

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Cobh Community Hospital
Centre ID:	OSV-0000558
Centre address:	Aileen Terrace, Cobh, Cork.
Telephone number:	021 481 1345
Email address:	cobh_hospital@eircom.net
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	Cobh Community Hospital
Lead inspector:	Mary O'Mahony
Support inspector(s):	Michelle O'Connor
Type of inspection	Unannounced Dementia Care Thematic Inspections
Number of residents on the date of inspection:	43
Number of vacancies on the date of inspection:	1

About Dementia Care Thematic Inspections

The purpose of regulation in relation to residential care of dependent Older Persons is to safeguard and ensure that the health, wellbeing and quality of life of residents is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer and more fulfilling lives. This provides assurances to the public, relatives and residents that a service meets the requirements of quality standards which are underpinned by regulations.

Thematic inspections were developed to drive quality improvement and focus on a specific aspect of care. The dementia care thematic inspection focuses on the quality of life of people with dementia and monitors the level of compliance with the regulations and standards in relation to residents with dementia. The aim of these inspections is to understand the lived experiences of people with dementia in designated centres and to promote best practice in relation to residents receiving meaningful, individualised, person centred care.

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 compliance with specific outcomes as part of a thematic inspection. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
11 October 2018 08:00	11 October 2018 20:30
11 October 2018 08:00	11 October 2018 20:30

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

Outcome	Provider's self assessment	Our Judgment
Outcome 01: Health and Social Care Needs	Compliance demonstrated	Substantially Compliant
Outcome 02: Safeguarding and Safety	Substantially Compliant	Non Compliant - Major
Outcome 03: Residents' Rights, Dignity and Consultation	Compliance demonstrated	Non Compliant - Moderate
Outcome 04: Complaints procedures	Compliance demonstrated	Substantially Compliant
Outcome 05: Suitable Staffing	Substantially Compliant	Non Compliant - Major
Outcome 06: Safe and Suitable Premises	Substantially Compliant	Non Compliant - Major
Outcome 07: Health and Safety and Risk Management		Non Compliant - Major
Outcome 12: Notification of Incidents		Non Compliant - Major

Summary of findings from this inspection

This inspection of Cobh Community Hospital was unannounced. The report sets out the findings of a thematic inspection which focused specifically on dementia care provision. Inspectors followed the experience of a number of residents with dementia within the service. As part of the thematic inspection process providers were invited to attend information seminars organised by the office of the Chief Inspector. In addition, evidence-based guidance was circulated to providers on best practice in dementia care and the thematic inspection process. The person in charge had completed the provider self-assessment tool on dementia care and forwarded this

prior to the inspection. There were 43 residents in the centre at the time of inspection, which was at full occupancy.

Staff had strived to create an environment in the centre which generally promoted wellbeing for residents with dementia who were seen to be treated with respect. The person in charge informed inspectors that staff were committed to providing high quality care for residents with dementia who lived there and she said that care was regularly reviewed to ensure that best practice was being adhered to. Residents said that they enjoyed living in the centre. They said that they felt safe due to their relationship with staff and they were positive about many aspects of their care.

During the inspection, inspectors met with residents, relatives, the person in charge and a number of staff from all roles. Inspectors observed practices and reviewed documentation such as care plans, allied health care records and the activity programme. A sample of staff files and residents' files were checked for relevant documentation. Inspectors used a validated observation tool to observe and record staff interactions with residents, the results of which will be outlined in the report. Overall, inspectors found that residents received good care. However, there were a significant number of non-compliances with the regulations for the sector, which were set out in this report.

Findings of non-compliance included among others:

- inadequate cleaning practices and lack of supervision of same:
- poor hygiene practices in relation to the suitable placement of a sluice room:
- garda vetting clearance not available in the centre for all:
- incomplete and inadequate training provision:
- fire safety concerns:
- unsafe storage of oxygen and other uncontrolled risks:

The Standards set by the Health Information and Quality Authority (HIQA) to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2016 and the judgment framework for dementia thematic inspections formed the basis for the findings made by inspectors. Due to the number of significant un-assessed risks in the centre and inadequate cleaning practices this thematic inspection report also included findings on health and safety and risk management. A further regulation on notifications was also assessed in this report. Inspectors found that there were four areas of major non-compliance with regulations for the sector and two areas of moderate non-compliance. An urgent action plan was issued in relation to the non-availability of the required Garda Vetting clearance for personnel who worked in the centre. The actions required to bring the centre into regulatory compliance were set out in the action plan at the end of this report.

Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

Outcome 01: Health and Social Care Needs

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

There was evidence that residents had access to specialist services such as GPs, physiotherapy, occupational therapy, dieticians, speech and language therapists, chiropody, mental health services, dentists and opticians. The advice of the tissue viability nurse was sought for the management of skin breaks or pressure sores. Other specialist advice was reflected in care plans and palliative access was available at end of life. All care plans were accessible electronically to nurses, with some accessibility to care staff also. A transfer letter template was printed automatically from the electronic database when a resident required transfer to hospital. This ensured good communication between the care sectors. Care plans were updated every four months or more frequently when there was a change to a resident's circumstances. Dietary needs were catered for and the modified diets required by a number of residents with dementia were seen to be nicely presented. Residents with dementia were supported to eat their meals when this was necessary and the menu was prepared on a daily basis with choice at each meal.

A sample of prescribed medications for residents with dementia were reviewed by inspectors. The prescription sheet did not always align with the administration sheet. In one case, a dietary supplement was administered and signed as given on a regular basis, however this was not included on the prescription sheet. In addition there were some gaps noted where staff were required to sign for administering medicines.

The person in charge, the clinical nurse manager (CNM) and the administrator were responsible for conducting pre-admission assessments. However, on the day of inspection documentary evidence of pre-admission assessments and the common summary assessment sheets (CSARs) could not be located for a sample of residents with dementia. This meant that inspectors could not verify whether management had received sufficient and adequate information, prior to admission of residents with dementia, in relation to medical history, suitability of placement or whether the resident's view was taken into account as regards moving to the centre. Inspectors also found that a number of residents' personal files were stored in an unlocked filing cabinet in an unlocked cupboard.

Each resident with dementia was assigned a key worker on admission. The key worker was the nurse responsible for liaising with relatives and the resident to ascertain the resident's preferences, complete assessments and create the care plans. Inspectors found that key workers were allocated protected time to document care plans. Staff spoken with, however, said that the time allocated was insufficient which meant that some plans were not prepared within 48 hours of admission, as required under Regulation 5 (3), and in some cases could take a long period of time to complete.

Judgment:

Substantially Compliant

Outcome 02: Safeguarding and Safety

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

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

The centre had procedures in place to deal with resident and operational finances. A receipt book was in use to record all financial transactions. An administrator recorded all income and expenditure in spread sheets which were audited twice a week by an accountant. Resident transactions were summarized in a patient property account ledger and were also recorded electronically. External audits also took place on a regular basis according to the administration staff. Administration staff explained that the Friends of Cobh Hospital group was the main fundraising arm of Cobh Community Hospital, which was a voluntary organization. However, the provider did not have a policy in place regarding donations and gifts, which had led to confusion and ambiguity in respect of donations made for specific purposes. Receipts were not always issued to parties making donations. This policy was immediately developed and was in place before inspectors left the premises.

On previous inspections it was identified that not all staff had received up-to-date refresher training on safeguarding people from abuse. Training records viewed by the inspector on this inspection indicated that staff had undertaken training in this aspect of care. The majority of staff spoken with by the inspector demonstrated adequate

knowledge relevant to their role in relation to protecting residents from abuse. However, one staff member spoken with did not demonstrate sufficient knowledge of all aspects of training such as the types of abuse that could be perpetrated. Inspectors formed the view that on-line training without evaluation and discussion impacted on the recognition, notification and investigation of allegations of alleged potential abusive interactions in the centre. The person in charge was requested to send in retrospective notifications of any allegations which she had received. This was a regulatory requirement. In addition copies of such notifications and allegations had not been maintained in the centre. Training records also indicated that all staff had up-to-date training in responsive behaviour since the previous inspection. Inspectors were concerned however that almost all of the required mandatory training was 'on-line' training with no classroom or evaluation aspect to the training sessions. Sessions were undertaken by staff at home in most cases with some staff requiring support to access the courses and complete these on a computer when not all staff may have sufficient skills in that area. Appropriate training of staff was further discussed under Staffing, in this report.

There was an up-to-date policy in the centre to support staff in interventions for residents who exhibited behaviours which were related to the behavioural and psychological symptoms of dementia (BPSD). Individualised care plans on behaviour issues were available in a sample of residents' files reviewed. Inspectors observed staff interacting with residents in a patient manner. A number of staff members spoken with confirmed that training had been provided to them in how to support residents with BPSD, however, as training was accessed on-line inspectors could not comprehensively evaluate the effectiveness of training. The training had not been evaluated or tested by management. A review of records indicated that a number of staff had yet to receive this training which was a mandatory requirement of the regulations. Further training was seen to have been scheduled.

Judgment:

Non Compliant - Major

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

Cobh Community Hospital employed two staff to organise activities for a total of ten hours, two days each week on Monday and Friday. However, the person in charge said that one organised activity took place most days such as, bingo, music, arts, knitting, boccia and exercise. Inspectors found that attendance levels were often low and visits by relatives were seen to be recorded in the documentation as the only 'activity' for a large number of residents. No specific details were recorded in residents' notes of

attendance or engagement levels with activities. Activities which had been previously available in 2017 were still advertised on the current activity board. For example, advocacy meetings, Sonas; an activity to potentiate sensory appreciation for residents with dementia was not being offered, the boutique initiative for residents with dementia and baking, no longer took place. Some advertised activities took place fortnightly, such as art and 'talking mats' (a communication aid) while others were facilitated on a monthly basis such as the book club. Aromatherapy was the main activity for high and maximum dependency residents, in particular those with advanced dementia, to avail of in their bedrooms. A large number of residents with dementia were facilitated to avail of aromatherapy on the day of inspection.

Residents with dementia had opportunities to receive visitors in private. A parlour, furnished with high backed chairs, a fire place and antique furniture was located just inside the entrance door to the center. A recently renovated dining and lounge area was located in the main building while a kitchenette, balcony and conservatory were available in the 'Sosciúin' unit. During the inspection, inspectors found however, that these lovely spaces were seen to be mostly vacant when checked during the inspection. While resident and relative forums were scheduled every few months, minutes of meetings indicated the main topics discussed were activities and events. Issues such as the general day-to-day running or organisation of the centre were not discussed. No actions were recorded following feedback received during these meetings. Residents with visual and hearing impairments were provided with communication aids. For example, an inspector conversed with one resident using a magnetic wipe-clean board.

Advocacy services were not currently available as described in documentation reviewed and in discussion with the person in charge. The provider had previously had an arrangement in place with a voluntary advocacy service, which visited the hospital on a fortnightly basis, for individual and group sessions. However, this had been discontinued and the person in charge had planned to negotiate a new service level agreement to contract an advocate. Emails to this effect were seen from the advocate group requesting an update as to the advocacy arrangements for residents. Inspectors formed the view that a number of residents in the centre on the day of inspection would greatly benefit from the independent support offered by advocacy in the transition period when settling in to a new centre. Inspectors were not assured that the centre had complied with the requirements of Regulation 9 (3) (f) which specified access to an independent advocacy service. The person in charge stated that it would be early 2019 before negotiations were completed. In the meantime she undertook that individual appointments would be facilitated where necessary.

Staff said that residents were offered choice with regard to meals and where to eat. The menu was written on a white board in the corridor and residents were complimentary about the overall standard of food. All residents chose to take breakfast trays in bed. Approximately ten to fifteen residents attended lunch daily in the main dining room. Only five residents were seen to converse and enjoy teatime, 16.30, in the 'Sosciúin' kitchenette, while only one resident had their tea-time meal in the large main dining area at this time. The majority of residents sat by their bed at tea-time which meant that they missed the opportunity to engage and socialise with each other and staff.

Not all residents could avail of a choice of pharmacist however. As this only concerned

the needs of one resident it was reasonable to expect that the resident's choice could be facilitated as there was a very specific reason for the request. The person in charge was asked to engage with the resident in relation to this in accordance with Regulation 29(1).

Some residents were seen to come and go from the designated centre. These residents had been risk assessed as safe to leave the centre unaccompanied and were asked to sign in and out, to ensure that staff knew their location. A large secure enclosed garden was maintained adjacent to the centre. In this area colourful manicured flower beds were surrounded by suitable pathways, trees and nice garden seating. Residents stated they enjoyed outings to the garden in summer. However, only one resident was seen in the garden on the day of inspection despite the blue sky and nice weather. Some residents said that they would like to get out more in the fresh air. Residents were supported to vote and observe religious practices. The majority of residents attended mass in the main dining room on Thursdays and Sundays. There was an oratory available also. Mass was streamed daily to TVs in residents' bedrooms. The centre also facilitated visits by ministers from other religions.

The Quality of Interaction Schedule (QUIS) observation tool was used to record the interaction between residents and staff during five minute time frames. The majority experience of residents during a 30 minute observation period was then calculated. Interactions and practice during these time frames could be evaluated as; 'positive and connective', task orientated, neutral, 'protective and controlling' or institutional. One observation period was conducted during an exercise session with 12 residents in attendance. Residents with dementia were seen to laugh and enjoy the experience. Staff were attentive, considerate and made a meaningful connection with residents. Overall, this observation period consisted of positive connective care. Further periods of observation occurred at lunchtime. Residents with dementia were supported to eat their meals with dignity. Kindness and respect were shown by staff. Staff were seen to speak with residents and explain the food choice. This observation period also involved positive connective care. Inspectors found however that they were restricted in the number of group observations as residents were more likely to be sitting in their bedrooms.

Judgment:

Non Compliant - Moderate

Outcome 04: Complaints procedures

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

Inspectors viewed the policy and procedure for making, investigating and handling

complaints. The process was displayed at the entrance to the centre. The contact details of an independent appeals person was available on the complaints process and contact details for the ombudsman were also available.

A review of the complaints log indicated that complaints were responded to. Actions taken following complaints were documented in the complaints book.

The satisfaction or not of each complainant was not always clearly recorded, which is a regulatory requirement.

Judgment:

Substantially Compliant

Outcome 05: Suitable Staffing

Theme:

Workforce

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

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

Findings:

The senior management team was not always available in the centre. Senior managers were appointed to organise and supervise the operation and overall governance of the centre. On the morning of the inspection the nurse in charge on that day stated that she was not a member of the senior management team, but was the nominated person in charge for the day, as the other senior team members were rostered to be off-duty. Inspectors found that the staff member was proficient in clinical care duties and very familiar with residents' needs. However, the staff member had not been given a handover as regards the supervisory duties and was unable to source the documentation or inform inspectors of complaints updates and a number of other issues required for the inspection. Other staff told inspectors that they felt that senior management were not adequately accessible on-site on a daily basis. The person in charge, who came on duty later that morning, stated however that staff had disagreed with her proposal to ensure that there was increased management presence and supervision at the weekends.

Inspectors found that the levels of nursing staff, care assistants and cleaning staff levels were inadequate given the assessed needs of residents and size and layout of the building. Part of the building was old and reflected the era when it was built, with a number of different mezzanine levels and divergent room layouts. Two nurses and two care assistants were rostered at night for the 43 residents over three floor levels. In view of the fact that 33 residents had been assessed as requiring ski-sheet evacuation and ten residents required wheelchair evacuation in the event of a fire, inspectors formed the view this was an inadequate number of staff to safely evacuate all residents. All 19 residents on the upper level were not mobile and some required wheelchair

evacuation.

Dedicated cleaning staff were not present in the centre on a daily basis. Multi-task attendants were sometimes re-deployed to cleaning duties when not required for caring duties. Inspectors saw cleaning rota checklists which had been completed for routine and weekly deep cleaning including; floor sweeping and washing, bins, handrails, showers, wash basins, commodes, towel dispensers and windows. However, it was evident to inspectors, staff, residents and relatives spoken with that adequate cleaning was not taking place as certain areas of the centre were seen to be dusty and very dirty during the inspection. This was addressed further under the Premises outcome in this report.

As addressed previously most of the extensive portfolio of training was done on-line by staff and there was no evaluation of the effectiveness or understanding of training on site, despite this being a requirement of the centre's own training policy as well as a regulatory requirement. Management systems were not in place to ensure training was effectively monitored, in line with Regulation 23. For example, some staff were unfamiliar with how to respond in the event of a fire, despite the fact that training had been completed recently.

A sample of staff files were reviewed. Garda (police) vetting disclosures (GV) in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 and 2016 were available onsite for all staff employed by the designated centre. However, no GV disclosure was available for volunteers on work experience. In addition, volunteers did not have their role and responsibilities set out in writing and were not always included in relevant training. Some volunteers did not have safeguarding training despite undertaking individualised activity sessions in residents' rooms on a weekly basis.

An urgent action plan was issued to the provider in relation to the lack of GV for all staff and volunteers and this was recorded as a major non compliance with the requirements of the regulations, due to the potential serious consequences of the lack of this documentation for all those working in the centre.

Judgment:

Non Compliant - Major

Outcome 06: Safe and Suitable Premises

Theme:

Effective care and support

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

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

Findings:

Cobh community hospital was established in 1908. Some corridors and doorways were quite narrow in the older section of the building. Forty three residents were accommodated over two floors in single, double and quadruple rooms. The older and main part of the hospital comprised three floors. The ground floor was split into two levels with the upper level accessible via a platform type lift or by a stairs consisting of six steps. Bedroom accommodation on the ground floor comprised four single bedrooms and two twin bedrooms. Bedroom accommodation on the upper level of the ground floor comprised 1 single en-suite bedroom and one four-bedded en-suite room. Bedroom accommodation on the first floor comprised three single bedrooms, four twin bedrooms and two four-bedded rooms. The second floor was used primarily as office space but also contained the hairdressing salon. The first and second floors were accessible by a large elevator and by stairs. This older section was connected by a corridor and stairs to a more recently built section on a lower level. This newer 12-bedded section, was very nicely decorated and there was a lovely interactive atmosphere amongst residents and staff.

Communal space in the older part of the centre consisted of a large combined sitting room and dining room that had been newly constructed in more recent times. There was a parlour with comfortable seating that could be used by residents for some quiet time or to meet with visitors in private. There was an oratory on the first floor.

Communal space in the newer part of the centre comprised a dining room, a sitting rooms and a conservatory. There was also a secure outdoor area and a roof garden. The newly constructed dining room contained a small kitchenette and five colourfully painted tables and chairs. Walls were decorated with large murals of Cobh train station and harbour. The dining room opened out into a bright, relaxed seating area with 15 comfortable high-backed chairs overlooking views of Cobh and the harbour.

However, improvements were still required, particularly in the usage of these rooms and in the provision of directional signs for residents with dementia, to support them in navigating the various areas within the centre. This remained particularly relevant in light of the diverse design and layout of the premises as a result of a number of extensions.

Inspectors formed the view that adequate and regular cleaning of the building was not taking place. Heavy dust was found along corridors and behind doors in the older section of the building. Skirting and architraves were dirty, dusty or damaged. Stairwells contained hanging cobwebs and dead insects. Dead insects were also seen behind the furniture in the under-utilised conservatory/storage room. Inspectors found that bathrooms had not been cleaned adequately with staining and rust visible on toilets, sinks and paper towel dispensers. In one bathroom the toilet backrest was damaged and detached. A backrest on this toilet had come loose and rusted metal supports were now facing towards the back of a sitting resident. This had not been risk assessed and had the potential to cause serious injury to vulnerable residents. Wheelchair foot-rests were also left on the ground in the corner of this bathroom, which could potentially be picked up by a resident with responsive behaviour. This had not been risk assessed. All foot pedal bins throughout the older section of the building were rusted and hadn't been cleaned properly. When inspectors moved these bins, in the bathrooms, items such as tissues, disposable gloves, dust and other waste were found on the floor underneath.

Lack of access to showers had been an ongoing issue for residents on the top floor of the main building, according to staff who spoke with inspectors. Until recently, just one shower was available for 19 residents, one shower having been broken for an extended period of time, Shower outlets were seen to be dirty and dusty and it was difficult for inspectors to ascertain how often they were used as on some days only one resident from the 43 had been supported to have a shower. Staff said that in the weeks prior to the inspection the showers had been repaired but access problems remained due to their location at a distance from residents' bedrooms. Twelve residents were accommodated in 12 single bedrooms in a newer section of the centre that was adjoined to the Park Road Day Centre, four of which had en-suite shower rooms.

Inspectors found that an accessible shower room and toilet on the 'Siochán' unit was used as storage for commodes and a sluice room was located within this shower room. This was separated from the shower area by a sliding door which was impeded from closing fully due to the position of the radiator on the inside wall. This sluice area had not been cleaned in a long time, as a pair of flip flops covered in dirt and mould were found behind a pipe on the ground. The placement of a sluice room within a shower room presented a very significant infection control risk as infectious spores from the bedpan washer would infiltrate the air in the shower room with the potential for cross infection. Risks were addressed under the health and safety dimension of this report.

Judgment:

Non Compliant - Major

Outcome 07: Health and Safety and Risk 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 following significant risks were identified by inspectors, the majority of which had not been risk assessed:

- Risks of cross infection due to the aforementioned location of a sluice room and the storage of wheelchairs in this same shower room;
- _The risk of infection due to the dirty premises.
- The potential injury from rusted items.
- Oxygen was found stored on corridors, in an open cupboard and in bedrooms without proper precautionary signage in place.
- Nasal prongs and masks were not always appropriately covered when not in use next to residents' beds and presented a potential infection control risk.
- Long leads were seen to hang down from lamps and televisions, which needed to be

secured to prevent an accident.

-Some doors to secure areas were left open or locks were damaged. The laundry room door didn't self-close.

-A door was left open to a lift hydraulic system which presented an electrical shock hazard.

-An open cupboard with a damaged lock was seen to store confidential resident files and oxygen cylinders. This was a data protection hazard as well as a hazard from the potential combustibility of oxygen cylinders.

-One of the washing machines in the laundry required repair or replacement. One machine was reported to often break down and a laminated sign was found nearby to indicate when the machine was broken. Service documentation was seen for these.

-A section of floor covering on the 'Talkara' unit corridor was lifting. The senior nurse explained they had tried to repair the flooring but there seemed to be an ongoing issue with rising damp.

-A corridor leading to the conservatory in the newer 'Sosciúin' section was used to store a hoist and impeded access to a stairs and fire exit. The conservatory itself was cold and used to store chairs, wheelchairs and frames.

- During the summer when the patio doors were open upstairs the pest control officers were called to the centre to investigate pests having gained access the centre.

-The risk of a breach of data protection.

Judgment:

Non Compliant - Major

Outcome 12: Notification of Incidents

Theme:

Effective care and support

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

No actions were required from the previous inspection.

Findings:

Not all notifications were submitted to the Chief Inspector in accordance with the requirements of Regulations. Where there was a suspicion or allegation of abusive interactions these had not been notified to the Chief Inspector.

Judgment:

Non Compliant – Major

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:

Mary O'Mahony
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 report¹

Centre name:	Cobh Community Hospital
Centre ID:	OSV-0000558
Date of inspection:	11/10/2018
Date of response:	18/12/2018

Requirements

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

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

Outcome 01: Health and Social Care Needs

Theme:

Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Not all care plans were completed within the time frame set out in the regulations.

1. Action Required:

Under Regulation 05(3) you are required to: Prepare a care plan, based on the assessment referred to in Regulation 5(2), for a resident no later than 48 hours after that resident's admission to the designated centre.

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

Please state the actions you have taken or are planning to take:

Offer of paid time to complete outstanding care plans has been on offer at all times and has been taken up by some staff. Support to complete Care Plans is permanently available. Additional Care Planning training will be provided to all nursing staff so that they are upskilled to enable the regulatory requirements to be met within legislated time frame.

Proposed Timescale: 25/02/2019

Theme:

Safe care and support

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

Not all records concerning residents were stored in a safe manner.

2. Action Required:

Under Regulation 21(6) you are required to: Maintain the records specified in paragraph (1) in such manner as to be safe and accessible.

Please state the actions you have taken or are planning to take:

Storage of residents' personal files are stored in locked cupboard completed 12th October 2018.

Proposed Timescale: 12/10/2018

Theme:

Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

The provider failed to ensure that all medicinal products were prescribed before administration and that all staff signed when administering medicines.

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:

Medication management training is provided regularly by Pharmacist and additional education days provided offsite. It is clear that the Medication management training will need to be increased to ensure upskilling in order to meet the requirements. This extra training has commenced with two nurses having completed the module at MUH in November 2018 and will continue until all staff have attended. This is dependent on

availability.

Proposed Timescale: 30/03/2019

Outcome 02: Safeguarding and Safety

Theme:

Safe care and support

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

The policy on personal property and personal finances did not contain guidance to management and staff on the receipt of donations which was particularly relevant in this centre.

4. Action Required:

Under Regulation 04(2) you are required to: Make the written policies and procedures referred to in regulation 4(1) available to staff.

Please state the actions you have taken or are planning to take:

Policy Document drawn up and available to all staff

Proposed Timescale: 12/10/2018

Theme:

Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

This mandatory training was accessed on line and undertaken individually by staff. Training was not evaluated or reviewed and there was no classroom element to training which did not assure inspectors that this training was sufficient to address the individual needs of residents in the centre.

5. 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:

As agreed classroom training will commence in January 2019 for Behaviour that is Challenging. This module will also be continued online to reinforce the information. Online evaluation has commenced by all staff and when complete an analysis will be undertaken to review suitability.

Proposed Timescale: 30/03/2019

Theme:

Safe care and support

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

This mandatory training was accessed on line and undertaken individually by staff. a staff member did not demonstrate sufficient knowledge of the types and indicators of abuse to assure inspectors that this training was sufficient. Training was not evaluated or reviewed and there was no classroom element to training.

6. 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:

As agreed, classroom training will commence in January 2019 in Prevention, detection and response to abuse. This module will also be continued online to reinforce the information. Online evaluation has commenced by all staff and when complete an analysis will be undertaken to review suitability

Proposed Timescale: 30/03/2019

Theme:

Safe care and support

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

The registered provider failed to ensure that all the records required to be maintained in the centre were available to view by inspectors as required under Schedule 3 (4) (j): and Schedule 4 (7) (1) (h):

- in particular records of investigations into alleged potentially abusive interactions.
- copies of notifications of the alleged events.

7. Action Required:

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

Please state the actions you have taken or are planning to take:

Retrospective reporting completed and submitted as requested. All recording of investigation into alleged potentially abusive interactions will be notified and kept in designated centre.

Proposed Timescale: 12/10/2018

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

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

Residents were not seen to use the conservatory which was cold and uninviting.

Residents were not seen to adequately use the new sitting/dining room particularly at tea time when only one resident was seen to have his tea there.

Therefore residents were not facilitated to avail of these rooms for recreation and occupation as well as for the social occasion of meal times.

8. Action Required:

Under Regulation 09(2)(a) you are required to: Provide for residents facilities for occupation and recreation.

Please state the actions you have taken or are planning to take:

Residents are encouraged to make use of recreational areas such as the Day/Dining rooms and Conservatory on a more regular basis. Heating has been increased in Conservatory and redecoration to make more user-friendly has been implemented.

Many Residents choose to take their Tea at the bedside even though they are encouraged to go to the Dining Room.

Proposed Timescale: 18/12/2018

Theme:

Person-centred care and support

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

Inspectors were not assured that the activities on the activity schedule were in line with those offered in the centre. A number of activities were no longer being offered despite being advertised on the activity schedule during the inspection.

In the absence of adequate documentation it was difficult to ascertain the participation level of residents in activity sessions and whether activities were suited to their needs and capabilities.

9. Action Required:

Under Regulation 09(2)(b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests and capacities.

Please state the actions you have taken or are planning to take:

All activities offered have been reviewed and amended where necessary. The Activity Leaders who provide 20 hours in total of activities to Residents are varied and cover all levels of capability. Music, Bingo, Knitting, Aromatherapy and Gentle Exercise are scheduled weekly in addition to the In-house Activities. Activity Leaders will ensure that attendance at activities is recorded for each Resident on a daily basis

Proposed Timescale: 18/12/2018

Theme:

Person-centred care and support

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

A resident's right to chose a pharmacist was not facilitated.

10. Action Required:

Under Regulation 09(3)(a) you are required to: Ensure that each resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.

Please state the actions you have taken or are planning to take:

Discussion will take place with Resident regarding their choice. As Pharmacy is currently out for tender, it is possible that the problem could be resolved with the outcome.

Proposed Timescale: 31/01/2019

Outcome 04: Complaints procedures

Theme:

Person-centred care and support

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

The satisfaction or not of all complainants was not recorded.

11. 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:

All complaints will be recorded and outcome listed

Proposed Timescale: 15/10/2018

Outcome 05: Suitable Staffing

Theme:

Workforce

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

The policy on staff training had not been fully implemented or adopted.

12. Action Required:

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

Please state the actions you have taken or are planning to take:

All training is very comprehensive and is not signed off until a pass is achieved. Exceptions to this are the practical components of moving and handling and infection control. Fire warden and fire evacuation procedures are also completed on a hands on practical session in addition to the online education. Evaluation of the effectiveness of understanding of training on line is currently underway. When completed this will be analysed for effectiveness.

Proposed Timescale: 18/12/2018

Theme:

Workforce

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

The registered provider had failed to ensure that the number and skill mix of staff was appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre. This included the allocation of staff on night duty, staff documentation time and cleaning staff availability.

13. Action Required:

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

Please state the actions you have taken or are planning to take:

- Fire evacuation training scheduled
- Classroom training scheduled for prevention, detection and response to abuse and behaviour that is challenging. Volunteers to be included in this training.
- Evaluation of all on-line training to be evaluated by all staff and analysed for level of effectiveness and comprehension
- Staff have allocated appropriate protected time for documentation
- Additional hours allocated for support staff on a daily basis
- Management will be rostered during weekends

Proposed Timescale: 25/02/2019

Theme:

Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement

in the following respect:

The person in charge had failed to ensure that staff had access to appropriate training.

14. Action Required:

Under Regulation 16(1)(a) you are required to: Ensure that staff have access to appropriate training.

Please state the actions you have taken or are planning to take:

Fire training re-scheduled so that all staff including those people who have had recent training will remember the content and directives of course and recognise how to respond in the event of a fire.

Proposed Timescale: 18/12/2018

Theme:

Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Inspectors were not assured that all staff were appropriately supervised due to the lack of senior personnel on weekends and on night duty.

15. Action Required:

Under Regulation 16(1)(b) you are required to: Ensure that staff are appropriately supervised.

Please state the actions you have taken or are planning to take:

Management to be in attendance weekends and night duty

Proposed Timescale: 15/12/2018

Theme:

Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Volunteers did not have their duties set out in writing.

16. Action Required:

Under Regulation 30(a) you are required to: Set out in writing the roles and responsibilities of people involved on a voluntary basis with the designated centre.

Please state the actions you have taken or are planning to take:

Job Specification Document to be drawn up for all areas which involve volunteers.

Proposed Timescale: 20/10/2018

Theme:

Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

The person in charge failed to provide a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 and 2016 for people involved on a voluntary basis with the designated centre.

17. Action Required:

Under Regulation 30(c) you are required to: Provide a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 for people involved on a voluntary basis with the designated centre.

Please state the actions you have taken or are planning to take:

Submitted the required documentation by the specified date.

Proposed Timescale: 19/10/2018

Outcome 06: 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:

The registered provider had failed to provide premises which conformed to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre: in particular:

The provision of appropriate storage areas:

The provision of appropriate sluicing facilities:

The provision of sufficient accessible showers:

Failure to maintain a clean premises and safe floor covering:

18. 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:

Appropriate storage area provided and items unrequired removed from shower area

All showers accessible

Sluicing facilities to be relocated

Deep Cleaning schedule reviewed in order to ensure a clean premises.

Floor covering to be renewed in Talkara corridor.

Proposed Timescale: 30/01/2019

Outcome 07: 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:

The registered provider failed to ensure that the risk management policy set out in Schedule 5 included hazard identification and assessment of risks throughout the designated centre. A number of these risks are listed in the report.

19. 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:

Garda Clearance is obtained for all employees and volunteers prior to commencement of duties at designated centre

Proposed Timescale: 11/10/2018

Theme:

Safe care and support

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

The registered provider failed 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.

20. 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 rusted items replaced.
- Wheelchairs not stored in bathroom.
- Deep cleaning to be continued on a more regular regime.
- Oxygen storage now identified with signage and stored appropriately in clinical room and where required on ward.
- Nasal prongs and masks covered and stored when not in use
- Long leads moved so no longer hanging down
- All doors to secure areas are undamaged/repaired

- Door to hydraulic lift closed and locked at all times
- Locks secured on doors containing oxygen and resident files
- Washing machines are regularly serviced and repaired if required. These machines are heavy duty machines and do break down from time to time with wait on repair time minimal.
- Section of floor has recently been replaced and repaired and there is no rising damp possible on a first floor. A builder has checked the flooring and has been engaged to renew the flooring area to ensure it is completely safe.
- Heat is maintained in Conservatory and all wheelchairs and frames have been removed
- Hoist has been removed from access to stairs.
- Doors will remain closed so that there is no access to any form of pest.
- Builder engaged to relocate sluice
- Deep cleaning of Conservatory completed and maintained

Proposed Timescale: 30/12/2018 with building works to floor and relocation of sluice 30/01/2019

Proposed Timescale: 30/01/2019

Theme:

Safe care and support

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

A fire-safe door was seen to be faulty which would have a significant impact on the integrity of the doors in the event of a fire,

21. Action Required:

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

Please state the actions you have taken or are planning to take:

All fire doors are undamaged

Proposed Timescale: 15/10/2018

Theme:

Safe care and support

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

A number of staff had not been instructed on how to evacuate residents down the stair wells.

In view of the fact that there were a number of mobile residents inspectors were not assured that the evacuation method in personal evacuations plans had been appropriately assessed.

For example. 33 residents had been assessed as requiring ski-sheet evacuation and 10 residents had been assessed as requiring wheelchair evacuation. Staff who had been trained as fire wardens were initially unaware that the training they had received was in relation to being a fire warden.

22. 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:

External trainer to provide training in fire prevention and emergency procedures, including evacuation procedures rescheduled in addition to recent fire warden training.

Proposed Timescale: 13/02/2019

Outcome 12: Notification of Incidents

Theme:

Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Notifications were not submitted as per Regulation 7 (1) (h).

23. Action Required:

Under Regulation 31(1) you are required to: Give notice to the chief inspector in writing of the occurrence of any incident set out in paragraphs 7(1)(a) to (j) of Schedule 4 within 3 working days of its occurrence.

Please state the actions you have taken or are planning to take:

Notification submitted retrospectively. All occurrence of any incident involving suspicion of an allegation of abusive interactions involving Residents will be reported within 3 working days.

Proposed Timescale: 11/10/2018