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:	Cobh Community Hospital
Centre ID:	OSV-0000558
Centre address:	Aileen Terrace, Cobh, Cork.
Telephone number:	021 481 1345
Email address:	cobh_hospital@eircom.net
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	Cobh Community Hospital
Provider Nominee:	Peter Morehan
Lead inspector:	Vincent Kearns
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	43
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
07 February 2017 08:00	07 February 2017 17:30
08 February 2017 08:00	08 February 2017 17:00

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

Outcome	Our Judgment
Outcome 02: Governance and Management	Non Compliant - Major
Outcome 03: Information for residents	Non Compliant - Moderate
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Substantially Compliant
Outcome 07: Safeguarding and Safety	Non Compliant - Moderate
Outcome 08: Health and Safety and Risk Management	Non Compliant - Major
Outcome 09: Medication Management	Non Compliant - Moderate
Outcome 11: Health and Social Care Needs	Substantially Compliant
Outcome 12: Safe and Suitable Premises	Non Compliant - Major
Outcome 13: Complaints procedures	Substantially Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Compliant
Outcome 18: Suitable Staffing	Non Compliant - Moderate

Summary of findings from this inspection

This report sets out the findings of a two day unannounced inspection, in which 12 outcomes out of a possible 18 outcomes were reported upon. The purpose of the inspection was to monitor on-going compliance with the Care and Welfare Regulations and the National Standards. Cobh Community Hospital was registered to provide accommodation for 43 residents. The centre was originally constructed in the early 20th Century and generally the design and layout of the premises is reflective of the period in which it was built.

As part of the inspection process, the inspector met with residents and their representatives, staff members, the clinical nurse manager and the person in charge. The inspector observed practices and reviewed documentation such as policies and procedures, care plans, medication management, staff records and accident/incident logs. Residents told the inspector 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. Most staff were able to demonstrate good knowledge of the residents' care needs when speaking with the inspector. However, an immediate action plan was issued to the person in charge in relation to inadequate provision of staff fire evacuation drills and inadequate staff knowledge of fire evacuation procedures. A satisfactory response in relation to this immediate action plan was received by the Health Information and Quality Authority (HIQA).

From the 12 outcomes reviewed during this inspection; two of the 12 outcomes were compliant and three outcomes substantially compliant with the regulations. However, the following four outcomes were deemed to be moderately non-compliant; information for residents, safeguarding and safety, medication management and suitable staffing. In addition, there were three outcomes found to be at major non-compliance; health and safety and risk management, governance and management and suitable premises. These non-compliances are discussed throughout the report and the action plan at the end of the 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 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):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
Overall there were a number of improvements since the time of the last inspection including improvements in the premises and care planning and residents' were well cared for and there was evidence that the person in charge had communicated the governance structure, roles, responsibilities and reporting relationships to all staff. However, further improvements were required to address the non-compliances as identified in this inspection and as outlined throughout this report. The issuing of an immediate action plan in relation to inadequate fire evacuation drills, fire safety training and staff knowledge was of particular concern in the context of the high dependency levels of residents and the challenging design and layout of the old premises. This particular failing was actioned under outcome 8 of this report however, given the cumulative failings identified in this inspection report, improvements in the management and governance systems were required to ensure that the service provided was safe, appropriate, consistent and effectively monitored particularly in relation to fire safety arrangements, risk management, staff training and staff competencies.

Since the last inspection there was a Clinical Nurse Manager appointed as a person participating in the management (PPIM) of the centre in February 2016 and the inspector noted that she had suitable experience and qualifications to effectively participate in the governance, operational management and administration of the centre. There was a report on the quality and safety of care for residents had been completed for 2015 and was available for review however, the inspector was informed that the annual report for 2016 was not available, as it was still in draft form.

The person in charge in conjunction with the clinical nurse manager had implemented measures to ensure that the care and services provided to residents was evidenced based and effectively monitored. For example there was documentary evidence that the clinical nurse manager and the person in charge were actively promoting effective care

planning and there had been a number of reviews and audits completed. Since the last inspection there had been improvements for example in the arrangements for communicating residents' dietary preferences and ensuring residents' nutritional needs were well met. The inspector noted that there was an effective system of communication between nursing and catering staff to support residents with special dietary requirements.

Staff appraisals were being implemented for all staff and the were regular staff meetings held. The inspector reviewed the minutes of staff meetings and noted that minutes reflected that a broad range of topics that were tabled and discussed with issues such as incidents and accidents, medication and pharmacy, the wearing of personal protective clothing and complaints were discussed. However, the inspector noted that the level of staff attendance recorded at recent meetings was low.

There were a number of audits were being conducted in the centre including audits in relation to care planning, skin care, infection, accidents and protection from abuse. There were meetings with residents and family as required and there was monthly advocacy meetings that were independently facilitated by an external advocacy organisation. On speaking with a number of residents and their representatives during this inspection, the inspector established that requests from residents as articulated at the residents' advocacy meetings were acted on. However, the inspector was informed that there were no records available of the issues discussed at these meetings and that the person in charge agreed to review this arrangement.

Judgment:
Non Compliant - Major

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.

The contracts of care reviewed contained details of the care and welfare of the resident in the centre and included details of the services to be provided, whether under the Nursing Homes Support Scheme or otherwise, to the resident concerned. The inspector reviewed a sample of contracts of care in place however, written details of the additional

service charges levied were not clearly outlined in the schedule of information with each contract. In addition, the contracts 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, "after" the terms.

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):
No actions were required from the previous inspection.

Findings:
The person in charge managed the centre with authority and accountability, the inspector saw she was present in the centre and was familiar with the residents and their social and health care needs. The person in charge was supported by a Clinical Nurse Manager on a day to day basis. There was a second Clinical Nurse Manager who was not available during this inspection. The person in charge was a registered and experienced nurse who was suitably qualified and experienced and evidence of her current registration with her regulatory body was in place. The the person in charge was fully informed of each resident's holistic requirements; overall demonstrated sound evidence based nursing knowledge and exercised her role, her professional and her regulatory responsibilities to a good standard. The person in charge worked full-time and was present in the centre from Monday to Friday and engage in on-going professional development including completing further education and training in palliative care, "journey of change", "let me decide" course as well as undertaking medication management and the protection of vulnerable residents training in 2016. Systems were in place for the transmission of learning for example the person in charge attended each morning handover meeting and the inspector noted that the person in charge and staff discussed a number of residents health and social care need and progress. The inspector also noted from speaking to staff and reviewing documentation that the clinical nurse manager had been actively supporting the person in charge in her role as a person participating in management for example by developing staff competencies in care planning and development.

Judgment:
Compliant

Outcome 05: Documentation to be kept at a designated centre

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

Theme:
Governance, Leadership and Management

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

Findings:
This outcome was not review aside from staffing records and in order to record the action as outlined under outcome 18 of this report.

Overall there were centre-specific policies that reflected the centre's practices and met the requirements of the Regulations. Records were kept securely and up-to-date and were easily retrievable. The inspector reviewed a sample of staffing record and most records were in place. However, not all records listed in Schedules 2 of the Regulations were in not place for example there was no reference from a previous employer for one staff file reviewed.

Judgment:
Substantially 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:
The person in charge confirmed that there was no active reported, suspected or alleged incident of abuse in the centre. The inspector was satisfied that there were policies and

procedures in place for the protection of residents. The person in charge was actively engaged in the operation of the centre on a daily basis. There was evidence of good recruitment practices including verification of references and a good level of visitor activity. There was an adequate policy in place for the prevention, detection andmanagement of any protection issues. Most staff spoken with confirmed their attendance at elder abuse training and were clear on their responsibilities. Staff outlined for example their on-going "vigilance" and their confidence in the person in charge to take appropriate action if and when required. However, not all staff had recently attended annual refresher training in a programme specific to protection of older persons. This issue was actioned under outcome 18 of this report.

The inspector saw that there was a positive, respectful interactions and an easy rapport between staff and residents. That residents were comfortable in asserting themselves and bringing any issues of concern to the person in charge. Residents and relatives spoken to articulated clearly that they had full confidence in the staff and expressed their satisfaction in the care being provided.

In relation to residents' financial transactions the inspector spoke informally with residents throughout the inspection and the feedback received from them was positive. The centre maintained day to day expenses for a number of residents and the inspector saw evidence that financial records were maintained. The inspector reviewed the systems in place to safeguard residents' finances which included a review of a sample of records of monies. However, in relation to money deposited by a resident for safekeeping or received on the resident's behalf the inspector noted that not all lodgements and withdrawals were adequately documented or signed for by residents, their representatives and/or staff. In addition, there was no arrangement for a written acknowledgement of the return of the money or valuables of for reviewing/auditing these arrangements to ensure good financial governance was in place.

There was a policy on responsive behaviours (a term used to describe how persons with dementia represent how their actions, words and gestures are a response to something important to them). Most staff had been provided with training in the centre on responsive behaviours. However, while further training was planned training records evidenced that not all staff had not received up-to-date training in this area.

There was evidence that residents who presented with responsive behaviour were reviewed by their General Practitioner (GP) and referred to other professionals for review and follow up as required. The inspector saw evidence of positive behavioural strategies and staff spoken to outline suitable practices to prevent responsive behaviours. Care plans reviewed by the inspector for residents exhibiting responsive behaviours were seen to reflect the positive behavioural strategies proposed including staff using person-centred de-escalation methods.

There was a commitment to a restraint free environment and person centred care in the centre and there was a policy on restraint which was due to be updated in March 2017. There was evidence that the use of restraint was generally in line with national policy. The inspector saw that there was a comprehensive assessment form in place for the use of restraints. These assessments also identified the use of bedrails as restraint and clearly identified what alternatives to bed rails had been tried to ensure bed rails were

the least restrictive method to be used. There were 13 residents using bedrails on the day of inspection and the inspector was assured by the practices in place and saw for example that alternative measures such as low profiling beds were being used to reduce the use of bed rails, when possible. Where bedrails were required for a resident, the inspector saw evidence that there was regular monitoring of residents, discussion with the resident's family and the GP.

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 inspector found that significant improvements were required in relation to fire safety for the following reasons:
● there were inadequate fire evacuation drills with the most recent fire safety drills recorded as having last been conducted in April 2015
● 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 the appropriate fire control techniques or procedures to be followed should the clothes of a resident catch fire.
Given the potential impact of these identified failings on residents, visitors and staff health and safety, the high dependency levels of residents (81% of residents either high or maximum dependency), the design and layout of the premises; the inspector issued the person in charge with an immediate action plan to take urgent remedial action in relation to conducting fire evacuation drills and staff knowledge of fire evacuation procedures. A satisfactory response in relation to this immediate action plan was received by HIQA.

There were personal emergency evacuation plans in place for residents, many of whom had significant challenges including cognitive impairment and restricted mobility. There was fire safety equipment located throughout the centre. There was a fire safety register that indicated that the fire alarm was serviced regularly and fire extinguishers were serviced most recently in August 2016. However, additional fire safety improvements were required:
● 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.

There was an up-to-date risk management policy that addressed the identification and assessment of risks and the controls in place. However, the risk management policy did not address all the requirements of the regulations. For example, the policy did not adequately address the management of, and the controls in place to mitigate against, self harm and abuse. The centre had other policies relating to health and safety and the safety statement had been reviewed in May 2016. There was a plan in place for responding to major emergencies likely to cause death, injury, serious disruption to essential services or damage to property. There was a record of incidents and accidents in the centre which recorded slips, trips and falls however, records seen were not adequate to ensure arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents. For example there were a number of incidents recorded that had not been risk assessed post incident to identify any additional controls or facilitate any organisational learning to prevent such incidents from reoccurring.

There was a risk register available in the centre however, the inspector found that the hazard identification process was inadequate. On the days of inspection, a number of potential hazards were identified by the inspector that had not been risk assessed including:
● none of the stair gates in the centre had been risk assessed
● none of the stair bannisters in the centre had been risk assessed
● there was unrestricted access to the staff changing room which contained a number of staff personal items including a number of unsecured personal bags
● there was unrestricted access to a number of sluice rooms that contained various cleaning agents and chemicals
● the storage of an unrestricted emergency trolley on the ground floor that contained potentially hazardous items such as needles, scissors and an Automated External Defibrillator (AED)
● there were electrical cables visible in a toilet on the ground floor
● there was unrestricted access to the maintenance store room that contained many potentially hazardous items including various tools and equipment
● there was unrestricted access to a kettle in a sitting room
● there was unrestricted access to the nurses office on the first floor which contained a number of hazards including residents' unused medication for return to the pharmacy
● the railings around the roof garden and adjacent to the sunroom had not been risk assessed
● the storage of latex gloves and plastic aprons were potentially hazardous to a resident with a cognitive impairment
● there was unrestricted access to the nurses office in Caoimhneas unit which contained hazardous items including an unsecured sharps box with used syringes and needles
● there was unrestricted access to an unsecured medication fridge that contained potentially hazardous items including insulin medication
● there was a lock on the door into the kitchenette on the first floor, however this lock had been disengaged leaving access to this room unrestricted.

The person in charge confirmed that two residents smoked tobacco. A policy was in place and reference the requirement for risk assessments to be completed and in practice each resident had been individually risk assessed in relation to their capacity to smoke safely. The inspector noted that where controls were required each resident was provided with continuous staff supervision.

Circulation areas, toilets and bathrooms were adequately equipped with handrails and grab-rails. Staff confirmed that personal protective equipment such as latex gloves and plastic aprons were available. The handling and segregation of laundry was in line with evidence based practice. However, the training matrix indicated that not all staff had completed training in infection prevention and control this issue was actioined under outcome 18 of this report. The communal areas and bedrooms were generally found to be clean and there was adequate standard of general hygiene at the centre. However, there were a number of infection control issues including:
● while there was a cleaning schedule available however, it did not adequately record the cleaning of the centre including any deep cleaning
● there were opened tubes of ointments and creams stored in a public bathroom in one unit without any residents' identifying details
● there was a bedpan unsuitably stored on a windowsill of a shower room
● there were cobwebs visible in a number of places particularly on high surfaces and windows.

Documentation seen indicated that hoists required for moving techniques in resident care were serviced regularly. Care plans contained a current manual handling assessment and plan that referenced the specific equipment required for resident and staff safety. Manual handling practices observed were seen to be in line with current best practice however, the training matrix recorded that not all staff were trained in manual handling and this issue was actioned under outcome 18 of this report.

Judgment:
Non Compliant - Major

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 inspector was satisfied that nursing staff demonstrated competence in medication administration/management practice and that action had been taken to address the deficit identified at the last inspection. For example medication audits were now conducted regularly and medications required to be crushed prior to administration were

prescribed by the residents' general practitioner. Each resident's prescription sheet and medication administration record demonstrated practice that was in substantial compliance with current regulations, regulatory body guidance and legislative requirements. There was a record of all nurses signatures recorded. All controlled (Misuse of Drugs Act) medicines were stored in a secure cabinet and a register of these medicines was maintained with the stock balances checked and signed by two nurses at the end of each working shift. This practice was observed by the inspector on the first morning of the inspection.

The centre had operational policies relating to the ordering, prescribing, storage and administration of medicines signed and dated as implemented by the person in charge. Medicines were supplied to the centre by a retail pharmacy business in a monitored dosage system and were appropriate. The person in charge confirmed that residents were facilitated to have their medicines dispensed by their pharmacist of choice. However, most but not all medicines were stored securely within the centre. On the first day of inspection the inspector noted that a number of medications were stored on a shelf in the nurses' office on the first floor, while awaiting return to the pharmacy. However, this arrangement was not adequate as access to this nurses' office was unrestricted and the inspector noted that the door into this office was generally open most of the time. In addition, the medication fridge in nurse office in Siochan unit contained a number of medicines or prescribed nutritional supplements that required refrigeration, including insulin. However access to this office was also unrestricted and the door of this fridge was also unsecured.

Judgment:
Non Compliant - Moderate

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

Theme:
Effective care and support

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

Findings:
At the time of inspection there were 43 residents living in the centre and staff had assessed the level of residents' dependence in their activities of daily living as follows; two low, six medium, 11 high and 24 maximum dependency. This equated to the vast majority (81%) of residents as being assessed as high to maximum dependency level. The inspector observed staff in the delivery of care to residents, interacted with staff

and reviewed records including medical records, nursing records, correspondence from other healthcare facilities and clinical audits. The inspector was satisfied that each resident's wellbeing and welfare was maintained by an adequate standard of evidence-based nursing care and appropriate medical and allied healthcare. The centre had a computerised care planning system in place and all staff could access this system through computers in nurses offices and via touch screen technology with screens conveniently located in a number of areas in the centre. Each resident's assessed needs were set out in residents' care plans. Based on a random sample of care plans reviewed; the inspector was satisfied that the care plans reflected the resident's assessed needs, assessment was supported by a number of evidenced-based assessment tools and plans of care to meet needs were appropriate and adequate. Assessments and care plans were reviewed four-monthly or more frequently as required. A daily nursing record of each resident's health, condition and treatment given was maintained and these records seen were adequate and informative. Each resident's vital signs were recorded regularly with action taken in response to any variations. The inspector noted that the computer system generated real-time audits of care planning and assessments however, the care planning system recorded the following:

- that there were 45 overdue care plan assessments
- that there were 73 overdue care plan evaluations
- that there were 43 overdue care plan actions.

There was evidence that timely and appropriate access to medical review and treatment was provided and was supported by the medical records seen by the inspector. On both days of inspection the inspector met two different general practitioners (GP's) and the person in charge described the very high commitment and clinical support that the GP's provided to residents and staff in the centre. There was documentary evidence of adequate access to other health professionals including speech and language therapy, dietetics, tissue viability, optical review and chiropody. On both days of the inspection the inspector observed that a number of residents required transferral to the acute hospital setting. Suitable referral and discharge records and records of the information provided when a resident was temporarily transferred or discharged from the centre were maintained.

There were measures identified in falls prevention care plans and evidence of falls being monitored in the centre. There were reassessments of falls risks and the updating of the falls prevention care plans by staff after each fall. Falls were reviewed individually to identify any possible antecedents or changes as appropriate. The inspector was satisfied that all staff spoken with were familiar with each resident's needs and care plans and overall few deficits were identified between planned and delivered care. Residents and their representatives to whom the inspector spoke were very complementary of the care, compassion and consideration afforded to them by staff in the centre.

Judgment:
Substantially 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:
This outcome was only reviewed form the perspective of following up on previous actions.

Cobh Community Hospital provided residential, respite and palliative care and was registered to accommodate 43 residents and on the days of inspection there were 43 residents living in the centre. 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.

Overall the centre was bright, warm and well ventilated and since the last inspection there had been considerable redecorating however, as identified on previous inspections there were a number of improvements required in relation to the premises including:
● some wooden door frames were chipped
● some walls and doors were in need of re-painting
● there were damaged/missing wall tiles in some bathrooms
● the elevator did not provide access to the upper level of the ground floor
● the ceiling light near the nurses' office on the first floor had no cover
● there continued to be evidence of inadequate storage for equipment for example a number of laundry trollies, commodes and hoists were stored in shower rooms
● not all toilets had lockable doors to ensure privacy.

There was some signage in the centre that had text and pictures to help residents to identify communal rooms and to support wayfinding. However, in the context of the dependency of residents and the confusing design and layout of the premises as a result of a number of premises extensions over the years; improvements were required in relation to adequate visual cues and signage to support residents in navigating the various areas within the centre.

There was a functioning call bell system in place and call bells were seen to be accessible from each resident's bed and in each room used by residents. The inspector observed that call bells were answered in a timely manner however, the inspector also noted that there was no call bell available for residents to seek assistance in the sunroom.

There was appropriate equipment provided to meet the needs of residents, hoists were

maintained and used as required. The grounds of the premises were well maintained, and there was an enclosed garden that could be used by residents. There was a chapel available in the centre that was well maintained. Since the last inspection considerable efforts had been made to improve the appearance of the centre. The inspector noted that a number of areas particularly the large dinning room and a number of bedrooms had been personalised with soft furnishings, ornaments and family photographs. However, the design and layout of the majority of the centre retained a hospital appearance and further improvements were required to make this centre more homely.

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

Findings:
Staff spoken with were familiar with the procedure for receiving and recording complaints. Residents and relatives spoken with said that they had no cause to complain but if they had, they would complain and were able to identify the person in charge as the appropriate person to bring their complaint to. The inspector reviewed the complaints log and noted that there were few recorded complaints and the person in charge agreed to review this low level of recorded complaints.

There was a complaint 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 representative was identified as the person to ensure that all complaints were appropriately responded to and that the complaints officer maintained suitable complaints' records, as required.

The inspector noted from a review of the complaint log that detailed any investigation into complaints and the outcome of the complaint. However, the complaints log was not adequate as the complaint record did not record whether or not the resident was satisfied and such records were not in addition to and distinct from the residents care plan, as required by regulation.

Judgment:
Substantially Compliant

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

Theme:
Person-centred care and support

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

Findings:
Residents were facilitated to exercise their civil, political and religious rights. Details of upcoming residents' activities were displayed on notice boards. There were facilities for recreation and events such as afternoon music held in the sitting room. There was no restriction on visiting times and relatives outlined to the inspector that they visited the centre at different times. Staff were observed delivering care in a dignified way that respected privacy for example, by knocking on the resident's bedroom door and awaiting permission before entering.

There was an activities such as bingo, arts & crafts, aromatherapy, knitting, Boccia and hand massage were on offer in the centre. Some residents were able to avail of trips to Mahon Point shopping, outings to greyhound racing at Curraheen Park or short holiday breaks to Ballybunion. The person in charge outlined monthly group activities including the "memory lane café", which was held on the last Friday of each month, the "snappy dresser" and the advocacy group monthly meetings that were facilitated by an independent advocate. There were also one-to-one activities for residents that did not participate in group activities. A number of residents were observed having their hair done in the hairdressing salon on the days of inspection. Contact details were available of an external advocate that was available to residents and their representatives.

Closed circuit television cameras (CCTV) were in operation at a number of locations including the reception area and on corridors and there was policy in place governing the use of CCTV cameras. There was signage indicating there were CCTV cameras in the centre.

The person in charge outlined that resident religious preferences were catered for and Roman Catholic residents religious ceremonies were celebrated in the centre including mass. In addition, religious practices of other religions were also catered for including the local Church of Ireland Clergyman who also visited the centre. There was a chapel available in the centre that was well maintained. Outside of religious ceremonies, the chapel was available as a quiet space for residents to pray and reflect.

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:
The staffing rota confirmed that there was a nurse on duty at all times. Staff spoken to informed the inspector that there was a full complement of staff as per the staff duty roster and overall the inspector was satisfied that at all times, there were adequate staff with the right skills, qualifications and experience to meet the assessed needs of the residents. The inspector was informed that the person in charge was on call each evening to provide managerial support/assistance and the person in charge gave a number of examples of when she had provided such assistance.

Residents and relatives to whom the inspector spoke described staff as being very attentive and kind in their dealings with residents and indicated that staff were caring, responsive to their needs and treated them with respect and dignity. A number of staff spoken to had worked in the centre for long periods of up to 31 years service and clearly demonstrated a good understanding of their role and responsibilities in relation to ensuring appropriate delivery of person-centred care to residents. 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.

From speaking to the person in charge and a review of documentation; staff appeared to be supervised appropriate to their role and responsibilities. The person in charge discussed staff issues with the inspector and suitable protocols and records were seen to be in place where concerns had been identified. There was an education and training programme available to staff and the training matrix indicated that some mandatory training was provided and a number of staff had attended training in areas such as cardio pulmonary resuscitation (CPR) and medication management. However, not all staff had completed mandatory training in fire evacuation or fire training, the detection and prevention of and responses to abuse and responding to and manage behaviours

that were challenging. These failings were discussed and actioned under outcome 7 and 8 of this report. In addition, the on-going education and training programme was not adequate as not all staff had up to date training in for example moving and handling and infection control.

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. However, there was no reference from a previous employer for one staff file reviewed. This issue has been action under outcome 5 of this report.

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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Regulation Directorate
Health Information and Quality Authority

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Action Plan

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

Provider's response to inspection report[1]

Centre name:	Cobh Community Hospital
Centre ID:	OSV-0000558
Date of inspection:	07/02/2017
Date of response:	27/03/2017

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 02: Governance and Management

Theme:
Governance, Leadership and Management

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

1. Action Required:

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

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:
Draft Annual Review for 2016 will be completed.

Proposed Timescale: 30/03/2017

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
To prepare the review referred to in regulation 23(1)(d) in consultation with residents and their families.

2. Action Required:
Under Regulation 23(e) you are required to: Prepare the review referred to in regulation 23(1)(d) in consultation with residents and their families.

Please state the actions you have taken or are planning to take:
Quarterly Resident and Family meetings planned for 2017 on the following dates: 04/04 2017, 27/06/2017, 12/09/2017, 12/12/2017. These meetings will be recorded and will be in addition to regular group advocacy meetings which are currently in place.

Proposed Timescale: 10/03/2017

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
To make available a copy of the review referred to in regulation 23(d) to residents and, if requested, to the chief inspector.

3. Action Required:
Under Regulation 23(f) you are required to: Make available a copy of the review referred to in regulation 23(d) to residents and, if requested, to the chief inspector.

Please state the actions you have taken or are planning to take:
Current Annual Review will be available to residents and Chief Inspector

Proposed Timescale: 30/03/2017

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
To put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored particularly in relation to fire safety arrangements, risk management, staff training and competencies.

4. 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:
Fire safety and evacuation training was completed for all staff on 7th and 14th February following previous fire safety and evacuation training for 21 staff members on 12th July 2016. The in-house fire and safety evacuation training is to be increased to quarterly on the following dates:12/04/17;30/05/17;29/08/17;07/11/17. External Fire safety and evacuation training is scheduled for 12/19/26th April. A fire safety inspection report will be generated by the external provider. The Cork County Council Fire and Building control department will be completing a full inspection on Tuesday 7th March from which a report will be generated.

Proposed Timescale: As stated above. Fire safety and evacuation training completed for all staff by both internal and external providers by 26th April. Further internal training scheduled quarterly.

Proposed Timescale: 26/04/2017

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:
To ensure the agreement referred to in regulation 24 (1) relates to the care and welfare of the resident in the designated centre and includes details of the fees, if any, to be charged for such services.

5. Action Required:
Under Regulation 24(2)(b) you are required to: Ensure the agreement referred to in regulation 24 (1) relates to the care and welfare of the resident in the designated centre and includes details of the fees, if any, to be charged for such services.

Please state the actions you have taken or are planning to take:
Resident will be advised in writing of fee schedule for external providers eg.

Podiatry/Physical therapy

Proposed Timescale: 10/03/2017

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
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 including the terms relating to the bedroom to be provided to the resident and the number of other occupants (if any) of that bedroom," after" the terms.

6. 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:
New residents will be made aware of information included in the Residents Handbook which will include terms on which the resident will reside in the centre including the type of bedroom being offered and the number of other occupants in that bedroom. The new resident will be made aware of room type and number of other occupants during pre-admission assessment.

Proposed Timescale: 10/03/2017

Outcome 05: Documentation to be kept at a designated centre

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Ensure that all records as set out in Schedule 2 are kept in a designated centre and are available for inspection by the Chief Inspector.

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

Please state the actions you have taken or are planning to take:
Reference for identified staff member requested from previous employer 1995-2001.

Proposed Timescale: 10/03/2017

Outcome 07: Safeguarding and Safety
Theme: Safe care and support **The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:** To ensure that all staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging. **8. Action Required:** Under Regulation 07(1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging. **Please state the actions you have taken or are planning to take:** All staff will have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging. All mandatory training will be completed for all staff throughout the month of March 2017
Proposed Timescale: 27/03/2017
Theme: Safe care and support **The Registered Provider is failing to comply with a regulatory requirement in the following respect:** To take all reasonable measures to protect residents from all forms of potential abuse including financial abuse. **9. Action Required:** Under Regulation 08(1) you are required to: Take all reasonable measures to protect residents from abuse. **Please state the actions you have taken or are planning to take:** Fully transparent system in place with two signatories implemented. As always this system is subject to Annual audit by external auditors.
Proposed Timescale: 10/03/2017

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:**

To ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre including the following risks:
● none of the stair gates in the centre had been risk assessed
● none of the stair banisters in the centre had been risk assessed
● there was unrestricted access to the staff changing room which contained a number of staff personal items including a number of unsecured personal bags
● there was unrestricted access to a number of sluice rooms that contained various cleaning agents and chemicals
● the storage of the emergency trolley on the ground floor
● there were electrical cables in a toilet on the ground floor
● there was unrestricted access to the maintenance store room
● there was unrestricted access to a kettle in a sitting room
● there was unrestricted access to the nurses office on the first floor which contained a number of hazards including medication for return to the pharmacy
● the railings around the roof garden and adjacent to the sunroom had not been risk assessed
● the storage of latex gloves and plastic aprons potentially were potentially hazardous to a resident with a cognitive impairment
● there was unrestricted access to the nurses office in Caoimhneas unit which contained an unsecured sharps box that contained used syringes and needles
● there was unrestricted access to an unsecured medication fridge
● there was a lock on the door into the kitchenette on the first floor, however this lock had been disengaged leaving access to this room unrestricted.

10. 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:
All stated risk assessments to be completed immediately and action taken to control risk.

Proposed Timescale: 30/03/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
To ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control abuse.

11. Action Required:
Under Regulation 26(1)(c)(i) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control abuse.

Please state the actions you have taken or are planning to take:
Risk management policy reviewed to include measures and actions in place to control abuse.

Proposed Timescale: 10/03/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
To ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control self-harm.

12. Action Required:
Under Regulation 26(1)(c)(v) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control self-harm.

Please state the actions you have taken or are planning to take:
Risk management policy reviewed to include measures and actions are in place to control self-harm

Proposed Timescale: 10/03/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
To ensure that the risk management policy set out in Schedule 5 includes arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents.

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

Please state the actions you have taken or are planning to take:
All incidents will be risk assessed post incident within an appropriate time frame and additional controls put in place where necessary.

Proposed Timescale: 10/03/2017

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:** To store all medicinal products dispensed or supplied to a resident securely at the centre. **14. 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:** Medication fridge in Sosciuin to be locked. Locked drawer in Nurses station to be provided for medication returns. Door to each nurses station to be closed at all times unless there are staff present.
Proposed Timescale: 10/03/2017

Outcome 11: Health and Social Care Needs
Theme: Effective care and support **The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:** To formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family. **15. Action Required:** Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family. **Please state the actions you have taken or are planning to take:** Care planning to be brought up to date and kept up to date in the future
Proposed Timescale: 10/03/2017

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:
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.

16. 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:
Walls, doors, door frames repainted. Damaged tiles in bathroom to be replaced.
The platform lift provides access to upper level of ground floor. Ceiling light has been recovered. All toilets to have secured locks applied to ensure privacy.
All rooms clearly named and numbered and occupants of rooms identified with signage

Proposed Timescale: 30/03/2017

Theme:
Effective care and support

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

17. 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:
General signage updated to give residents and visitors clear identification of communal rooms and to support wayfinding.
Call bell to be operational in conservatory in Sosciuin.
Increase level of personalisation to make centre more homely

Proposed Timescale: 30/03/2017

Outcome 13: Complaints procedures

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
To ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.

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

Please state the actions you have taken or are planning to take:
Record of complaints will give detail of investigation, outcome and level of resident satisfaction

Proposed Timescale: 10/03/2017

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
To fully and properly record all complaints and the results of any investigations into the matters complained of and any actions taken on foot of a complaint are and ensure such records are in addition to and distinct from a resident's individual care plan.

19. Action Required:
Under Regulation 34(2) you are required to: Fully and properly record all complaints and the results of any investigations into the matters complained of and any actions taken on foot of a complaint are and ensure such records are in addition to and distinct from a resident's individual care plan.

Please state the actions you have taken or are planning to take:
All complaints will be recorded and investigated and appropriate action taken

Proposed Timescale: 10/03/2017

Outcome 18: Suitable Staffing

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
To ensure that staff have access to appropriate training for example moving and handling and infection control.

20. 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:
All mandatory training postponed from November/December 2016 rescheduled for March 2017

Proposed Timescale: 31/03/2017