<table>
<thead>
<tr>
<th><strong>Centre name:</strong></th>
<th>Cobh Community Hospital</th>
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</thead>
<tbody>
<tr>
<td><strong>Centre ID:</strong></td>
<td>OSV-0000558</td>
</tr>
<tr>
<td><strong>Centre address:</strong></td>
<td>Aileen Terrace, Cobh, Cork.</td>
</tr>
<tr>
<td><strong>Telephone number:</strong></td>
<td>021 481 1345</td>
</tr>
<tr>
<td><strong>Email address:</strong></td>
<td><a href="mailto:cobh_hospital@eircom.net">cobh_hospital@eircom.net</a></td>
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<tr>
<td><strong>Type of centre:</strong></td>
<td>Health Act 2004 Section 39 Assistance</td>
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<tr>
<td><strong>Registered provider:</strong></td>
<td>Cobh Community Hospital</td>
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<tr>
<td><strong>Provider Nominee:</strong></td>
<td>Peter Morehan</td>
</tr>
<tr>
<td><strong>Lead inspector:</strong></td>
<td>John Greaney</td>
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<tr>
<td><strong>Support inspector(s):</strong></td>
<td>None</td>
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<tr>
<td><strong>Type of inspection</strong></td>
<td>Announced</td>
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<tr>
<td><strong>Number of residents on the date of inspection:</strong></td>
<td>43</td>
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<tr>
<td><strong>Number of vacancies on the date of inspection:</strong></td>
<td>0</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.

Please note the definition of the following term used in reports: responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).
Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration renewal decision. This monitoring inspection was announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 01 June 2017 08:15
To: 01 June 2017 18:30

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

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Our Judgment</th>
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</thead>
<tbody>
<tr>
<td>Outcome 01: Statement of Purpose</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 02: Governance and Management</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 03: Information for residents</td>
<td>Substantially 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>
</tr>
<tr>
<td>Outcome 07: Safeguarding and Safety</td>
<td>Compliant</td>
</tr>
<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>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 10: Notification of Incidents</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 11: Health and Social Care Needs</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 12: Safe and Suitable Premises</td>
<td>Non Compliant - Major</td>
</tr>
<tr>
<td>Outcome 13: Complaints procedures</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 14: End of Life Care</td>
<td>Compliant</td>
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<tr>
<td>Outcome 15: Food and Nutrition</td>
<td>Compliant</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>
</tr>
</tbody>
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Summary of findings from this inspection

Cobh Community Hospital provides residential, respite and palliative care and is registered to accommodate 43 residents. On the days of inspection the centre was fully occupied. The centre was originally constructed in the early 20th Century and overall, the design and layout of the premises was largely reflective of the period in which it was built. The older and main part of the hospital comprised three floors with resident' bedrooms on the ground, upper ground and first floors. 31 of the residents were accommodated in this part of the centre in single, twin, triple and quadruple bedrooms. 12 residents were accommodated in 12 single bedrooms in a newer section of the centre that was adjoined to the Park Road Day Centre.
This report sets out the findings of a two day inspection, which was a follow-up to an inspection carried out in February 2017. In addition to following up on the actions required from that inspection, additional outcomes were inspected against, that were not inspected on that occasion. The purpose of the inspection was to monitor on-going compliance with the Care and Welfare Regulations and the National Standards in response to an application to renew the registration of the centre. The renewal application included an application to increase the capacity of the centre by one, to 44 residents.

During the inspection, the inspector met with a number of residents, relatives and staff members, including the person in charge and clinical nurse managers. The inspector observed practices and reviewed records such as nursing care plans, medical records, accident and incident logs, policies and procedures and a sample of personnel files. Residents to whom the inspector spoke stated that they were happy living in the centre and that they felt safe there.

Overall, the findings of this inspection indicated that residents received care to a good standard. Staff members spoken with were knowledgeable of residents’ individual needs. Staff were seen to interact with residents in a caring and respectful manner. Residents were comprehensively assessed on admission and care plans were developed in accordance with the findings of the assessments. Residents had good access to medical, specialist and allied health services and there was evidence of regular review.

Some improvements, however, were required. While an annual review of the quality of care was now complete, it lacked detail in relation to the findings from audits and the action plan did not contain enough detail in relation to responsibilities and timelines for implementation of the plan. One of the twin bedrooms on the first floor had previously been the dining room and was converted to a single bedroom, as dining facilities were now on the ground floor. In the application to renew their registration as a designated centre, the provider had applied to increase bed capacity from 43 residents to 44 by converting this room from a single to a twin. HIQA were not informed, however, of the conversion of the dining room to a bedroom and as such, were in breach of their registration by not complying with the information contained in the previous application to renew or with their statement of purpose.

Additional required improvements included:
• a Directory of Residents was not maintained in the centre
• some staff required refresher training in fire safety
• the contract of care was in the process of being revised but not yet finalised
• coded locks had been applied to the sluice and medication fridge but were not at all times locked.

The action plan at the end of this report identifies where improvements are needed to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Standards for Residential Care Settings for Older People in Ireland.
Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

**Outcome 01: Statement of Purpose**
*There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.*

**Theme:**
Governance, Leadership and Management

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

**Findings:**
There was a written statement of purpose that accurately described the service that is provided in the centre. The statement of purpose contained all of the information required by Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

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

**Findings:**
There was a clearly defined management structure. The person in charge reported to the providers and was supported in her role by two clinical nurse managers. At the most
recent inspection in February 2017 it was identified that the annual review of the quality and safety of care was in draft form and was not yet available. On this inspection the annual review was completed and was available to the inspector for review. Some improvements, however, were required in relation to the contents of the review. For example, the review lacked detail in relation to findings from audits and there were no timelines or responsibilities assigned in relation to planned improvements. Additionally, there was inadequate detail in relation to findings and resulting actions from consultations with residents and their relatives.

At the last inspection it was identified that there were required improvements in governance and management due to the cumulative findings from that inspection. On this inspection it was identified that many of the actions from that inspection were satisfactorily addressed. For example, fire drills had been conducted and all members of staff had attended; staff knowledge around fire safety had improved; the risk register was updated to include identified risks; an annual review of the quality and safety of care was completed, however, some improvements were still required; based on a sample of personnel files reviewed all the requirements of Schedule 2 were now met; and all complaints were now being recorded. These issues are addressed in more detail in the relevant outcomes of this report.

Judgment:
Substantially Compliant

Outcome 03: Information for residents
A guide in respect of the centre is available to residents. Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

Theme:
Governance, Leadership and Management

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

Findings:
There was a guide to the centre available for residents that included a summary of the services & facilities available, the terms and conditions of residency, the procedure respecting complaints and the arrangements for visits.

At the last inspection it was identified that the contracts of care did not include the terms relating to the bedroom to be provided to the resident and the number of other occupants (if any) of that bedroom. On this inspection, it was identified that this issue was being addressed. Prospective residents were informed in writing of the terms relating to the bedroom to be provided to the resident and the number of other occupants (if any) of that bedroom. Details of fees for additional services were also provided to residents. A process was commenced whereby this would be included as an appendix to each contract.


Judgment:
Substantially Compliant

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

Theme:
Governance, Leadership and Management

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

Findings:
The inspector reviewed a sample of staff files and found that they contained all of the information required under Schedule 2 of the regulations. The person in charge confirmed to the inspector that all staff and volunteers were Garda vetted. Records were kept secure, were accessible and were kept for the required period of time. Residents’ records were kept in a secure place.

While most of the information required to be maintained in a directory of residents was retrievable electronically, the centre did not maintain a Directory of Residents as required by the regulations, either electronically or in a hardcopy format. The centre was adequately insured against accident or injury and insurance cover complied with all the requirements of the regulations.

Inspectors found that the medical and nursing records were comprehensive. The care plans and the record of care provided to residents were accurately documented. All of the key policies as listed in Schedule 5 of the regulations were in place and kept under regular review.

Judgment:
Non Compliant - Moderate

Outcome 06: Absence of the Person in charge
The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.
Theme: Governance, Leadership and Management

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

Findings:
There was no period when the person in charge was absent from the centre for a period in excess of 28 days. Adequate arrangements were in place to manage the centre in the absence of the person in charge.

Judgment:
Compliant

Outcome 07: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme: Safe care and support

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

Findings:
There were policies and procedures in place to guide staff on what to do in the event of suspicions or allegations of abuse. The person in charge confirmed that there were no active suspicions or allegations of abuse. Residents spoken with by the inspectors stated that they felt safe in the centre and would have no difficulty in speaking to a staff member if they had any concerns. Visitors were seen to come and go throughout the two days of the inspection. Staff members were seen to interact with residents in a caring and respectful manner.

At the last inspection it was identified that not all staff had received up-to-date refresher training on safeguarding people from abuse. Training records viewed by the inspector on this inspection indicated that all staff had now received up-to-date training in relation to recognising and responding to allegations or suspicions of abuse. Staff spoken with by the inspector demonstrated adequate knowledge relevant to their role in relation to protecting residents from abuse. It was also identified that not all staff had up-to-date training in responsive behaviour. Training records also indicated that all staff were now up to date in this training.

At the last inspection it was identified that records of financial transactions were
maintained for small sums of money held for safekeeping on behalf of residents. However, it was found that not all lodgements and withdrawals were adequately documented or signed for by residents, their representatives and/or staff. Additionally, no written acknowledgement of the return of the money or valuables of for reviewing/auditing these arrangements to ensure good financial governance was in place. These issues were satisfactorily addressed on this inspection. A new receipt book was in place and all transactions, whether lodgements or withdrawals, were signed for either by the resident, relative or two members of staff. There was also a system in place for independent audit of these arrangements by the centres accountant to ensure good financial governance was in place.

**Judgment:**
Compliant

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**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:**
At the last inspection it was identified that significant improvements were required in relation to fire safety. Due to the potential impact of the findings, an immediate action plan was issued and the provider submitted a satisfactory response to the plan. Improvements required in relation to fire safety on that inspection included:

- there were inadequate fire evacuation drills
- not all staff had received fire safety training
- some staff were unclear when questioned as to how to assist residents with restricted mobility in the event of a fire evacuation of the centre or in relation to the use of evacuation equipment in the event of a fire
- some staff were unclear when questioned of the appropriate fire control techniques or procedures to be followed should the clothes of a resident catch fire
- some fire resisting doors were held open with door wedges and/or chairs
- the fire resisting doors required review for example there was a significant gap noticed between the floor and the fire resisting door into the first floor nurses' office
- one running man sign to assist fire evacuation was not illuminated.

On this inspection most of these issues were addressed satisfactorily. Fire drills were now conducted regularly and records indicated that all staff had attended a fire drill since the last inspection. Staff spoken with by the inspector were able to clearly identify the most appropriate means of evacuation of residents in the event of a fire, including those residents with restricted mobility and the use of evacuation aids, such as ski
sheets. Staff members were also clear on what to should a resident's clothes catch fire. A programme of fire safety training had been commenced by an external provider and most, but not all, staff had received up-to-date training in fire safety measures. The training for a number of staff was due to expire in the weeks following this inspection and the person in charge was advised to ensure that training remained up-to-date for all staff. There was no evidence of the use of door wedges to keep fire doors open and all signs identifying the nearest exit were illuminated. A Chief Fire Officer had inspected the premises since the last inspection and items identified as requiring attention, most notably in relation to fire doors, were addressed.

The inspector reviewed the risk management policy in the context of requirements identified at the last inspection. The policy now addressed the requirements of the regulations, including the risks and controls in place to mitigate against self harm and abuse. Since the last inspection the risk register had been reviewed and potential hazards identified at that inspection had been included and additional control measures were put in place, where it was identified they were required. For example:

• a keypad controlled lock was now in place to prevent unrestricted access to the staff changing room
• coded locks had been put on sluice rooms
• the emergency trolley that contained potentially hazardous items such as needles, scissors was decommissioned and removed, as it was deemed superfluous to requirements
• electrical cables were no longer visible in a ground floor toilet
• the door to the maintenance storeroom that contained many potentially hazardous items was locked
• covers had been installed around latex glove and plastic apron dispensers making them less visible and reducing the risk to residents with a cognitive impairment
• a lock had been applied to a cupboard containing medicines for return to the pharmacy
• a coded lock had been applied to the medication fridge
• the nurses office in Caoimhneas unit was no longer freely accessible by residents
• the kettle in a sitting room was now stored in a cupboard when no longer in use
• the kitchenette was locked at all times when not in use during the days of the inspection
• access to the roof garden was restricted and residents could only access it under staff supervision
• the risk register had been updated to include items such as stair gates, the railings on the roof garden, and stair bannisters.

While significant improvements were identified in response to the findings of the last inspection, some improvements, however, were still required in relation to risk management. For example:

• while there was a coded lock on the doors to the sluice rooms, the lock was not always engaged
• while there was a lock on the medication fridge, the lock was not always engaged
• the matrix for calculating risk on the incident log was not always calculated accurately.

Improvements were noted in infection prevention and control practices since the last inspection. A new system had been put in place by housekeeping staff to document the
cleaning schedule, including deep cleaning. The communal areas and bedrooms were generally found to be clean and there was adequate standard of general hygiene at the centre. There were no cobwebs visible, which was a finding at the last inspection and all creams and ointments were stored appropriately and identified for individual resident use. All staff had attended infection prevention and control training since the last inspection. Most, but not all, staff had up-to-date training in manual handling.

**Judgment:**
Non Compliant - Moderate

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

**Findings:**
There were written operational policies and procedures in relation to the management of medications. Medication administration practices observed by the inspector were in compliance with relevant guidance. Training records viewed by the inspector indicated that nursing staff had attended medication management training.

At the last inspection it was identified that a number of medications were stored on a shelf in the nurses' office on the first floor, while awaiting return to the pharmacy. The door to the nurses' office was not locked and residents could access these medications. On this inspection it was found that a lock had been placed on one of the cupboards in the nurses' offices and medications due to be returned to the pharmacy were stored here. This cupboard was found to be locked throughout the two days of the inspection. The door to the nurses' office was found to be secured when nurses were not present.

On the last inspection the inspector noted that the medication fridge in the nurses' office in Siochan unit was not locked and access to the nurses' office was unrestricted. On this inspection it was found that a coded lock had been attached to the fridge. However, on at least one occasion, the inspector noted that the lock was not engaged and the door to the nurses' office was not locked.

**Judgment:**
Substantially Compliant

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**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:
A record of all incidents occurring in the centre was maintained. Based on a review of the incident log, required notifications were submitted to HIQA in a timely manner.

Judgment:
Compliant

Outcome 11: Health and Social Care Needs
Each resident’s wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident’s assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

Theme:
Effective care and support

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

Findings:
Residents were assessed on admission and at regular intervals the rafter using recognised assessment tools. Care plans were developed for issues identified on assessment and these were seen to be personalised and provided adequate guidance on the care to be delivered. Residents had good access to medical care and there was evidence that they were reviewed regularly by the general practitioner (GP). Residents also had good access to allied health and specialist services. Speech and language therapy, dietetics, occupational therapy, and physiotherapy were available through the community and residents were usually reviewed within a short space of time from referral. A consultant in geriatric medicine visited the centre approximately every two months to review and assess residents on a referral basis. An optician service and dental service usually visited the centre annually.

At the last inspection it was identified that a significant number of care plans were overdue for review. A review of care plans on this inspection identified that all were up to date.
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:**
Cobh Community Hospital provides residential, respite and palliative care and was registered to accommodate 43 residents. On the days of inspection the centre was fully occupied. The centre was originally constructed in the early 20th Century and overall the design and layout of the premises was largely reflective of the period in which it was built.

The older and main part of the hospital comprised three floors. The ground floor was split into two levels with the upper level accessible via a platform type lift or by a stairs consisting of six steps. Bedroom accommodation on the ground floor comprised four single bedrooms and two twin bedrooms. Bedroom accommodation on the upper level of the ground floor comprised 1 single en suite bedroom and one quadruple en suite bedroom. Bedroom accommodation on the first floor comprised three single bedrooms, four twin bedrooms, and two quadruple bedrooms. The second floor was used primarily as office space but also contained the hairdressing salon. The first and second floors were accessible by a large elevator and by stairs.

One of the twin bedrooms on the first floor had previously been the dining room and was converted to a single bedroom, as dining facilities were now on the ground floor. A twin bedroom on the ground floor was reduced to a single room to allow more space for the occupant of that room. In the application to renew their registration as a designated centre the provider had applied to increase bed capacity from 43 residents to 44 by converting this room from a single to a twin. HIQA were not informed, however, of the conversion of the dining room to a bedroom and as such, the registered provider was in breach of their registration by not complying with the information contained in the previous application to renew or with their statement of purpose.

12 residents were accommodated in 12 single bedrooms in a newer section of the centre that was adjoined to the Park Road Day Centre. Four of these bedrooms were en suite.
with shower, toilet and wash hand basin, four were en suite with toilet and wash hand basin and four had a wash hand basin only.

Overall the centre was bright, warm and well ventilated and since the last inspection there had been considerable redecorating done. Improvements to the premises in response to the findings of the last inspection included:
• walls, doors and door frames were painted
• damaged wall tiles were replaced
• a cover was attached to the ceiling light near the nurses station
• locks were applied to all toilets.

Additional signage was put in place since the last inspection to support residents identify various communal rooms and bedrooms in the centre. However, improvements were still required, particularly signage in the centre to support residents in navigating the various areas within the centre. This is particularly relevant in light of the confusing design and layout of the premises as a result of a number of premises extensions over the years

Communal space in the older part of the centre comprised a large combined sitting room and dining room that had been newly constructed since the last inspection. There was a parlour with comfortable seating that could be used by residents for some quiet time or to meet with visitors in private. There was an oratory on the first floor. There was a large well maintained garden with lots or shrubbery and seating areas for residents. Communal space in the newer part of the centre comprised a dining room, a sitting rooms and a conservatory. There was also a secure outdoor area and a roof garden.

Judgment:
Non Compliant - Major

Outcome 13: Complaints procedures
The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:
Person-centred care and support

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

Findings:
There was a complaints policy in place and the complaints' procedure was prominently displayed in the main entrance hallway. The person in charge was the designated complaints officer and the provider was identified as the independent appeals process. The policy also identified a person to ensure that all complaints were appropriately responded to and that the complaints officer maintained suitable complaints' records, as required.
A review of the complaints log identified that a record of all complaints was maintained and the satisfaction or not of the complainant was recorded. This was an improvement on the findings of the last inspection.

**Judgment:**
Compliant

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**Outcome 14: End of Life Care**

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

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

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

**Findings:**
There were written policies and procedures in place for end-of-life care and for the management of residents' resuscitation status. Staff provided end of life care to residents with the support of their GP and the community palliative care team, to which there was good access. Religious preferences were documented and there was evidence that they were facilitated. Most residents were catholic and a priest visited the centre each week to celebrate mass. The needs of other denominations were respected and supported. Family and friends were facilitated to remain with the resident and there were adequate facilities for relatives to remain overnight. There was a single room designated as the palliative care room for use by residents approaching end of life.

**Judgment:**
Compliant

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**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 were policies and procedures to guide practice in relation to the management of nutrition. There were systems in place to ensure residents' nutritional needs were met, and that they did not experience poor hydration. Residents were assessed for the risk of malnutrition on admission and at regular intervals thereafter using a validated tool. Residents' were weighed regularly. There was an effective system of communication between nursing and catering staff to support residents with special dietary requirements. Inspectors found that residents on weight reducing, diabetic, high protein and fortified diets, and also residents who required modified consistency diets and thickened fluids received the correct diet.

All residents had breakfasts in their bedrooms but a number of residents had their lunch and supper in the dining rooms. Some residents spoken with by the inspector stated that they preferred to eat in their bedrooms. The person in charge was advised to support residents, particularly new admissions, to eat their meals in the dining room by creating an environment whereby mealtimes would be a social occasion and an opportunity for residents to interact with each other.

Residents that required assistance with their meals were assisted by staff in a respectful and dignified manner. Choice of food was available at mealtimes and meals appeared to be nutritious and were attractively presented.

**Judgment:**
Compliant

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**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:**
The centre had a policy on residents’ personal property and possessions. Residents appeared well groomed and had adequate storage space for personal belongings in their rooms, including access to a lockable drawer. All clothes, bedding and linen was laundered on site. Colour coded bins were used to separate laundry and red alginate bags were used to identify contaminated infectious material. All clothes were clearly labelled and residents and relatives seemed happy with the service. The laundry facility itself was efficiently organised and supported the segregation of clean and dirty linen.

**Judgment:**
**Outcome 18: Suitable Staffing**

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

**Theme:**

Workforce

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

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

**Findings:**

The inspector reviewed the staff roster that confirmed there was a nurse on duty at all times. Based on the observation of the inspector and a review of the roster the inspector was satisfied that there were adequate staff with the right skills, qualifications and experience to meet the assessed needs of the residents. The person in charge, however, was requested to review the roster in light of the sharing of cleaning and laundry duties by one staff member. The inspector was not satisfied that adequate arrangements were in place or that an adequate risk assessment was undertaken to prevent cross contamination by the non-segregation of cleaning and laundry duties.

Residents and relatives spoken with by the inspector were complimentary of the care provided and confirmed that staff were, responsive to their needs. The inspector observed positive interactions between staff and residents over the course of the inspection and found staff to have good knowledge of residents' needs as well as their likes and dislikes.

The inspector reviewed the staff training matrix that identified a significant programme of training had been undertaken since the last inspection. Most staff now had up-to-date training in fire safety. All staff had received up-to-date training in manual handling, infection prevention and control, hand hygiene, safeguarding and responsive behaviour.

The inspector reviewed a sample of staff files which included the information required under Schedule 2 of the regulations. Registration details with Bord Altranais agus Cnáimhseachais na hÉireann, or Nursing and Midwifery Board of Ireland for 2017 for nursing staff were seen by the inspector.

**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:

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

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Cobh Community Hospital</th>
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</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000558</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>01 June 2017</td>
</tr>
<tr>
<td>Date of response:</td>
<td>29 June 2017</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:
Improvements were required in relation to the contents of the annual review. For example:
• the review lacked detail in relation to findings from audits and there were no timelines or responsibilities assigned in relation to planned improvements
• there was inadequate detail in relation to findings and resulting actions from consultations with residents and their relatives.

1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
1. **Action Required:**
Under Regulation 23(d) you are required to: Ensure there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that 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:**
Review of Annual Review to include time lines and assignment of responsibility for actions in relation to planned improvements.

Resulting actions related to Annual Family questionnaires will be included in review

**Proposed Timescale:** 29/06/2017

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**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:**
Prospective residents were informed in writing of the terms relating to the bedroom to be provided to the resident and the number of other occupants (if any) of that bedroom. A process was commenced whereby this would be included as an appendix to each contract but was not yet complete.

2. **Action Required:**
Under Regulation 24(1) you are required to: Agree in writing with each resident, on the admission of that resident to the designated centre, the terms on which that resident shall reside in the centre.

**Please state the actions you have taken or are planning to take:**
Letter to prospective Resident informing of the terms of the bedrooms to be provided and number of other occupants was in place but will now be physically attached to contract of care document.

**Proposed Timescale:** 19/06/2017

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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 most of the information required to be maintained in a directory of residents was...
retrievable electronically, the centre did not maintain a Directory of Residents as required by the regulations, either electronically or in a hardcopy format.

3. **Action Required:**
Under Regulation 19(1) you are required to: Establish and maintain a Directory of Residents in the designated centre.

**Please state the actions you have taken or are planning to take:**
The Directory of Residents is available in both electronic and hard copy form.

**Proposed Timescale:** 01/06/2017

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### 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:**
While significant improvements were identified in response to the findings of the last inspection, some improvements, however, were still required in relation to risk management. For example:
- while there was a coded lock on the doors to the sluice rooms, the lock was not always engaged
- while there was a lock on the medication fridge, the lock was not always engaged
- the matrix for calculating risk on the incident log was not always calculated accurately.

4. **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:**
Lock on sluice room door to be engaged at all times
Lock on medication fridge to be engaged at all times
The matrix for calculating risk on the incident is accurate

**Proposed Timescale:** 01/06/2017

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**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
A programme of fire safety training had been commenced by an external provider and most, but not all, staff had received up-to-date training in fire safety measures. The
training for a number of staff was due to expire in the weeks following this inspection and the person in charge was advised to ensure that training remained up-to-date for all staff.

5. 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 remaining staff updated in fire safety training provided by an external organisation.

In house fire safety training and evacuation 13/06/2017
Fire Warden training for 20 staff members booked September 2017

Proposed Timescale: 14/07/2017

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 the last inspection the inspector noted that the medication fridge in the nurses' office in Siochan unit was not locked and access to the nurses' office was unrestricted. On this inspection it was found that a coded lock had been attached to the fridge. However, on at least one occasion, the inspector noted that the lock was not engaged and the door to the nurses' office was not locked.

6. Action Required:
Under Regulation 29(4) you are required to: Store all medicinal products dispensed or supplied to a resident securely at the centre.

Please state the actions you have taken or are planning to take:
Lock to be engaged on medication fridge at all times

Proposed Timescale: 01/06/2017

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:
One of the twin bedrooms on the first floor had previously been the dining room and was converted to a single bedroom, as dining facilities were now on the ground floor. In the application to renew their registration as a designated centre the provider had applied to increase bed capacity from 43 residents to 44 by converting this room from a single to a twin. HIQA were not informed, however, of the conversion of the dining room to a bedroom and as such were in breach of their registration by not complying with the information contained in the previous application to renew or with their statement of purpose.

7. Action Required:
Under Regulation 17(1) you are required to: Ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.

Please state the actions you have taken or are planning to take:
Statement of purpose reviewed to reflect change of designation of dining room to a twin bedroom to facilitate a variance from 43 beds to 44 beds

Proposed Timescale: 05/06/2017

Outcome 18: Suitable Staffing
Theme:
Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The person in charge, however, was requested to review the roster in light of the sharing of cleaning and laundry duties by one staff member.

8. Action Required:
Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

Please state the actions you have taken or are planning to take:
Roster to reflect cleaning and laundry duties that are completed by one staff member on 3 days each week will be clearly segregated

Four days weekly the cleaning and laundry duties are carried out by different staff members.

Proposed Timescale: 09/06/2017