

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Cottage Hospital
<b>Centre ID:</b>	OSV-0000534
<b>Centre address:</b>	Scarlet Street, Drogheda, Louth.
<b>Telephone number:</b>	041 980 1100
<b>Email address:</b>	aoife.bailey@hse.ie
<b>Type of centre:</b>	The Health Service Executive
<b>Registered provider:</b>	Health Service Executive
<b>Provider Nominee:</b>	Maura Ward
<b>Lead inspector:</b>	Sonia McCague
<b>Support inspector(s):</b>	None
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	15
<b>Number of vacancies on the date of inspection:</b>	8

## About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

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

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

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

From: 18 January 2017 09:20 To: 18 January 2017 17:30

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

<b>Outcome</b>	<b>Our Judgment</b>
Outcome 01: Statement of Purpose	Non Compliant - Moderate
Outcome 02: Governance and Management	Non Compliant - Moderate
Outcome 03: Information for residents	Substantially Compliant
Outcome 04: Suitable Person in Charge	Non Compliant - Moderate
Outcome 05: Documentation to be kept at a designated centre	Non Compliant - Moderate
Outcome 07: Safeguarding and Safety	Non Compliant - Moderate
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 09: Medication Management	Non Compliant - Moderate
Outcome 11: Health and Social Care Needs	Compliant
Outcome 12: Safe and Suitable Premises	Substantially Compliant
Outcome 18: Suitable Staffing	Non Compliant - Moderate

**Summary of findings from this inspection**

This report sets out the findings of a monitoring inspection, the purpose of which was to evaluate compliance with the regulations, review information received, and follow up on the previous actions required following the previous inspection in April 2015.

In August 2016, the management team had notified the Health Information and Quality Authority (HIQA) of staff shortages, delayed discharges and a decision taken to restrict admissions to one unit for a maximum of 14 residents. This was followed up with a revised Statement of purpose September 2016.

A decision to re-open the ground floor unit to accommodate six admissions from the acute hospital was subsequently organised by management and took effect on the day of the inspection. The main finding from this inspection was that the governance and management arrangements required considerable improvement. As a result, updates regarding resident admissions and occupancy levels were sought by the inspector and provided by the person in charge, following this inspection.

During the course of the inspection, the inspector met with residents and staff, the person in charge and the provider nominee. The views of residents and staff were listened to, practices were observed and documentation was reviewed.

Overall, the inspector found that the healthcare needs of residents were delivered by staff that discharged their duties in a respectful and dignified way. However, the systems, arrangements, resources and measures in place to manage staff and govern this centre required significant improvement.

Some aspects of the service were unclear and improvements were required in relation to the identification, assessment and management of risk. The statement of purpose, admission policy, contract of care, and transitional care assessment documents required review. Non-compliances were also found in relation to medication management and the premises.

Actions required following the last inspection in April 2015 had been progressed, but further improvements were required.

The findings are discussed throughout the report and actions required are outlined in the Action Plan at the end of the report.

**Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.**

***Outcome 01: Statement of Purpose***

***There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.***

**Theme:**

Governance, Leadership and Management

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

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

**Findings:**

The statement of purpose (SOP) and functioning of the centre was reviewed and revised since the previous inspection and registration, and following a change in management that included a change in the person in charge of this centre.

The revised SOP was submitted to the Health Information and Quality Authority (HIQA) in September 2016 following discussions with the new person in charge, during a fitness interview. The changes to the operational capacity of the centre were put in place due to staff shortages. While registered in 2015 for a maximum of 23 short stay residents the maximum functioning capacity in September 2016 was 14 due to staff shortages which resulted in one of the two units being closed.

The revised statement of purpose (September 2016) detailed and contained information in relation to the matters listed in schedule 1 of the regulations. However, the subsequent and recent changes found on inspection had not been formally communicated to the Chief Inspector in a revised statement of purpose in writing that included changes in:

- the admission policy, criteria (inclusion and exclusion) and arrangements
- the length of stay was unclear
- the staffing arrangements and
- the closed unit had re-opened, was operational on the day of inspection with a plan to accommodate six new admissions following a service level agreement with an external staffing agency.

The aims and objectives of the centre were to provide transitional care to older people following an acute illness and hospital treatment, and an emergency admission from the community had been accommodated since the previous inspection.

The centre was registered in 2015 as a short stay service that provided transitional care to residents within a timeframe of 30 days from admission to discharge. However, this was not consistently achieved or reflective in practice due problems encountered during the stay and discharge planning stage, such as a deterioration in resident's health, delays in a suitable home care package or unsuitable housing that involved other external agencies input.

The inspector confirmed that the length of stay for some of the existing residents and a previous resident had exceeded the agreed timeframe. A contingency plan or protocol was not in place to manage and respond to delays in resident discharge as a likely event of the intended service.

**Judgment:**

Non Compliant - Moderate

***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):**

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

**Findings:**

The governance and management arrangements at the time of this inspection required improvement to ensure high quality care in a safe environment.

Deficiencies were found in the assessment and management of risk, education and training of staff, and the co-ordination and management of the service being provided.

Based on the overall findings from this inspection the inspector found there was an insufficient deployment of resources prior to the re-opening of a unit that had previously been closed due to staff shortages. Rostered staff were not sufficiently trained, supervised in practice or following incidents and were not involved in the pre-admission assessments of residents being admitted to the centre. While staffing numbers were increased to facilitate an increase in residents from 14 to 20, improvements were required to ensure the delivery of care was safe, appropriate and effective.

Based on the inspector's observations, improvement was required in relation to the planning, consideration and communication of admissions and in the communication arrangements with residents, and their family, when transferring between units to

facilitate safe admissions and transitions.

The inclusion and exclusion criteria for admission to the centre were unclear and did not sufficiently guide the practice found.

The inspector confirmed that the policy and practice of pre-assessing prospective residents prior to admission to this centre was previously carried out by senior staff working in the centre to ensure the service could meet the resident's needs before admission. However, this arrangement had recently changed to maintain the limited staffing resources within the centre. The inspector confirmed with staff that residents being admitted on the day of the inspection had a pre-admission assessment carried out by an external person who worked at the referral source. This was not a robust system to ensure that residents were suitably placed and the arrangement posed a significant risk to the safety and welfare of new and existing residents. The authority and accountability for all admissions to the centre required urgent review. One resident arrived to the centre without prior notice and without all of the necessary documents required for admission.

While there was a clearly defined management and reporting structure in place within the centre, management resources were depleted. The person in charge, as Director of Nursing, along with an assistant Director of Nursing both had responsibility for three designated centres, had involvement in a community based service, and had responsibility as a designated officer that included the delivery of safeguarding training to staff working in the three designated centres. An absence of an assistant director of nursing from the management structure remained unfilled from August 2016. There were high activity levels and a high turnover of residents within the centre and management staff that had left and transferred on secondment to other services had not been replaced within the overall governance structure.

Overall, improvement was required in the governance and management of the centre. An evaluation of the systems and arrangements in place to review and monitor the quality of care delivered was required to ensure the service is safe, consistent, appropriate and effectively monitored.

The inspector was not satisfied that that management were sufficiently supported to be engaged in the effective governance, operational management and administration of the designated centre due to their level of involvement in other services.

An annual review of the quality and safety of care delivered to residents for 2016 was being completed to inform the service plan for 2017.

**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:**

A comprehensive easy to read guide to the services of the centre was available for residents. It included a summary of the centre's services and facilities, the terms and conditions of residence, the complaints procedure, admission, discharge and visiting arrangements for residents. However, the current management arrangements were not reflected in the Residents' Guide, and some of the terms and conditions of stay were not reflected in practice.

The inspector reviewed the template of the residents' (transitional care) contract of care, which set out the services to be provided, and the terms and conditions of a resident's stay. However, some terms and conditions of stay outlined within the contract were not reflected in practice. For example, some residents were identified by staff as having cognitive impairment and or a diagnosis of dementia. A referral to other teams or consideration of an alternative placement when a risk is identified, such as dementia or cognitive impairment, had not been made, as outlined in the terms of the contract.

A full review of resident's contracts of care, residents guide and information for residents was required in line with the statement of purpose and function.

**Judgment:**

Substantially Compliant

***Outcome 04: Suitable Person in Charge***

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

**Theme:**

Governance, Leadership and Management

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

No actions were required from the previous inspection.

**Findings:**

The person in charge is a nurse with a minimum of three years experience in the area of nursing of the older person within the previous 6 years. She had sufficient knowledge of the legislation and her statutory responsibilities.



The person in charge was based in this centre but had responsibility for the governance and management of three designated centres as the Director of Nursing. She also had involvement in some aspects of community services or allied healthcare teams.

The assistant director of nursing post for this centre has been vacant since 15 August 2016. This post and support role to the person in charge had not been replaced following this planned absence. The deputy for the person in charge was the person in charge of two other designated centres, operated by the provider.

As outlined in outcome 2, the inspector was not satisfied that that person in charge was sufficiently supported and engaged in the effective governance, operational management and administration of the designated centre.

**Judgment:**

Non Compliant - Moderate

***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):**

No actions were required from the previous inspection.

**Findings:**

Records listed in Schedules 2, 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People), Regulations 2013 (as amended) were stored safely and made available on request. A sample of records was reviewed by the inspector. These included records relating to fire safety, staff rosters, training records and recruitment files, and residents' medication and clinical records, as well as the centre's directory of residents.

Some improvement was required in relation to the following:

- filing arrangements did not to ensure ease of access to records regarding healthcare decisions. Records of up to four weeks previous had not been filed in residents' medical notes to inform their care and treatment requirements or review
- residents' transitional care assessment record did not consistently include the name of the assessor and date completed
- a photograph of a resident admitted five days previously was not available on the

records, as required

- the quality of the black and white photograph record was poor
- the maintenance of records associated with fire safety checks such as fire extinguishers was not available and
- the recorded details of fire safety and evacuation drills required further development.

A sample of staff files was reviewed and found to be compliant with the schedule 2 of the regulations.

A record for visitors to sign in and out was available on each floor.

An electronic directory of residents was maintained in the centre; however, it required improvement as follows:

- it had not been updated to reflect the correct number of 14 residents. The number of residents on the printed copy made available included 12 named residents. Two residents were not included, one of whom had been admitted five days prior to this inspection
- the date the resident was first admitted to the centre, date of transfer to another service or hospital and date of return by residents' (re-admission) were not sufficiently detailed
- the record in general was not user friendly, fully complete or easily accessible, and was seen to be difficult to navigate in order to produce the information received.

The inspector was informed that the operating policies and procedures for the centre, as required by Schedule 5 of the regulations, were available in each unit and on a shared drive. However, during discussions with staff, some were not aware that policies were available or accessible on each unit.

Samples of policies, listed in Schedule 5, were reviewed by the inspector in relation to the practices observed. Some improvement was required in relation to the policies and or practices relating to resident admission, risk management, health and safety, and disposal of unused medicines, as discussed under other outcomes. For example, the admission policy criteria included the following which was not the current practice found:

- nursing staff from the centre to undertake the pre-admission assessment
- all the specified documents to accompany the resident on transfer and admission
- patient is deemed to require long term care and
- involvement of the nursing home subvention office that was to be informed of the transfer.

**Judgment:**

Non Compliant - Moderate

***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:**

Measures were in place to protect residents from being harmed or suffering abuse. There was a policy which provided guidance for staff to identify and manage incidents or allegations of elder abuse. This included information on the various types of abuse, assessment, and reporting and investigation process.

The training records identified that most staff had opportunities to participate in training in the identification, response and protection of residents from abuse. Staff spoken with were fully knowledgeable regarding the signs of abuse, reporting procedures and what to do in the event of a disclosure about actual, alleged, or suspected abuse. The person in charge and deputy demonstrated that they had implemented the designated centre's policy in response to an allegation which included a referral to a dedicated safeguarding officer. Reasonable measures were taken and put in place following the allegation.

The inspector found that 93% of residents in the centre used bedrails. There was no evidence that less restrictive devices, which could achieve the goals of transitional care, were available and tried before bedrails were used. On examination of bedroom furniture, the inspector found that all of the beds seen in the centre had bedrails attached. Some bedrails were removable while others were fixed. On enquiry the inspector confirmed that alternative or least restrictive measures had not been trialled before bedrails were used. A limited availability of alternative less restrictive equipment such as, low-low beds, sensory alarms and floor mats was found. Improvement was required in relation to the high rate and use of bedrails, in accordance with the national guidance document that promotes a restraint free environment. The staff training record showed that training on restraint and on the use of restrictive devices had not been provided to staff.

Staff reported and recorded in the restraint register that some residents' use of bedrails had been at their request. In the sample of resident's notes reviewed, a record of the decision regarding the use of bedrails was available, following a risk assessment, to show the decision was made in consultation with the resident. The decision was also reflected in the resident's care plan. However, there was no documentary evidence seen that residents were checked on a two hours basis when bedrails were in use.

**Judgment:**

Non Compliant - Moderate

***Outcome 08: Health and Safety and Risk Management***

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

**Theme:**

Safe care and support

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

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

**Findings:**

The centre had policies and procedures relating to health and safety that included a health and safety statement which was a comprehensive document that referenced the provision and frequency of mandatory training such as cardio pulmonary resuscitation (CPR), manual handling and fire safety. However, it required review in relation to the requirements and frequency of CPR training.

Staff training records showed that 75% of staff nurses and many care workers did not have up-to-date CPR training. The records showed that some staff did not have a date for CPR training while others had training dates ranging from 2013 to 2010. This training is generally recommended and refreshed every two years.

The health and safety statement included that all staff were to receive manual handling training every two years. However, this was not achieved by rostered staff and was confirmed in the training records reviewed. Manual handling practices observed were safe and appropriate, with assistive equipment such as overhead and portable hoists available for use.

Most staff had up-to-date training in fire safety and completed a fire drill, however, there were some gaps found in this training records. Furthermore, all rostered staff, such as relief staff, were not included in the training records received.

Risk management protocols were in place, however, the identification, control and management of hazards and risks required improvement.

The inspector reviewed the risk register which included rated risks that were identified in 2015 and 2016. There was little recorded evidence to demonstrate that the risks within the register had been subject to regular review or had been resolved or escalated appropriately. A risk of a missing person was previously recorded on the register, however, this risk had not been reviewed and it was established that mobile residents with a cognitive impairment were accommodated in the centre. The person in charge acknowledged this finding and told the inspector she had engaged with a risk advisor to get support in the management of risks and development of the register.

Arrangements in place for investigating and learning from serious incidents or adverse events such as medication errors required improvement.

Other risks identified on this inspection included the following:

- limited security and open access to a unit was found at times during the inspection

despite secure key coded doors in place and in use at other times

- there was more than one entrance and exit to the building where other services were located
  - uncontrolled means (stairway and lift) from the administration area that enabled access the centre's first floor facilities. The ground floor of the building was used for administration offices, day care service and doctor on call services
  - housekeeping in parts required improvement. An unused kitchen fridge and an out of date oxygen cylinder that had an expiry date of 2013 was unnecessarily stored in a room in use by staff
  - two sets of fire doors in one part of the centre (rooms 23 and 24) did not close fully
  - the provision of a padded fire evacuation (ski pad) equipment had not been consider for residents(14) accommodated on the first floor
  - the external metal fire escape as an alternative means of escape from the first floor was seen to be rusty in parts and
  - the floor covering in the main kitchen was reported to be in a defective condition.
- Staff had access to hand washing facilities and hand sanitisers on corridors. Staff were seen using these facilities between resident contact. The standard of cleanliness throughout was good, however, in some parts, the building material and paintwork on walls, architrave and skirting was in need of repair, replacement and or painting.

Fire safety and response equipment was provided. Suitable arrangements were in place in relation to the servicing of fire safety equipment. The fire alarm system was recorded as serviced on a quarterly basis and fire safety equipment lighting and extinguishers were serviced on an annual basis.

Fire exits were identifiable by obvious signage and exits were unobstructed to enable means of escape. Staff were trained in fire safety, the records showed most were up-to-date and those who spoke with the inspector confirmed this. Records reviewed confirmed a weekly fire alarm test and checks of escape routes. Fire drills were carried out regularly. However, the provision of fire drills to residents and staff, and the recording practices required further improvement to ensure a drill simulating evening and night time conditions was practiced that identified successes or failures.

**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 were written operational policies relating to the ordering, prescribing, storing and

administration of medicines to residents. The inspector was informed that none of the residents at the time of the inspection were self-medicating.

The processes in place for the handling of medicines, including controlled drugs, were safe and in accordance with current guidelines and legislation. However, some improvements were required in relation to the practices and procedures found.

Timely access to a medical officer was reported by staff, observed and found in a review of resident records. An arrangement for the review of residents, and their prescribed medicines, by the medical officer on a regular basis was in place. Records were available to demonstrate this arrangement was implemented in practice. The medical officer was in the centre reviewing residents during the inspection and spoke with the inspector about his involvement in residents care.

Nursing staff described practices in relation to the ordering, transcribing, prescribing and administration of medicines that reflected safe standards. Two medication errors were reported since the previous inspection. A causative factor of a recent error was attributed to the absence of the resident's photograph from the prescription kardex. Staff described learning and changes made with measures put in place to mitigate the risk of errors. On examination of the residents' prescription and administration records, the inspector found that all the necessary prescription and administration fields were completed. However, a photograph of a resident that had been admitted five days prior to the inspection was not available on the prescription kardex. The rationale for this omission was insufficient and the finding did not demonstrate that all of the learning and safeguarding measures, described by staff, were implemented in practice. The quality of photographs on the remaining prescription kardexs was poor and in black and white print.

In addition, the supervision arrangement for staff following a medicine administration error was minimal, and support arrangements for staff were not recorded or available in staff files. Staff appraisal, performance reviews or competency assessments were not carried out. This is included in the action plan of outcome 18.

The inspector was informed that audits of medicines were carried out by a pharmacist. However, a record of audits was not available or maintained in the centre for inspection.

Procedures were described for the return of unused medicines; however, medicines of a previous resident last administered in December 2016 remained in stock.

**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:**

Arrangements were in place to ensure each resident's healthcare was maintained by a team of nursing, medical and allied healthcare professionals.

An assessment of residents was completed following admission to inform care planning and access to appropriate healthcare services. From an examination of a sample of residents' care plans, and discussions with residents and staff, the inspector was satisfied that the nursing, allied healthcare and medical care needs of residents were assessed and appropriate interventions and/or treatment plans implemented.

There were processes in place to ensure that when residents were admitted, transferred or discharged to and from the centre, relevant and appropriate information about their care and treatment was available and maintained, and shared between providers and services. However, this was not fully achieved with an admission on the day of inspection, as outlined in outcome 2.

A selection of care records and plans were reviewed. A pre-assessment prior to residents' admission formed part of the admission procedure. There was a documented assessment of activities of daily living, including communication, personal hygiene, continence, eating and drinking, mobility, spirituality and sleep. Psychological care plans were also completed in a sample reviewed.

There was evidence of a range of assessment tools being used to monitor clinical observations and areas such as the risk of falls and malnutrition, mobility status and skin integrity.

Physiotherapy, occupational therapy (OT) and dietician services were among the services available to residents in the centre. A multi-disciplinary smart care plan with weekly recorded updates formed part of the review process. A member of staff, whose role as a discharge co-ordinator, was involved in the transitional care process and was actively engaged in regular consultations with residents, family, external agencies, staff and the multi-disciplinary team members to progress discharges. Case conference meetings to discuss and review residents care plans formed part of the on-going care service aimed at a safe and appropriate discharge to the community.

Residents had good access to medical services, and an out-of-hours medical service. Psychiatry and speech and language therapy (SALT) services were available on a referral basis. Residents were satisfied with the service provided and were keen to return home to the community.

**Judgment:**

Compliant

**Outcome 12: Safe and Suitable Premises**

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

**Theme:**

Effective care and support

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

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

**Findings:**

The centre is not purpose built and is registered for a maximum capacity of 23 residents. Residents' accommodation is on the ground and first floor. Other healthcare services are operated from and based within the premises.

The inspector inspected parts of the centre and found the premises to be clean, warm, well ventilated and in a reasonable state of repair generally but requiring modernisation and redecoration in some areas.

The inspector was informed that a separate service located on the ground floor was being redecorated. Two rooms were reconfigured since the previous inspection, the treatment room and nurses office.

Signage was visible to advertise the day and dining room facilities located beyond the key coded doors and at the opposite end of one unit. The day room facilities were not seen in use by residents during the inspection.

There was a main kitchen on the first floor where meals were prepared, cooked and served from. Dining facilities were provided on both floors. Seven residents, supported by three staff, dined in the first floor dining room for the lunch time meal. Other residents had meals in their bedrooms.

Sleeping accommodation was provided in a combination of single rooms and multiple occupancy rooms with one room containing four residents. The multiple occupancy room was a former hospital ward and although the occupancy of the room was reduced in comparison to their former use as wards, the room resembled that of an acute setting. The screening in the four bedded room was laid out for eight beds. This arrangement was not reconfigured to maximise residents' space and enhance privacy. Portable screening was required due to the limitations of the existing screening layout.

A lockable storage space as a secure facility for the safe-keeping of residents' personal property was available to residents.



All bedrooms were provided with sinks and the centre was provided with communal bathroom facilities. However, the privacy screening seen in a twin room and multiple occupancy room did not extend to enable a resident to use the wash hand basin in private.

Handrails were provided on corridors, and grab-rails were available in bathrooms and toilets. All bedrooms and communal areas were fitted with a call bell system, and displays clearly identified the location of a call.

Television and Radios were provided to rooms although the television was not viewable by all residents in some multiple occupancy rooms. Bedrooms had limited personalised items of residents.

In addition to the stairways, there was a passenger lift provided between floors and the circulation spaces are suitable for the needs of the residents, with assistance.

Closed circuit television (CCTV) cameras were seen in corridors.

Car parking facilities were available at the centre, but limited.

The fixtures, fittings, furniture and layout throughout the centre resemble a hospital building which is not suitable for long term residential accommodation as previously recognised by the provider.

This centre provides a valued service within the community. However, the building is not of a suitable design and layout for the provision of residential care for long term occupancy by dependant residents.

The provider has not submitted a costed, time-bound plan to bring the premises into compliance with the Regulations.

**Judgment:**

Substantially Compliant

***Outcome 18: Suitable Staffing***

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

**Theme:**

Workforce

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

No actions were required from the previous inspection.

**Findings:**

Staffing levels and the skill mix were sufficient to meet the healthcare needs of the residents.

Staff confirmed that they had encountered some delays in carrying out their duties and responsibilities due to plans to transfer residents between units to prepare for admissions. The morning medicine round had run later than usual and was completed at 10:30hrs.

The management team explained that arrangements and systems were put in place to equip staff to re-opening a unit and admit an additional six residents. An agreed staffing plan was seen completed and was reflected in the actual roster and service level agreement document seen between the provider and an agency service. The agency service had agreed to supply nursing staff to facilitate the increase of resident numbers and the re-opening on the ground floor unit that was closed for up to six months. Staff were seen to be supportive of residents and responsive to their needs.

The inspector spoke with a number of residents, who were complimentary of the staff and of the care that this service provided. Staff were seen to be kind and friendly towards all residents and respectful towards their preferences and wishes, for example, facilitating them to dine where they choose and to return to bed on request.

The inspector reviewed the actual and planned roster for staff and found that the number of management, nursing, care and support staff were adequate. Requests and residents' alarm bells were responded to by staff during the inspection. Some residents in discussions with the inspector confirmed that staffing levels were satisfactory and that staff were supportive of them to achieve their goal of returning home.

Recruitment procedures were described and in place. Samples of staff files were reviewed against the requirements of schedule 2 records and found to be compliant. However, as discussed in outcomes 2 and 9, staff governance, training, management arrangements, appraisal and review required improvement.

A staff training programme was described in policies and a record of staff training was available. However, as discussed in other outcomes, all rostered staff employed by the provider had not completed up-to-date mandatory and relevant training. Some rostered staff were not included on the training record and deficiencies were found in the provision and frequency of mandatory training such as moving and handling, cardio pulmonary resuscitation (CPR), fire safety and elder abuse.

The inspector was informed that there were no volunteers involved in the centre.

**Judgment:**

Non Compliant - Moderate

## Closing the Visit

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

### **Acknowledgements**

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

### ***Report Compiled by:***

Sonia McCague  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority

## Health Information and Quality Authority Regulation Directorate

### Action Plan



#### Provider's response to inspection report<sup>1</sup>

Centre name:	Cottage Hospital
Centre ID:	OSV-0000534
Date of inspection:	18/01/2017
Date of response:	16/02/2017

#### Requirements

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

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

#### Outcome 01: Statement of Purpose

##### Theme:

Governance, Leadership and Management

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

The changes found on inspection had not been formally communicated to the Chief Inspector in a revised statement of purpose in relation to:

- the admission policy, criteria (inclusion and exclusion) and arrangements
- the length of stay was unclear
- the staffing arrangements and
- the closed unit had re-opened, was operational on the day of inspection with a plan to

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

accommodate six new admissions following a service level agreement with an external staffing agency.

The centre was registered in 2015 as a short stay service that provided transitional care to residents within a timeframe of 30 days from admission to discharge. However, this was not consistently achieved or reflective in practice due to problems encountered during the stay and discharge planning stage, such as a deterioration in resident's health, delays in a suitable home care package or unsuitable housing that involved other external agencies input.

The inspector confirmed that the length of stay for some of the existing residents and a previous resident had exceeded the agreed timeframe. A contingency plan or protocol was not in place to manage and respond to delays in resident discharge as a likely event of the intended service.

**1. Action Required:**

Under Regulation 03(2) you are required to: Review and revise the statement of purpose at intervals of not less than one year.

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

The statement of purpose has been robustly reviewed in conjunction with the admission policy, resident's guide, contract of care and consent for admission. It will be forwarded to the authority upon its completion.

The statement of purpose has been amended to extend the timeframe for length of stay from 30 days to 60 days as this is a more realistic timeframe given the current difficulties in the health system relating to accessing home care supports and aids and appliances.

The service provided by this centre is the only facility that provides rehabilitation to older people transitioning from the acute hospital to allow them to return home. On occasions, there can be unplanned delays due to home circumstances/adaptations. In the event that a residents' stay is at risk of exceeding the stated timeframe of 60 days an individual contingency plan will be enacted with the commencement of a process to meet with the wider MDT and all relevant stakeholders to address the issues causing the delay in order to expedite a safe discharge to the residents' place of choice.

**Proposed Timescale:** 28/02/2017

**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:**

The governance and management arrangements required improvement to ensure high quality care in a safe environment.

Deficiencies were found in the assessment and management of risk, education and

training of staff, and the co-ordination and management of the service being provided.

Based on the overall findings from this inspection there was an insufficient deployment of resources prior to the re-opening of a unit that had previously been closed due to staff shortages.

Rostered staff were not sufficiently trained, supervised in practice or following incidents and were not involved in the pre-admission assessments of residents being admitted to the centre.

The inspector confirmed with staff that residents being admitted on the day of the inspection had a pre-admission assessment carried out by an external person who worked at the referral source. This was not a robust system to ensure that residents were suitably placed and the arrangement posed a significant risk to the safety and welfare of both new and existing residents.

Based on the inspector's observations, improvement was required in relation to the planning, consideration and communication of admissions.

The authority and accountability for all admissions to the centre required improvement. One resident arrived to the centre without prior notice and without all of the necessary documents required for admission.

Management resources were depleted. The person in charge, as Director of Nursing, along with an assistant Director of Nursing both had responsibility for three designated centres, had involvement in a community based service, and had responsibility as a designated officer that included the delivery of safeguarding training to staff working in the three designated centres. A vacancy in the management structure created by the absence of an assistant director of nursing had not been addressed since August 2016 and management staff that had left and transferred on secondment to other services had not been replaced within the overall governance structure.

Improvement was required in the governance and management of the centre. An evaluation of the systems and arrangements in place to review and monitor the quality of care delivered was required to ensure the service is safe, consistent, appropriate and effectively monitored.

The inspector was not satisfied that management were sufficiently supported to be engaged in the effective governance, operational management and administration of the designated centre due to their level of involvement in other services.

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## **2. Action Required:**

Under Regulation 23(c) you are required to: Put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

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

The new arrangement to reopen beds in the Cottage had been planned from two weeks previously to allow for a planned reopening. The clinical staff rostered on the day were as follows:

A Clinical Nurse Manager, three nurses (one of whom was an agency nurse), five care attendants and a third year BSc student nurse. Staff were being supported on the day by the PIC and the discharge coordinator. The provider nominee was also onsite.

There were 14 residents being cared for on the first floor that morning with a plan to move two mobile residents, who were due to go home shortly, downstairs to Unit 1 to facilitate the admission of two previously assessed and accepted residents to the first floor ward (Unit 2).

We will ensure that there will be adequate staff on duty to meet the needs of residents onsite and new admissions,

We will plan and co-ordinate all admissions to correspond with staffing levels and numbers

We will continue to monitor the number of admissions that the Centre can safely deal with during any period of time to ensure safety of all residents and staff

We will ensure that the Statement of Purpose is at all times changed to reflect any changes in future in the service and that the Health Information and Quality Authority is notified as per the Regulations.

The Person in Charge will ensure that all residents are referred to the designated centre through the Office of the Person in Charge/Director of Nursing.

On receipt of a referral from the referring Hospital, the Person in Charge will arrange for a Senior Nurse from the Centre to undertake a pre admission assessment in conjunction with a nurse from the Referring Hospital.

On receipt of a pre admission assessment, the Person in Charge will determine that the Centre is appropriate and can meet the needs of the person being referred.

The Person in Charge will then correspond with the referring Hospital outlining a planned date and time of admission to the Centre.

All referrals and admissions will be closely monitored to ensure that this robust system is working and any deviance from this system will be Risk assessment and reported

The unfilled post of Assistant Director of Nursing has been prioritised by the HSE and the campaign to recruit has commenced. It is envisaged that this post will be filled within the next quarter. In the interim we have arranged for a nurse manager to redeploy from another service to provide support and cover for day to day operation of the centre.

This will free up the Person in Charge to concentrate more on ensuring that there is proper governance in place.

A Clinical Nurse Manager 2 is in place within the Centre.

The Person in charge receives an up to date report throughout as twenty four hour period on all residents admitted to the Centre

A designated Discharge Officer is in place to ensure that residents are safely discharged to their own homes.

The Centre also has the services of a Risk Advisor who is based on the site of the designated Centre

**Proposed Timescale: 13/03/2017**

### Outcome 03: Information for residents

**Theme:**

Governance, Leadership and Management

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

The current management arrangements were not reflected in the Residents' Guide, and some of the terms and conditions of stay were not reflected in practice.

**3. Action Required:**

Under Regulation 20(2)(b) you are required to: Prepare a guide in respect of the designated centre which includes the terms and conditions relating to residence in the centre.

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

The Resident's Guide, Statement of Purpose and Contract of Care have all been revised to ensure that the Centre's Terms and Conditions are clear and transparent.

**Proposed Timescale: 22/02/2017**

**Theme:**

Governance, Leadership and Management

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

Some terms and conditions of stay outlined within the contract were not reflected in practice. For example, some residents were identified by staff as having cognitive impairment and or a diagnosis of dementia. A referral to other teams or consideration of an alternative placement when a risk is identified, such as dementia or cognitive impairment, had not been made, as outlined in the terms of the contract.

A full review of resident's contracts of care, residents guide and information for residents was required in line with the statement of purpose and function.

**4. Action Required:**

Under Regulation 24(2)(a) you are required to: Ensure the agreement referred to in regulation 24 (1) relates to the care and welfare of the resident in the designated centre and includes details of the services to be provided, whether under the Nursing Homes Support Scheme or otherwise, to the resident concerned.

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

The admission policy is being reviewed by the PIC and the management team in conjunction with the contract of care, the resident's guide and the statement of purpose to ensure that the exclusion criteria are clearly stated and contingency plans are in place in the event that the planned admission period or purpose has to be changed due to changing circumstances in the resident's health or living arrangements and supports. There may be occasions whereby some older residents are admitted to the Centre who



may be experiencing Delirium secondary to an acute illness and whereby the effects of that delirium may last for a number of weeks. The Centre does not admit people living with dementia and this is part of the exclusion criteria  
We will continue to monitor closely all referrals and admissions to ensure that all residents when admitted are appropriately placed. We will also ensure that as part of the assessment process, it is determined if and when delirium may be occurring and the expected duration of same

**Proposed Timescale:** 28/02/2017

#### **Outcome 04: Suitable Person in Charge**

**Theme:**

Governance, Leadership and Management

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

The inspector was not satisfied that that person in charge was sufficiently supported and engaged in the effective governance, operational management and administration of this designated centre due to their level of involvement in other services and in charge of two other centres.

**5. Action Required:**

Under Regulation 14(4) you are required to: If the person in charge is in charge of more than one designated centre provide evidence to the chief inspector that the person in charge is engaged in the effective governance, operational management and administration of the designated centres concerned.

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

The unfilled post of Assistant Director of Nursing has been prioritised by the HSE and the campaign to recruit has commenced. It is envisaged that this post will be filled within the next quarter. In the interim we have arranged for a nurse manager to redeploy from another service to provide support and cover for day to day operation of the centre.

The PIC or deputy to the PIC attend the weekly MDT meetings and a process has been commenced to alert the PIC of any resident who may be at risk of approaching or breaching the 60 day timeframe. The PIC is providing ongoing monitoring of resident's length of stay through morning and evening reports.

**Proposed Timescale:** 31/03/2017

#### **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:**

Some improvement was required in relation to the policies and or practices relating to resident admission, risk management, health and safety, and disposal of unused medicines, as discussed under other outcomes. For example, the admission policy criteria included the following which was not the current practice found:

- nursing staff from the centre to undertake the pre-admission assessment
- all the specified documents to accompany the resident on transfer and admission
- patient is deemed to require long term care and
- involvement of the nursing home subvention office that was to informed of the transfer.

**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:**

The Pre admission assessment will be completed by Nursing Staff from the Designated Centre. The Person in Charge will ensure that all residents are referred to the designated centre through the Office of the Person in Charge/Director of Nursing.

On receipt of a referral from the referring Hospital, the Person in Charge will arrange for a Senior Nurse from the Centre to undertake a pre admission assessment in conjunction with a nurse from the Referring Hospital.

On receipt of a pre admission assessment, the Person in Charge will determine that the Centre is appropriate and can meet the needs of the person being referred.

The Person in Charge will then correspond with the referring Hospital outlining a planned date and time of admission to the Centre.

The Person in Charge will review all documentation available prior to accepting any resident for admission

All referrals and admissions will be closely monitored to ensure that this robust system is working and any deviance from this system will be Risk assessment and reported.

The Centre does not admit knowingly any resident known to require extended Care.

The admission Policy has been amended to reflect this Policy.

As no resident is admitted to the Centre requiring Long Stay Care, there is no requirement to notify the Nursing Home Support Office.

We will ensure that all drugs are appropriately disposed of in line with the Centre's Policy on the Disposal of out of Date Medicines or medicines no longer required by a Resident.

**Proposed Timescale:** 28/02/2017

**Theme:**

Governance, Leadership and Management

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

During discussions with staff, some were not aware that policies were available or

accessible on each unit.

**7. Action Required:**

Under Regulation 04(2) you are required to: Make the written policies and procedures referred to in regulation 4(1) available to staff.

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

We accept that some staff were not aware of where key Policies and Procedures were stored. No Policy is introduced or developed without going through a Clinical Governance Procedure with all staff to ensure that the contents of the Policy are understood.

We will now ensure that all staff sign a Read and Understood Declaration

In addition to overcome staff being unaware of where Policies were placed, the Centre designed its own electronic version of all policies to ensure that staff had easy access to same.

We will ensure that all staff are familiar with this data base with particular emphasis on Agency Nursing Staff. The Clinical Nurse Manager has undertaken and has been supported by the PIC to ensure that all staff have as part of their induction and ongoing, familiarisation with all policies and procedures.

**Proposed Timescale:** 30/03/2017

**Theme:**

Governance, Leadership and Management

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

An electronic directory of residents was maintained in the centre; however, it required improvement as follows:

- it had not been updated to reflect the correct number of 14 residents. The number of residents on the printed copy made available included 12 named residents. Two residents were not included, one of whom had been admitted five days prior to this inspection
- the date the resident was first admitted to the centre, date of transfer to another service or hospital and date of return by residents' (re-admission) were not sufficiently detailed
- the record in general was not user friendly, fully complete or easily accessible, and was seen to be difficult to navigate in order to produce the information received.

**8. Action Required:**

Under Regulation 19(3) you are required to: Ensure the directory includes the information specified in paragraph (3) of Schedule 3.

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

The Centre accepts that all information required under Schedule Three was not available. A Staff member is in place solely to ensure that Schedule 3 Records are updated as often as required

All information as per Schedule three will be kept updated on a daily basis

The omission to the register was amended immediately and the person with responsibility for keeping the register updated was reminded of the importance of having up to date correct information in the register at all times. The register is checked daily by the PIC or her deputy  
The register is currently being reformatted to be more user friendly and to include all the details required relating to readmissions as per Schedule three

**Proposed Timescale:** 06/03/2017

**Theme:**

Governance, Leadership and Management

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

Some improvement was required in relation to the filing arrangements as the arrangement found did not to ensure ease of access to records regarding healthcare decisions.

Records of up to four weeks previous had not been filed in residents' medical notes to inform their care and treatment requirements or review

**9. Action Required:**

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

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

The medical officer has been consulted by the PIC in relation to how the decision to resuscitate or not is recorded to ensure it is easily seen and known by all relevant health care personnel

A new system to ensure timely filing of resident notes has been commenced and is audited regularly

Proposed Timescale: 10/02/2017 and ongoing

**Proposed Timescale:** 10/02/2017

**Theme:**

Governance, Leadership and Management

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

Some improvement was required in relation to the following:

- filing arrangements did not to ensure ease of access to records regarding healthcare decisions. Records of up to four weeks previous had not been filed in residents' medical notes to inform their care and treatment requirements or review
- residents' transitional care assessment record did not consistently include the name of

the assessor and date completed

- a photograph of a resident admitted five days previously was not available on the records, as required
- the quality of the black and white photograph record was poor
- the maintenance of records associated with fire safety checks such as fire extinguishers was not available and
- the recorded details of fire safety and evacuation drills required further development.

**10. 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 PIC has ensured that a new system to ensure timely filing of resident's notes has been commenced and is being regularly audited.

The PIC will ensure that the name of the assessor and date of recording at all times will be included on all resident records

A colour printer has been ordered for the Centre and in the meantime the resident's photographs are being printed on another accessible colour printer in the administration office.

Regular audits are being carried out to ensure photos are attached to the drug administration sheet at all times.

The company responsible for fire safety management were contacted immediately after the inspection and have included the information relating to the fire extinguishers in the fire book. All are catalogued and have been serviced as per recommended guidelines.

Learning which took place following evacuation drills which have been carried out in the Centre and stored at unit level have been copied and added to the fire book so they are easily accessible for review in conjunction with all details relating to fire safety

**Proposed Timescale:** 10/02/2017

**Outcome 07: Safeguarding and Safety**

**Theme:**

Safe care and support

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

Improvement was required in relation to the high rate and use of bedrails, in accordance with the national guidance document that promotes a restraint free environment.

There was no evidence that less restrictive devices, which could achieve the goals of transitional care, were available and tried before bedrails were used.

93% of residents in the centre used bedrails.

On examination of bedroom furniture, the inspector found that all of the beds seen in the centre had bedrails attached.

The inspector confirmed that alternative or least restrictive measures had not been trialled before bedrails were used. A limited availability of alternative less restrictive equipment was found.

The staff training record showed that training on restraint and on the use of restrictive devices had not been provided to staff.

**11. Action Required:**

Under Regulation 07(3) you are required to: Ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.

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

The Centre has adapted the National Policy in relation to Restraint.

A restraint decision process is in place and will be actively monitored and audited to ensure compliance with National Policy

A plan to reduce the usage of bed rails has commenced in the centre and use of less restrictive aids will be trialled.

The reason for usage is explored and risk assessed on admission and bed rails are not employed as a matter of course on admission. In light of discharge arrangements some residents may require bedrails at home and this will be taken into account during assessment.

Alternative aids are being sourced for use in place of bedrails.

The staff training record showed that training on restraint and on the use of restrictive devices had not been provided to staff.

Training on restraint usage for staff is being planned as part of the training schedule for first and second Quarter of 2017 and will be prioritised.

**Proposed Timescale:** 28/04/2017

**Outcome 08: Health and Safety and Risk Management**

**Theme:**

Safe care and support

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

Staff training records showed that 75% of staff nurses and many care workers did not have up-to-date CPR training. The records showed that some staff did not have a date for CPR training while others had training dates ranging from 2013 to 2010.

The health and safety statement included that all staff were to receive manual handling training every two years. However, this was not achieved in practice.

The identification, control and management of hazards and risks required improvement.

The inspector reviewed the risk register which included rated risks that were identified in 2015 and 2016. There was little recorded evidence to demonstrate that the risks within the register had been subject to regular review or had been resolved or escalated appropriately.

Other risks identified on this inspection included the following:

- limited security and open access to a unit was found at times during the inspection, despite secure key coded doors in place and in use at other times
- there was more than one entrance and exit to the building where other services were located
- uncontrolled means (stairway and lift) from the administration area that enabled access the centre's first floor facilities. The ground floor of the building was used for administration offices, day care service and doctor on call services
- housekeeping in parts required improvement. An unused kitchen fridge and an out of date oxygen cylinder that had an expiry date of 2013 was unnecessarily stored in a room in use by staff
- two sets of fire doors in one part of the centre (rooms 23 and 24) did not close fully
- the provision of a padded fire evacuation (ski pad) equipment had not been considered for residents(14) accommodated on the first floor
- the external metal fire escape as an alternative means of escape from the first floor was seen to be rusty in parts and
- the floor covering in the main kitchen was reported to be in a defective condition.

## **12. Action Required:**

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

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

The training record is being reviewed and updated. CPR training is being prioritised for nurses and will be then delivered to care staff. The Centre has a nurse trained and skilled in delivering AED and CPR. Training is planned to commence every Wednesday from Mid March to ensure that all staff have received CPR Training

Three members of staff in the Centre are now trained to deliver manual handling training and this training will be included in the 2017 training schedule and delivered to all staff requiring same.

The PIC, in consultation with the risk advisor, is carrying out a total review of the risk register to ensure that it reflects current risks in a meaningful manner. Risks are discussed at monthly local management meetings and escalated to senior management at regular governance meetings as required.

There are key codes to all doors into and out of the centre. A key code was installed in the lift following the inspection and the lift cannot be used to travel from outside to inside the centre without first using the code. This code will be changed regularly. Currently the door at the bottom of these stairs is locked when the area is not attended by staff from the centre. A key code to the door at the top of the stairs will now be installed.

All inappropriately stored equipment was removed immediately and the area will be monitored on an ongoing basis to ensure compliance

These doors which are situated beside the main kitchen were inspected immediately by the fire safety officer and were in full working order. The release button had not been used to close the doors during the inspection and so the doors did not close correctly. When tested, the closed correctly.

The fire officer has been contacted to obtain a ski sheet for the top of both stairs as recommended.

The external metal fire escape as an alternative means of escape from the first floor was seen to be rusty in parts and the floor covering in the main kitchen was reported to be in a defective condition.

The fire officer has been informed of the rust in evidence on the fire escape and will address same. The floor covering in the kitchen does require changing and funding has been sought in the capital plan for 2017 as a priority. The cost to replace the flooring is €13,000 and approval for same has not yet been granted.

**Proposed Timescale: 03/04/2017**

**Theme:**

Safe care and support

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

Arrangements in place for investigating and learning from serious incidents or adverse events such as medication errors required improvement.

**13. 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:**

Following the incident referred to, an action plan was developed and the member of staff in question undertook a period of supervision while performing that clinical skill. A programme of training in relation to medication management was successfully



undertaken. The PIC, in conjunction with the CNM, continued ongoing supervision informally and were assured that learning from the incident had been implemented. A hazard alert sheet was distributed to ensure all nurses were made aware of the incident immediately. The omission of a photograph on a medication Kardex was as a result of not having a clear system in place in the absence the ward clerk. A system has now been implemented that the nurse in charge each day ensures that a photograph is taken as part of the admission process. This process is being closely audited on an ongoing basis.

All serious incidents and adverse events are added to the risk register and discussed at local management governance meetings and escalated as required to senior management.

**Proposed Timescale:** 27/01/2017

**Theme:**

Safe care and support

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

The provision of fire drills to residents and staff, and the recording practices required further improvement to ensure a drill simulating evening and night time conditions was practiced that identified successes or failures.

**14. Action Required:**

Under Regulation 28(1)(e) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and residents are aware of the procedure to be followed in the case of fire.

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

Fire drills will be carried out in night time conditions and learning from same will be recorded and discussed with staff

**Proposed Timescale:** 28/02/2017

### **Outcome 09: Medication Management**

**Theme:**

Safe care and support

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

On examination of the residents' prescription and administration records, the inspector found that a photograph of a resident that had been admitted five days prior to the inspection was not available on the prescription kardex. The rationale for this omission was insufficient and the finding did not demonstrate that all of the learning and

safeguarding measures, described by staff, were implemented in practice.

The quality of photographs on the remaining prescription kardexs was poor and in black and white print.

The inspector was informed that audits of medicines were carried out by a pharmacist. However, a record of audits was not available or maintained in the centre for inspection.

**15. Action Required:**

Under Regulation 29(2) you are required to: Facilitate the pharmacist concerned in meeting his or her obligations to a resident under any relevant legislation or guidance issued by the Pharmaceutical Society of Ireland.

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

This omission should not have occurred. The nurse in charge now takes responsibility for ensuring that the photograph of the resident is taken on admission, with the resident's consent, and is attached to the Kardex. Ongoing audits are carried out to ensure compliance with same.

Photographs are now all in colour and ongoing audits on kardexes are being carried out to ensure that this is place.

The pharmacist was contacted during the inspection and the audits which had been conducted on site were obtained and are now available on the ward. All future audits will be reported in a timely manner and learning from same will be discussed and actioned

**Proposed Timescale:** 27/01/2017

**Theme:**

Safe care and support

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

Medicines of a previous resident (no longer in the centre) that was last administered in December 2016 remained in stock.

**16. Action Required:**

Under Regulation 29(6) you are required to: Store any medicinal product which is out of date or has been dispensed to a resident but is no longer required by that resident in a secure manner, segregated from other medicinal products and dispose of in accordance with national legislation or guidance in a manner that will not cause danger to public health or risk to the environment and will ensure that the product concerned can no longer be used as a medicinal product.

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

We will ensure that all medicines are disposed of in line with Schedule 5 Policy on the Disposal of out of date or unused medicines

These medicines have been returned to the pharmacy to be disposed of as per national guidelines.  
The disposal of medicines will be audited ongoing to ensure that all medicines are effectively and safely disposed of

**Proposed Timescale:** 27/01/2017

## **Outcome 12: Safe and Suitable Premises**

### **Theme:**

Effective care and support

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

The centre is not purpose built and the building is not of a suitable design and layout for the provision of residential care for long term occupancy by dependant residents.

The provider has not submitted a costed, time-bound plan to bring the premises into compliance with the Regulations.

The centre is registered for a maximum capacity of 23 residents. Residents' accommodation is on the ground and first floor. Other healthcare services are operated from and based within the premises.

The centre requires modernisation and redecoration in some areas.

The day room facilities on the first floor unit are not in close proximity to the bedroom accommodation and are beyond a key coded door.

A multiple occupancy (four bed) room was a former hospital eight bed ward and although the occupancy of the room was reduced in comparison to their former use as a ward, the room resembled that of an acute setting. The screening in the four bedded room was laid out for eight beds. This arrangement was not reconfigured to maximise residents' space and enhance privacy. Portable screening was required due to the limitations of the existing screening layout.

All bedrooms were provided with a wash hand basin and the centre was provided with communal bathroom facilities. However, the privacy screening seen in a twin room and multiple occupancy room did not extend to enable a resident to use the wash hand basin in private.

Car parking facilities available at the centre were limited.

The fixtures, fittings, furniture and layout throughout the centre resemble a hospital building which is not suitable for long term residential accommodation as previously recognised by the provider.

**17. 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:**

The provider acknowledges that the centre is not of a suitable design or layout for long term care, however, the care provided in this centre is for short term care only for residents up to a maximum of 60 days before being discharged to the place of their choice. On the rare occasion where this time period may be breached every effort will be made to ensure all supports are utilised to assist the resident to safely go home or to assist the resident to access appropriate long term care if that is now the only option. The centre is not for use as a long term care residential facility as per the statement of purpose.

Quotes are being obtained for the painting of the centre, prioritising those areas in a poor state of repair.

The key code was added to the door as a result of a previous inspection. Long term care has been removed from the centre since 2013 and the aim of the centre is to promote independence by encouraging the resident to mobilise more. Residents are assisted to access the sitting room whenever they wish.

The company who supply and maintain the screening has been contacted to assess the screening arrangement and amend as appropriate. Portable screening has been ordered in the meantime.

There is currently renovation work being carried out to the doctor on call service on site and subsequently there are more vehicles parked in the centre car park at present. When this work has been completed the shortage of car park spaces will be alleviated.

A programme in place to personalise bedrooms and communal spaces such as the sitting room and the quiet room. In the meantime we will ensure that all resident areas are personalised as much as possible

**Proposed Timescale:** 31/05/2017

**Outcome 18: Suitable Staffing**

**Theme:**  
Workforce

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

Staff governance, training, management arrangements, appraisal and review required improvement.

The supervision arrangement for staff following a medicine administration error was minimal, and support arrangements for staff were not recorded or available in staff files.

Staff appraisal, performance reviews or competency assessments were not carried out.

**18. Action Required:**

Under Regulation 16(1)(b) you are required to: Ensure that staff are appropriately supervised.

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

A process of practice development and training needs assessment for all staff has commenced in the centre. The manager of the centre has been and will continue to be supervised and supported by the PIC and a process of regular one to one meetings between the PIC and the CNM has commenced.

The Person in Charge receives a full update on all residents at 08.00 am.

The Person in Charge along with the Deputy PIC is available 24 hours per day should staff wish to contact them in an emergency or out of hours.

There is always at least two senior nurses on duty over a twenty four hour period over a seven day period

A training needs assessment will now be completed and a staff performance system implemented based on outcomes

**Proposed Timescale:** 30/05/2017

**Theme:**

Workforce

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

All rostered staff employed by the provider had not completed up-to-date mandatory and relevant training.

Some rostered staff were not included on the training record and deficiencies were found in the provision and frequency of mandatory training such as moving and handling, cardio pulmonary resuscitation (CPR), fire safety and elder abuse .

**19. Action Required:**

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

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

The training record has been thoroughly reviewed and reformatted to ensure that all staff are included in the records.

The training schedule for 2017 is currently being finalised and all mandatory training is being prioritised to those members of staff who have not completed same within the allotted time frame.

**Proposed Timescale:** 30/05/2017