

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Clonakilty Community Hospital
Centre ID:	OSV-0000559
Centre address:	Clonakilty, Cork.
Telephone number:	023 88 33 205
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Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Lead inspector:	Caroline Connelly
Support inspector(s):	Mary O'Mahony and Maria Scally Day 1
Type of inspection	Announced
Number of residents on the date of inspection:	108
Number of vacancies on the date of inspection:	14

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

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

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

The inspection took place over the following dates and times

From:	To:
24 January 2018 10:00	24 January 2018 19:00
25 January 2018 08:50	25 January 2018 18:10

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

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

Summary of findings from this inspection

This report sets out the findings of an announced registration renewal inspection. The provider had applied to renew their registration which is due to expire on the 24 June 2018. The centre was currently registered to accommodate the needs of 129 residents and there were 108 residents residing there on the days of the inspection. The centre is operated by the Health Service Executive (HSE) and is located on the outskirts of Clonakilty town and comprises of five separate units. As part of the

inspection the inspector met with the residents, the person in charge, the provider nominee, the two Assistant Directors Of Nursing (ADON), the Clinical Nurse Managers (CNM), nurses, care staff, activities staff, support staff and numerous other staff members. Inspectors observed practices, the physical environment and reviewed all governance, clinical and operational documentation such as policies, procedures, risk assessments, reports, residents' files and training records to inform this application.

The inspectors were not satisfied that there was a clearly defined management structure that identified the lines of authority and accountability, that specified roles, and detailed responsibilities for all areas of service provision as required by the regulations. The person in charge was an experienced nurse manager and the inspectors interacted with her throughout the inspection process. The two ADON's were involved in the day to day management of the centre and interviews were conducted with them during the inspection. The ADON's deputised in the absence of the person in charge. The management team was proactive in response to some of the actions required from the previous inspection and inspectors viewed a number of improvements in the centre. However there were a number of actions that remained outstanding which included issues with premises and residents rights and provision of privacy and dignity which are discussed throughout the report.

A number of quality questionnaires were received from residents and relatives and the inspectors spoke to many residents and relatives throughout the inspection. The collective feedback from residents and relatives was one of general satisfaction with the service and care provided. Comments from residents included " Staff are hard working and diligent ", " the surrounding gardens are so well cared for and give great pleasure in the summer time" a number of residents praised the staff, the food and activities. Relatives stated collectively that they feel their relative is well looked after. One relative stated that the "ease with which the staff connect with residents and visitors has a positive impact on residents". Relatives were complimentary about their ability to visit and staff being open with information about their relative. However a number of residents did tell the inspectors that they found residing in the multi occupancy rooms difficult. This was due to the lack of privacy and increased noise levels disturbing them during the day and the night. A few residents and relatives said they would like more storage space and another resident said more toilets were required. A few relatives stated that they feel there should be more private rooms especially if a resident is dying to give more privacy for the resident and the family. The relatives felt it was a difficult time and distressing for other residents in a multi-occupancy room. All of these issues were looked into and discussed further in the body of the report. Family involvement was encouraged and the inspectors saw numerous visitors in and out of the centre during the two day inspection. There was a residents committee which facilitated the residents' voice to be heard and this was run by the activity staff and resident advocate.

Inspectors found that residents' healthcare and nursing needs were met to a good standard. Residents had easy access to medical, allied health, psychology and psychiatry of later life services. A number of the allied health staff were on site or in close proximity to the centre. Staff generally interacted with residents in a kind and respectful manner and inspectors found that residents appeared to be very well

cared for. Residents could exercise some choice in their daily life and were consulted on an ongoing basis. Residents could practice their religious beliefs.

Since the previous inspection there had been improvements in activities and the introduction of activities three evenings per week. Staffing levels had improved in the evening and there had been the introduction of dedicated cleaning staff on a number of units. Improvements were seen in medication management and a number of beds had been removed from overcrowded rooms. However the inspectors found that there continued to be major non-compliance in relation to the premises which consisted mainly of large multi-occupancy rooms and similar to findings on previous inspections the premises did not meet the individual and collective needs of residents in terms of their privacy, personal space, access to communal space and adequate and accessible sanitary facilities. This had a significant negative impact on the privacy and dignity and quality of life of residents who resided in the centre. The inspectors identified that safeguarding issues and the lack of training for staff and of senior staff following the safeguarding policy in relation to allegations of abuse were of great concern. There was no vetting disclosure available for one staff member out of the sample of four staff files viewed. These areas and actions required are detailed in the body of the report, which should be read in conjunction with the action plan at the end of this report. The action plan at the end of the report identifies improvements necessary to ensure compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Standards for Residential Care Settings for Older People in Ireland 2016.

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

Outcome 01: Statement of Purpose

There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

A detailed Statement of Purpose was made available which accurately described the facilities and services available to residents.

The statement of purpose was updated during the inspection to include the current conditions attached by the Chief Inspector to the designated centre's registration under Section 50 of the Health Act 2007 and details in relation to the size of the rooms in the centre and was found to meet the requirements of legislation.

Judgment:

Compliant

Outcome 02: Governance and Management

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

Theme:

Governance, Leadership and Management

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

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

Findings:

The centre was operated by the Health Service Executive (HSE) who was the registered provider. The provider representative who had responsibility for a number of other centres was available to the management team. There was evidence of regular meetings between the provider representative and all the persons in charge from the community

hospitals in the area. The meetings were a forum for discussion, sharing of ideas and promotion of developments in services and practices.

The inspector saw that there was a management structure in place. Each unit was managed by a CNM2 who was supported by a CNM1 or senior staff nurse. The centre was managed by a full time person in charge who was supported in her role by two ADON's during the day and two CNM3's at night. However the inspectors were not satisfied that there was a clearly defined management structure that identified the lines of authority and accountability that specified roles, and detailed responsibilities for all areas of service provision as required by the regulations. This was evidenced by a lack of knowledge of senior staff of the actions to be taken in response to some allegations of abuse. The role of the ADON's and CNM3's did not appear to be clearly defined in relation to specified roles and responsibilities. There was a lack of a senior nurse rota identifying who was in charge of the centre on a daily basis. The CNM's on the units did not have control of their own staffing arrangements as discussed further in Outcome 18. Although the senior management team were in the centre Monday to Friday they were based in an office away from the resident areas and time spent out in the resident area was limited.

The management team displayed knowledge of the regulatory requirements. They were proactive in response to a number of actions required from previous inspections and inspectors viewed a number of improvements throughout the centre. However, as previously identified other actions required further action and a number of actions remained non-compliant. The provider had given assurances that premises would be renovated to ensure compliance with the standards and the regulations and to ensure it met the privacy and dignity needs of the residents. The time frame for completion furnished to HIQA and therefore a current condition of the registration of the centre is by 2020. However the person in charge confirmed that although there were some initial plans drawn up for the renovation of the centre nothing had been agreed to date.

Inspectors saw evidence of the collection of key clinical quality indicators data including pressure ulcers, falls, the use of psychotropic medications, bed rails, medication management and administration, the assessment of risk and health and safety. Inspectors saw that there were some systems in place for monitoring the quality and safety of care provided to residents. These included internal audits and reviews such as falls audits, nursing documentation audit, infection control audit, hand hygiene audit, manual handling audit, bed time audit and evening activity audit. These audits had taken place throughout 2017 and were ongoing. Audit outcomes and any corrective actions were documented and had resulted in changes to practices particularly around activities and bedrail usage. However the inspectors were not satisfied that there were comprehensive management systems in place to ensure that the service provided was safe, appropriate, and consistent and effectively monitored in that a number of instances had not been documented or recorded in accordance with the centres policies and procedures.

There was evidence of consultation with residents and relatives through residents meetings chaired by an external resident advocates. Inspectors noted that issues raised by residents were brought to the attention of the person in charge by the advocate and items were followed up on subsequent meetings. The person in charge told the

inspectors that a comprehensive survey had been undertaken in 2017 and the inspectors saw that the results of same were discussed with the CNM's and appropriate actions taken on issues raised. The inspectors saw that an annual review of the quality and safety of care and support in the designated centre had been undertaken by the management team in accordance with the standards. This review was made available to the inspectors and there were a number of recommendations and actions from this review that are currently being actioned. However as identified on the previous inspection there was no evidence of resident relative consultation and this had been made available to residents and relatives as required by the legislation.

Judgment:

Non Compliant - Major

Outcome 03: Information for residents

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

A Residents' Guide was available which included a summary of the services and facilities provided, terms and conditions relating to residence, procedure respecting complaints and the arrangements for visits. This guide had been updated recently and was found to meet the requirements of legislation.

Samples of residents' contracts of care were viewed by the inspector. The inspector found that contracts had been signed by the residents/relatives and found that the contract outlined all of the services and responsibilities of the provider to the resident and the fees to be paid. The contracts also included any additional charges. However, the contracts did not include the bedroom that the resident will occupy and the number of other residents in that bedroom as is required by legislation.

Judgment:

Substantially Compliant

Outcome 04: Suitable Person in Charge

The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The inspectors interacted with the person in charge throughout the inspection process. There was evidence that the person in charge was engaged in the governance, operational management and administration of the centre on a day-to-day basis. Inspectors were satisfied that she was a registered nurse, was suitably qualified and had a minimum of three years experience in nursing of the older person within the previous six years, as required by the regulations.

She had extensive managerial experience and had been the person in charge of the centre for 14 years. There was evidence that the person in charge had a commitment to her own continued professional development and had completed many courses such as diploma in Health Services Management and a Higher Diploma in Leadership and Management. Staff, residents and relatives all identified her as the person who had responsibility and accountability for the service.

Judgment:

Compliant

*Outcome 05: Documentation to be kept at a designated centre
The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.*

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The Directory of Residents was reviewed by one of the inspectors who found that it complied with Schedule 3 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

The designated centre has all of the written operational policies as required by legislation and found that these were reviewed and updated at intervals not exceeding three years as required.

The inspector reviewed a sample of four staff files and found that they contained most of the information required under Schedule 2 of the regulations; however, two staff files did not contain evidence of photo identification. The centre had in place HSE Garda Vetting Liaison Officers Garda vetting report confirmation forms for staff. However, this is not a disclosure in accordance with the National Vetting Bureau Act 2012 as required

by schedule 2 of the 2013 care and welfare regulations. A full vetting disclosure was made available for three of the four staff members requested by the inspector following the inspection. However one vetting disclosure was not available for a staff member employed before 29 April 2016 therefore this needs to be in place by April 2018.

Residents' records were reviewed by the inspector who found that they complied with Schedule 3 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. The records listed in Schedule 4 to be kept in a designated centre were all maintained and made available to the inspector. New secure trolleys had been purchased to ensure the safekeeping and confidentiality of residents records.

The inspectors were satisfied that most of the records listed in the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 were maintained in a manner so as to ensure completeness, accuracy and ease of retrieval with the exception of items missing from staff files as outlined above. There was a room in the administration area dedicated to staff and other files which were maintained in a very complete and organised manner.

Judgment:

Substantially Compliant

Outcome 06: Absence of the Person in charge

The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

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

Deputising arrangements were in place to cover for the person in charge when she was on leave. One of the ADON's who works full time in the centre was in charge when the person in charge is on leave. CNM3's were in charge of the centre at night and CNM's are in charge of the centre at weekends and evenings. However as discussed and actioned under outcome 2 Governance there was not a senior nurse rota to identify who was in charge of the centre on a daily basis.

Judgment:

Compliant

Outcome 07: Safeguarding and Safety

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

Theme:

Safe care and support

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

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

Findings:

Inspector reviewed the policies on meeting the needs of residents presenting with responsive behaviour and restraint use. The policy on behaviours that challenged outlined guidance and directions to staff as to how they should respond and strategies for dealing with behaviours that challenged. The policy on restraint was based on the national policy and included clear directions on the use of restrictive procedures including risk assessment and ensuring that the least restrictive intervention was used for the shortest period possible. On the previous inspection inspectors identified that there were 72 residents out of the 103 current residents using bedrails at the time of the inspection. Inspectors found this was a very large percentage of bedrail usage and required that this is reviewed to promote a reduction in the use of bedrails. On this inspection the number using bedrails had substantially reduced to 47 out of 108 residents. There were alternatives such as low profiling beds, crash mats and bed alarms in use for a number of residents and the person in charge confirmed that further low profiling beds and equipment were to be purchased. Staff told the inspector there was a commitment to further reduction in bedrail usage through good assessment and inspectors confirmed this needed to be promoted to aim towards a restraint free environment.

A policy and procedure was in place in relation to the management of behaviour that is challenging dated January 2018. However, a small number of staff had also yet to receive training in this area. There was evidence of regular involvement of psychiatric services including specialist nurse review and review by the psychiatrist as required. There had been a reduction in the use of chemical restraint and a full review is undertaken when as required anti-psychotic or sedating medications are used. A number of residents also received regular review by the psychologist who advised on plans and course of actions which were all seen to be documented in the residents medical notes. Nurses acted on the advice of the psychiatrist and psychologist. However inspectors saw inconsistencies in responsive behavioural plans viewed, some were found to be very comprehensive to guide and direct consistent care. Other plans were not comprehensive and did not fully prescribe and direct care to ensure staff all adopted a consistent approach. This is actioned under Outcome 11 Health and Social Care.

There was a policy and procedures in place for safeguarding vulnerable persons at risk of abuse which had been reviewed in June 2016 and included the roles and responsibilities for staff and the procedures for reporting abuse. However, it was confirmed with management that 30 staff members had yet to receive training in

safeguarding and safety. Two staff had trained as designated officers and there was a safeguarding team in place. However inspectors found that the measures in place to protect residents from suffering harm or abuse were not sufficiently robust. There had been a number of allegations of abuse where the policy on safeguarding had not been followed fully and in one instance there had been a delay in action by senior staff of nine days from a serious allegation until an investigation into an allegation of abuse had commenced and the correct action was taken as required by the centres policy and procedure. The centre had provided training to a large number of the care and nursing staff yet allegations of abuse had not always been reported as required by policy and national guidelines. Inspectors required that the training was revisited to ensure it was appropriate to ensure the safety of the residents and to ensure the centre adopted a policy of zero tolerance to any form of abuse in the centre. HIQA had also not been informed of these allegations in the required timeframe of 72 hours and was also not informed of one previous incident this is actioned under Outcome 10 notifications. The whole policy, procedure and practice around safeguarding in the centre required review to ensure it was sufficiently robust to ensure the safety of residents.

On the previous inspection inspectors found that staff held monies in safekeeping for a number of residents and this was to enable them to buy toiletries and other items from the mobile shop service. The mobile shop was a lovely service run by a care assistant with the assistance of administration staff. However the staff member had monies for residents and was providing them with goods which were all documented but there was no record of any signatures for these transactions and no evidence of any checks or audits of monies or records. On this inspection the inspectors saw that a more robust system was adopted where double signatures were on all transactions and a list of all items purchased.

There was a resident advocate who attended the centre on a weekly basis. Positive feedback was given to inspectors about the advocacy service provided in the centre.

Judgment:
Non Compliant - Major

Outcome 08: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Safe care and support

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

Findings:
The centre had policies and procedures in place relating to health and safety and the safety statement was available to all. These were in date and comprehensive. A risk management policy was in place; however inspectors found that it required updating to cover details regarding the measures and actions in place to control the risks specified in the regulations. Inspectors also viewed the risk register however it did not adequately

identify all hazards in the centre and all the controls necessary in order to manage the risks. The health and safety committee met bi-annually and there was a designated health and safety officer in place.

There was an emergency plan in place for responding to major emergencies likely to cause death, injury, serious disruption to essential services or damage to property. It also identified where the residents could be relocated to in the event they could not return to the centre.

Inspectors saw that the fire policies and procedures were centre-specific. The fire safety plan was viewed and found to be comprehensive. There were notices for residents and staff on "what to do in the case of a fire" appropriately placed throughout the building. Colour-coded floor plans were displayed throughout the centre which identified 'Where You Are Now' in line with best practice. Staff demonstrated an appropriate knowledge and understanding of what to do in the event of fire. Detailed Personal Emergency Evacuation plans (PEEPS) were seen to be completed for residents outlining the assistance they would require in an emergency situation. The inspectors noted documentary evidence that fire drills were carried out regularly and the learnings from each drill were clearly documented. These were usually led by the HSE fire officer, the inspectors recommended the centre staff also organise and run their own internal fire drills. There was suitable fire equipment provided in the centre. Records were available to inspectors that showed the fire alarm was serviced on a quarterly basis and fire safety equipment was serviced annually. The fire register was maintained which showed that the fire panel, break glass units, fire doors and fire equipment were all checked on a weekly basis on each unit. Emergency lighting was tested weekly as were the fire alarms and there were records of this. However, the centre's training matrix indicated that not all staff had received up-to-date mandatory fire training. New staff had received a fire induction which was confirmed by a new staff member.

Inspectors noted there were limited arrangements in place to monitor visitors to the centre, a visitor's book was not in place for guests to sign in and out and visitors did not have to buzz for entry. There were visitors books on the different units but in the case of fire it would be difficult to establish who was in the building.

Accidents and incidents were recorded on incident forms and were submitted to the person in charge and there was evidence of action in response to individual incidents. These were also reviewed and discussed at the health and safety bi-annual meetings. In addition, they were followed up at the daily ward hand-over meetings. There were reasonable measures in place to prevent accidents such grab-rails in toilets and handrails on corridors. However the inspectors noted that in a number of areas linen trolleys and other equipment were stored in front of handrails preventing residents having access to same. Oxygen cylinders were also stored on corridors there was no advisory signage in relation to the danger in relation naked flames and the risk assessment for storage of oxygen did not sufficiently outline the controls measures required for safe storage. Clinical risk assessments were undertaken, including falls risk assessment, assessments for dependency, assessments for malnutrition and assessments for pressure ulcer formation. Records viewed by the inspector indicated that staff had received up to date moving and handling training. Hoists were all last serviced in December 2017 and the residents' beds were being serviced on the days of inspection

The environment was observed to be clean and generally well decorated throughout. Personal protective equipment, such as gloves, aprons and hand sanitizers were located throughout the premises. All hand-washing facilities had liquid soap and paper towels available. There were policies in place on infection prevention and control and staff that were interviewed demonstrated knowledge of the correct procedures to be followed. Hand hygiene training was on-going and staff demonstrated good hand hygiene practice as observed by the inspectors. Arrangements for the disposal of domestic and clinical waste management were appropriate. Infection control training was ongoing and provided to staff on a regular basis. However on a number of units residents nebuliser and oxygen masks were left uncovered on residents bedside lockers these should be covered in line with best practice guidelines in infection control. Dedicated cleaning staff were now in place on most of the units.

A current insurance policy was demonstrated.

Judgment:

Non Compliant - Moderate

Outcome 09: Medication Management

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

Theme:

Safe care and support

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

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

Findings:

There had been a number of improvements in medication management since the previous inspection these included improvements in medication administration practices, prescriptions and the provision of new medication trolleys. The centre-specific policies on medication management were made available to inspectors. The policies included the ordering, receipt, administration, storage and disposal of medicines. The policies were comprehensive and evidence based. The policies were made available to nursing staff who demonstrated adequate knowledge of this document. Medicines for residents were supplied by a community pharmacy.

Medicines were stored in a locked cupboard or in new medication trolleys. Medications requiring refrigeration were stored securely and appropriately. The temperature of the medication refrigerator was noted to be within an acceptable range; the temperature was monitored and recorded daily. Controlled drugs were stored in accordance to best practice guidelines and nurses were checking the quantity of medications at the start of each shift. The inspector did a count of controlled medications with the nurse which accorded with the documented records.

There were appropriate procedures for the handling and disposal for unused and out of date medicines and the documenting of same. Medications that required crushing were

individually prescribed. As required medications stated the frequency of dose to ensure there was a maximum dose in 24 hours that could not be exceeded.

Comprehensive medication audits were undertaken by the pharmacist and there was evidence of actions taken as a result of findings. The pharmacist visited the centre and provided medication reviews, stock control, advice and education for staff. Medication errors were recorded and investigated accordingly. Medication errors and near misses were recorded and monitored by the CNM's on each ward. The CNM's reported to the inspectors that these were discussed at ward hand-over meetings to mitigate risk of recurrence.

Judgment:

Compliant

Outcome 10: Notification of Incidents

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

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

The inspector saw that there was a comprehensive log of all accidents and incidents that took place in the centre.

Incidents as described in the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 have generally been reported in accordance with the requirements of the legislation. There were timely quarterly returns and written notifications were received within three days of accidents as required. However there were a number of allegations of abuse that were either not reported to HIQA or they were reported outside the required 72 hour notification period.

Judgment:

Non Compliant - Major

Outcome 11: Health and Social Care Needs

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

Theme:

Effective care and support

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

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

Findings:

There was evidence of timely access to health care services facilitated for all residents. Four different General Practitioner (GP) practices acted as medical officers provided medical services to the centre and an on call medical service was available in the evenings and out of hours and this was confirmed by residents. A sample of medical records reviewed demonstrated that resident's were reviewed on a regular basis. Specialist medical services were also available when required. Reviews and on-going medical interventions as well as laboratory results, were evidenced. There were policies in place to ensure that relevant information was shared between providers and services for when the resident was admitted to, transferred or discharged from the centre. Pre admission assessments were completed on potential residents using the new system to ensure the centre had more comprehensive information on all residents prior to admission to ensure appropriate placement in the centre and CNMs would be able to prepare for the needs of the resident being admitted. This was particularly relevant as the centre had admitted a number of transitional care residents in the previous number of months.

All referrals and appointments were recorded and blood tests were completed as per the GPs instructions. Nurses had received training in venepuncture and regularly took blood in the centre. A physiotherapist was present in the centre and referral could be made by nurses or medical officer as required. The inspector also saw that residents had access to podiatry, dental, optical, dietetic and speech & language services as required. Residents in the centre also had access to the specialist mental health of later life services and to Psychology services. The psychiatrist and psychologist had offices based on the grounds of the centre and was available to review and follow up residents with mental health needs and residents who displayed behavioural symptoms of dementia. Treatment plans were put in place and regular reviews and follow-up to consultations were completed as required. The inspectors saw comprehensive reviews and plans in the medical notes but as previously discussed in outcome 7 these did not always transfer into care plans and responsive behavioural plans to be followed through by the staff in the centre. Overall residents and relative's expressed satisfaction with the medical care provided.

On the previous inspection the centre had implement a whole new system of assessment and care planning documentation. On this inspection the inspectors saw that staff were much more familiar with the system and each resident's needs were determined by comprehensive assessment with care plans developed based on identified needs. The assessment process involved the use of a variety of validated tools to assess each resident's risk of deterioration. For example, risk of malnutrition, falls, level of cognitive impairment and pressure related skin injury among others. Pain charts in use reflected appropriate pain management procedures. The inspectors reviewed a number of care plans for residents and these were seen to be person centred with evidence of residents and/or their relative's involvement in the development of care plans. Care plans were generally up to date and were individualised. However as discussed in Outcome 7 care plans for some residents exhibiting responsive behaviours were not sufficiently detailed to ensure all staff provided care in a consistent manner in relation to

behaviours exhibited. The inspector saw "key to me" information and support plans that had been completed for residents which included detailed information on residents likes, dislikes, hobbies and interests. The activity staff completed social care plans were updated in line with resident's participation in group or one to one activities. On the previous inspection inspectors saw that the assessment tools were reviewed and updated on a four monthly basis there was no evidence that the care plans were reviewed as a result of the updating of assessment as required by legislation. On this inspection this was now seen to be in place. Since the previous inspection resident's assessment and care plans were now maintained in specialist portable, lockable documentation trolleys to protect the privacy of the residents and to provide secure storage for the records.

Good wound care management was evident in the centre and there was evidence that wound care was evidence based. Inspectors saw that attention was given to promoting continence and assessments were completed to ensure correct use of continence products. Inspectors observed that residents appeared to be well cared for, which was further reflected in residents' comments that their daily personal care needs were well met.

Judgment:

Substantially Compliant

Outcome 12: Safe and Suitable Premises

The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:

Effective care and support

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

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

Findings:

Clonakilty Community Hospital is located on the outskirts of Clonakilty town and comprised of two buildings which date back to the 1800's. Resident accommodation is spread across five units and the centre is registered to provide long term, respite, palliative and dementia care for 129 residents. The five units comprised of:

Saoirse, the dementia specific unit, comprises of two single rooms with en suite assisted showers, toilets and hand basins and two large multi-occupancy rooms. There is a homely dining/day room and a second homely sitting room, further communal space was provided in an open area set out like a street which included comfortable seating and a dining table.

AnGraig has one single bedroom and four multi-occupancy bedrooms with five beds each with full en-suite facilities

Dochas has six multi-occupancy rooms with five beds each with full en-suite facilities, there is also a single room used for end of life care.

Crionna has nine multi-occupancy rooms some six bedded, some 5 bedded and some four bedded with full en-suite facilities

Sonas , Consists of multi-occupancy rooms varying from six bedded rooms down to two bedded rooms.

All of the units now have their own dining rooms but not all have a sitting room/lounge. On some units there continued to be not enough dining space to accommodate all residents. There is a café, shop, chapel and enclosed gardens with extensive car parking.

Since the last inspection seven beds have been removed from a variety of multi-occupancy rooms and the centre is now applying to resister for 122 beds instead of the 129 it was currently registered for.

The centre had been refurbished and upgraded over recent years and a number of eight bedded-rooms had been reduced to five bedded rooms with full en-suite facilities. Dining rooms had been added to units and some doors had been widened to ensure better access. A number of areas were redecorated and were seen to be decorated in a homely and cosy fashion. Since the last inspection in March 2017 four beds were removed from the multi-occupancy rooms in Sonas unit which allowed residents better space in those rooms. Three further beds were removed from Crionna unit. However as identified on the previous inspection there remained significant limitations within the physical environment which negatively impacted on the freedom, choice, privacy, dignity and autonomy of residents and these have been described in detail in previous inspection reports. Similar to findings on all previous inspections the design and layout of parts of the premises did not conform to the matters listed in Schedule 6 of the Health Act 2007(Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

The design and layout did not meet the individual and collective needs of residents for space, storage and privacy. This will be addressed further under Outcome 16: Residents' privacy, dignity and consultation. The person in charge stated that arrangements were in place to address the premises failings with the work proposed to be completed in 2021. However these plans were in the very early stage of development and not formally agreed.

Issues previously identified on inspections with regards to the limitations of the premises that remained issues on this inspection included:

1) inadequate number of toilets for residents use, for example, there was just one usable toilet in the female section of Sonas for eight residents as the second toilet was not fit for purpose because it was so small when a resident used the facility the door could not be closed

2) inadequate provision of bathing facilities

3) inadequate communal space in Dochas and An Ghraig; most residents in these units continued to be seated near their beds for large parts of the day.

4) Multi-occupancy bedrooms; some could not accommodate a bed-side chair or wardrobe alongside residents' beds particularly the seven bedded room in Saoirse unit and a five bedded room in Crionna unit.

5) some multi-occupancy bedrooms and single rooms could only be accessed via other multi-occupancy bedrooms

- 6) some toilet and shower facilities could only be accessed through a series of multi-occupancy bedrooms
- 7) a number of residents did not have easy access to their wardrobes
- 8) equipment stored in bedrooms and corridors such as laundry trolleys and hoists
- 9) lack of private space for residents to meet their visitors in private if they wished
- 10) lack of private rooms to accommodate residents, especially at end-of-life care.

The centre was generally clean throughout and well maintained. The gardens were attractively laid out, secure and well maintained. A secure garden was available with easy access from the dementia specific unit. Outdoor furniture and fencing here was painted brightly and there was a newly developed walkway for residents to enjoy the garden with raised beds.

The café by the main reception was a pleasant social place for staff, residents and relatives. Feedback from residents and relatives commented on the value of the cafe.

A number of rooms both on the ground floor of the main building and the first floor of Sonas unit were used as meeting rooms for both HSE staff and visiting groups. A hairdressing service was available on site as was a physiotherapy service and a day centre. The day centre was not generally used by residents in long term care but was utilised by residents receiving respite care.

The centre had closed-circuit television cameras (CCTV) and there was a policy in place to support its use. All cameras were in public areas. There was a sign to inform residents, staff and visitors that CCTV was in operation.

Inspectors saw evidence of the use of assistive devices, for example, hoists, wheelchairs, walking aids, clinical monitoring equipment and specialist seating provided for residents' use. There was a functioning call-bell system in place.

Judgment:

Non Compliant - Major

Outcome 13: Complaints procedures
The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

Inspectors saw a complaints policy dated April 2017 that was found to be centre-specific. However, this required updating to include a nominated complaints officer and also a nominated person who held a monitoring role to ensure that all complaints were responded to as required by the regulations.

Inspectors viewed the complaints log and found that whether or not the resident was

satisfied with the outcome of their complaint was not always recorded as required.

Judgment:

Substantially Compliant

Outcome 14: End of Life Care

Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

Resident's religious needs were facilitated with mass taking place regularly in the centre and the rosary said frequently. Mass took place in the centre's church during one of the days of the inspection and a large number of residents attended along with their family members. Residents from other religious denominations were visited by their ministers regularly as required. The inspectors reviewed the centre's policy on end-of-life care which was seen to be comprehensive to guide staff in providing holistic care at the end of life stage. The inspectors reviewed a sample of residents' care plans with regards to end-of-life care and noted that they generally recorded residents' preferences at this time. A number of residents stated that in the event that their needs changed in the future they would prefer to be cared for in the centre.

Staff training records indicated that a number of staff had attended training on palliative care issues including spiritual care, psychological support, pain management and communicating with the bereaved relatives. The person in charge stated that the centre was well supported by the specialist team from the local community. Records which the inspectors viewed indicated that the palliative team were responsive to the GP and the staff in providing specialist advice in pain relief and symptom management.

Overall the inspectors found that care practices and facilities in place were designed to ensure residents received end of life care in a way that met their individual needs and wishes and respected their dignity and autonomy. However a single room was not always available for end of life care and relatives and residents identified this as an issue when residents received end of life care in a multi-occupancy room. The relatives felt it was a difficult time and distressing for other residents in a multi-occupancy room and there was a lack of privacy for the resident who is at end of life and their family. Relatives said they had seen this happen on a number of occasions and this is actioned under premises.

Judgment:

Compliant

Outcome 15: Food and Nutrition

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

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

There was an up-to-date policy in place for food and nutrition which included a recognised risk assessment and residents care plans contained evidence of regular monitoring of fluid and nutritional status.

The substantial improvements in the overall provision of food and nutrition as identified on the previous inspection had continued and were working well. The colour coded menu system indicated food consistency and the tray system of serving meals in the kitchen was consistent with residents' menu choices and food consistency required. An inspector visited the kitchen and spoke with the head chef and catering staff who explained the layout of the kitchen and food safety precautions in place. The dry goods store was well stocked. Cold rooms and freezers were available. There was a separate meat preparation and gluten-free area, fire equipment and hand washing facilities. Food deliveries were labelled respecting ingredients and dates. A daily deep clean schedule was seen and there was a good standard of cleanliness. Training was provided to staff in safe food handling along with other relevant and mandatory training.

There were systems in place to ensure residents' nutritional needs were met, and that the residents received adequate hydration. The 'Malnutrition Universal Screening Tool' ('MUST') was used for residents on admission. Weights were recorded monthly for all residents and upon readmission from hospital. Nutritional care plans were available for some residents, which described the level of assistance required. Residents were provided with a choice of nutritious meals at mealtimes and the inspector saw staff assist residents with eating and drinking. This was undertaken in a discrete and sensitive manner. Residents were complimentary about the food provided. Nutritional supplements were administered as prescribed. There was very good access to the dietician and Speech and Language therapist (SALT). Staff were aware of residents who required specialised diets or modified diets and were knowledgeable regarding the recommendations of the dietician and SALT.

There were dining rooms on all five units and tables were attractively set. Improvements in the dining experience were seen. Inspectors saw that on most of the units the majority of residents were coming to the dining rooms for their lunch, there was less residents at tea-time. Some of the dining rooms were seen to be homely and kitchen like. However on some units there continued to not enough dining space to facilitate all the residents living there and this will was actioned under outcome 12 Premises.

Judgment:

Compliant

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

Theme:

Person-centred care and support

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

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

Findings:

Numerous visitors were observed throughout both days of inspection where staff members knew the names of visitors and vice versa. Feedback from relatives was that staff took time to talk with family members both when they visited and when they rang to enquire about their relative. Visitors told the inspectors that they were always made welcome and said that if they any concerns they could identify them to the staff and were assured they would be resolved. The centre operated an open visiting policy and this open visiting policy was observed throughout the inspection. Relatives commended staff on how welcoming they were to all visitors. However the inspectors saw that many visitors continued to visit residents in the multi-occupancy bedrooms as there were limited private or communal rooms for visiting. These visiting arrangements did not promote or protect the dignity of the residents in the other beds who may require personal care or be trying to sleep/rest watch television while visitors were in their bedroom.

The manner in which residents were addressed by staff was seen by inspectors to be respectful. Inspectors heard staff addressing residents by their preferred names and speaking in a clear, respectful and courteous manner. Staff paid particular attention to residents' appearance, dress and personal hygiene and were observed to be very caring towards the residents.

Residents were consulted through the residents committee and through feedback questionnaires. The resident advocate facilitated the residents' committee meetings and many residents attended these meetings. Issues raised at these meetings were reported back to the person in charge for resolution and followed up on subsequent meetings with updates and progress. The inspectors saw minutes of these meetings and also spoke to the resident advocate. The advocate knew residents well and there was evidence of where she had to advocate on behalf of residents even when it went against the policy and procedures of the centre and the resident's rights were upheld. There were pictures and contact details available for the resident advocate and confidential recipient on resident notice boards.

Since the previous inspection the activities had increased there were now two staff allocated to activities one three days per week and the other two to three days per week. The external activity group also provide three sessions per week and musicians also attend the centre weekly. Inspectors saw a variety of activities ongoing during the two days of inspection. Residents were offered a choice of group activities as well as one-to-one sessions. Some families and residents had completed a 'Life Story' as part of their reminiscence therapy. A daily activities record detailing the residents' involvement in the activity was maintained. Activities included art therapy, music, bingo, exercises, card playing, gardening, and aromatherapy. Residents' art was displayed in the centre. Inspectors met a number of activity staff who were providing individual and group activities and also a number of musicians who played for the residents. There were activities now available three nights per week which included a film evening, a music session and bingo. Feedback from residents was very positive and the inspectors saw the lively music session on the first evening of the inspection on Crionna unit where there were approximately twenty residents in attendance. However due to lack of space attendance at group activities was not always possible for all residents and a number were seen to remain by their beds.

Inspectors saw that although televisions were provided to residents in the multi-occupancy bedrooms, the position of some of these televisions required review some were positioned too high. Others were positioned in close proximity to other resident's televisions, therefore when two or more televisions were on at the same time in the multi-occupancy rooms it was very distracting and residents and staff said the noise level was too much. A number of residents told inspectors that overall the noise level in the multi-occupancy bedrooms was disturbing and upsetting especially if a fellow resident was disturbed and shouting. A number of residents described how they would love a single room as their sleep was regularly disturbed by other residents calling out and staff attending to them at night in the multi-occupancy rooms. Other residents said they would love more space for their personal belongings.

Inspectors saw that although staff promoted residents privacy and dignity as best as they could in the multi-occupancy rooms. Although there was a great increase in activities since the last inspection and a number of residents spent time away from their bedrooms. The inspectors saw that on a number of units a large number of the residents continued to spend long periods of the day in their bedrooms, either in bed or on a chair at their bedside. As residents sat by their own bedside and not close enough to engage in conversation with the resident in the bed next to them this meant that some residents had few opportunities to meet, interact and engage with each other on a social basis. Many did attend the dining rooms for meals and for some activities but returned to their bedrooms immediately following same. Lack of personal space between and around the beds also affected the residents' ability to make their bed area personalised and homely and the inspectors noted that although some residents had personalised their bed spaces others were sparse. In one of the five bedded rooms on Crionna and the seven bedded room on Saoirse the beds were too close together and did not allow residents space for possessions and privacy and dignity. Two residents in a six bedded room were using the bed spaces of empty beds and said the room was only suitable for the current four residents and not six residents. The inspectors concluded that as a consequence of the prevalence of mainly large multi-occupancy rooms, lack of day rooms and the fact that some residents spent most of the day by their beds, the

centre continued to appear institutionalised and hospital-like and did not provide residents the opportunity to undertake personal activities in private.

Judgment:

Non Compliant - Major

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

Theme:

Person-centred care and support

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

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

Findings:

There was an up-to-date policy on residents' personal property and possessions. The majority of residents were accommodated in multi-bedded rooms which afforded little space, privacy or room for personal storage. Although there had been some improvements in personalisation of bed spaces these rooms were generally not personalised as space did not allow. In one six bedded room there were two empty beds and the residents in the other beds in the room had used the empty bed areas to store their belongings and make the room more homely. In many cases, lockers and wardrobes were quite small and did not accommodate sufficient clothing to allow residents to exercise choice. Since the last inspection beds had been removed from some rooms which allowed residents easier access to their clothing but there still remained a number of residents where the wardrobes were stored away from residents bedsides. Therefore they were inaccessible for residents which made it difficult for them to retain control over their possessions and clothing.

Laundry in the centre is outsourced with bedding and towels going to one laundry service and personal linen going to a different service. On the previous inspection there were a number of complaints in the complaints log in relation to missing clothing. The person in charge had highlighted it to staff to be vigilant and separate laundry trolleys and bags were available and this extra vigilance and clear laundry bags have improved the issue of clothing going missing.

Judgment:

Non Compliant - Moderate

*Outcome 18: Suitable Staffing
There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an*

appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

Theme:
Workforce

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

No actions were required from the previous inspection.

Findings:

Inspectors observed warm and appropriate interactions between staff and residents and they observed staff chatting easily with residents. A number of residents and relatives spoke very positively of staff and indicated that staff were caring, responsive to their needs and treated them with respect and dignity. However a couple of relatives and residents said that at times an odd staff member could be sharp with a resident but overall felt the majority of the staff were very kind and caring.

Inspectors viewed the staff training and education records. An overall training matrix was in place and individual records were maintained. Mandatory training was in place and training records confirmed that staff had received up to date training in fire safety, safe moving and handling, safeguarding vulnerable persons and training in responsive behaviours. However as identified and actioned in Outcomes 7 and 8 not all staff had training in safeguarding, responsive behaviours and fire training. Other training provided included, care planning, dementia specific training, infection control, end of life, syringe driver training, care planning, dysphagia and medication management. A lot of training was provided on site by external and internal trainers. Training facilities were available in house which including fully equipped conference and training rooms. The inspectors saw that other training courses had been booked and were scheduled for the coming months. Staff confirmed that they were facilitated and encouraged to attend training and through their staff appraisals were able to highlight their training needs.

Systems of communication were in place to support staff with providing safe and appropriate care. There were handover meetings each day to ensure good communication and continuity of care from one shift to the next. Inspectors saw records of staff meetings at which operational and staffing issues were discussed. The inspector saw that staff had available to them copies of the regulations and standards. Inspectors found staff to be well informed and knowledgeable regarding their roles and responsibilities. However from talking to staff and reviewing the duty rotas and as identified on the previous inspection there was evidence that staff were frequently moved from unit to unit. Although this had improved somewhat since the previous inspection it remained an issue. The duty rota was completed centrally by the night staff with the CNM's on the units not having control over the allocation of their staff or skill mix. This practice is not good for continuity of care. It also did not allow for allocation of nurses to act as key workers for a set group of residents, ensuring all of the residents' needs were documented and set out in their care plans to direct their care.

Since the previous inspection most units now had dedicated cleaning staff. On the

previous inspection the inspectors required that staffing levels in the evening were reviewed. On this inspection inspectors saw that staffing levels had increased in the evening with the addition of twilight shifts. There was also the addition of activity staff 3 evenings per week which the inspectors saw residents enjoying on the first day of the inspection. However the inspectors continued to see residents by their beds or in beds from late afternoon early evening and the person in charge was required to keep staffing levels under review to ensure all the needs of the residents were met taking into account the size and layout of the centre.

Judgment:
Substantially Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Caroline Connelly
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:	Clonakilty Community Hospital
Centre ID:	OSV-0000559
Date of inspection:	24/01/2018
Date of response:	28/03/2018

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 02: Governance and Management

Theme:

Governance, Leadership and Management

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

The inspectors were not satisfied that there was a clearly defined management structure that identified the lines of authority and accountability, that specified roles, and detailed responsibilities for all areas of service provision as required by the regulations.

1. Action Required:

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

Under Regulation 23(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:

HIQA did not agree this action plan with the provider despite affording the provider two attempts to submit a satisfactory response

Proposed Timescale:

Theme:

Governance, Leadership and Management

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

The inspectors were not satisfied that there were comprehensive management systems in place to ensure that the service provided was safe, appropriate, consistent and effectively monitored.

2. Action Required:

Under Regulation 23(c) you are required to: Put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

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

HIQA did not agree this action plan with the provider despite affording the provider two attempts to submit a satisfactory response

Proposed Timescale:

Theme:

Governance, Leadership and Management

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

The annual review was not prepared in consultation with residents and their families and was not made available to them as required by the regulations.

3. Action Required:

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

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

The annual review will take into consideration the views of the residents and their families. This will take place through the residents' committee and relatives' meetings and will be clearly documented.

Proposed Timescale: 30/12/2018

Outcome 03: Information for residents

Theme:

Governance, Leadership and Management

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

The contracts did not include the bedroom that the resident will occupy and the number of other residents in that bedroom as is required by legislation.

4. 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:

All contracts of care will be amended to include whether the resident will be in a single, 4 or 5 bed ward and to which Unit they will reside.

Proposed Timescale: 30/06/2018

Outcome 05: Documentation to be kept at a designated centre

Theme:

Governance, Leadership and Management

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

Two staff files did not contain evidence of photo identification as required by Schedule 2 of the regulations.

5. 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:

All staff records will be reviewed to include photo identification.

Proposed Timescale: 30/06/2018

Outcome 07: Safeguarding and Safety

Theme:

Safe care and support

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

Not all staff had training to respond to and manage behaviour that is challenging.

6. Action Required:

Under Regulation 07(1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.

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

All staff will be allocated time to attend Responsive Behaviour training. Training has been booked for 14th Feb. 2018, 18th April 2018 and 9th May 2018.

Proposed Timescale: 30/06/2018

Theme:

Safe care and support

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

Inspectors found that the measures in place to protect residents from suffering harm or abuse were not sufficiently robust. There had been a number of allegations of abuse where the policy on safeguarding had not been followed fully and in one instance there had been a delay in action by senior staff of nine days from a serious allegation until the correct action was taken following policy and procedure.

7. Action Required:

Under Regulation 08(1) you are required to: Take all reasonable measures to protect residents from abuse.

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

HIQA did not agree this action plan with the provider despite affording the provider two attempts to submit a satisfactory response

Proposed Timescale:

Theme:

Safe care and support

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

It was confirmed with management that 30 staff members had yet to receive training in safeguarding and safety.

8. 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:

HIQA did not agree this action plan with the provider despite affording the provider two attempts to submit a satisfactory response

Proposed Timescale:**Theme:**

Safe care and support

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

The inspectors were not satisfied that the investigation into an allegation of abuse had commenced immediately following the allegation being made.

9. Action Required:

Under Regulation 08(3) you are required to: Investigate any incident or allegation of abuse.

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

HIQA did not agree this action plan with the provider despite affording the provider two attempts to submit a satisfactory response

Proposed Timescale:**Outcome 08: Health and Safety and Risk Management****Theme:**

Safe care and support

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

The inspectors noted that in a number of areas linen trolleys and other equipment were stored in front of handrails preventing residents having access to same. Oxygen cylinders were also stored on corridors there was no advisory signage in relation to the danger in relation naked flames and the risk assessment for storage of oxygen did not sufficiently outline the controls measures required for safe storage.

10. Action Required:

Under Regulation 26(1)(a) you are required to: Ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.

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

HIQA did not agree this action plan with the provider despite affording the provider two attempts to submit a satisfactory response

Proposed Timescale:

Theme:

Safe care and support

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

The risk management policy required updating to cover details regarding the measures and actions in place to control the risks specified in the regulations.

11. Action Required:

Under Regulation 26(1) you are required to: Ensure that the risk management policy set out in Schedule 5 includes all requirements of Regulation 26(1)

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

HIQA did not agree this action plan with the provider despite affording the provider two attempts to submit a satisfactory response

Proposed Timescale:

Theme:

Safe care and support

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

Not all staff had received training in fire safety.

12. 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:

All staff will attend the necessary fire safety courses that meets Regulation 28 (1)(d). Training has been booked for staff on 8th March 2018, 14th May 2018 and 6th June 2018.

Proposed Timescale: 30/06/2018

Outcome 10: Notification of Incidents

Theme:

Safe care and support

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

There were a number of allegations of abuse that were either not reported to HIQA or they were reported outside the required 3 day required notification period.

13. 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:

All allegations of abuse will be reported within the required 3 day notification period.

Proposed Timescale: 22/03/2018

Outcome 11: Health and Social Care Needs**Theme:**

Effective care and support

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

Care plans for some residents exhibiting responsive behaviours were not sufficiently detailed to ensure all staff provided care in a consistent manner in relation to behaviours exhibited.

14. Action Required:

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

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

HIQA did not agree this action plan with the provider despite affording the provider two attempts to submit a satisfactory response

Proposed Timescale:

Outcome 12: Safe and Suitable Premises**Theme:**

Effective care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory

requirement in the following respect:

Issues previously identified on inspections with regards to the limitations of the premises that remained issues on this inspection included:

- 1) inadequate number of toilets for residents use, for example, there was just one usable toilet in the female section of Sonas for eight residents as the second toilet was not fit for purpose because it was so small when a resident used the facility the door could not be closed
- 2) inadequate provision of bathing facilities
- 3) inadequate communal space in Dochas and An Ghraig; most residents in these units continued to be seated near their beds for large parts of the day.
- 4) multi-occupancy bedrooms; some could not accommodate a bed-side chair or wardrobe alongside residents' beds particularly the seven bedded room in Saoirse unit and a five bedded room in Crionna unit.
- 5) some multi-occupancy bedrooms and single rooms could only be accessed via other multi-occupancy bedrooms
- 6) some toilet and shower facilities could only be accessed through a series of multi-occupancy bedrooms
- 7) a number of residents did not have easy access to their wardrobes
- 8) equipment stored in bedrooms and corridors such as laundry trolleys and hoists
- 9) lack of private space for residents to meet their visitors in private if they wished
- 10) lack of private rooms to accommodate residents, especially at end-of-life care.

15. Action Required:

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

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

HIQA did not agree this action plan with the provider despite affording the provider two attempts to submit a satisfactory response

Proposed Timescale:

Outcome 13: Complaints procedures

Theme:

Person-centred care and support

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

A person who is not involved in the matter of the subject of the complaint to deal with complaints was not nominated in the complaints policy.

16. 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:

We will review and amend the Complaints Policy as required. The Director of Nursing is the nominated Complaints Officer, and this will be reflected in the policy.

Proposed Timescale: 22/03/2018

Theme:

Person-centred care and support

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

A record of whether the resident was satisfied with the outcome of their complaint was not always available in the complaints log.

17. 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:

A record of the level of satisfaction of the complainant, and the outcome will be recorded in the complaints log.

Proposed Timescale: 22/03/2018

Theme:

Person-centred care and support

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

The complaints policy did not outline a nominated person who held a monitoring role to ensure that all complaints were responded to as required by the regulations.

18. Action Required:

Under Regulation 34(3) you are required to: Nominate a person, other than the person nominated in Regulation 34 (1)(c), to be available in a designated centre to ensure that all complaints are appropriately responded to and that the person nominated under Regulation 34 (1)(c) maintains the records specified under in Regulation 34 (1)(f).

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

The Complaints Policy has been altered to include the General Manager as the nominated person for the Centre to ensure all complaints are appropriately responded to and that the Director of Nursing maintains records specified under Regulation 34 (1) (f).

Proposed Timescale: 22/03/2018

Outcome 16: 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 limited in their choice of bedroom due to a lack of private accommodation, residents were limited in their choice of sitting area during the day. As there was not enough dining space on all units residents on those units did not always have choice in dining areas.

19. 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:

HIQA did not agree this action plan with the provider despite affording the provider two attempts to submit a satisfactory response

Proposed Timescale:

Theme:

Person-centred care and support

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

Due to the large number of multi-occupancy rooms in a number of the units residents were not able to undertake personal activities in private.

20. 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:

HIQA did not agree this action plan with the provider despite affording the provider two attempts to submit a satisfactory response

Proposed Timescale:

Theme:

Person-centred care and support

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

Inspectors saw that many visitors visited residents in the multi-occupancy bedrooms, as there were limited private or communal rooms for visiting. These visiting arrangements

did not promote or protect the dignity of the residents in the other beds, who may require personal care or be trying to sleep/rest, watch television while visitors were in their bedroom.

21. Action Required:

Under Regulation 11(2)(b) you are required to: Make suitable communal facilities available for a resident to receive a visitor and a suitable private area which is not the resident's room, if required.

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

- Within the confines of the existing building, we will maximise resident's capacity to freedom and choice by providing additional spaces for residents and visitors to have private conversations
- A review of the premises will be conducted, in an effort to identify areas that may be developed into communal spaces, for use by the residents, in advance of the capital plan development.
- Visitors will be asked to vacate the bedrooms when possible to allow privacy.
- The advocate conducted a recent survey on residents' preferences of how and where they would like to spend their day. Following this survey, each resident's preferences were noted in their care record and staff respond to their requests.

Proposed Timescale: 30/06/2018

Outcome 17: Residents' clothing and personal property and possessions

Theme:

Person-centred care and support

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

The majority of residents were accommodated in multi-bedded rooms which afforded little space, privacy or room for personal storage. In many cases, lockers and wardrobes were quite small and did not accommodate sufficient clothing to allow residents to exercise choice. In a number of the rooms the wardrobes were stored away from residents' bedsides therefore they were inaccessible for residents which made it difficult for them to retain control over their possessions and clothing.

22. Action Required:

Under Regulation 12(c) you are required to: Provide adequate space for each resident to store and maintain his or her clothes and other personal possessions.

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

HIQA did not agree this action plan with the provider despite affording the provider two attempts to submit a satisfactory response

Proposed Timescale:

Outcome 18: Suitable Staffing

Theme:

Workforce

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

As identified on the previous inspection there was evidence that staff were frequently moved from unit to unit. Although this had improved somewhat since the previous inspection it remained an issue. The duty rota was completed centrally by the night staff with the CNM's on the units not having control over the allocation of their staff or skill mix.

23. 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:

To meet regulation 15 (1), Management will ensure that the number and skill mix of staff is appropriate to meet the needs of the residents. All CNM's will be given greater input and responsibility into the skill mix and allocation of staff on their ward.

2. To ensure greater continuity of care, a review of the duty rotas will take place in consultation with the CNM's, to allow for staff to be allocated to the same ward for a period of 12 months.

Proposed Timescale: 30/06/2018