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:	Cois Abhainn Residential Centre
Centre ID:	OSV-0000583
Centre address:	Greencloyne, Youghal, Cork.
Telephone number:	024 92 765
Email address:	cois.abhainn@hse.ie
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Patrick Ryan
Lead inspector:	Vincent Kearns
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	22
Number of vacancies on the date of inspection:	10

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:
21 February 2017 08:00	21 February 2017 17:00
22 February 2017 08:00	22 February 2017 16:30

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

Outcome	Our Judgment
Outcome 02: Governance and Management	Non Compliant - Moderate
Outcome 03: Information for residents	Non Compliant - Moderate
Outcome 04: Suitable Person in Charge	Compliant
Outcome 07: Safeguarding and Safety	Substantially Compliant
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	Compliant
Outcome 12: Safe and Suitable Premises	Non Compliant - Major
Outcome 13: Complaints procedures	Non Compliant - Moderate
Outcome 16: Residents' Rights, Dignity and Consultation	Compliant
Outcome 18: Suitable Staffing	Compliant

Summary of findings from this inspection

This report sets out the findings of a two day unannounced inspection, in which 11 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. Cois Abhainn Residential Centre provided a 24 hour care service for a maximum of 32 residents who were accommodated seven days a week. The centre catered for low to medium dependency residents only. Residents to whom the inspector spoke confirmed that they were well cared for and were very complementary about the kindness and standard of care provided to them by all staff in the centre. According to the centres' statement of purpose the bed designation was divided up as follows:

- 25 continuing care beds
- four respite care beds
- three convalescent beds.

On the days of inspection there were 22 residents living in the centre. The centre

was located on the outskirts of Youghal town and was in walking distance of shops, banks, the post office, church and all other local amenities. The centre was originally constructed in the early 1970's and had been renovated a number of times since then however, 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, multitask attendants, the chef, clerical staff, the Clinical Nurse Manager 2 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 very 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 and staff were able to demonstrate good knowledge of the residents' care needs when speaking with the inspector.

From the 11 outcomes reviewed during this inspection; four of the 11 outcomes were compliant and one outcome substantially compliant with the regulations. However, the following four outcomes were deemed to be moderately non-compliant; information for residents, governance and management, complaints and medication management. In addition, there were two outcomes found to be at major non-compliance; health and safety and risk 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):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
The provider had ensured sufficient resources to ensure the delivery of care in accordance with the Statement of Purpose. There was a defined management structure in place with which staff were familiar. The governance arrangements in place were suitable to ensure the service provided was safe, appropriate and consistent to meet the identified needs of residents.

Since the last inspection a Clinical Nurse Manager 2 (CNM2) was appointed as a person participating in the management of the centre. This CNM 2 was an experienced nurse and from speaking to the residents, staff and interview there was evidence that the CNM 2 was a competent and effective manager who supported staff and the person in charge in the effective delivery of person centred care.

The person in charge was the Acting Director of Nursing who was based on site five days a week. The person in charge described to the inspector how supportive the provider representative had been and gave examples of how the provider representative was contactable and responsive to any requests for support. The person in charge also outlined the arrangements for the provider representative to regularly meet with the person in charge in order to support her in her role of managing the centre. There was evidence of some quality improvement strategies and monitoring of the services. Since the last inspection there had been a number of improvements including installation of a new resident call bell system, a new fire alarm system, improvements in the décor of the premises, improvements in choice of residents' activities, the roll out of a new care planning system and Wi-Fi was now freely available in the centre for residents use.

The inspector reviewed audits completed. A system of audits was planned on an annual basis and included clinical data over a range of areas namely medication management,

falls, admissions and discharges, care planning complaints and accidents and incidents. There was an annual report on the quality and safety of care was compiled for 2015 with copies made available to the residents or their representative for their information as required by the regulations. However, the report required review as it was not comprehensive, did not reference the findings from the various audits and did not include a quality improvement plan. In addition, the annual report on the quality and safety of care compiled for 2016 was still in draft and was not available on inspection.

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:
There was a folder that was located in the main sitting room and it contained much important resident information including copies of the complaint policy, Your Service Your Say (HSE national complaints policy) details of the available advocacy services, copies of the minutes of residents' committee meetings and details of forthcoming meetings and copies of the HIQA standards. 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, an overview procedure in respect of 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, the contracts were not adequate for the following reasons:
● written details of the fees to be charged were not recorded in all contracts
● written details of the additional service charges levied were not recorded in all contracts
● 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 had been involved in the governance of the centre at initially Clinical Nurse Manager 2 from 2010 and as person in charge since April 2014. The person in charge had significant experience working in the field of Gerontological nursing. The inspector was satisfied that the person in charge was engaged in the governance, operational management and administration of this centre on a regular and consistent basis. She was a registered nurse who worked full time. She had significant experience as a nurse and demonstrated a good knowledge and understanding of the residents in her care and knowledge of her responsibilities under the regulations. The person in charge was very responsive to the inspection process for example when the inspector informed the person in charge that the fire safety notices were out of date, these notices were immediately replaced on the second day of the inspection. The person in charge had attended various clinical and professional development training courses to keep her skills up-to-date. Courses attended included training in areas such as communicating with residents with dementia, challenging behaviours, medication management and safeguarding. She also attended relevant conferences during the year. She was well known to residents and both residents and the staff confirmed that she was available to provide support at time and she confirmed that she maintained an open door policy to residents, their representatives and staff.

Judgment:
Compliant

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

Theme:
Safe care and support

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

Findings:
There centre was fully committed to providing a restraint free environment and the clinical Nurse Manager 2 informed the inspector that there was no restraint currently in use in the centre.

The person in charge confirmed that there was no active reported, suspected or alleged incident of abuse in the centre. There was evidence that any allegations of abuse had been recorded, investigated, appropriate action taken and reported to HIQA and other agencies as required. 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 and management 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 and the CNM2 to take appropriate action if and when required.

The inspector saw that there were genuine, positive and respectful interactions between staff and residents and there was evidence of an ongoing warm and easy atmosphere in the centre. Those residents were very comfortable in asserting themselves and bringing any issues of concern to the person in charge. Residents 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 inspector reviewed the arrangements in place in relation to the maintenance of residents' day to day expenses and the centre managed a number of residents financial transactions. The inspector saw evidence that financial records were maintained using the Health Services Executive (HSE) financial computer software. The inspector reviewed the systems in place to safeguard residents' finances which included a review of a sample of residents' records of monies. The inspector noted that all lodgements and withdrawals were adequately documented or signed for by residents, their representatives and/or staff. In addition, there were suitable arrangement for a written acknowledgement of the return of the money or valuables and adequate reviewing/auditing of these arrangements. The inspector was informed by staff that the financial records were audited both internally and by an external auditor 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 most but not all staff had not received up-to-date training in this area.

Judgment:
Substantially Compliant

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 person in charge informed the inspector that no residents smoked tobacco in the centre. The fire policies and procedures were centre-specific. The fire safety plan was viewed by the inspector and found to be adequate. There were notices for residents and staff on "what to do in the case of a fire" appropriately placed throughout the building. The person in charge informed the inspector and records showed that fire drills were undertaken twice per year. There were personal emergency evacuation plans in place for residents, many of whom did not have significant challenges or significant cognitive impairment or restricted mobility. There was fire safety equipment located throughout the centre.The fire safety alarm had been recently upgraded/replaced in July 2016 and there were records of suitable maintenance and servicing of fire fighting equipment including fire extinguishers, fire safety blankets and emergency lighting. There were records of fire evacuation drills completed both during the day and night time and involving residents. It was noted that residents actively participated in these fire drills and there was evidence of changes made following learning from recent fire evacuation drills. For example, the main entrance doors had been completely changed following a fire evacuation drill which had highlighted a number of insufficiencies in the previous entrance doors. The provider had replaced these entrance doors with an automated door opening system suitable for residents with a reduced mobility. The inspector was informed that these new doors also automatically opened to allow easy evacuation from the centre in the event of the fire alarm being activated. However, the inspector found that improvements were required in relation to fire safety for the following reasons:
● not all staff had adequate knowledge of the residents personal emergency evacuation plans
● most but not all staff had received up-to-date fire safety training
● most but not all staff were clear when questioned about the appropriate fire control techniques or procedures to be followed should the clothes of a resident catch fire
● there were a number of gaps (blanks) in the recording of the daily monitoring fire safety checklist
● the fire resisting doors required review for example there was a significant gap noticed between the floor and the fire resisting door into the nurses' rest room

Clinical risk assessments were undertaken, including falls risk assessment, assessments for dependency, assessments for malnutrition and assessments for pressure ulcer formation. The provider had contracts in place for the regular servicing of all equipment and the inspector viewed records of equipment services which were up-to-date. Accidents and incidents were recorded on incident forms using the HSE national incident

and accidents reporting system. There was evidence that all incidents and accidents were submitted to the person in charge and there was evidence of action in response to individual incidents which included slips, trips and falls. There were reasonable measures in place to prevent accidents such grab-rails in most toilets and handrails on corridors and safe walkways were seen in the garden area. 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, accidents and injuries to residents, visitors and staff or abuse. In addition, the following potential hazards were identified as requiring risk assessments:

- the arrangement for respite residents to bring their own medications into the centre in medication containers that were not tamper proof
- there were no grab rails in toilet off bedroom number 14
- there was only one grab rail in the visitors toilet
- there was unrestricted access to a kettle located in an unrestricted staff rest room
- the unrestricted storage of latex gloves and plastic aprons

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. However, this plan was not adequate as it did not for example detail of any alternative venue in the event of an evacuation of the centre, following any such major emergency.

The environment was observed to be very clean and personal protective equipment, such as gloves, aprons and hand sanitizers were located throughout the premises. All hand-washing facilities had liquid soap and paper towels available. There were policies in place on infection prevention and control and staff that were interviewed demonstrated knowledge of the correct procedures to be followed. Hand hygiene training was on-going and staff demonstrated good hand hygiene practice as observed by the inspector. Arrangements for the disposal of domestic and clinical waste management were appropriate. Cleaning staff were knowledgeable in regard to procedures on cleaning residents' bedrooms and en suites. A colour coded cleaning system was in use. The inspector noted that the levels of cleanliness and housekeeping, décor and furnishings were of a high standard. Schedules of cleaning were available and were regularly updated. Deep cleaning schedules ran in tandem with the daily cleaning.

Circulation areas and most toilets and bathrooms were adequately equipped with handrails and grab-rails. Staff confirmed the suitable use of personal protective equipment such as latex gloves and plastic aprons. Since the last inspection the handling and segregation of laundry had improved with the provision of specific plastic baskets to segregate clean and soiled laundry and all bed linen was laundered by an external laundry service. The communal areas and bedrooms were found to be clean and there was good standard of general hygiene at the centre. However, there were a number of infection control issues including:

- there was an opened tube of cream stored in a public bathroom without any residents' identifying details
- a number of areas in the centre such as en suite toilets were difficult to clean due to the uneven surfaces of the walls
- there was visible rust on a number of waste peddle bins

● the cleaning trolley was unsuitably stored in the laundry room
● there was no sink for staff use available in the laundry room
● there was visible rust in a number of places on the stainless steel sink of the sluice room.

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 and the training matrix recorded that all staff were trained in manual handling.

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

Findings:
The centre-specific policies on medication management were made available to the inspector and had been reviewed in July 2016. The policies included the ordering, receipt, administration, storage and disposal of medicines. The policies were made available to nursing staff who demonstrated adequate knowledge of this document. Medicines for residents were supplied by a community pharmacy. Nursing staff with whom the inspector met outlined a robust procedure for the ordering and receipt of medicines in a timely fashion. Medicines were stored in a locked cupboard, medication trolley or within a locked room only accessible by nursing staff. Medicines requiring refrigeration were stored securely and appropriately. The temperature of the medication refrigerator and storage areas was noted to be within an acceptable range; the temperature was monitored and recorded daily. Staff informed the inspector that a number of residents were responsible for their own medication after they have been appropriately assessed. Safe medication management practices were reviewed and monitored. However, the arrangements for managing the medications of residents admitted for respite admission required review particularly those medications that were in non-tamper proof containers. This issue was actioned under outcome 8 of this report.

Medications requiring additional controls under the Misuse of Drugs Regulations were seen to be suitably stored however, robust measures were not in place for the handling and storage of controlled drugs or were not accordance with current guidelines and legislation. The inspector noted that there were a number of gaps in the records for staff to confirm that the stock balance of such medicines was correct. In addition, there

were gaps in the Misuse of Drugs Regulations register for the administration of these medicines, which was not in line with the Misuse of Drugs Regulations.

Nursing staff with whom the inspector spoke demonstrated knowledge of the general principles and responsibilities of medication management. Medication administration was observed and the inspector found that the nursing staff adopted a person-centred approach and a sample of medication prescription records was reviewed. Medicines were recorded and administered generally in accordance with guidance issued by An Bord Altranais agus Cnáimhseachais (Irish Nursing and Midwifery Board of Ireland). However, practice in relation to the transcription of medications was not in line with the centre-specific policy or guidance issued by An Bord Altranais agus Cnáimhseachais for all prescriptions seen. For example the inspector noted that in relation to one medication that had been prescribed via a facsimile; the medication administration record sheet had not been suitably amended/transcribed to record this change in medication administration. In addition, staff explained that a number of residents also had medications prescribed per phone call by their GP. However, such prescribed prescriptions were not always signed by the prescriber within 72 hours. The inspector noted that this unsafe practice had been identified in previous HIQA inspection reports and that the person in charge had attempted to make alternative arrangements to ensure compliance with the regulations. However, as identified during this inspection this practiced continued.

The maximum daily dosage for PRN (as required) medicines was not consistently indicated on the prescription sheet. In some cases the dose and route of administration were not clear and there was no further information available in care plans to guide staff.

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:
The inspector was satisfied that residents' healthcare requirements were met to a good standard. The inspector joined the morning handover each morning of the inspection

and noted that staff including the Clinical Nurse Manager 2 discussed residents clinical and health and social care needs and highlighted to all staff any changes or issues of concern. The centre catered for low to medium dependency residents only. Residents to whom the inspector spoke confirmed that they were well cared for and were very complementary about the kindness and standard of care provided to them by all staff in the centre.

There was evidence to support that residents' healthcare requirements were adequately and regularly assessed by competent nursing staff and that arrangements were in place to meet assessed needs. On admission residents were facilitated to retain access to their general practitioner (GP) of preference. There was documentary evidence that residents, as appropriate to their needs, had access to other healthcare professionals and services including dietetics, speech and language therapy, occupational therapy, psychiatry, chiropody and physiotherapy. Further arrangements were in place to facilitate optical and dental review. There was evidence of seasonal influenza vaccination. The inspector saw that each resident had a nursing plan of care and that there was a significant changes being made to the care planning record system in line with national HSE care planning changes. Nursing staff used a key-nurse system for care plan completion. The inspector reviewed a random sample of care plans and was satisfied that the system was clearly understood by staff and the general standard of care planning was good. There was evidence that each care plan was informed by assessment and reassessment as required and at a minimum four monthly intervals. Care plans were completed in consultation with the resident and/or their representative and were supported by a suite of validated assessment tools. In general care plans were person centred, clearly set out the arrangements to meet identified needs as specific to each resident and incorporated interventions prescribed by other healthcare professionals. 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.

There was a low reported incidence of wounds. The inspector saw that the risk of wound development was regularly assessed. Preventative strategies including pressure relieving equipment were implemented. A validated assessment tool was used to establish each resident's risk of falling and there was evidence of the routine implementation of falls and injury prevention strategies including close monitoring or residents, the use of hip-protectors and low beds. The resident's right to refuse treatment was respected and recorded and brought to the attention of the relevant GP. There were procedures in place and records seen supported that relevant information about the resident was provided and received when they were absent or returned to the centre from another care setting.

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:
Cois Abhainn Residential Centre provided a 24 hour care service for a maximum of 32 residents who were accommodated seven days a week. According to the centres' statement of purpose the bed designation was divided up as follows:
● 25 continuing care beds
● four respite care beds
● three convalescent beds

On the days of inspection there were 22 residents living in the centre. Cois Abhainn was located on the outskirts of Youghal town and was in walking distance of shops, banks, the post office, church and all other local amenities. The centre originally opened in 1976 and celebrating 40 years of caring for people last year however, the overall design and layout of the premises was largely reflective of the period in which it was built. 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:
● there were a number of residents' toilets that were inadequate in size, design or layout to meet residents needs
● paintwork in some walls and doors was marked or damaged by friction from beds and other equipment and required attention
● the laundry room was not adequate in size, design or layout; there was no designated wash-hand basin and there was no shelving or storage racks in the laundry
● there continued to be evidence of inadequate storage for equipment for example a number of chairs and wheel chairs were stored in corridors and the cleaning trolley was stored in the laundry room.

Working call bells were accessible from each resident's bed and in each room used by residents and the inspector observed that call bells were answered in a timely manner. A number of circulation areas, toilet facilities and shower/bathrooms had non slip flooring and most were adequately equipped with hand-rails and grab rails. All walkways and bathrooms were equipped with handrails and grab-rails. One toilet had a single grab rail and inspectors discussed with the person in charge the benefits to residents of having a second grab rail installed. Signage throughout the centre had text and pictures to help residents to identify communal rooms and to support way finding. Of particular note were signs on residents' bedroom doors that had been positioned at eye height. Some toilet seats had a contrasting colour and some corridor walls had painted murals of local well know scenes which had been chosen by residents. However, the person in charge

agreed to review the premise in relation to ensuring adequate visual cues and signage to support residents in navigating the various areas within the centre.

There was an inner courtyard/garden which had been renovated to provide a picturesque sensory garden with raised flower beds, safe walking areas and seating for residents to enjoy. There was also a seating area to the front of the building with car parking available for residents, relatives and visitors.

Resident's bedrooms were personalised with soft furnishings, ornaments and family photographs. All residents' bedrooms could be locked and bedroom doors had a number and the resident's name. A separate kitchen was located off the main dining room. The inspector observed the kitchen to be visibly clean and well-organised. The inspector spoke to the chef who enthusiastically described menu options for residents and was very clear on residents dietary preferences and residents were very complementary about the choice and quality of food provided in the centre.

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:
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 Clinical Nurse Manger 2 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.

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 residents or persons acting on their behalf did raise matters of concern to them; these matters were investigated, remedial action was taken, feedback was provided and some complainant satisfaction was established. There was evidence that any actions required for improvement were communicated to staff as relevant and were implemented. However, the complaints records were not adequate as

the complaint record did not always record whether or not the resident was satisfied as required by regulation. In addition, the complaints log was unsuitable used to improperly record incidents of responsive behaviours, accidents and adverse incidents.

Judgment:
Non Compliant - Moderate

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:
The inspector was satisfied that residents were consulted about how the centre was planned and run. Contact details were available of an external advocate that was available to residents and their representatives. Details of upcoming residents' meetings were displayed on notice boards and occurred monthly. A resident satisfaction survey had been completed in December 2016 and was very complementary about the care and support provided in the centre. There was evidence of residents participation in their care plan development and reviews. Residents had access to a number of informative documents including copies of the HIQA standards, copies of REACH (HIQA newsletter for residents in residential care), "Open Your Eyes" (HSE Information booklet on elder abuse), copy of the complaints' policy, "Your Service Your Say" (national HSE booklet on complaints management), minutes of the residents committee meetings and details of the next meeting. In addition there was free Wi-Fi available through out the centre and the Clinical Nurse Manager 2 informed the inspector that they hoped to have a computer tablet available for resident's use shortly.

It was clear that residents had the opportunity to exercise personal autonomy and choice, be it what hour they chose to get up or dine at or whether or not the partook in activities. Residents were facilitated to exercise their civil, political and religious rights. There was no restriction on visit 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 provided by staff in the centre and also by individual staff attending the centre on Wednesday of each week . In addition, there were activities provided by people external to the centre providing in-house group entertainment. The inspector spoke to one of the external staff who supported residents in participating in activities and she outlined her satisfaction in

working with the residents for the past nine years. There were activities such as bingo, arts & crafts, hand massage and rings and exercise were on offer in the centre. The inspector observed very good participation in the afternoon activities which included exercises with soft ball which seemed to be greatly enjoyed by many residents. There were also one-to-one activities for residents that did not participate in group activities.

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 on Thursdays. 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):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
Based on the review of the staff rota the inspector was satisfied that there were sufficient staff with the right skills, qualifications and experience to meet the assessed needs of residents at all times. Staff included at least one staff nurse at all times.

Residents 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 at all times treated them with respect and dignity. A number of staff spoken to had worked in the centre for many 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 very 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.

Staff confirmed to the inspector that they had been facilitated in accessing continuing

professional education by the provider. The person in charge and the Clinical Nurse Manger 2 outlined how they promoted and supported staff training and development for example they outlined the setting up of a group email address for staff to ensure that all received updates on any policy, training or opportunities that became available. The Clinical Nurse Manger stated that this was also an effective means of sharing any new developments or learning from courses that individual staff might have obtained. From speaking to the person in charge, the Clinical Nurse Manager 2 and a review of documentation; staff were supervised appropriate to their role and responsibilities. There was an education and training programme available to staff and the training matrix indicated that mandatory training was provided to most staff 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 training, and responding to and manages behaviours that were challenging. These failings were discussed and actioned under outcome 7 and 8 of this report.

All nursing staff were on the live register with Bord Altranais agus Cnáimhseachais na hÉireann, or Nursing and Midwifery Board of Ireland and many of the multi-task attendants had completed the Further Education and Training Awards Council (FETAC) level five qualifications.

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 for 2017 for nursing staff were seen by the inspector.

Judgment:
Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Vincent Kearns
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:	Cois Abhainn Residential Centre
Centre ID:	OSV-0000583
Date of inspection:	21/02/2017
Date of response:	06/04/2017

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:
Annual Review to be completed as required under regulation 23(d)

Proposed Timescale: Completed 16th March 2017

Proposed Timescale: 16/03/2017

Outcome 03: Information for residents

Theme:
Governance, Leadership and Management

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

2. 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:
An Addendum will be added to all Contracts of Care outlining details of fees to be charged, if any, for services provided to residents as per regulation 24 (1)

Proposed Timescale: 30/04/2017

Theme:
Governance, Leadership and Management

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

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:
The contract of care will be amended to include the specific room type that will apply to the resident while residing in Cois Abhainn.

Proposed Timescale: Completed 27th February 2017

Proposed Timescale: 27/02/2017

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 staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.

4. 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 completed training by 30th March

Proposed Timescale: Completed by 30th March 2017

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 staff are trained in the detection and prevention of and responses to abuse.

5. 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:
Training will be provided on March 24th for all staff who have not yet received this training.

Proposed Timescale: Completed 24th March 2017

Proposed Timescale: 24/03/2017

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 the measures and actions in place to control abuse.

6. 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 Assessment Completed and included in Local Risk Management Policy

Proposed Timescale: Completed 10th March 2017

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 accidental injury to residents, visitors or staff.

7. Action Required:
Under Regulation 26(1)(c)(iii) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control accidental injury to residents, visitors or staff.

Please state the actions you have taken or are planning to take:
Risk Assessment Completed and included in Local Risk Management Policy

Proposed Timescale: Completed 22nd February 2017

Proposed Timescale: 22/02/2017

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.

8. 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 Assessment Completed and included in Local Risk Management Policy

Proposed Timescale: Completed 10th March 2017

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 there is a plan in place for responding to major incidents likely to cause death or injury, serious disruption to essential services or damage to property includes an alternative location for residents in the event of an evacuation of the centre.

9. Action Required:
Under Regulation 26(2) you are required to: Ensure that there is a plan in place for responding to major incidents likely to cause death or injury, serious disruption to essential services or damage to property.

Please state the actions you have taken or are planning to take:
Two local venues have been sourced if evacuation needed. Local GAA club facilities and Parish Hall. Contact numbers in Emergency Response folder.

Proposed Timescale: Completed 6th March 2017

Proposed Timescale: 06/03/2017

Theme:
Safe care and support

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

To ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.

10. 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:
All creams/lotions for single person use will be labelled accordingly.
Grab rails will be installed in room 14 and visitor's toilet.
Risk Assessment has been completed for kettle and latex gloves storage.
New bins have been ordered.
Stainless Steel sink in Sluice room will be inspected by infection control and recommendations implemented.

Proposed Timescale: 30/04/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
To make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.

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

Please state the actions you have taken or are planning to take:
Further fire training to include emphasis on how to deal with resident should their clothes catch fire on 30th March 2017.
Fire Evacuation training on 28th March 2017.

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, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and residents are aware of the procedure to be followed in the case of fire.

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

Please state the actions you have taken or are planning to take:
Further training arranged for staff on 30th March 2017.
Fire Evacuation training on 28th March 2017.

Proposed Timescale: Completed March 30th 2017

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 make adequate arrangements for reviewing fire precautions including the daily monitoring of fire safety arrangements, staff knowledge of residents personal evacuation plans and reviewing fire resisting doors.

13. Action Required:
Under Regulation 28(1)(c)(ii) you are required to: Make adequate arrangements for reviewing fire precautions.

Please state the actions you have taken or are planning to take:
Staff to insure completion of fire checks daily and fire alarm weekly.
Fire Officer to review and certify fire doors.
Personal Safety plans to be on inside wardrobe door of each resident and also in Residents Care Plan.

Proposed Timescale: 30/04/2017

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 ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.

14. Action Required:
Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.

Please state the actions you have taken or are planning to take:
HSEland Medication Management completed in 2016 by all nursing staff and to be completed annually. Controlled drugs monitoring now audited daily. Respites and convalescence will not be admitted if they do not have medication charts and drugs in order as per local admission policy.
Assistant Director of Public Health Nursing informed of admission policy in Cois Abhann and requested to inform all Public Health Nurses.
All residents have lockable lockers which are used for medicines following assessment when self medicating.
Residents asked to bring in newly dispensed medicines when coming for respite/convalesence.
Risk assessment sent monthly to General Manager requesting GP contracted hours for Cois Abhann.
Letter resent to GP's requesting compliance with transcribing and follow up signature within 72 hour time period.(Previously sent in May 2015)

Proposed Timescale: 31/05/2017

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.

15. 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 design team will be appointed shortly and plans developed for the Hospital.
These plans will comply with the requirements of the recently issued new 2016 HIQA standards (as published 3rd May 2016) and the amendment to the Regulation (S.I. No. 293 of 2016).

The environment will be assessed, and any interim measures identified to improve the privacy and dignity of the residents will be pursued, pending funding.

Proposed Timescale: 31/12/2021

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.

16. 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:
The Person in Charge will maintain 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.
This will be recorded in the Complaints Book.

Proposed Timescale: 10/04/2017

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.

17. 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:
The Complaints Book will record all complaints. It will record the results of investigations into the complaint, and actions taken on foot of the complaint.

The Complaints Book will be kept only for Complaints Records, and will be distinct from the Residents Care Plan.
Proposed Timescale: 10/04/2017