<table>
<thead>
<tr>
<th>Centre name:</th>
<th>The Cottage Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0004587</td>
</tr>
<tr>
<td>Centre address:</td>
<td>70 Irishtown, Clonmel, Tipperary.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>052 612 2605</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:marie@wnh.ie">marie@wnh.ie</a></td>
</tr>
<tr>
<td>Type of centre:</td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>Tipperary Healthcare Limited</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Vincent Kearns</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>None</td>
</tr>
<tr>
<td>Type of inspection:</td>
<td>Announced</td>
</tr>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>24</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>1</td>
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About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration renewal decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

<table>
<thead>
<tr>
<th>From:</th>
<th>To:</th>
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<tbody>
<tr>
<td>16 January 2018 08:30</td>
<td>16 January 2018 17:30</td>
</tr>
<tr>
<td>17 January 2018 07:30</td>
<td>17 January 2018 16:00</td>
</tr>
</tbody>
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The table below sets out the outcomes that were inspected against on this inspection.

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Our Judgment</th>
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<tbody>
<tr>
<td>Outcome 01: Statement of Purpose</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 02: Governance and Management</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 03: Information for residents</td>
<td>Compliant</td>
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<tr>
<td>Outcome 04: Suitable Person in Charge</td>
<td>Compliant</td>
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<tr>
<td>Outcome 05: Documentation to be kept at a designated centre</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 06: Absence of the Person in charge</td>
<td>Compliant</td>
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<tr>
<td>Outcome 07: Safeguarding and Safety</td>
<td>Compliant</td>
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<tr>
<td>Outcome 08: Health and Safety and Risk Management</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 09: Medication Management</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 10: Notification of Incidents</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 11: Health and Social Care Needs</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 12: Safe and Suitable Premises</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 13: Complaints procedures</td>
<td>Compliant</td>
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<td>Outcome 14: End of Life Care</td>
<td>Compliant</td>
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<tr>
<td>Outcome 15: Food and Nutrition</td>
<td>Compliant</td>
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<tr>
<td>Outcome 16: Residents' Rights, Dignity and Consultation</td>
<td>Compliant</td>
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<tr>
<td>Outcome 17: Residents' clothing and personal property and possessions</td>
<td>Compliant</td>
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<tr>
<td>Outcome 18: Suitable Staffing</td>
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Summary of findings from this inspection

This was an announced inspection following an application by the provider representative of the Cottage Nursing Home to re-register of a designated centre. The centre was a two-story Georgian building that had originally been the cottage hospital in Clonmel town and accommodation provided for up to 25 residents on both the ground and first floor. The premises is directly accessed from the main street, is
in close proximity to the town of Clonmel and is close to all amenities including a church and a post office which were located across the street from the centre.

As part of the inspection process the inspector met with residents, staff members, the provider representative and the person participating in management (PPIM) who was an Assistant Director of Nursing (ADON). As the person in charge was on leave at the time of this inspection, the provider representative and the ADON were both readily available to facilitate this inspection. The inspector observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files. Residents spoken with expressed a high level of satisfaction with the service they experienced in the centre and this satisfaction was also evident from residents returned satisfaction questionnaires viewed by the inspector. Other documents reviewed included training records, residents’ care plans and minutes of meetings.

On the previous unannounced inspection in May 2017, there was a number of improvements required including health and safety and premises issues. However, on this inspection, the inspector noted considerable improvements in the premises and the provider representative confirmed that all the required fire safety improvements had been completed. In addition, all the actions from the previous inspection had been either completed or progressed toward completion.

There were 18 outcomes monitored on this inspection, 17 of the 18 outcomes were compliant or substantially compliant with the regulations. However, one outcome was deemed to be moderately non-compliant; health and safety and risk management. 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 01: Statement of Purpose
There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

**Theme:**
Governance, Leadership and Management

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

**Findings:**
There was a written statement of purpose dated January 2018. The inspector reviewed the statement of purpose which declared the aims, objectives and ethos of the centre and summarised the admission criteria, facilities available and services provided. The services and facilities outlined in the statement of purpose and the manner in which care was provided, reflected the diverse needs of residents. The statement of purpose contained all of the information required by schedule 1 of the regulations and was reviewed annually.

**Judgment:**
Compliant

### Outcome 02: Governance and Management
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.

**Theme:**
Governance, Leadership and Management

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

**Findings:**
The inspector met with the provider representative who informed the inspector that he had taken charge of the centre since 2010. The provider representative described the
management structure that included who was in charge, who was accountable and what the reporting relationships were. The inspector also met the person participating in management (PPIM) who was a Assistant Director of Nursing (ADON). As the person in charge was on leave at the time of inspection, the provider representative and the ADON were both readily available to facilitate this inspection. The provider representative informed the inspector that he regularly met both the person in charge and ADON each week. He stated that he was in daily phone contact plus he was on site in the centre at least twice a week, depending on service requirements. There was an active quality management system in place to improve the quality and safety of the service. This system included undertaking regular comprehensive audits, resident surveys and structured management meetings. The audits included, amongst others: falls, hygiene and infection control, care planning, the use of restraint, complaints, and wound care and medication administration practices. The inspector noted that following each audit an action plan was developed containing any changes and/or learning that was required as well as the identity of the accountable person for implementing each action. Specific time's lines were also provided and each action was reviewed by the management team. The findings from this quality management system were used to inform the annual review of the safety and quality of care completed for 2017. The ADON had made this report available to residents as required.

The inspector noted significant improvements on this inspection and all the actions from the previous inspection had been either completed or sufficiently progressed toward completion. For example, on the last inspection there was an issue in relation to fire safety including the installation of automatic fire door releases. On this inspection, the provider representative confirmed that all the required fire safety improvements had been completed including installation of automatic fire-door releases on all doors, as required. The provider representative outlined significant building works/enhancements that had been completed in the centre. These works included a new heating and hot water system including hot water temperature control and thermostatically controlled heating in each room. There had been a full electrical rewiring of premises including a new electrical board, WIFI was now available in all areas, with data and TV sockets in each bedroom. There had been considerable renovation works completed included new floor covering, new wash hand basins, repainting and decoration of most residents' bedrooms as well as new lighting. Sluice rooms had been fully tiled with new stainless-steel sinks, racking and wash hand basins installed. There were also new non-slip flooring in toilets and shower rooms and the sluice rooms were now restricted with the installation keypad locks on doors. A number of bathrooms had been fully retiled with the installation of new toilets, sinks and wheelchair accessible showers, grab rails and non-slip flooring. Residents to whom the inspector spoke were delighted with the improvements and commented that the premises seemed much brighter and more comfortable.

As mentioned above, deputising arrangements for the person in charge were satisfactory. The ADON was in post since 2014 and was well known to residents and staff. The inspector noted that there was a good level of staff supervision and staff appraisals had been completed for all staff.

The inspector spoke to a number of staff who explained their areas of responsibility and were found to be knowledgeable and resident oriented in their approach. Staff to whom
the inspector spoke to were aware of the regulations governing the sector and the national standards. Evidence of consultation with residents was available in a sample of care plans reviewed, the survey results and minutes of residents' meetings. During the two days of this inspection, the inspector noted a high number of visitors in the centre. Many residents and relatives spoken with by the inspector were complementary of their experience of care and the improved facilities at the centre. The provider representative informed the inspector that adequate resources were available to ensure on going premises upkeep and to continuous professional development of staff.

There was evidence of meetings with staff and regular meetings were held with residents. The ADON was clearly known to residents and relatives to whom the inspector spoke with. Many residents and visitors were very complementary of care and support provided by the staff. From a review of the minutes of residents' meetings it was clear that issues identified were addressed in a timely manner and that the person in charge and the management team were proactive in addressing any concerns or issues raised. Where areas for improvement were identified in the course of the inspection; both the ADON and the provider representative demonstrated a conscientious approach to addressing these issues. Both demonstrated a clear commitment to compliance with the regulations as evidenced by the improvements identified on this inspection.

**Judgment:**
Compliant

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

**Theme:**
Governance, Leadership and Management

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

**Findings:**
There was a Residents' Guide which was made available to residents and included a summary of the services and facilities provided, terms and conditions relating to residence, procedure respecting complaints and the arrangements for visits. Copies of this guide were noted to be made available near the entrance to the centre and in the sitting rooms and found to meet the requirements of legislation.

The inspector reviewed a sample of residents' contracts of care. The inspector noted that contracts had been signed by the residents/relatives and found that the contract was clear, user-friendly and outlined the services and responsibilities of the provider representative to the resident and the fees to be paid. Since the previous inspection the contracts had been amended to contain details of 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, as required by regulation.

**Judgment:**
Compliant

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**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 worked in the centre since 2015 and had been appointed to the post of person in charge in 2015. While the person in charge was on leave at the time of the inspection, the inspector had met the person in charge on the previous inspection in May 2017. The inspector had noted on that inspection that she was fully engaged in the governance and administration of the centre on a consistent basis. That she worked full time in the centre and was a qualified nurse with considerable experience in the area of nursing the older person. On that inspection the inspector formed the view that the person in charge possessed the clinical knowledge to ensure suitable and safe care and to meet her legislative and statutory responsibilities and was committed towards providing a person centre high quality service. This view was also informed by the improvements that the person in charge with support of the ADON had implemented in the centre since the previous inspection. For example, there had been improvements in the quality assurance process with on going comprehensive auditing, all staff had received written appraisals and all staff mandatory training was up to date. In addition, there had been improvements in care planning including improved needs assessments and consultation with residents. All residents spoken to were very complementary about the care and attention that the person in charge provided them. All staff spoken to described the person in charge as being always approachable to all residents, their relatives and staff. Staff stated that the person in charge was fully aware of residents' care and support needs, regularly met all staff including the night staff and attended the daily handover. Residents spoken to by the inspector confirmed that the person in charge met with them each day and frequently met many residents' representatives. The inspector noted that the person in charge also attended the residents' committee meetings and there was evidence that she was very proactive in listening to residents and acting on any issues raised by residents.

**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):
No actions were required from the previous inspection.

Findings:
Residents' records were reviewed by the inspector who found that they complied with Schedule 3 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. The records listed in Schedule 4 to be kept in a designated centre were all maintained and made available to the inspector.

The inspector reviewed the centre's operating policies and procedures and noted that the centre had all site specific policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. These policies were reviewed and updated at intervals not exceeding three years as required by Regulation 4.

Overall the centre-specific policies reflected the care given in the centre and informed staff with regard to up-to-date evidenced best practice or guidelines. There was evidence of on-going training to staff on policies and procedures and staff had signed off on these once they had received the training.

The inspector viewed the insurance policy dated June 2017 and saw that the centre was adequately insured against accidents or injury to residents, staff and visitors.

The inspector reviewed a sample of staff files and found that they contained all of the information required under Schedule 2 of the Regulations.

The inspector was satisfied that the records listed in Part 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 were maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. Overall records were seen to be maintained and stored in line with best practice and legislative requirements.

Judgment:
Compliant
Outcome 06: Absence of the Person in charge
The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:
Governance, Leadership and Management

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

Findings:
There had been no instances since the last inspection whereby the person in charge was absent for 28 days or more and the provider representative was aware of the responsibility to notify HIQA of any absence or proposed absence of the person in charge.

There were suitable deputising arrangements in place to cover for the person in charge when she was on leave. The ADON who had worked in the centre since 2010 and had been appointed to the post of ADON in 2015. As the person in charge was on leave at the time of this inspection, the inspector met the ADON who fully facilitated the two days of this registration renewal inspection. The provider representative informed the inspector that the ADON was fully engaged in the governance and administration of the whole centre. The inspector noted that the ADON worked full time in the centre and was a qualified nurse with good experience in the area of nursing the older person.

The inspector formed the view that the ADON possessed the clinical knowledge to ensure suitable and safe care and to meet her legislative and statutory responsibilities. The inspector formed this view due to the aforementioned improvements that the ADON under the overall governance of the person in charge had implemented in the centre. Residents spoken to confirmed that the ADON was a attentive and caring manager and staff also expressed their confidence in the support and guidance provided by the ADON. The inspector noted that the ADON also regularly attended various management/quality/safety meetings including the falls review meeting, responsive behaviours meetings and restraint reduction meetings.

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:
The inspector noted that since the previous inspection improvements had been made to the management of the use of restraint in the centre. There was evidence that the use of restraint was in line with national policy. The restraint register recorded eight residents using bedrails on the days of inspection. From the sample of records viewed all residents with any form of restraint; there was evidence that there was regular checking/monitoring of residents, discussion with the resident's family, the visiting physiotherapist and the General Practitioner (GP). The inspector saw that there was an assessment in place for the use of restraint which clearly identified what alternatives had been tried to ensure that the particular form of restraint was the least restrictive method to use. For all residents with a bedrail in place; there was also a risk assessment completed and the details entered onto the restraint register. These details were reviewed at least every quarter or more often if appropriate. The inspector was assured by the practices in place and saw that whenever possible alternative measures were used. For example, there were low-low beds and sensor alarms used for a number of residents to reduce the use of bed rails in the centre. There was on-going auditing of the use of restraint with the most recent audit recorded as having been completed in November 2017.

The inspector found that there were measures in place to protect residents from suffering harm or abuse. There were policies and procedures in place to guide staff in the care and protection of residents. For example, there was a policy on respecting the privacy and dignity of residents and a recently reviewed policy on protecting residents accounts and personal property. Staff interviewed demonstrated a good understanding of safeguarding and elder abuse prevention and were clear about their responsibility to report any concerns or incidents in relation to the protection of a resident. Staff training in elder abuse and safeguarding training was provided on an on-going basis in-house. From a review of the staff training records all staff had received up-to-date training in a programme specific to protection of older persons. This training was supported by the aforementioned policy documents on safeguarding which defined the various types of abuse and outlined the process to be adopted to investigate abuse issues should they arise.

The inspector reviewed the arrangements in place in relation to the maintenance of residents' day to day expenses and the centre managed a small number of residents' financial transactions. The inspector reviewed the system 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 two 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 provider representative confirmed that that the financial records were audited to ensure good financial governance was in place. In relation to the storage of valuables, the inspector noted that all residents were provided with a lockable storage facility in their bedrooms.
The provider representative was a pension agent for a small number of residents. In relation to these pension accounts the provider representative informed the inspector that he was in full compliance with the Department of Social Protection guidelines in relation to being a pension agent and there were transparent arrangements in place to safeguard residents’ finances and financial transactions.

There was a policy on behaviours that challenged and the inspector noted that eight of the 24 residents were assessed as having behaviours that challenged. There was evidence that for residents who presented with behaviours that challenge; they were reviewed by their GP or other professionals for full review and follow up as required. Staff spoken to were clear on the support needs for residents exhibiting behaviours that challenge including the use of positive behavioural strategies. Care plans reviewed by the inspector for residents exhibiting behaviours that challenge were seen to include positive behavioural strategies. In addition, from a review of training records the inspector noted that all staff had received training in the management of behaviours that challenge.

**Judgment:**
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):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
On the previous unannounced inspection in May 2017, considerable non compliance was identified in relation to health and safety. However, the inspector noted significant improvements on this inspection and all the actions from the previous inspection had been either completed or sufficiently progressed toward completion. For example, on the last inspection there was an issue in relation to fire safety including the installation of automatic fire door releases. On this inspection, the provider representative confirmed that all the required fire safety improvements had been completed including the installation of automatic fire-door releases on all doors, as required.

There was a risk management policy as set out in schedule 5 of the regulations and included all of the requirements of regulation 26(1). The policy covered the identification and assessment of risks and the precautions in place to control the risks identified. There was a risk register available in the centre which covered for example, risks such as residents' falls risks, fire safety risks and as the premises was located on a busy street; road safety risks. There was a centre specific safety statement dated as being most recently reviewed in January 2018. The inspector was informed that the provider representative, the person in charge and the ADON met regularly to review health and safety issues including any incidents, accidents or near misses in the centre. There were
records of minutes of these meetings which also recorded a review of procedures and practices including risk management and fire safety in the centre. The centre had a computerized care planning and recording system in place and all accidents and incidents were recorded via this system on incident forms. All were reviewed by the person in charge, ADON and provider representative and there was evidence of action in response to individual incidents.

Clinical risk assessments were also undertaken, including falls risk assessment, assessments for dependency and assessments for pressure ulcer formation. The inspector noted that there had been a small number of accidents and incidents recorded in the centre. Following each incident there was recorded information/communication with relevant persons such as the person in charge, the residents' GP, next of kin, the clinical observations taken and any learning/changes required to prevent reoccurrence. The provider representative outlined a number of improvements implemented in relation to enhancing the health and safety since the previous inspection. These included the installation of a new fire alarm system/panel and fire detectors throughout the premises. Installation of new emergency exit lighting, enhanced fire proofing and repair of all fire seals on fire doors. There had been the installation of non-slip surfaces in bedrooms and new hand rails had been installed in a number of toilets and bathrooms. In addition, there had been the installation of new stainless steel sluice sinks and storage racking in the sluice rooms.

The inspector reviewed all notifications made to HIQA and crossed referenced them against the recorded accidents in the centre. The inspector noted that suitable notifications had been made in relation to all accidents in the centre. However, the hazard identification process required improvement as a number of potential hazards were identified by the inspector that required action including:

- the unrestricted access to the kitchen required risk assessing as there may have been items potentially hazardous to residents with a cognitive impairment stored in the kitchen
- the unrestricted access to the staff changing room required risk assessing as there may have been items potentially hazardous to residents with a cognitive impairment stored in this room
- the water drain near the laundry room required risk assessing as it was a potential trip hazard
- the noise level in the laundry room required risk assessing
- the unrestricted access to the staff clothes/locker/storage room required risk assessing as there may have been items potentially hazardous to residents with a cognitive impairment stored in this room.

There was fire safety training provided by an outside fire safety instructor and the inspector saw that fire training was provided to staff on dates in 2017 with the most recent training recorded as provided in December 2017. All staff spoken to demonstrate an appropriate knowledge and understanding of what to do in the event of fire and all staff had up to date fire training as required by legislation. A number of staff were identified as fire wardens and the inspector noted that each warden had a particular management role in the event of a fire alarm sounding. Evidence of this arrangement working was seen on the second day of inspection when there was a false fire alarm sounding and suitable response by the fire warden and staff was observed by the
inspector. There were fire policies and procedures that were centre-specific. The fire safety plan was viewed by the inspector and found to be adequate. There were fire safety notices for residents, visitors and staff appropriately placed throughout the building. The inspector noted that two residents smoked tobacco in the centre and there was a smoking area provided for residents' who smoked tobacco. There were adequate arrangements in place including records of a risk assessment completed for these residents. These records also referenced their capacity to smoke safely including any monitoring/observations requirements. The inspector examined the fire safety register which detailed services and fire safety tests carried out. Fire fighting and safety equipment had been regularly tested, the fire alarm and the emergency lighting was last tested in January 2018. All staff spoken to stated that they had participated in a fire evacuation drill in the centre. Records viewed evidenced that fire evacuation drills were practiced regularly in the centre with the most recent completed in December 2017 and all staff had attended a fire evacuation drills. A number of residents to whom the inspector spoke were knowledgeable about the fire safety arrangements in the centre including the fire evacuation drills and stated that they would recognize the sound of the fire alarm. Staff spoken to knew the evacuation requirements for each resident and many residents had good levels of mobility. The inspector reviewed residents' personal emergency evacuation plans (PEEP's) and noted that suitable PEEP's had been completed for each resident living in the centre. All fire door exits were unobstructed and fire fighting and safety equipment had been tested and the fire alarm was last tested in January 2018. In addition, there were records of weekly fire alarm and emergency lighting and daily monitoring of fire exits.

Latex gloves and plastic aprons were located throughout the centre and staff confirmed that they used personal protective equipment such as latex gloves and plastic aprons as appropriate. Overall there were systems to support staff knowledge and implementation of best practice to ensure good infection prevention and control were in place. The communal areas and bedrooms were found to be clean and there was good standard of general hygiene in the centre. The inspector noted that all staff had received training in hand hygiene. Staff that were spoken to demonstrated knowledge of the infection prevention and control procedures to be followed or demonstrated suitable hand hygiene practices. All hand-washing facilities had liquid soap. There were centre specific policies and procedures in place on infection prevention and control. However, there were a number of infection control issues including:

- the cleaning practices as described by some staff to the inspector were not in keeping with the centres' cleaning policy or with best practice
- the floor/wall covering/plaster in some parts of the laundry room was damaged and required repair/replacement and meant that it was not possible to effectively clean these areas of the laundry room
- there was no water in the wash hand sink in the laundry room
- the size and layout of the laundry room was not adequate as it did not provide adequate space for the separation of clean and dirty laundry and facilitate good infection prevention and control practice and therefore posed a risk of cross contamination
- the slings used for supporting residents using a lifting hoist were not individualized to each resident and therefore potentially compromised the prevention of cross contamination
- the floor covering in some areas required repair/replacement for example the linoleum floor covering was cracked/stained on the corridor/some toilets and could not be
appropriately cleaned
- the sluicing practices as described by staff to the inspector were not adequate as they were not in keeping with best infection control practice.

In relation to the inadequate laundry room the provider representative informed the inspector that he would convert another existing outside building that was much larger and more suitable into a new laundry facility as part of the ongoing renovation programme in the centre. The provider representative stated that he would make this matter a priority and he expected that these conversion building works would be completed within four to six weeks.

**Judgment:**
Non Compliant - Moderate

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**Outcome 09: Medication Management**

*Each resident is protected by the designated centre’s policies and procedures for medication management.*

**Theme:**
Safe care and support

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

**Findings:**
The inspector noted that there were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents which had been reviewed most recently in July 2016. Staff were observed adhering to appropriate medication management practices. The medication trolley was suitably secured and the medication keys were held by the staff nurse on duty. The inspector observed a nurse administering the lunch time medications, and this was carried out in line with best practice. Medications were administered and disposed of appropriately in line with An Bord Altranais and Cnáimhseachais na hÉireann Guidance to Nurses and Midwives on Medication Management (2007). Controlled drugs were stored in accordance to best practice guidelines and nurses were checking the quantity of medications at the start of each shift. The inspector did a count of controlled medications with the nurse which accorded with the documented records.

The inspector reviewed a number of medication prescription charts and noted that all included the resident's photo, date of birth, GP and details of any allergy. The transcribing of medication records was completed by nursing staff and the inspector observed that transcribed orders were signed and dated by the transcribing nurse and checked by a second nurse. In addition each transcription was co-signed by the prescribing doctor as outlined in the centre's policy. There was a system of ongoing audit and analysis in place for reviewing and monitoring safe medication management practices. The nursing staff completed a quarterly medication administration audit that included nursing practice and medication records reviews. However, these medication audits were not adequate as they did not review the practice of transcribing as required by An Bord Altranais and Cnáimhseachais na hÉireann Guidance to Nurses and Midwives.
Medication errors were recorded and there was evidence that appropriate action was taken as a result of same. Nursing staff undertook regular updates in medication management training as evidenced by training records.

There were appropriate procedures for the handling and disposal of unused and out of date medicines and the documenting of same. The fridge containing medications was located in a secure office. There was evidence that the temperature of the fridge was monitored daily and that the fridges contained medication only.

**Judgment:**
Substantially Compliant

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### Outcome 10: Notification of Incidents

A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

**Theme:**
Safe care and support

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

**Findings:**
The inspector saw that there was a comprehensive log of all accidents and incidents that took place in the centre. Incidents as described in the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 had been reported in accordance with the requirements of the legislation. There were timely quarterly returns and written notifications were received within three days of accidents and incidents as required.

**Judgment:**
Compliant

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### 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 attended the morning staff handover meeting on the second day of this inspection. The inspector noted that the staff nurse on night duty gave updates on all residents care and support needs from the previous night to incoming day duty nurses and healthcare staff. The centre had a computerized care planning system in place and from a review of care plans there were adequate details to support staff in effectively managing residents' health problems. The inspector observed both nursing and other staff inputting records of on-going care provision using touch screens that were located in a number of areas in the centre.

The statement of purpose stated that the centre catered for low to maximum dependency residents including residents with dementia, respite care, learning disability, physical disability, acquired brain injury, long term care, convalescent and palliative care. The ADON outlined how all prospective residents were assessed by a member of the nursing management team. This pre-admission assessment was carried out to ensure that each resident met the admission criteria as stated in the centres' statement of purpose. Following the assessment the planned admission was communicated in detail to the nursing staff to arrange transfer/admission. The inspector noted on the days of inspection that there was one vacancy and from the 24 residents living in the centre; eight residents had been assessed as having maximum dependency. Two residents assessed as having high dependency needs, 12 residents as having medium care needs and two residents as having low dependency care needs.

On the previous inspection improvements were required for some care plans and on this inspection, the inspector noted from a sample of care plans reviewed that each residents' care plan and care needs were contemporaneously recorded and reflected changes in their circumstances and identified health and social care needs. The ADON informed the inspector that she and the person in charge monitored residents care plans as appropriate. Assessments and care plans were reviewed four-monthly or more frequently as required. From a review of a sample of residents care plans, the inspector noted evidence that all care plans and care plan assessment were up to date 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. Overall there were adequate systems in place for the assessment, planning, implementation and review of healthcare needs. Based on a random sample of care plans reviewed; overall the inspector were 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 identified needs. There were assessments of residents overall health and social care needs on admission and on readmission following return from acute hospital care and as required for example, when clinical deterioration was noted. The assessment process involved the use of a variety of validated tools to assess each resident's risk of deterioration. For example, risk of malnutrition, falls, level of cognitive impairment and pressure related skin injury among others. There was a choice of GP's attending the centre with ten GP's currently visiting the centre and there was evidence of regular GP reviews from the sample of residents' records reviewed. There was evidence of access to specialist and allied healthcare services to meet the care needs of residents. For example, speech and language therapist (SALT), psychiatry, opticians, dentists and chiropody services. Access to
palliative care specialists, dietician and physiotherapy were also available. For example, there was visiting physiotherapist who called to the centre each week and there was regular support provided by the visiting community psychiatric nurse. There was evidence that the person in charge monitored the care planning system to ensure that residents’ support and care needs were met. For example, the person in charge and/or the ADON, staff nurses and care staff attended the handover meetings, liaised with GP’s and allied healthcare professionals and regularly reviewed care plans to ensure appropriate care provision. The inspector found that the care plans were person centred and individualised. The ADON, nursing staff and health care assistants spoken with were familiar with and knowledgeable regarding residents up to date needs. Overall there were adequate systems were in place for the on going assessment, planning, implementation and review of healthcare needs and theses included the aforementioned nursing assessments, care plans and clinical risk assessments.

There was evidence of active falls prevention in the centre and there was a falls prevention team which included the visiting physiotherapist and who met each month to review any falls that occurred in the centre. All residents had been risk assessed using a multifactorial falls risk assessment in relation to their risk from falls. The level of falls in the center was reviewed regularly by the person in charge and ADON and also at regular care staff meetings to promote the reduction in the incidence of falls within the center. This meeting also reviewed any other such incidences of slips, trips or near misses in the center. All incidences of falls were reviewed individually to identify any possible antecedents or changes/learning that could be obtained to prevent any re-occurrence. Subsequently, measures were identified in residents’ falls prevention care plans and there were also reassessments of falls risks by staff after each fall. The inspector was satisfied that overall care plans contained few identified deficits between planned and delivered care. Residents and their representatives to whom the inspector spoke were complementary of the care, compassion and consideration afforded to them by staff.

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

Findings:
The centre was a two-story Georgian building that had originally been the cottage hospital in Clonmel town and accommodation for up to 25 residents was provided on
both floors. The premises were directly accessed from the main street and the centre was close to all amenities with a church and post office located across the road.

The provider representative outlined significant building works/enhancements that had been completed in the centre during 2017. These works included a new heating and hot water system including hot water temperature control and thermostatically controlled heating in each room. There had been a full electrical rewiring of the premises including a new electrical board, WIFI was now available in all areas, with data and TV sockets in each bedroom. Completion of the fire safety improvements including installed new soft closing door-closers connected to fire panel on bedroom doors, enhanced fire proofing, installation of a new fire alarm panel, fire detectors and new fire exit lights and emergency lighting. There had been new floor covering, new wash hand basins, repainting and decoration of most residents' bedrooms as well as new lighting fittings. Sluice rooms had been fully tiled with new stainless-steel sinks, racking and wash hand basins installed. The sluice rooms were now restricted with the installation keypad locks on the doors into the two sluice rooms. A number of bathrooms had been fully retiled with the installation of new toilets, sinks and wheelchair accessible showers, grab rails and non-slip flooring. However, as identified and actioned in outcome 8 of this report the laundry room/area were not suitable in the design, size and layout. The inspector formed the view that the size and layout of the laundry room was not adequate as it did not comply with good infection prevention and control practice and posed a risk of cross contamination. In addition, the following areas for improvements were noted:

- there was an area of stained flooring on the corridor near the entrance to the kitchen
- the door into the laundry was in need of repair
- there was a crack in the window glass of a first floor corridor window that needed repair
- the wooden step into the laundry room was cracked and needed repair
- the heating radiator in the laundry room was not working.

In relation to the inadequate laundry room the provider representative gave assurances that he would convert another outside building that was much larger and more suitable into a new laundry facility as part of the on going renovation programme in the centre. The provider representative also stated that he would make this matter a priority and he expected that these conversion building works would be completed within four to six weeks.

The inspector noted that many of the resident's bedrooms were personalised with soft furnishings, ornaments and family photographs. Ten residents were accommodated on the ground floor in four single bedrooms and three twin bedrooms. There was adequate shower, toilets including assisted toilet and wash-hand basins provided for residents' use on the ground floor. Also accommodated on the ground floor were the main kitchen and ancillary areas, dining room, recreational room, a residents’ smoking area located to the rear of the premises adjacent to the laundry room. There was a staff toilet and staff changing facilities, sluice room, linen storage area and separate toilet facilities for catering staff. The first floor was accessed by means of the main stairwell or by the passenger lift. Fifteen residents were accommodated on the first floor in five single bedrooms, two twin bedrooms and two triple bedrooms. One of the triple bedrooms was ensuite. There was adequate shower, toilets including assisted toilet and wash-hand basins provided for residents’ use on the first floor. A communal area and a small “quiet
room” were also provided on the first floor. A recently refurbished sluice room and storage room were also accommodated on the first floor. There was an enclosed fire escape provided that was accessed from the lift lobby and exited onto the ground floor to the rear of the building. Each bedroom provided adequate storage for personal possessions including a lockable storage space. Adequate screening was provided in shared bedrooms. The two communal areas and the dining room that were provided for residents were seen to have been recently renovated, were bright and were homely in appearance. The dining room on the ground floor provided seating for eight residents and meals were served in one sitting. Several residents on the first floor took their meals in the communal area on the first floor or in their rooms, if they wished.

Sluice rooms were secure and appropriately equipped. Working call bells were accessible from each resident’s bed and in each room used by residents. Heating, lighting and ventilation was adequate to the layout of the premises with circulation areas, toilet facilities and shower/bathrooms adequately equipped with hand-rails and grab-rails.

A separate kitchen was provided and the kitchen was visibly clean and well-organised. There were suitable and sufficient cooking facilities, kitchen equipment and tableware available.

**Judgment:**
Substantially Compliant

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**Outcome 13: Complaints procedures**

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

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

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

**Findings:**
A centre-specific comprehensive complaints policy was in place dated as most recently reviewed in May 2016. The complaints policy identified the nominated complaints officer and also included an independent appeals process as required by legislation. A summary of the complaints procedure was displayed prominently near the main entrance and was included in the statement of purpose.

The inspector reviewed the electronic complaints log detailing the investigation, responses, outcome of any complaints and whether the complainant was satisfied. All complaints viewed had been dealt with appropriately. The inspector noted that the complaints process was most recently audited in January 2017 and an action emanated from this audit which recorded a number of changes that had been subsequently made including improved communication processes.

Residents with whom the inspector spoke were able to identify the complaints officer,
stated that any complaints they may have had were dealt with promptly and were satisfied with the complaints procedure.

**Judgment:**
Compliant

**Outcome 14: End of Life Care**
*Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.*

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

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

**Findings:**
The policy on the management of end of life care which was dated as reviewed most recently in August 2016. Overall there was evidence of a good standard of medical and clinical care provided. The ADON outlined that as required appropriate access to specialist palliative care services was provided. There was evidence of good end of life practices including suitable end of life care plans with recorded communications with the resident in relation to their wishes and preferences, including their spiritual needs. There was evidence of on-going dialogue with residents' families or their representatives in relation to the residents' end of life needs. The inspector found that staff were aware of the policies and processes guiding end of life care. Staff to whom the inspector spoke outlined suitable arrangements for meeting residents' needs, including ensuring their comfort and care. Staff spoken to were able to describe suitable and respectful care practices in relation to end of life care provision. The inspector noted that families were notified in a timely manner of deterioration in residents’ condition and were supported and updated regularly as required. There were facilities to support relatives remain with their loved ones during end-of-life including facilitating families to remain overnight, if required

**Judgment:**
Compliant

**Outcome 15: Food and Nutrition**
*Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.*

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

**Outstanding requirement(s) from previous inspection(s):**
The action(s) required from the previous inspection were satisfactorily implemented.
Findings:
Residents were provided with food and drink at times and in quantities adequate for their needs. Assistance was observed and was offered to residents in a discreet, patient and sensitive manner by staff. The dining experience was a social occasion and a number of residents were seen chatting with each other throughout their meal. Staff also used meal times as an opportunity to engage in a meaningful way with residents, particularly with residents to whom they gave assistance. Those residents on modified diets were offered the same choices as people receiving normal diets. A three week rolling menu was in place to offer a variety of meals to residents. Tables in dining rooms were appropriately set with cutlery condiments and napkins. Residents spoken with agreed that the food provided was always very good and appetising. Overall residents were happy with the food provided in the centre and some residents stated that that "the food was really very good". Food was served from the kitchen by a team of staff and was well presented. The inspectors spoke with kitchen staff who outlined how they were knowledgeable about residents dietary needs and preferences. The inspector noted that the most recent environmental health officer report dated January 2018 contained a small number of recommendations and some minor actions required. In this small centre the kitchen staff regularly spoke to all residents to elicit residents' feedback.

The inspector noted from a review of training records that all kitchen staff had received Hazard Analysis and Critical Control Point (HACCP) training. Modified consistency diets were served appropriately with each element of the meal presented in separate portions on the plate. A list of all special diets required by residents was compiled on foot of the individual residents' reviews and copies were available in the kitchen.

Drinks such as water, milk, tea and coffee were available. Access to fresh drinking water was available at all times and jugs of water were observed in residents' rooms. Evidence of referral to relevant allied health professional including dietician or speech and language therapists was found and there was a system in place to monitor the intake of residents identified as at risk of malnutrition. The inspector looked at this system in place to monitor food intake. The system of recording was found to be detailed/consistent enough to enable meaningful analysis as to the adequacy of intake for at risk residents.

Judgment:
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:**
There was evidence that residents and/or the representatives were consulted with and participated in the organisation of the centre. For example, there were records of meetings with resident and their family’s available and such consultation was confirmed by residents and relatives to whom the inspector spoke. Regular residents committee meetings were held with the most recent meeting recoded as having occurred in November 2017. The ADON outlined that the role of these meetings was to ensure residents' actively participated in decision making within the centre. The inspector noted that the residents' committee was facilitated by the person in charge and the committee met regularly to discuss issues such as changes to the premises, renovation works, future activities or planned parties. Feedback and suggestions were recorded with an action plan with timeframes for completion of any actions required. There was evidence of changes having been made as a result of these meetings. For example, there had been an issue about choice of activities provided and a number of subsequent changes to the provision of activities had occurred.

Residents' right to choice, and control over their daily life, was also facilitated in terms of times of rising /returning to bed and whether they wished to stay in their room or spend time with others in the communal rooms. Overall, residents’ rights, privacy and dignity were respected, during personal care, when delivered in their own bedroom or in bathrooms. A number of residents spoken with confirmed that they were afforded choice in relation their daily lives and for example, were facilitated to receive visitors in private.

There were no restrictions to visiting in the centre and the inspector observed several visitors at different times throughout the two day inspection. One visitor stated that she visited the centre at different times including early afternoon and another relative visited each evening. She stated that overall they were assured by what they saw and heard from staff in the respectful way that they provided care and support to their relative and other residents.

A programme of varied internal activities and external trips was in place for residents. Information on the day's events and activities was prominently displayed in the centre. The activities coordinator was very visible and actively involved with supporting residents. Residents to whom the inspector spoke with confirmed that the activities coordinator was well known to residents, provided on-going support to them and was very approachable. The inspector spoke to the activities coordinator who outlined how she delivered the programme which included both group and one to one activities. The inspector was told that residents’ spiritual needs were met through regular prayers in the centre and Mass celebrated every Thursday. The inspector was also informed that any other religious denominations were catered for as necessary.

**Judgment:**
Compliant
**Outcome 17: Residents’ clothing and personal property and possessions**
Adequate space is provided for residents’ personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.

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

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

**Findings:**
There was a centre-specific policy on residents' personal property and possessions that was recorded as being most recently reviewed in November 2017. From a sample of residents' records reviewed by the inspector, there were records in place of individual resident's clothing and personal items.

Residents’ laundry was adequately maintained and laundry facilities were provided on-site. There were issues in relation to the design and layout of the laundry room which have been already identified in outcomes eight and 12 of this report. However, aside from these required improvements, there were appropriate arrangements in place for the regular laundering of linen and clothing and procedures were in place for the safe return of residents' personal clothing items.

The inspector reviewed the arrangements for managing residents' finances and noted that there were suitable records and system of double signing for transactions. Residents that the inspector spoke with indicated that they were satisfied with the arrangements in place in relation to the management of residents’ personal property. Each resident had a secure storage facility in their bedroom for the safekeeping of any personal items or small quantities of monies.

The provider representative confirmed that the centre was a pension agent for three residents however, the provider representative also confirmed that he was compliant with the Department of Social Protection guidelines in relation to the management of pensions for residents.

Residents were facilitated to have their own items, such as assisted equipment or furniture and personal memorabilia. The inspector noted that most bedrooms had been personalized with individual residents' items, photographs and art work. Each resident had suitable furniture in their bedrooms to store clothing and personal items in their own bedside cabinets and wardrobes.

**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:
An actual and planned roster was maintained in the centre. The inspector reviewed a sample of staff rosters which showed that the person in charge was on duty Monday to Friday and that she was supported in her role by the ADON, staff nurses and other members of the staff team. The inspector observed practices and spoke to a number of both day and night duty staff including the ADON, the activities coordinator, cleaning and household staff, healthcare assistants and kitchen staff, staff nurses on both day and night duty and the provider representative. Staff appeared to be supervised appropriate to their role and responsibilities. This was evidenced by speaking to residents, staff and management including the provider representative and a review of documentation including staff rosters, reporting arrangements and staff files. Records viewed by the inspector confirmed that there was an adequate level of training provided with numerous training dates scheduled for 2018. Staff told the inspector they were encouraged to undertake training by the person in charge. Mandatory training was on-going and staff had attended a number of trainings with all staff had completed mandatory training in areas such as fire training. In addition, fire evacuation practice drills were provided along with other mandatory training for example, training in manual handling and safeguarding and safety and all were found to be up to date. Staff also attended training in areas such as the prevention of falls, hand hygiene and infection control and medication management.

The inspector reviewed a sample of staff files which included the information required under Schedule 2 of the regulations. The provider representative confirmed that all staff had suitable Garda vetting in place. Registration details with Bord Altranais agus Chnáimhseachais na hÉireann, or Nursing and Midwifery Board of Ireland 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

<table>
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<th>The Cottage Nursing Home</th>
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</tr>
<tr>
<td>Date of inspection:</td>
<td>16/01/2018</td>
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<tr>
<td>Date of response:</td>
<td>07/02/2018</td>
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Requirements

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

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

Outcome 08: Health and Safety and Risk Management

Theme:
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
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 potential hazards:
- the unrestricted access to the kitchen required risk assessing as there may have been items potentially hazardous to residents with a cognitive impairment stored in this room
- the unrestricted access to the staff changing room required risk assessing as there may have been items potentially hazardous to residents with a cognitive impairment

1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
stored in this room
● the water drain near the laundry room required risk assessing as it was a potential
trip hazard
● the noise level in the laundry room required risk assessing
● the unrestricted access to the staff clothes/locker/storage room required risk
assessing as there may have been items potentially hazardous to residents with a
cognitive impairment stored in this room.

1. **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:**
A key pad will be installed on the kitchen door to secure the kitchen area. A key pad will
be installed on the staff changing room/lockers to reduce the risk of potential hazards
to residents with cognitive impairments. A risk assessment has being completed to
assess the noise level in the laundry room. A risk assessment has being completed to
assess the water drain near the laundry room. The drain will be reinstalled level with
the ground to reduce risk of falls

**Proposed Timescale:** 01/03/2018

**Theme:**
Safe care and support

**The Registered Provider (Stakeholder) 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
including the following infection control issues:
● the cleaning practices as described by staff to the inspector were not in keeping with
the centres' cleaning policy and with best practice
● the floor/wall covering/plaster in some parts of the laundry room was damaged and
required repair/replacement and meant that it was not possible to clean these areas of
the laundry room
● there was no water in the wash hand sink in the laundry room
● the size and layout of the laundry room was not adequate as it did not provide
adequate space for the separation of clean and dirty laundry and facilitate good
infection prevention and control practice and therefore posed a risk of cross
contamination
● the slings used for supporting residents using a lifting hoist were not individualized to
each resident and therefore potentially compromised the prevention of cross
contamination
● the floor covering in some areas required repair/replacement for example the
linoleum floor covering was cracked/stained on the corridor/some toilets and could not
be appropriately cleaned
● the sluicing practices as described by staff to the inspector were not adequate as they
were not in keeping with best infection control practice.

2. **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:**
The water has being reconnected in the wash hand sink in the laundry room. We plan to move the laundry room to another existing outside building on the grounds by 1st April 2018. While we are renovating the new laundry room, all sluicing of clothes will be done in the sluicing rooms. New slings have being ordered to ensure each resident will have their own individual sling. Old lino flooring which is cracked or stained will be replaced with new lino by the 1st June 2018. In relation to cleaning practices, all housekeeping staff has re-read our policy on cleaning CCE-010 paying particular attention to section 5.0-5.14 Cleaning process. A cleaning process has also being developed and put in the front of the communication book for cleaning staff to reference. 6th February 2018

**Proposed Timescale:** 01/06/2018

**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 and medication audits include a review of the practice of transcribing as required by An Bord Altranais and Cnáimhseachais na hÉireann Guidance to Nurses and Midwives on Medication Management (2007).

3. **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:**
We have amended our medication audit to include the reviewing practice of transcribing by nurses.

**Proposed Timescale:** 07/02/2018
**Outcome 12: Safe and Suitable Premises**

**Theme:**
Effective care and support

The Registered Provider (Stakeholder) 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 including:
- there was an area of stained flooring on the corridor near the entrance to the kitchen
- the door into the laundry was in need of repair
- there was a crack in the window glass of a first floor corridor window that needed repair
- the wooden step into the laundry room was cracked and needed repair
- the heating radiator in the laundry room was not working.

4. **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: We plan to move the laundry room to another existing outside building on the grounds which will irradiate all issues associated with the old laundry. This laundry room will be in operation by the 1st April 2018. All old flooring in the corridors will be replaced by the 1st June 2018. A new glass panel has being ordered for the window and will be installed before the 1st March 2018.

**Proposed Timescale:** 01/06/2018