Health Information and Quality Authority
Regulation Directorate

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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	Cottage Hospital
Centre ID:	OSV-0000534
Centre address:	Scarlet Street, Drogheda, Louth.
Telephone number:	041 980 1100
Email address:	aoife.bailey@hse.ie
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Maura Ward
Lead inspector:	Sonia McCague
Support inspector(s):	Una Fitzgerald
Type of inspection	Unannounced
Number of residents on the date of inspection:	14
Number of vacancies on the date of inspection:	6

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 ior 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:	To:
05 May 2017 09:00	05 May 2017 16:05

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

Outcome	Our Judgment
Outcome 01: Statement of Purpose	Non Compliant - Moderate
Outcome 02: Governance and Management	Non Compliant - Moderate
Outcome 03: Information for residents	Non Compliant - Moderate
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	Compliant
Outcome 12: Safe and Suitable Premises	Non Compliant - Moderate
Outcome 13: Complaints procedures	Compliant
Outcome 18: Suitable Staffing	Non Compliant - Moderate

Summary of findings from this inspection

This follow-up inspection was unannounced and took place over one day. It was a focused inspection carried out to assess the progress in relation to matters arising from the previous inspection on 18th January 2017 that resulted in 19 required actions. These related to the maintenance of documentation, safeguarding, risk and medication management, premises and staffing. The inspectors found that progress had been made in some areas. However, further improvements were required in most of the outcomes followed up on.

The person in charge was in the centre at the commencement of and during the inspection. The inspection process was facilitated by the person in charge, assistant director of nursing and the provider nominee. Feedback on the inspection findings was provided to the person in charge and provider nominee.

The centre is registered to accommodate a maximum of 23 residents. However, a management decision not to admit over 20 residents at any time due to limited

resources had been implemented. On the day of inspection there were 14 residents accommodated in two units, six on the ground floor and eight on the first floor.

The inspectors met with residents and spoke with staff and management. Documentation was reviewed and practices were observed. While progress was noted, further improvement was required in areas previously identified. Further Improvement in the governance and management of pre-admission assessments to determine suitability of residents, implementation of policies and specifications regarding the terms of contracts and completed agreements, and in relation to the maintenance and repair of the premises was required. Staff training and supervision had not been sufficiently addressed at the time of this inspection. As a result, the provider and person in charge were required to take immediate action to address the deficiencies presenting a risk to residents and the service provision. A requirement to provide information and written confirmation of action taken was received 8 May 2017, as requested.

The outstanding actions required are restated in this report at the end for response by the provider and the overall findings are outlined within the body 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. The revised SOP was submitted to the Health Information and Quality Authority (HIQA) along with an updated action plan response on the 26 April 2017.

The revised statement of purpose detailed and contained information in relation to the matters listed in schedule 1 of the Regulations. While registered for a maximum of 23 short stay residents the maximum functioning capacity was 20 residents. There was accommodation for six on the ground floor and 14 on the first floor.

The aims and objectives of the centre were to provide transitional care to older people following an acute illness and hospital treatment. In an emergency, an admission from the community may be accommodated.

The centre was registered in 2015 as a short stay service to provide transitional care to residents within a timeframe of 30 days from admission to discharge. However, as previously reported 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. As a result, HIQA requested an audit of resident occupancy and length of stay completed between 1 March 2016 and 20 March 2017. The audit findings showed 193 residents were admitted to the centre during this period (55 weeks). The audit reported 25% of the 193 residents admitted were transferred back to an acute hospital, 38% of residents admitted stayed longer than 30 days, 7.25% stayed over 60 days and 67% of residents admitted were discharged home. A percentage of residents were transferred to long term care (5%) and a small number had an unexpected death (2%).

Following on from this the provider took the decision to amend the statement of purpose and exclude the specific timeframe for the length of stay. However, the intention to support residents on a short term basis aimed within a 30 day timeframe continued to be promoted in practice. The inspectors confirmed that the length of stay for two of the existing 14 residents had exceeded the 30 day timeframe.

Inspectors found that the criteria for admission and the exclusion criteria outlined in the statement of purpose had not been demonstrated or adhered too. As discussed in Outcome 2, there was no evidence of a pre-admission assessment by a nurse from the centre. In addition, residents with a diagnosis of dementia and alzheimers disease had been admitted to the service for short stay care despite the diagnosis of dementia being stated as a criterion for exclusion. A review of the criteria in association with the admission policy and arrangement for pre-admission assessments required further improvements as previously reported. The application of admission criteria outlined in the statement of purpose required review and implementation in practice.

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 since the previous inspection had improved; however, further improvement was required to ensure high quality care to ensure the delivery of an appropriate and effective service. Some of the actions outlined in the action plan responses to the previous inspection findings had not been completed in a timely manner or within the specified timeframes.

Improvements had progressed in relation to the assessment and management of risk, education and training of staff, and the co-ordination and management of the service provided, however, further improvement was needed. Inspectors found that some rostered and contracted staff had not completed mandatory training as required, and the supervision and appraisal arrangements for staff had not been sufficiently robust or improved, as indicated in the action plan response to the last inspection.

Staff absenteeism and shortages was reported and seen recorded in rosters reviewed which resulted in a reliance on agency staff to provide this on-going service. For example, two of the three day nurses working on the day of the inspection were agency staff, and one of the four care attendants were from a agency provider. One rostered care attendant was off sick on the day of the inspection and inspectors were told that there was no relief staff available to cover the absence.

There was no recorded evidence that staff from the centre were involved in the pre-admission assessments of residents being admitted to the centre. The current statement of purpose stated that 'a pre admission assessment is undertaken by a delegated senior nurse on duty. This assessment will review the care being provided, and raise any queries or concerns in relation to particular care prescribed'. However, this was not demonstrated in practice. In addition, the admission criteria outlined in the SOP and admission policy was not implemented in practice as a resident that did not meet the admission criteria had been admitted. A fax record of a pre-admission assessment carried out by an external person who worked at the referral source was seen in residents' files. As previously reported, the system and arrangements found did not robustly show that some residents were suitably assessed to ensure the service could meet their needs in accordance with the centre's policy.

As previously reported, management resources were depleted. The Director of Nursing (Person in Charge) and the Assistant Director of Nursing (ADON) both had responsibility for three designated centres in addition to involvement in a community based service, and the ADON had responsibility for the delivery of safeguarding training to staff working n the three designated centres. An absence of another ADON from the management structure remained unfilled from August 2016.

Overall, further improvements were required to ensure effective governance, operational management and administration of the designated centre.

An annual review of the quality and safety of care delivered to residents for 2016 was completed since the previous inspection 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):
Some action(s) required from the previous inspection were not satisfactorily

implemented.

Findings:
A comprehensive easy to read information guide to the services of the centre was available for residents.

A full review of resident's contracts of care, residents guide and information for residents was completed in line with the statement of purpose and function. The revised SOP was submitted to the Health Information and Quality Authority (HIQA) along with an updated action plan response on the 26 April 2017.

In the sample of four residents files reviewed three were incomplete. Two residents had no written agreement on file and one had been signed by a resident's representative but had not been signed as agreed by the provider's representative.

Residents contract of care 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. It had been updated to include the current management arrangements and the terms and conditions of stay, which inspectors were told was the subject of a national review.

Judgment:
Non Compliant - Moderate

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

Findings:
As previously reported 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 and 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. Inspectors were informed by the Person in charge and provide nominee that the recruitment of a suitable candidate to this post has been challenging and unproductive.

The deputy for the person in charge was the person in charge of two other designated centres, operated by the provider and was involved in an ongoing programme to deliver training which decreases the availability to perform as intended.

As previously reported, improvement was required to ensure that person in charge and deputy were 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):
Some action(s) required from the previous inspection were not satisfactorily implemented.

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, residents' medication and clinical records, as well as the centre's directory of residents.

As per the action plan arising out of the last inspection the centre had carried out a review of the admissions policy and the updated policy was sent into the authority. The centre now has a colour printer to ensure that documents are of an improved quality. However not all new policies and procedures had been implemented in practice. For example, the pre- admission assessment was not carried out in line with the policy to determine if the service could meet the assessed needs of each resident and to ensure that residents were admitted in line with the statement of purpose.

As per the last inspection the centre had identified that further work was required to ensure that the electronic directory of residents is accurate and current. On the day of

inspection there was one resident that had been admitted to hospital eleven days prior to the inspection. This resident name and detail remained on the directory as a current resident.

Inspectors reviewed the documents to be held in respect for each member of staff. Inspectors reviewed a sample of staff files and found that the files were complete and had the documents required under the regulations.

Actions required under the documentation to be kept under regulation 28 Fire were actioned and are discussed in more detail under outcome 8.

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

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 there are currently nine staff who are due updates and dates to attend this training are planned. Staff spoken with were fully knowledgeable regarding the signs of abuse, reporting procedures and what to do the in the event of a disclosure about actual, alleged, or suspected abuse. On review of the incident log, inspectors noted that there had been two incidents reported relating to suspected financial abuse that were fully investigated. This was discussed with the person in charge and improvements were required in the reporting of all notifiable incidents to HIQA.

On the last inspection 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. Inspectors examined resident files and reviewed the documentation in use for the management of restraint. The centre has a restraint register on each floor. On the ground floor two out of six residents were using bedrails. On the first floor all eight residents were using bedrails. The centre had an assessment document on

restraint decision making process and controls for each individual resident as part of their assessment on restraint usage. This document outlined a restraint decision tree. There is also a risk assessment and a template on alternatives to be tried. This comprehensive assessment was contained within each file. However there was further development work required as the form was not appropriately filed out in all cases. A consent form for the use of bedrails was signed in all cases. Only in one file did the resident sign their own consent form. Evidence that the rationale and decision to continue with the use of bedrails was evidenced in one file only.

As identified in the last inspection, there was no evidence that less restrictive devices, which could achieve the goals of transitional care, were tried before bedrails were used. There is limited availability of alternative and less restrictive equipment. The person in charge informed inspectors that all beds have the rails removed and only post assessment are the bedrails reattached. The person in charge informed the inspector that the decision to place bedrails on a resident's bed is made at a weekly multidisciplinary meeting. However the inspector could not find documented evidence of this decision. The centre has brought in a two hourly monitoring checklist of all bedrail usage and there was clear evidence that this form was consistently filed in.

The staff training record showed that training on restraint and on the use of restrictive devices had still not been provided to staff. This training was due completion by 28 April 2017. The person in charge confirmed that this training on restraint usage for staff has been delayed and is now confirmed for May 2017. Training gaps within the centre are discussed in detail within Outcome 18.

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. There was an up-to-date health and safety statement. The centre had a comprehensive risk management policy that included items set out in regulation 26(1). An inspector reviewed the risk register which included rated risks that were identified in 2015 and 2016 and updated to reflect changes in 2017. There was documented evidence that areas of high risk had been recorded and there was evidence to demonstrate that the risks within the register had been subject to regular review and have been escalated appropriately. For example,

the risk associated with the need for the recruitment of an ADON into the service to support the governance and management requirements was recorded on the risk register.

Improvement was seen on the identification, control and management of hazards and risks. The risk registrar identified and classified all risk. Additional control measures were also identified. Satisfactory procedures, consistent with the Authority's standards were in place for the prevention and control of healthcare associated infections. While processes were in place they are not always followed by staff. The last hygiene audit carried out on 28 February 2017 identified areas of improvement required. The audit highlighted that the sign off sheets on cleaning schedules were not filed in. The inspectors noted that this continued to be an area in need of improvement. The sign off sheet for the cleaning schedule in the dining room on the first floor had not been completed since 11 April 2017 (27days).

There was suitable fire equipment provided within the centre. Fire exits were unobstructed and there were means of escape identified. Arising from the last inspection a survey had been carried out on the exit and means of escape by an external unprotected metal staircase from the upstairs dining hall to ascertain the impact the extensive areas of rust had on the safety of the exit stairwell. The centre was awaiting the report findings on this survey. Fire evacuation procedures were prominently displayed throughout the building. While the majority of staff were trained in what to do in the event of a fire, some gaps did exist. Training is discussed further in Outcome 18. The fire alarm was serviced on a quarterly basis. Weekly bell tests were carried out every Tuesday. The centre last carried out a simulation drill on the 5 April 2017. The centre now has padded fire evacuation (ski pad) equipment in place to aid evacuation of residents accommodated on the first floor, if necessary.

On the last inspection training gaps were identified as a moderate non-compliance. The risk registrar had scored this risk as 12/25. An operational or administrative clinical nurse manager (CNM) had been assigned as a support to the person on charge since the previous inspection to manage and address current gaps. The management were currently re-designing the training matrix that captures this data. Staff training is discussed in detail under outcome 18

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:
The actions required under this outcome from the previous inspection were addressed satisfactorily.

On examination of the residents' prescription and administration records, the inspectors found that all the necessary prescription and administration fields were completed and a photograph of each resident was available on the prescription kardex.

Audits of medicines carried out by a pharmacist were available and maintained in the centre for inspection.

Arrangements were in place to ensure out of date medicines or medicines belonging to a former resident were disposed of in accordance with the centre's policy and or returned to the pharmacy.

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 the building is not of a suitable design and layout for the provision of residential care for long term occupancy by dependant residents. This was previously reported by HIQA and acknowledged by the provider.

The future plan for the service was unknown by management at this time and the registration of the centre expires in June 2018. A costed, time-bound plan specific to this centre has not been provided, as previously requested.

The centre is registered for a maximum capacity of 23 residents and was operating at a maximum of 20. Residents' accommodation was on the ground and first floors. Other healthcare services were operated from and based within the premises.
Additional security measures were put in place to prevent inappropriate entry into the

centre. Key codes were installed at the entrance of the unit.

The provider acknowledged that the centre is not of a suitable design or layout for long term care or residency. However, ongoing improvement to the state of repair and decor of the premises was required to ensure it was suitable for its stated purpose. Residents lived in a largely clinical, hospital type environment and a medical culture of care was evident. All the residents on the first floor had bedrails in use and residents spent their day predominantly in their bedrooms with limited opportunity for socialising.
Residents were seen being assisted by staff to access the dining room areas for lunch. Staff told inspectors that residents were encouraged and assisted to use the sitting room and quiet room. However the sitting rooms were unoccupied throughout the inspection. The layout and furnishings in these rooms were not homely and inspectors observed that furniture, such as an arm chair in the day room on the first floor required repair or replacement as the cover was torn and in poor state of repair.

A programme of personalising and modernising some bedrooms and communal areas was ongoing. Colourful pictures and wall hangings were seen in parts of the centre.

Quotes were obtained for the painting of the centre, and areas in a poor state of repair had been prioritised. For example, the corridors on both units had been painted since the previous inspection. Other areas of paint work needed attention and floor covering in parts was loose and coming away from the wall in areas such as the nurse's office on the ground floor and along the corridor to the Director of Nursing office. Chipped surfaces on parts of the stairwell that run from the entrance to the first floor may pose a risk to residents and visitors or staff. The metal fire escape stairs was the subject of a review and no changes had been made to this structure or its appearance.

The four bedded room was vacant during this inspection. Portable screening was available to promote the privacy and dignity of residents occupying this bedroom. However, 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.

Car parking space was inadequate. In the afternoon cars parking spaces were limited resulting in cars parked outside of allocated spaces leaving it difficult to exit.

As previously reported, the centre requires modernisation and redecoration in areas. Improvement to the entrance to the centre is to be addressed and modernised by July 2017.

Judgment:
Non Compliant - Moderate

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

Theme:

Person-centred care and support

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

Findings:
This outcome sets out the inspection findings relating to the management of complaints. There were policies and procedures for the management of complaints. The complaints process was strategically displayed throughout the centre. The inspectors reviewed the complaints log.

The management of all complaints received had been investigated promptly, a record of the outcome was documented. The inspectors also saw evidence of improvements for residents as a result of complaints. Records indicated that complaints were minimal, a total of two to date in 2017.

The centre had an appeals officer and also directed the complainant to the office of the Ombudsman if unhappy with the outcome.

Residents spoken with on the day told inspectors that they would not hesitate to make a complaint if they had one. Relatives said that they were satisfied with the care provided and were aware of who they could complain to if they needed to. HSE initiative 'your service your say' information leaflets were freely available and complaint forms were left in prominent areas for any individual to lodge a complaint.

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

Findings:

On the day of the inspection staffing levels and the skill mix were sufficient to meet the healthcare needs of the residents. The inspectors 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.

Management have made some progress in training staff in line with the health and safety statement but significant gaps still exist in fire training (four out of 32 staff had not received any training since 2015), elder abuse (nine out of 32 staff were due an update) and one carer and five nurses were all due an update in manual handling training. All staff had yet to receive training on restraint management. There were three nurses who did not have up-to-date cardio pulmonary resuscitation (CPR) training. The person in charge had booked and confirmed that this will be addressed immediately and inspectors requested that the centre inform HIQA when staff had completed this training. While efforts have been made to ensure compliancy there continued to be significant gaps that had potential to impact negatively on residents.

The centre was operating with and dependant on the use of agency staff. This was identified within the risk registrar. The centre had a written service level agreement whereby the agency had accountability to ensure that all staff meet the requirements of the regulations. On the day of inspection the inspectors found and identified gaps in the agreements and training arrangements. The was discussed at the feedback meeting and the person in charge has agreed to address this with the service providers to ensure that the care and welfare of residents is not compromised.

The provider had informed HIQA that a process of regular one to one meetings between the person in charge and the clinical nurse manager supervising staff and ensuring service deliver had commenced. This had been initiated.

Staff training, appraisal and review required improvement as per the findings on the last inspection. The centre informed HIQA that a process of practice development and training needs assessment for all staff had commenced in the centre. Arising from the training needs assessment that was to be carried out, a staff performance system was to be implemented based on outcomes. However, to date the centre had not progressed this action plan. One staff appraisal had been conducted and this review was seen by the inspector. The supervision arrangements for all staff required improvement to ensure quality standards, safe practice and accountability.

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:

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Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	Cottage Hospital
Centre ID:	OSV-0000534
Date of inspection:	05/05/2017
Date of response:	29/05/2017

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 criteria for admission and the exclusion criteria outlined in the statement of purpose had not been adhered too.

The application of admission criteria outlined in the statement of purpose required review and implementation in practice.

[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 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:
Action: The statement of purpose will be amended to include the admission and exclusion criteria clearly stating that the length of stay cannot exceed 30 days. The statement of purpose will be submitted to the authority with this action plan.

The admission criteria are as follows:
• Individuals who have a home care package approved and are awaiting funding so that a suitable home care package can be put in place within 30 days of admission.
• Individuals awaiting aids and/or appliances, which should be in place within 30 days of admission.
• Individuals requiring minor home adaptations that will be completed within 30 days of admission.
• The transitional care service will meet the needs of individuals who the Specialist Geriatric Multi Disciplinary Team has determined have reached a plateau in their rehabilitation and whose care plan needs will be provided within 30 days.

Exclusion Criteria for Transitional Care.
• Individuals under the age of 18.
• Individuals listed for long stay care that have submitted, or are in the process of submitting, an application for Nursing Home Support Funding
• Individuals with a diagnosis of dementia which means that they require 1: 1 supervision or care or causes them to wander or display behaviours that challenge
• Any individual considered at risk to exceed the maximum 30 day length of stay in a transitional care bed.

Proposed Timescale: 29/05/2017

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:
Further improvements were required to ensure effective governance, operational management and administration of the designated centre.

Some of the actions outlined in the action plan responses to the previous inspection findings had not been completed in a timely manner or within the specified timeframes.

As previously reports, deficiencies remained in the assessment and management of admissions, completion of agreed contracts, application of policies, staff training and supervision and within the premises.

Staff absenteeism and shortages was reported and seen recorded in rosters which resulted in a reliance on agency staff to provide this service.

The future plan for the service was unknown by management at this time and the registration of the centre expires in June 2018. A costed, time-bound plan specific to this centre has not been provided, as previously requested.

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:
Deficiencies remained in the assessment and management of admissions, completion of agreed contracts, application of policies, staff training and supervision within the premises.
Action: The admission and exclusion criteria have been amended in the Statement of Purpose as above and have been clearly communicated to the referring hospital. This is part of a review process of all documentation governing the admission process, residents stay their discharge. The following documents are currently being reviewed:
Pre admission Assessment
Contract of Care
Resident's information guide
Admission policy
Consent for admission
The process will be completed by 30th June 2017.

Action: Family members and residents receive the contract of care on admission and sometimes do not return it in a timely manner. A process to track the status of the contract of care has been commenced to ensure that the process is completed in a timely manner in accordance with regulation. This process has commenced since 29/05/2017 and will be ongoing.

Action: There is a process to ensure that all policies are implemented in practice. The process is overseen at ward level by the nurse manager and monitored by the Person in Charge.
This process is in place and is subject to ongoing review

Staff training and
Action: All staff are in receipt of ongoing mandatory training. The training record was incomplete at the time of inspection due to staff sick leave. This record has been updated and all mandatory training is ongoing.
Staff Supervision
Action: A proposal is being developed to enhance nursing governance and management to enhance supervision.

Staff absenteeism and shortages was reported and seen recorded in rosters which resulted in a reliance on agency staff to provide this service.

Action: There is a managed arrangement with an agency which was agreed to provide staff to open beds and ensure safety of residents.

The future plan for the service
Action: The PIC and Provider discussed the future plans of the centre with the inspector and the inspector was advised that the development for the St. Mary's campus was for long term care only. It was discussed that this centre would continue to provide transitional care in the Cottage Hospital as it is not suitable for long term care.
A costed time bound plan specific to the centre will be submitted to the authority by 30 June 2017.

Proposed Timescale: 31/12/2017

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:
In the sample of four residents files reviewed three were incomplete. Two residents had no written agreement on file and one had been signed by a resident's representative but had not been signed as agreed by the provider's representative.

3. 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:
There is now a process in place to monitor the timely return of the Contracts of care and the efficient signing of same. This process is being monitored

Proposed Timescale: 29/05/2017

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:
As previously reported 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 and allied healthcare teams.

The deputy for the person in charge was the person in charge of two other designated centres, operated by the provider and was involved in an on-going programme to deliver training which decreases the availability to perform as intended.

Improvements were required to ensure that the person in charge was sufficiently supported and engaged in the effective governance, operational management and administration of the designated centre.

4. 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 outstanding post of the Assistant Director of Nursing (ADON) has now been prioritised by the HSE. A proposal is in development to recruit a further nurse manager to improve the governance and management of the centre.
The deputy PIC is no longer involved in delivering training and the PIC no longer has any governance over the community geriatrician team.
An interim arrangement to cover the outstanding ADON post will be in place by the end of June 2017.

Proposed Timescale: 30 June 2017 (substantive post by 31 December 2017)

Proposed Timescale: 31/12/2017

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:
Policies and procedures had not been fully evidenced in practice. For example, further improvement is required in the pre assessment carried out to determine if the service can meet the assessed needs of each potential resident, and ensure that residents are admitted in line with the statement of purpose.

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

Please state the actions you have taken or are planning to take:
The Statement of Purpose has been amended to clearly define the admission criteria and the exclusion criteria.
The Admission policy is currently being reviewed in conjunction with the pre admission

assessment and other pertinent documentation pertaining to the admission process to ensure that all relevant information is accurately captured and recorded.
This process will be complete and in practice by 30th June 2017

Proposed Timescale: 30/06/2017

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
As per the last inspection the centre had identified that further work was required to ensure that the electronic directory of resident's is accurate and current. On the day of inspection there was one resident that had been admitted to hospital eleven days prior to the inspection. This resident's name and details remained on the directory as a current resident.

6. Action Required:
Under Regulation 21(3) you are required to: Retain the records set out in Schedule 3 for a period of not less than 7 years after the resident has ceased to reside in the designated centre.

Please state the actions you have taken or are planning to take:
One entry was not contemporaneous on the day of the inspection as the resident had been discharged back to the acute setting and was due to be readmitted. The person responsible for updating the electronic record has been reminded of the importance of ensuring that the record is accurate at all times and must be prioritised each morning. The manager in charge of the centre during weekends and when the clerical support is unavailable will take responsibility for ensuring Schedule 3 records is accurately maintained. This process is monitored on an ongoing basis.

Proposed Timescale: 29/05/2017

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:
The documentation relating to restraint was not consistently completed as required.

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

There was limited availability of alternative and less restrictive equipment.

The person in charge informed inspectors that all beds have the rails removed and only post assessment are the bedrails reattached. She told an inspector that the decision to place bedrails on a resident's bed is made at a weekly multidisciplinary meeting. However the inspector was not provided with documented evidence of this decision.

7. 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:
Full audit of all restraint documentation, care plans and equipment has been undertaken. The outcome of the audit has been discussed with staff and actions required to improve the management of documentation relating to restrictive aids and risk assessments have been immediately implemented.

The OT manager has been contacted to give advice on alternatives to restraint. A programme to replace existing beds with low-low beds and crash mats will be commenced following discussion at MDT meeting which is scheduled for Wednesday 31 May

Specific training tailored to suit the requirements and shortcomings identified in the audit has been designed and will be delivered to all staff in the centre commencing on 1st June. The schedule for staff training in restraint is as follows:

Thursday 1st June - 14.30 - 17.00
Friday 2nd June - 14.30 - 17.30
Monday 5th June - 09.00 - 12.30
- 14.30 - 17.00
Tuesday 6th June - 09.00 - 12.30
- 14.30 - 17.00
Monday 12th June - 09.00 - 12.30
- 14.30 - 17.00
Tuesday 13th June - 09.00 - 12.30
- 14.30 - 17.00
All staff will attend this training and ongoing supervision and monitoring of the implementation of the policy will be undertaken by a nominated lead.

Proposed Timescale: 30/06/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Improvements were required in the reporting of all notifiable incidents to HIQA..

8. Action Required:

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

Please state the actions you have taken or are planning to take:
The deputy PIC is the designated safeguarding officer for the centre. All staff are trained in recognising and responding to abuse. Ongoing training sessions are provided to staff and management will ensure that all notifiable incidents are submitted to the authority in accordance with regulation.

Proposed Timescale: 30/06/2017

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:
While processes are in place for the prevention and control of healthcare associated infections they are not always followed by staff.
The last hygiene audit carried out on the 28.02.2017 identified areas of improvement required. The audit highlighted that the sign off sheets on cleaning schedules were not being filed in. The inspectors noted that this continued to be an area in need of improvement. The sign off sheet for the cleaning schedule in the dining room on the first floor had not been filed in since 11 April 2017 (27days).

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

Please state the actions you have taken or are planning to take:
This cleaning schedule had not been signed in the dining room but the cleaner had carried out the work. The importance of signing the correct schedule has now been clarified with her and it is being monitored on a daily basis.
A full audit of the schedule of cleaning and the equipment and chemicals being used was carried out on 15/03/2017 and a new system which is currently being trialled in another unit will be commenced in the centre as soon as possible. Full training and supervision on the new schedule of cleaning will be provided and monitoring of compliance will be maintained by the PIC.

Proposed Timescale: 31/08/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in

the following respect:
Arising from the last inspection a survey had been carried out on the exit and means of escape by an external unprotected metal staircase from the upstairs dining hall to ascertain the impact the extensive areas of rust had on the safety of the exit.

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

Please state the actions you have taken or are planning to take:
HSE estates and fire officer are dealing with this matter. The engineers report has been reviewed by the HSE estates manager and necessary actions to comply with this regulation will be implemented as soon as possible.

Proposed Timescale: 31/08/2017

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:
On-going improvement to the state of repair and decor of the premises was required to ensure it was suitable for its stated purpose.

A plan to prioritise maintenance and repair work was needed.

An arm chair in the day room on the first floor required repair or replacement as the cover was torn and in poor state of repair.

The privacy screening curtains in the four bedded room was laid out for eight beds. This arrangement was not reconfigured to maximise residents' space and enhance privacy.

Chipped surfaces on some of the stairs that run from the entrance to the first floor may pose a risk persons.

No changes had been made to the metal fire escape stairs and structure although an assessment had been carried out.

Improvement to the entrance to the centre is to be addressed and modernised by July 2017.

11. 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:
A plan to prioritise maintenance and repair work was needed.
Action: There are currently maintenance contracts in place for the following essential services and equipment:
The generator
The boiler
The lift
Medical gases
Hoists
Beds
Mattresses
Water
Fire
Due to unfilled vacancies in administration and maintenance there was a delay in progressing the painting and decorating plans. There is now a maintenance manager in place and a site visit was carried out 29/05/2017 and the plan will be progressed in a more timely and structured manner.

An arm chair in the day room on the first floor required repair or replacement as the cover was torn and in poor state of repair.
Action: The arm chair has been removed and replaced with a chair of good quality.

The privacy screening curtains in the four bedded room was laid out for eight beds. This arrangement was not reconfigured to maximise residents' space and enhance privacy.
Action: The company responsible for the screening was contacted immediately and the screens were inspected. A quote to carry out the work has been received and the work will commence as soon as possible.

Chipped surfaces on some of the stairs that run from the entrance to the first floor may pose a risk persons.
Action: The appropriate company were contacted to assess the stairs. They have inspected the work that is required and they have given a commitment that the work will be prioritised and will be concluded by 31 July.

No changes had been made to the metal fire escape stairs and structure although an assessment had been carried out.
Action: HSE estates and fire officer are dealing with this matter. The engineers report has been reviewed by the HSE estates manager and necessary actions to comply with this regulation will be implemented by 31 August 2017.

Improvement to the entrance to the centre is to be addressed and modernised by July 2017.
Action: Works will commence to this entrance this week and are due to be completed by mid July. This will provide a new entrance to the Transitional Care Unit

Proposed Timescale: 31/08/2017

Outcome 18: Suitable Staffing

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
On the day of inspection records evidenced the following training gaps:
-Fire training: 4/32 staff had not received any training since 2015
-Elder abuse: 9/32 staff were due an update
-Manual Handling training: 1 healthcare assistant and 5 staff nurses were due an update.
-Restraint Management: All staff have yet to receive training on restraint management.
-Cardio pulmonary resuscitation (CPR) training: three nurses employed by the provider.

Training gaps were found for persons working in the centre on a contract basis.

While efforts have been made to ensure compliancy, there continues to be significant gaps in the training and development of staff that may potentially impact negatively on residents.

12. 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:
On the day of inspection records evidenced the following training gaps:
Action:
Fire training: 4 outstanding staff who require training will be prioritised to attend the next fire training.
Elder abuse: Staff who are over due training will be prioritised by the end of June to attend this training.
Manual Handling training: Two full dates for training have been scheduled during June and there healthcare assistant and 5 staff nurses due an update will be prioritised.
Restraint Management: a schedule of training throughout June has been scheduled and all staff will attend same
Cardio pulmonary resuscitation (CPR) training: All nurses at the centre have received CPR training.

Training gaps were found for persons working in the centre on a contract basis.
Action: The agency responsible for the supply of nurses on a contractual basis were contacted and records have been received detailing all mandatory training carried out by each nurse. This record is available in the Centre. All nurses are up to date with mandatory training. One nurse on the day of the inspection was awaiting her CPR refresher training and attended this on 16/05/2017.
All nurses working on a contractual basis will be included in the restraint training being delivered to staff as outlined above. The manager of the agency has been reminded that staff need to complete mandatory training to enable them to work within a

designated centre.

While efforts have been made to ensure compliancy, there continues to be significant gaps in the training and development of staff that may potentially impact negatively on residents.
Action: Training schedule has been now updated and it facilitates the tracking of those staff who are due any mandatory training. Those staff identified above have been prioritised for training.

Proposed Timescale: 30/06/2017

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff training, appraisal and review required improvement as per the findings on the last inspection.

To date the center has not progressed this action plan. One staff appraisal has been conducted and this review was seen by the inspector.

The supervision arrangements for all staff required improvement to ensure quality standards, safe practice and accountability.

13. 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:
The supervision arrangements for all staff required improvement to ensure quality standards, safe practice and accountability.
Action: Appraisals of all staff, commencing with nurses have commenced and will continue on an ongoing basis. Training and education gaps which are identified through this process will be addressed.
The process to appoint a second nurse manager to support the nurse manager with supervision and appraisals has commenced on 25/05/2017

Proposed Timescale: 30/11/2017