from the records demonstrated if all staff had completed their mandatory fire training.

18. Action Required:
Under Regulation 28(1)(d) you are required to: Make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.

Please state the actions you have taken or are planning to take:
All staff receive up to date mandatory fire training. This is demonstrated in our records. However, a spreadsheet of mandatory training is now being developed to ensure that such information is more easily observable and retrievable.

Proposed Timescale: 16/09/2015

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A fire safety register was in place for daily, weekly and monthly fire safety checks; while some checks were recorded, several were not evidenced.

19. Action Required:
Under Regulation 28(1)(a) you are required to: Take adequate precautions against the risk of fire, and provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.

Please state the actions you have taken or are planning to take:
Staff responsible for the recording of fire safety checks have been informed of this outcome and understand the importance of ensuring all fire safety checks observed are documented.

Proposed Timescale: 16/09/2015

Theme:
Safe care and support
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The policy relating to smoking was not comprehensive as it did not include a risk assessment of residents wishing to smoke; in addition safety precautions including fire safety precautions were not included in the policy even though fire safety equipment was evidenced in the smoking room.

20. Action Required:
Under Regulation 28(1)(a) you are required to: Take adequate precautions against the risk of fire, and provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.

Please state the actions you have taken or are planning to take:
The current risk assessment and controls in place for resident’s wishing to smoke will be reviewed to secure a more specific risk assessment is in place. The fire safety policy will be reviewed and updated as above.

Proposed Timescale: 01/10/2015

Outcome 10: Notification of Incidents
Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Notifications regarding restraint were not included in the quarterly returns submitted to the Authority.

21. Action Required:
Under Regulation 31(3) you are required to: Provide a written report to the Chief Inspector at the end of each quarter in relation to the occurrence of any incident set out in paragraphs 7(2) (k) to (n) of Schedule 4.

Please state the actions you have taken or are planning to take:
All forms of restraint to include cot-side restraint will be reported in quarterly returns going forward

Proposed Timescale: 06/07/2015

Outcome 11: Health and Social Care Needs
Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
One person admitted for respite care did not have their moving and handling risk assessment updated on this admission; neither was there a plan of care for their
22. **Action Required:**
Under Regulation 05(1) you are required to: Arrange to meet the needs of each resident when these have been assessed in accordance with Regulation 5(2).

**Please state the actions you have taken or are planning to take:**
All admissions to Dunmanway Community Hospital have a Moving and Handling risk assessment and a nutritional plan of care complete within 24 to 48 hours of admission as per regulation.

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<th>Proposed Timescale: 16/09/2015</th>
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**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There was little evidence that residents and/or relatives were involved in care planning.

23. **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:**
As far as possible residents and/or relatives are included in the care planning process at least very quarter when care plans are reviewed by Nursing staff. Where possible Nursing staff request residents and/ or relatives to sign the care plan when consultations take place and this is also documented in the communication sheet.

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<td>Effective care and support</td>
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**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
One resident’s care plans stated ‘as above’, directing the reader to the risk assessment; consequently, the resident did not have a plan of care for those activities of daily living.

24. **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:**
A full review of resident’s care plans and risk assessments are documented separately as required. Staff have been instructed not to use the words ‘as above’ when repeating assessments.

**Proposed Timescale:** 16/09/2015  
**Theme:**  
Effective care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**  
Risk assessments were not always completed in accordance with the Regulations, for example, one resident’s moving and handling risk assessment was last completed in 08/10/14.

**25. 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:**  
Following the inspector’s feedback, a full review of Moving and Handling Risk assessments was carried out. All risk assessments are now up to date and staff have been instructed to adhere to their timely review as per regulations.

**Proposed Timescale:** 16/09/2015  
**Theme:**  
Effective care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**  
While some care plans had resident-specific information to direct person-centred care, others did not.

**26. 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:**  
Will ensure all resident care plans are resident specific and person centred.

**Proposed Timescale:** 06/07/2015  
**Theme:**  
Effective care and support
The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was little evidence that residents and/or relatives were involved in care planning.

27. 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:
As far as possible residents and/or relatives are included in the care planning process at least very quarter when care plans are reviewed by Nursing staff. Where possible Nursing staff request residents and/ or relatives to sign the care plan when consultations take place and this is also documented in the communication sheet.

Proposed Timescale: 06/07/2015

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A sample of prescriptions/drug administration records were examined and while nurse signed following administration of medication, sometimes administration records were blank.

One resident was prescribed pain medication one – two daily and while most nurses documented the dosage given, others did not; in addition after care was not always recorded.

28. 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:
Nursing staff informed and advised to ensure dosage given to residents is recorded at all times and include aftercare in care plan.

Proposed Timescale: 06/07/2015

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:
The there were significant limitations within the physical environment which negatively impacted the freedom, choice, privacy, dignity and autonomy of residents and these have been described in detail in previous inspection reports.

Limitations of the premises included:

1) there was just one communal room for sitting, dining and recreational space for 23 residents
2) a designated dining room was not available
3) there was limited private space for residents to meet their visitors
4) equipment storage space was totally inadequate
5) one sluice room was very small and did not have appropriate storage equipment for urinals and bedpans, the second sluice room did not have adequate storage equipment
6) there were four four-bedded rooms.

29. **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:**
1. Specific sitting room, dining room and recreational space being segregated in the new development plans to accommodate 23 high dependency residents per room at any one time.
2. As per point one.
3. Private space will be provided for residents to meet their visitors in the new development plan.
4. Extra equipment storage space will be accommodated in the new development plan.
5. A new sluice room in the new development plan will provide extra space for the storage of equipment.
6. The three four bedded rooms will be reorganised to provide for 3 two bedded rooms. This will require the additional build of 6 single rooms in the new development plan.

A design team has been appointed and plans will be completed by June 2015.

Planning permission will then be applied for, and provided there are no objections, it is anticipated planning will be granted by September 2015.

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

We then expect construction to commence in Dunmanway Community Hospital, subject to the appropriate statutory approval and funding for same, by January 2016.

It is expected that the building works will be completed by April 2017.

Costings for the proposed works have not been provided to us at this present time, these will be sent to HIQA, on receipt of this information.
**Proposed Timescale:** 01/04/2017

## 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:
There was insufficient evidence to determine that the programme of activities was developed following consultation with residents to ensure activities available were in accordance with their interests and capacities.

30. **Action Required:**
Under Regulation 09(2)(b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests and capacities.

Please state the actions you have taken or are planning to take:
The programme of activities has been developed in accordance with resident’s active feedback. This feedback is both verbal and written. Activities are discussed with residents independently every two months and documented evidence of same exists.

**Proposed Timescale:** 16/09/2015

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

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no evidence to suggest that feedback was actively sought from residents on an on-going basis on the services provided to enable them to maximise their independence, make informed decisions or exercise personal autonomy and choice.

31. **Action Required:**
Under Regulation 09(3)(d) you are required to: Ensure that each resident is consulted about and participates in the organisation of the designated centre concerned.

Please state the actions you have taken or are planning to take:
Verbal feedback is sought from residents by staff on a daily basis. Such feedback will be built into the end of year quality of life review on an annual basis.

**Proposed Timescale:** 31/12/2015

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

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The art teacher held an art exhibition in the town and sent an invitation to residents to attend, however, residents were not consulted about this and consequently no one attended.

32. **Action Required:**
Under Regulation 09(3)(c)(iv) you are required to: Ensure that each resident has access to voluntary groups, community resources and events.

**Please state the actions you have taken or are planning to take:**
The PIC will ensure that all residents are kept fully informed on local events.

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

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was a large notice board on the main corridor which contained information relevant to staff and not residents, for example, hazard identification, bodily fluid exposure, healthcare risk and non risk waste.

33. **Action Required:**
Under Regulation 09(3)(d) you are required to: Ensure that each resident is consulted about and participates in the organisation of the designated centre concerned.

**Please state the actions you have taken or are planning to take:**
The notice board now contains information relevant to residents and their families. Staff information has been removed.

| Proposed Timescale: 16/09/2015 |