

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Cahercalla Community Hospital & Hospice
Centre ID:	OSV-0000444
Centre address:	Cahercalla Road, Ennis, Clare.
Telephone number:	065 682 4388
Email address:	info@cahercalla.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Cahercalla Community Hospital Company Limited By Guarantee
Lead inspector:	Catherine Sweeney
Support inspector(s):	Una Fitzgerald
Type of inspection	Unannounced Dementia Care Thematic Inspections
Number of residents on the date of inspection:	101
Number of vacancies on the date of inspection:	5

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 inform a registration decision. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
23 May 2019 11:00	23 May 2019 16:30
24 May 2019 08:00	24 May 2019 17:30

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	Substantially Compliant	Non-Compliant - Moderate
Outcome 02: Safeguarding and Safety	Substantially Compliant	Compliant
Outcome 03: Residents' Rights, Dignity and Consultation	Substantially Compliant	Non-Compliant - Moderate
Outcome 04: Complaints procedures	Substantially Compliant	Non-Compliant - Major
Outcome 05: Suitable Staffing	Substantially Compliant	Compliant
Outcome 06: Safe and Suitable Premises	Substantially Compliant	Substantially Compliant
Outcome 07: Health and Safety and Risk Management	Not applicable	Substantially Compliant
Outcome 08: Governance and Management	Not applicable	Non-Compliant - Major

Summary of findings from this inspection

Cahercalla Community Hospital and Hospice is a registered designated centre that provides care for a maximum of 106 residents. On the days of inspection, there were a total of 26 residents with a formal diagnosis of dementia. The person in charge informed the inspectors that there were also residents in the centre who had symptoms of dementia without having a formal diagnosis. Inspectors tracked the care pathways of residents with dementia and spent periods of time observing staff interactions with residents. A validated observational tool, the quality of interactions schedule (QUIS) was used to rate and record the quality of interactions between staff and residents, with specific emphasis focused on residents who had dementia.

Documentation such as care plans, clinical records, policies and procedures, and staff records were reviewed.

This dementia thematic inspection focused on the care and welfare of residents who had dementia. The provider completed a self-assessment and compared the service with the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013 and the National Standards for Residential Care Settings for Older People in Ireland (2016). The inspectors also reviewed the provider's application to increase the designated centre's capacity from 106 to 113 beds.

The governance and management systems in place for this designated centre were poor and required significant improvement to ensure that the centre operated in accordance with the Health Act 2007 as amended. In addition, findings on the day evidenced that the management team displayed poor knowledge of their responsibilities as set out in regulation requirements. This is evidenced by:

- The management team had failed to apply for an application to vary condition 8 of the centre registration that had stated that reconfiguration works in the centre would be completed by the 31 December 2018.
- The management had failed to adhere to its own statement of purpose (SOP) by using a room designated as storage as a bedroom. This was an unregistered bedroom and a breach of Condition 5 of their registration.
- The management team demonstrated poor knowledge and understanding of the identification and management of complaints and was operating outside of their complaints policy.
- The centre did not issue contracts of care to five residents admitted for short term care.
- The organisation of activity provision required significant development.
- There was poor evidence of residents being consulted about the organisation of the centre.

Repeated actions from the last inspection, including the provision of activities to all residents and an assessment and care planning process review, had not been fully addressed.

The inspectors followed up on unsolicited information that had been received by the Office of the Chief Inspector since the last inspection. This information related to the management of complaints. Findings evidenced that the information received was substantiated. Inspectors also followed up on the action plan from the last inspection and found that while some progress had been made, Regulation 9 on Residents' Rights and Regulation 5 on Individual Assessment and Care Plan required further development to be brought into full regulatory compliance.

A newly refurbished unit that includes two single rooms, three double rooms, a day room and a dining room had been added to the centre. The building work had been completed to a high standard and is discussed in the body of the report.

During this inspection, of the eight outcomes assessed, there were two major non

compliances, two moderate non-compliances and two substantial compliance and two which were compliant. The findings are discussed in the body of the report and improvements are outlined in the action plan at the end for response.

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):

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

Findings:

Inspectors focused on the experience of residents with dementia and tracked the journey prior to and from admission into the centre. Files were reviewed on specific aspects of care, such as nutrition, wound care, mobility, access to health care and supports, medication management, and end of life care.

Inspectors were satisfied that residents' overall health and social care needs were met. Inspectors spoke to a number of residents over the two days of inspection. Residents spoken with stated that they were very satisfied with the care they received in the centre. Residents reported that they felt safe, adding that they were treated very well.

A review of the assessment of residents' health and social care needs and care plan process was conducted. A range of up-to-date risk assessments were completed for residents including the risk of developing pressure ulcers falls risk, nutritional assessment, dependency and moving and handling. However, Inspectors noted that assessment of specific needs of residents was not always completed. For example, a resident who had complex pain and had been administered pain medication had no formal pain assessment documented.

The care plans were based on the activities of residents' daily lives. While some care plans were well developed, others were not person-centred and did not guide care. In particular, care plans relating to residents with a diagnosis of dementia did not identify the residents' symptoms of dementia and the interventions required to manage these symptoms. Inspectors noted that the care plans relating to end of life care for residents with dementia also lacked person-centred detail and required further development.

A process of care plan review was in place. Resident and family involvement was not clearly identified in the care plans. Residents told inspectors that they were not clear about their plan. The changing needs of residents were not identified in care plan reviewed by inspectors.

A full range of services were available to the residents including speech and language

therapy (SALT), physiotherapy, occupational therapy (OT), dietetic services, tissue viability and psychiatry of later life. Chiropody and optical services were also provided. Eligible residents were supported to avail of the national health screening programme. The inspectors reviewed a sample of residents' records and found that residents had been referred to these services, regularly reviewed and results of appointments were written up in the residents' notes.

There was a policy for monitoring and recording the nutritional intake of residents with dementia which is put into practice. Each resident with dementia was provided with a well-balanced, wholesome and nutritional diet. Residents were offered choice at all meals. Assistance was offered to residents with a diagnosis of dementia in a discreet and respectful manner. Snacks are available throughout the day. Residents were very positive about the availability and the quality of the food in the centre.

The centre has written policies and procedures in relation to medication management. Safe medication practices were observed by inspectors. There is a robust system of reviewing and monitoring medication management.

Judgment:

Non-Compliant - Moderate

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:

Measures to protect residents from being harmed or suffering abuse were in place. Policies and procedures were in place for the prevention, detection and response to allegations of abuse. Staff who spoke with the inspectors confirmed that they had received training on safeguarding vulnerable adults and were familiar with the reporting structures in place. In addition, staff confirmed that there were no barriers to raising issues of concern.

A review of training records indicated that staff were provided with up-to-date knowledge and skills, appropriate to their role, to enable them to manage responsive behaviours. There was good access to allied healthcare professionals and advice received from the psychiatry of later life team (POLL) was taken on board which had a positive outcome for residents. The care plans for residents did not guide care. Staff identified two residents who were exhibiting responsive behaviours. The staff were observed to be knowledgeable regarding residents' behaviours. However, the resident records did not include a description of the types of behaviours which the resident sometimes demonstrated and did not provide guidance on strategies to prevent the behaviours and to calm the resident if the behaviour escalated. A review and further development on the content of care plans is required to ensure that this key information

on how to best manage any incidents is documented. This is actioned under Outcome 1 Health and Social Care needs.

The centre had a policy on the use of restraint. The centre actively promoted a restraint-free environment. Staff were clear that restraint measures were a last resort and only considered when less restrictive interventions had not achieved the desired outcome to keep a resident safe. Resident records reviewed met with regulatory requirements.

There were systems in place to safeguard residents' money. The centre acted as a pension agent for six residents. The administrator confirmed that the centre is in compliance with the department of social welfare guidelines. The money was held in a resident account separate to the centre's account. In addition small amounts of money are kept in the centre for resident personal use. The staff member responsible for residents' money explained the systems regarding documenting transactions. There were clear systems in place to ensure that residents could access their money in a timely manner. Records reviewed evidenced signatures against all transactions.

Judgment:

Compliant

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

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

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

Findings:

Residents were facilitated to exercise their civil, political and religious rights. Residents had been facilitated to vote in the referendum and elections that occurred at the time of the inspection. Residents have access to a local newspaper only. The national papers were not available in the centre unless requested by an individual resident for their personal use only. Residents listen to the local radio station to get their information on what is happening in the local community.

Resident meetings were held. Inspectors spoke with three residents who stated that they did not feel that they were consulted with on the running of the centre. The records of the residents meetings did not evidence that residents were consulted about how the organisation of the centre is planned and run. In addition, the records did not indicate how many residents attended the meetings. Inspectors were not able to ascertain how the centre seeks feedback from residents and family on the management of the centre. An independent advocacy service was promoted on the centre's noticeboard; however there was no evidence that residents were aware of how to access information in relation to their rights.

There were arrangements in place for each resident to receive visitors in private.

The inspectors spoke with the activities personnel. There was an activities schedule on display that was reviewed and updated each week. Inspectors were informed that the staff did not organise outings for residents as the uptake was poor in the past. The centre organises garden events which residents attend. There was an emphasis on music and entertainment provided by volunteers. An inspector observed an afternoon session of music that was enjoyed by the residents that attended. The atmosphere in the room was welcoming and inclusive of all. Residents sang along. Staff were mostly observed speaking to residents in a polite, respectful and friendly manner, using residents' names and explaining what was happening during assistance. Choice was offered when snacks and drinks were being served. Staff and resident interactions were kind and patient.

The activities staff stated that they conducted one-to-one activities when possible. As part of the dementia focus, the inspectors spent periods of time observing the quality of interactions between staff and residents. Some residents were observed sitting for long periods without any social engagement. Residents told inspectors that there was limited interaction with staff, and they were not aware of the activities that were taking place. While some residents had opportunities to participate in activities, improvements were required to ensure that all residents were provided with appropriate social and recreational engagement suitable to their assessed and stated interests. This is a restated issue from the previous inspection.

Inspectors had concerns in relation to the dignity and privacy of two residents who shared a small double room in the garden wing of the centre. This issue was discussed with the management team on the day of inspection.

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 found significant gaps in the management of complaints within the centre. There was no clear management structure in relation to the lines of authority and accountability in relation to the management of complaints.

There was a policy and a procedural guide for the management of complaints within the centre and it is made available to the residents in the resident guide and in prominent positions around the centre. However, this policy was not implemented in practice. For example, unsolicited information that had been received by the Chief Inspector in relation to a complaint made by a family. Inspectors were informed that correct

procedures had been followed, in line with the centre's policy. However, a complaints log was not completed, reviewed and updated. There was no documentation available to support any of the actions taken by the management team to resolve the issues. The outcome and satisfaction level of the complainant was not recorded.

Inspectors were informed by the person in charge that any verbal complaints received by the centre were managed and resolved immediately but were not documented.

The management team displayed poor insight into what constitutes a complaint and the identification and management of complaints. Inspectors spoke with a member of the management team who had been involved in the management of a complaint but had not documented any of the interventions in relation to the issue. There was no record of investigation in relation to whether these complaints has been addressed in a timely and appropriate manner.

There was no nominated person in place to deal with complaints.

A full review of the complaints management system was required.

Judgment:

Non-Compliant - Major

Outcome 05: Suitable Staffing

Theme:

Workforce

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

No actions were required from the previous inspection.

Findings:

A number of staff files were viewed and found to be compliant with regulatory documentation requirements. The person in charge confirmed that all staff had a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 and 2016 on file.

The education and training available to staff enables them to provide care that reflects up-to-date, evidenced based practice. The training records reviewed by the inspectors evidenced no gaps in mandatory training. All staff had completed mandatory training in safeguarding and safety, annual fire safety training and manual handling training. There was a robust system of staff appraisal in place.

Evidence of current professional registration for registered nurses was seen by the inspector. Recruitment and induction procedures were in place. Staff spoken with felt supported by the management team. The clinical nurse managers supervised staff appropriate to their role. The inspector reviewed actual and planned rosters for staff, and found that staffing levels and skill mix were sufficient to meet the needs of residents. Ongoing review of resident dependency and staffing levels were monitored to

inform staffing levels and skill mix. Staff spoken with confirmed that they had sufficient time to carry out their duties and responsibilities.

All volunteers in the centre had their roles and responsibilities documented and a vetting disclosure on file.

Judgment:

Compliant

Outcome 06: Safe and Suitable Premises

Theme:

Effective care and support

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

No actions were required from the previous inspection.

Findings:

The design and layout of the centre was not in line with the centre's statement of purpose. A reconfiguring of rooms in the centre since the last registration had led to the conversion of a room that was designated for storage into a resident bedroom. This was an unregistered bedroom, not identified in the statement of purpose. The management team had not informed the Office of the Chief inspector of the changes in the layout of the designated centre. This issue is addressed under Outcome 8, Governance and Management.

The three-storey building accommodates residents in five separate units. A newly refurbished area of the centre is a continuation of the ground floor level and is finished to a high standard. It consisted of two single rooms, three double rooms, a large dayroom and a large dining room. This area included an enclosed garden with safe and suitable walking surface and seating. This garden is fully accessible to residents on the ground floor unit of the centre. There is a sufficient number of toilets, bathrooms and showers to meet the residents' needs. Assisted toilets contained grab rails in the bath, shower and toilet areas. Toilets have non-slip floors and are step-free and spacious enough to accommodate residents and assistants.

The premises and grounds were well maintained with suitable heating, lighting and ventilation. The floor covering throughout the centre was safe and well maintained. The centre was clean and suitably decorated. There is adequate storage for resident's belongings. There was an attractive chapel in the centre that was open and seen to be used frequently. Inspectors observed that residents with a diagnosis of dementia were encouraged and supported to furnish their rooms with personal items.

The size and layout of a twin bedroom in the garden unit was restrictive and did not allow free movement around furniture and equipment. This was discussed with the management team on the day of inspection.

There was a lack of signage to direct residents around the centre. Inspectors discussed

the use of additional signage to meet the needs of ambulant residents with a diagnosis of dementia. The addition of directional signage throughout the centre would support residents to navigate the centre and locate their bedrooms, indoor and outdoor communal areas and bathroom facilities. There were clocks available in every room of the centre; however, there were no calendars or orientation boards to orientate residents with dementia to time and place.

There were painted murals covering the fire door access out of this unit. These murals resulted in emergency exit not being clearly identified. Inspectors were also concerned at the potential risk posed by a number of open stairwells in the centre. The safety concerns relation to the premises is addressed under Outcome 7 Health and Safety and Risk Management.

Judgment:

Substantially Compliant

Outcome 07: Health and Safety and Risk Management

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

The centre had policies and procedures relating to health and safety within the centre and were last reviewed in May 2018. The centre had a suite of risk management policies that included the requirements set out in Regulation 26(1). The centre had a risk register last updated in March 2019 that was kept under constant review by the management team. The register identified areas of risk within the centre and the control measures in place to minimise any negative impact on residents.

Arrangements consistent with the national guidelines and standards for the prevention and control of healthcare associated infections were in place. Staff had access to personal protective equipment such as aprons and gloves, hand washing facilities and hand sanitisers on corridors. Staff were seen using these facilities between resident contact. Signs were on display to encourage visitors to use the hand sanitisers.

Household staff spoken with were knowledgeable on the system in place to ensure that the cleaning regime minimised the risk of cross infection. The cleaning schedule included the routine daily chores but also contained detail of a deep cleaning schedule. Residents spoken with confirmed that their bedrooms were cleaned on a daily basis. The inspector observed that the standard of cleanliness throughout the building was of a high standard.

Fire safety records were reviewed by the inspectors. There was an 'Internal management of emergency' policy in place which included detail in relation to fire management. A fire safety register was available for inspection. A record of yearly

servicing of the fire safety system within the building and a record of equipment maintenance was available for review. All staff had received training and were aware of evacuation procedures. A personal evacuation plan was in place for all residents. A record of fire drills was in place which detailed the timing of compartment evacuation and lessons learned.

Issues relating to the smoking room raised in the previous inspection report had been addressed.

A door in the dining room of the newly renovated unit was identified by emergency lighting as being an emergency escape door. The door was locked with a key and opens inwards. During the inspection the general manager contacted the architect who confirmed that this door was not an emergency access. The signage and lighting for this door was removed on the second day of the inspection.

A number of issues required review:

- Inspectors noted an emergency exit door opening into an enclosed internal garden. The enclosed garden was only accessible through an iron gate which was locked with a bolt. Keys for this gate could only be accessed at reception. This meant that there was no escape route through the emergency exit.
- A number of open stairwells in the centre required a risk review.
- Fire doors in the Garden wing upper floor had been painted as a dresser. This resulted in the fire escape route being unclear.
- Floor plans displayed on the corridors did not accurately reflect the layout of the centre. Two fire doors had been decommissioned by the management team. The self-closing features of the door had been removed. The doors continued to be labelled as fire doors.

Judgment:

Substantially Compliant

Outcome 08: Governance and Management

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The centre had policies in place which were in line with the requirements of Schedule 5 of the regulations. There was a system of auditing areas such as medication management, infection control, incidents and falls, and care plan documentation. These audits identified trends and key recommendations for practice. Quality and safety meetings were scheduled monthly and the recommendations from audits were

discussed. There was an appropriate proposed schedule for admission and staffing for the admission of residents to the newly refurbished unit. An annual review of the service for 2018 was available but did not include evidence that the review was prepared in consultation with residents and their representatives.

While management systems were in place, inspectors were not satisfied that the systems were sufficiently robust to ensure that the service provided was safe, appropriate, consistent and effectively monitored. The findings on this inspection relate to:

- Rooms in the centre had been reconfigured. An unregistered bedroom was in use in the centre. The changes to the layout of the centre were not communicated to the Office of the Chief Inspector. Management had poor knowledge and understanding of the requirements of the Health Act.
- Failure to comply with regulation in relation to the management of complaints. A number of unsolicited pieces of information were received by the Office of the Chief inspector since the last inspection. The information related to the communication of concerns from relatives to the management team. The management team were aware of these concerns but had failed to record the complaint including any detail of any investigation, the outcome, or any action taken on foot of the complaint in order to improve the quality of care. There was no clear management structure in relation to the lines of authority and accountability in relation to the management of complaints.
- The centre did not provide contracts of care to residents receiving short term or palliative care.

Findings from this inspection raised concern on the management team's understanding of the Health Act, specifically the conditions of registration of this designated centre. The centre is registered as per Condition 7 to accommodate 106 residents. The management team informed the inspectors that in April 2018, a twin room on St. Joseph's ward had been converted to a dining room, bringing the capacity of the centre to 104. Inspectors were informed by the management team that they were operating at full capacity of 105 residents, having converted a room that was designated as a storeroom into a resident bedroom. This meant that the registered provider had breached Condition 5 of their registration which is a breach of the Health Act 2007.

The management team informed the inspectors of a number of resident issues which had resulted in conflict between the centre and residents' representatives. The issues were not documented as complaints. No record was kept in relation to interventions taken to address issues raised. The management of these issues was not clear and transparent.

The organisation of activity provision required significant development, the findings are described under rights, dignity and consultation.

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:

Catherine Sweeney
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:	Cahercalla Community Hospital & Hospice
Centre ID:	OSV-0000444
Date of inspection:	23/05/2019
Date of response:	01/08/2019

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:

The changing needs of residents were not identified and included in care plan reviews

1. Action Required:

Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's

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

family.

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

Care plans will be reviewed every 4 months as per regulation 05 (4) or sooner if there has been a change in the resident's needs.

Our care plans will reflect the change in a residents care needs. This will ensure all staff have a clear picture of the residents they are looking after.

Training days will continue to be provided to staff in relation to Dementia Care/ Pain Management/Safeguarding and all staff will be required to attend.

Proposed Timescale: 30/09/2019

Theme:

Safe care and support

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

Care plans were not person-centred and did not guide care.

2. 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.

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

A care plan will be devised for all residents within 48 hrs. of admission with an emphasis on ensuring the plan is person centred.

Specific care plans will be implemented for residents with dementia to reflect their individual needs.

Auditing, every 4 months will be carried out on all plans with special note to be taken in relation to Dementia/Palliative care residents.

Proposed Timescale: 30/09/2019

Theme:

Safe care and support

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

Assessment of the residents' specific care needs was not documented.

3. Action Required:

Under Regulation 05(2) you are required to: Arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to the designated centre.

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

Assessments will be reviewed and revised, a pain score will be introduced to complement our existing assessments to ensure all residents can express their level of pain through a standard tool. Our pre admission assessment will be reviewed to ensure we have a better knowledge and background history of our new residents prior to admission.

Assessment and Care planning audits will be carried out every 4 months with results and recommendations for improvement disseminated at our multidisciplinary team meetings which are held monthly.

Proposed Timescale: 30/09/2019

Theme:

Safe care and support

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

Resident and family involvement was not clearly identified in the care plans.

4. Action Required:

Under Regulation 05(5) you are required to: Make the care plan, or revised care plan, prepared under Regulation 5 available to the resident concerned and, with the consent of that resident or where the person-in-charge considers it appropriate, to his or her family.

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

The nurse completing the care plan whether on admission or revising it will ensure the resident has his/her wishes documented on it.

This will be achieved by pre admission interviews and also updated 4 monthly during their stay with us or sooner if there is a change in the resident's needs.

Proposed Timescale: 30/09/2019

Theme:

Safe care and support

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

Care plans relating to end of life for residents with dementia lacked person-centred detail and required further development.

5. Action Required:

Under Regulation 13(1)(d) you are required to: Where the resident approaching end of life indicates a preference as to his or her location (for example a preference to return home or for a private room), facilitate such preference in so far as is reasonably practicable.

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

When reviewing a care plan the residents wishes in relation to end of life will be

ascertained. If the resident is unable to express their wishes staff will approach the next of kin sensitively to find out the wishes of the resident.
All wishes will be taken on board, especially provision of private rooms and family facilities to make their stay as comfortable and dignified as possible.
End of life training has taken place since the inspection and will continue to be part of our in house Education programme.

Proposed Timescale: 30/09/2019

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:

The records of the residents meetings did not evidence that residents are consulted about how the centre is planned and run.

6. Action Required:

Under Regulation 09(3)(d) you are required to: Ensure that each resident is consulted about and participates in the organisation of the designated centre concerned.

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

To improve present arrangements a questionnaire will be circulated twice a year to residents and their families. This will give them a formal opportunity to express their wishes or bring forward new ideas to benefit Cahercalla Community Hospital & Hospice. Resident meetings will also give residents the opportunity to bring forward ideas that can improve their lives here in Cahercalla. The agenda for these meetings will include this item going forward.

The Board of Directors will also be kept up to date on a monthly basis of these findings.

Proposed Timescale: 30/08/2019

Theme:

Person-centred care and support

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

While some residents had opportunities to participate in activities, improvements were required to ensure that all residents were provided with appropriate activities suitable to their assessed and stated interests.

7. 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:

A formal review of our Activities Programme is currently underway. This includes

putting in post additional staff with recognised qualifications in this field.

We have refurbished an existing building which will include a new sitting room which will provide communal space to our Ground floor residents to enable them to come out of their rooms to socialise.

We will review our Activity Programme to incorporate going outside our facility to give residents the opportunity of visiting the town of Ennis or other locations they may suggest through our residents forum.

Proposed Timescale: 30/09/2019

Theme:

Person-centred care and support

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

Inspectors had concerns in relation to the dignity and privacy of two residents who shared a small double room in the garden wing of the centre.

8. Action Required:

Under Regulation 09(3)(b) you are required to: Ensure that each resident may undertake personal activities in private.

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

Bedroom has been changed to a single room. This has been reflected on our revised Statement of Purpose and floor plans.

Proposed Timescale: 17/06/2019

Theme:

Person-centred care and support

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

National newspapers were not available in the centre unless requested by an individual resident for their personal use only.

9. Action Required:

Under Regulation 09(3)(c)(ii) you are required to: Ensure that each resident has access to radio, television, newspapers and other media.

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

National and local newspapers are now being provided to each area on a daily & weekly basis.

Television and radio is freely available in all rooms to our residents.

We have installed a large TV in our newly refurbished area to encourage groups of residents to watch for example sporting events or a DVD.

Proposed Timescale: 30/07/2019

Theme:

Person-centred care and support

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

Residents did not feel they were consulted or able to participate in the organisation of the designated centre.

10. Action Required:

Under Regulation 09(3)(d) you are required to: Ensure that each resident is consulted about and participates in the organisation of the designated centre concerned.

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

A questionnaire will be circulated to all residents or their families in February and September, the findings will be incorporated into our annual review.

Residents will be made aware of the ways in which they can participate in the organisation such as completing the questionnaire, attending residents meetings and completing comment cards which are available in the centre.

The Board of Directors will be made aware of these findings and action plans implemented as a result of these findings.

Proposed Timescale: 15/10/2019

Theme:

Person-centred care and support

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

Residents did not have access to advocacy services.

11. Action Required:

Under Regulation 09(3)(f) you are required to: Ensure that each resident has access to independent advocacy services.

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

During our Resident forum meetings we will have an independent person in attendance. We have invited an outside advocacy agency to come and give a talk at these forums to ensure all residents are aware of outside services available to them.

We will ensure notice boards on each floor have contact details of above agencies to allow residents or their families access them directly.

Proposed Timescale: 30/08/2019

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:

No measures had been put in place, as a result of the management of a complaint, for areas which required improvement.

12. Action Required:

Under Regulation 34(1)(h) you are required to: Put in place any measures required for improvement in response to a complaint.

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

Our Complaints policy has been revised which clearly states what action we are required to take.

There is a clear pathway which will be placed on our notice boards on each floor outlining the steps to take in the event of a complaint.

All complaints will be logged and a full review will take place at our monthly Quality & Safety Committee meetings. Results and recommendations for improvement will be disseminated at our multidisciplinary team meetings which are held monthly.

The Board of Directors will be made aware of all complaints on a monthly basis.

Proposed Timescale: 01/09/2019

Theme:

Person-centred care and support

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

Complaints are not fully or properly recorded.

13. Action Required:

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

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

All complaints will be recorded in a complaints log which will be available on each floor. The complaints log will be reviewed by our designated complaints officer who has been appointed.

Complaints that are dealt with and resolved require a signature from complaints officer to close it.

Board of Directors will receive a monthly report of all complaints.

Training sessions will take place for all staff regarding the handling and recording of complaints.

Proposed Timescale: 01/09/2019

Theme:

Person-centred care and support

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

The centre does not have a nominated person to deal with complaints.

14. Action Required:

Under Regulation 34(1)(c) you are required to: Nominate a person who is not involved in the matter of the subject of the complaint to deal with complaints.

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

A Complaints Officer has been appointed to deal with complaints. Our Complaints policy has been amended to reflect this, staff will be made aware of changes to policy to ensure it is followed correctly. All complaints will be dealt with as per the revised policy.

Proposed Timescale: 01/09/2019

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:

There was a lack of signage to direct residents around the centre. There was no calendars or orientation boards to re-orientate residents with dementia to time and place.

15. Action Required:

Under Regulation 17(1) you are required to: Ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.

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

A review of signage within the centre is taking place.

Our signage at the Main entrance to be changed to include directional signage to each floor.

Clearer signage, clocks and calendars to be fitted on each floor to aid all residents and visitors.

Our Statement of Purpose will reflect all rooms in relation to purpose and size.

Proposed Timescale: 01/09/2019

Theme:

Effective care and support

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

The size and layout of a twin bedroom in the garden unit was restrictive and did not allow free movement around furniture and equipment.

16. Action Required:

Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

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

This room has been changed to a single room.
It is also reflected on our Statement of Purpose.

Proposed Timescale: 20/06/2019

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:

A Risk assessment required review in terms of open the stairwells.

17. Action Required:

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

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

Risk assessments will be carried out on first floor and second floor landings, any risk identified will be addressed.

Exit doors to our Internal Garden have been replaced with a 30 minute fire door with self-closer fitted on it. Completed 01/08/2019

Exit gate from Internal Garden reviewed and lock removed from gate to allow free movement from Garden in the event of an emergency. Completed 01/08/2019

A painted fire door (mural) has been removed and replaced with a 30 minute fire door as per Architect/Fire Officers approval. Completed 01/08/2019

Proposed Timescale: 30/08/2019

Theme:

Safe care and support

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

A risk review of fire escapes, fire doors and fire compartment maps is required.

18. 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 escape routes, fire doors and compartment maps have been reviewed & revised.
New fire doors have been installed where they were required.
New fire compartment maps have been put in place at the relevant points throughout the building as stated on drawings.

Proposed Timescale: 01/08/2019

Outcome 08: Governance and Management

Theme:

Governance, Leadership and Management

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

There was no clear management structure in relation to the lines of authority and accountability in the management of complaints.

19. Action Required:

Under Regulation 23(b) you are required to: Put in place a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

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

A full review has taken place of our management structure, this includes the appointment of a Complaints Officer following a full revision of our Complaints policy. These changes can be seen on our notice boards throughout Cahercalla Community Hospital & Hospice.

Our Board of Directors has approved all of these changes and require updates on a monthly basis at meetings going forward.

Proposed Timescale: 01/08/2019

Theme:

Governance, Leadership and Management

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

An annual review of the service for 2018 was available but did not include evidence that the review was prepared in consultation with residents and their representatives.

20. Action Required:

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

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

A questionnaire will be sent out to residents or their families every February and

September, these results or suggestions will be taken into account when planning for 2020.

This will be acknowledged in our annual review.

Residents their independent representatives will be made aware that the annual review is taking place and suggestions for improvement will be taken on board and incorporated into our plans for the coming year.

Proposed Timescale: 30/09/2019

Theme:

Governance, Leadership and Management

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

Five residents in the centre did not have contracts of care in place.

21. Action Required:

Under Regulation 24(1) you are required to: Agree in writing with each resident, on the admission of that resident to the designated centre, the terms on which that resident shall reside in the centre.

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

Contracts of Care were immediately issued to the five residents identified during the inspection. Contracts of Care are now issued to all residents (both long and short term) on admission. A system to track the issuing and return of contracts is in place and is monitored by the Person in Charge.

Proposed Timescale: 30/06/2019