Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People

Name of designated centre:	Kanturk Community Hospital
Name of provider:	Health Service Executive
Address of centre:	Kanturk, Cork
Type of inspection:	Unannounced
Date of inspection:	04 July 2018
Centre ID:	OSV-0000572
Fieldwork ID:	MON-0024258

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

Kanturk Community Hospital is a designated centre operated by the Health Service Executive (HSE) and registered to accommodate a maximum of 40 residents. The centre is a single-storey building located on the outskirts of Kanturk town. Accommodation is provided for residents in six single rooms and five wards where occupancy levels range from four to nine residents. The centre provides residents with access to a communal sitting and dining area, as well as a small visiting room and a secure garden area with seating. The service provides continuing care for people, mainly over 65 years of age, across a range of abilities from low to maximum needs, though in some instances younger residents can be accommodated. The service also provides respite, palliative and rehabilitative care. The centre provides residents with medical and pharmacy services, as well as a range of allied healthcare services that are accessible on referral. A registered medical practitioner regularly attends the centre. Residents are provided with relevant information about the service that includes advice on health and safety, how to make a complaint and access to advocacy services.

The following information outlines some additional data on this centre.

Current registration end date:	27/06/2018
Number of residents on the date of inspection:	40

How we inspect

To prepare for this inspection the inspector or inspectors reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
04 July 2018	10:15hrs to 17:30hrs	Mairead Harrington	Lead
04 July 2018	10:15hrs to 16:00hrs	Susan Cliffe	Support

Views of people who use the service

The inspection took place over one day. Inspectors met and spoke with residents throughout the inspection in various locations of the centre, including on the wards, in communal areas and in individual rooms. Inspectors received feedback from several residents on each of the wards and also met with some of their visitors and relatives. Feedback was generally positive about the standard of care provided. Residents commented on staff being helpful and considerate, and that they felt their well-being had improved as a result of their time in the centre. Some residents spoken with commented that there was little to do during the day and that they would like to go outside more.

Capacity and capability

The findings of this inspection were that the registered provider had failed to ensure that an effective and safe service was provided for residents living in Kanturk Community Hospital.

The registered provider had not ensured that the service provided met the needs of the residents living there, particularly in terms of the arrangements for fire-safety, infection control, staffing, access to meaningful recreation and activities, personal accommodation and storage. Although some improvements, namely the refurbishment and decoration of some bedrooms and work to the visitor's room, had been completed, the provider had not adequately addressed many previously identified regulatory non-compliance's, nor had it taken a proactive approach to ensure that the designated centre was fit for purpose. For example, senior managers confirmed that information relating to occupancy levels was not used by the registered provider to inform the profile and number of residents living in the designated centre. Long-term residents continued to be accommodated in multi-occupancy rooms for up to nine people, a situation which adversely impacted on the daily quality of life, privacy and dignity of many residents. These circumstances were acknowledged by both staff and management.

The registered provider had not ensured that the prevailing culture in the centre was appropriate in terms of delivering a social model of care. While some good examples of person-centred care were in evidence where staff were seen to provide assistance to individual residents that considered personal preferences appropriately, the culture observed in relation to daily routines generally reflected a medical model of care. In these instances care was characterised by task orientation and institutional practices that did not prioritise recreation and social interaction for residents, for example. In particular the registered provider had failed to ensure that residents in the centre had access to meaningful activities on a daily basis.

Interim governance and management arrangements in place did not empower local

managers with the necessary authority to effect the substantive cultural change required in the centre. Specifically the provider had yet to recruit and formally appoint a director of nursing, the senior nursing position in the designated centre. In the absence of such an appointment that position had been filled in an acting capacity for over a year. Action was also incomplete with regard to the segregation of staff roles and related training.

This inspection found that the registered provider had not ensured that there was an effective system of risk management in place. For example repeated issues identified by the service fire-safety manager in relation to areas of risk had not been effectively addressed as detailed further in this report.

In addition gaps in record management were also evident including:

- recording of information for notification on a quarterly basis was incomplete,
- four personnel records reviewed did not contain An Garda Síochána (police) vetting disclosures in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012.

On a positive note action had been taken since the last inspection to address training gaps with all staff now trained in fire-safety, manual and people handling and safeguarding residents from abuse. Measures such as audits and review were in place to monitor the quality of service and records were maintained and available for reference. Quality management systems included regular meetings to review issues in relation to health and safety or clinical governance. Regional meetings also took place across the organisation to ensure shared learning. These systems required further development to ensure that learning and areas for improvement identified were proactively addressed to effect an improvement in the quality of life for residents.

Residents were provided with a guide that included information on the facilities and services as well as how to raise a complaint or concern and the contact details of independent advocacy services. Opportunities for consultation took place, such as regular resident meetings, and records of these were available for reference. An annual quality review was in place though it was incomplete and required further development in relation to consultation processes in keeping with regulatory requirements

In conclusion the findings of this inspection were that significant action was required on the part of the registered provider to ensure improved regulatory compliance and the provision of a safe and effective service for residents.

Regulation 15: Staffing

Staffing levels were in keeping with the assessed needs of residents having regard to the size and layout of the service. Contingency arrangements were kept under review in relation to managing staff absences. Appropriate systems of supervision

were in place with a registered nurse on duty at all times.

Judgment: Compliant

Regulation 16: Training and staff development

Multi-task attendants (MTA's) continued to undertake both household duties and also the provision of personal care to residents, altering roles as circumstances and staffing levels changed over shifts. Management confirmed that not all MTA's had received specific training or education relevant to the provision of resident care. The roles of MTA's were not clearly documented. Arrangements for ensuring that MTA's had the appropriate level of competence for the duties of care being undertaken were unclear and appraisals were not taking place.

Judgment: Not compliant

Regulation 21: Records

An Garda Síochána (police) vetting disclosures in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 were not available in the designated centre for each member of staff, as required under Schedule 2 of the regulations. In addition a record of complaints was not available for reference at the centre at the time of inspection as required under Schedule 4 of the regulations.

Judgment: Not compliant

Regulation 23: Governance and management

Management systems in place were not in keeping with the statement of purpose and could not consistently and effectively ensure that the service provided was safe and appropriate. Risk management processes were not effectively implemented, particularly in relation to fire-safety. The deployment of staff resources was not always appropriate and in keeping with the assessed needs of residents, particularly in relation to facilitating personal preferences, such as access to outside space. The annual quality review did not fully reflect consultation processes.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

Contracts of care had yet to be revised to fully reflect regulatory requirements in keeping with an action proposed by the provider in response to findings from the last inspection.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Notifications returned as part of required information on NF39's were incomplete and did not include figures on the use of chemical restraint.

Judgment: Not compliant

Regulation 34: Complaints procedure

Procedures for receiving and responding to complaints were in keeping with the requirements of the regulations. A complaints policy was in place and a summary of the procedure was on display in the centre. The policy cited relevant legislation and identified both the complaints and appeals officer. The procedure summarised an internal appeal process and provided contact information for the office of the Ombudsman.

Judgment: Compliant

Quality and safety

The findings of this inspection are that significant improvements are required to enhance the quality of life of residents living in Kanturk Community Hospital. The prevailing culture of the designated centre was one reflective of a hospital rather than a home. The daily life of residents was dictated by unconscious institutional practices with very little opportunity for autonomy and personal choice.

Management had taken some positive action to address areas for improvement that had been identified on the previous inspection. Training for all staff had been completed in safeguarding and the management of responsive behaviours. Parts of the centre had been refurbished and nursing stations had been reviewed to alleviate

pressure on the available personal space for residents.

Systems were in place to monitor the quality and safety of the service, though action in response to areas identified for improvement was not always effective. A risk assessment by the fire-safety manager had identified issues to be addressed in relation to occupancy levels and staffing arrangements, particularly at night, where the recommended control measures had not been fully implemented. Procedures for fire-safety management required attention and improvement.

Inspectors found that staff demonstrated good knowledge and understanding of the needs of residents, though this information was not always reflected in individual care plans. Overall, residents received a good standard of care and access to medical resources and the services of allied healthcare professionals were in keeping with the assessed needs of residents.

During the course of this inspection institutional practices were seen to impact on many aspects of each resident's day to day living experience. Residents were not afforded choice in terms of when to get up in the morning, whether or not they wished to have a wash, or even in choosing where to sit in a communal dining room at meal time. Staff were kind and well-meaning but care did not evidence a resident's right to choice.

A large communal dining area and sun room were available for residents and many residents were seen to access this area independently or with the assistance of staff. However, residents were not offered a choice of where to sit at lunch time and instead were directed by staff to sit in "their" seat at lunch time. The women sat in the area of the sun room and the men sat inside this in the adjacent day room. Residents verbalised a wish to sit in different areas with different people for different meals, with men and women mixing, but they didn't think they could.

On the day of the inspection, a beautiful summer's day, one resident's request to sit outside in the sun was not facilitated. Instead that resident was brought back to sit beside her bed after lunch where she would be safe, sitting in a very small confined space looking at another resident in the bed across from her. This was in spite of the fact that there was a lovely sheltered and protected outdoor space available that allowed residents to watch passers-by and interact with acquaintances accessing other services on this campus. However, no staff were allocated to the outdoor area to support residents to avail of it. Staff explained that the resident in question could only avail of this resource when relatives were available to accompany the resident ensuring that the resident didn't fall. While several residents were seen to avail of this area during the day, there were at least five residents seated in the sun room who expressed a wish to also sit outside but explained that they did not think that they could.

During the course of this inspection it became evident that there was very limited choice of daily activities for residents. Dedicated activities took place for only 2.5 hours per week and the centre was otherwise reliant on community groups or student programmes that were not regularly available.

Personal storage facilities were very limited and some residents were living in the

centre for more than a year with only a standard bedside locker for personal storage. Many of these could not be locked as residents had not been provided with a key. The clothing of some residents was seen stored on an open shelf in a separate room which could not be accessed by any resident independently. The manner in which this clothing was stored was chaotic and disrespectful. Personal space between beds was cramped; in one 4 bedded area all four residents chose to spend the day by their bedside. In this instance specialised seating for one resident took up significant space occupying the area between two beds so that another resident could not sit out in a chair to have lunch.

Overall the quality and safety of care in Kanturk Community Hospital required significant review to achieve compliance with the regulations for designated centres for Older People. Institutional practices and limitations of the premises continue to impact adversely on the quality of life for residents living there.

Regulation 11: Visits

Having regard to the number of residents accommodated in communal rooms, the provision of only one private visiting room was not adequate to the requirements of the service.

Judgment: Not compliant

Regulation 12: Personal possessions

Appropriate personal storage arrangements and facilities were not in place to ensure that residents could retain practical control over, and access to, their personal belongings. In the absence of available personal storage residents' belongings and clothing were seen under beds, on window sills, or hung around bed-frames, on the back of armchairs and on wardrobe doors for lack of appropriate storage.

Many residents could not independently access their own belongings when and if they wished to.

Judgment: Not compliant

Regulation 17: Premises

The premises did not provide accommodation and facilities for all residents that was appropriate to their needs in accordance with the statement of purpose as prepared under Regulation 3. A condition of registration referenced in the statement of purpose required that reconfiguration of the physical environment be completed by

December 2018. This was based on a commitment given by the provider to the Chief Inspector. However, at the time of inspection works in this regard had not commenced.

Judgment: Not compliant

Regulation 26: Risk management

A comprehensive risk management policy was in place that identified the controls and measures for managing identified risks. However, risk areas identified during inspection that had not been addressed included unrestricted access to risk-related areas, such as sluice rooms when the doors were left open.

Also there was no signage to indicate that an oxygen cylinder was stored in a nurses' station.

Judgment: Not compliant

Regulation 27: Infection control

Infection prevention and control procedures to protect residents from the risk of healthcare-associated infections were inadequate, such as:

- beds were arranged in very close proximity to each other
- only one of three sluices was functional at the time of the inspection and there were no alternative arrangements in place for the appropriate cleaning of urinals and commodes
- cloths and cleaning items were observed hanging from or lying on hand wash sinks for extended periods of time
- access to restricted areas that presented a potential risk in relation to infection control, such as cleaning rooms and the sluice, were not consistently controlled
- cleaning products were stored with sterile dressings in one storage unit and a disused catheter was observed beneath a bed
- equipment such as wheelchairs and commodes were inappropriately stored in residents rooms, bathrooms and corridors.

Judgment: Not compliant

Regulation 28: Fire precautions

Areas of risk that had been identified by the service fire-safety manager had not

been effectively addressed. These included:

- occupancy levels
- staffing arrangements,
- inadequate or obstructed evacuation access in some areas of the centre such as a narrow corridor and doorway.

It was evident during the inspection that access through corridors and fire-escapes was often impeded by the positioning of furniture and bins. In addition mobile air-conditioning units that were in place to alleviate hot weather conditions also presented a hazard for effective evacuation of the centre.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Care plans were not being regularly revised to reflect changing requirements and did not adequately reflect the actual circumstances of care for each resident. A recent update of the care plan of one resident was a paper exercise which was not in any way reflective of the personal preferences or recent allied health review and assessment of the resident. Care planning for end-of-life preferences was not always in place.

Judgment: Not compliant

Regulation 6: Health care

The centre provided appropriate access to medical and healthcare services.

Judgment: Compliant

Regulation 8: Protection

There were relevant policies and procedures in relation to the safeguarding of residents and all staff had received training in this regard.

Judgment: Compliant

Regulation 9: Residents' rights

Appropriate arrangements were not in place to ensure that the rights of residents were respected in relation to privacy, dignity and their ability to exercise personal choice. Examples included:

- Multi-occupancy rooms that were crowded and afforded residents very limited personal space, privacy or storage for personal belongings.
- Accommodation layout was such that visitors and residents had to walk through the personal space of residents for access; the nine-bedded ward could only be accessed by walking through the adjacent eight-bedded ward, for example.
- In some bed spaces no privacy screens were in place.
- Mobile privacy screens and window curtains were not routinely used by staff and did not effectively protect personal privacy when personal care was provided or when a resident wished to be alone.
- Information around care planning arrangements for individual residents was sometimes displayed adjacent to a resident's bed, and such practice did not protect private information about the resident.
- The close proximity of bed spaces limited residents in the extent to which they could exercise choice around activities in their personal space, such as watching TV or listening to the radio, without adversely impacting on other residents.
- These circumstances confined residents and limited the extent to which they could be facilitated to exercise choice with regard to how and where they ate their meals, where they spent their day and how or with whom they interacted.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Not compliant
Regulation 12: Personal possessions	Not compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management	Not compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Kanturk Community Hospital OSV-0000572

Inspection ID: MON-0024258

Date of inspection: 04/07/2018

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant 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 document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:

1. Following recent agreement with the Unions, segregation of roles is being implemented from 15th October 2018 which will ensure clarity of cleaning, caring and kitchen roles. This will be implemented when the new roster commences on 15th October 2018.

2. The concept of Performance Coaching is to be introduced, starting with the DON and CNM2 whereby in time all staff will be given an opportunity to review their roles and responsibilities. This also provides staff with an opportunity to identify goals for the year and any training needs.

3. CNM2 and identified senior staff nurses will be facilitated to attend Performance Coaching training to assist as part of the team in carrying out performance coaching to all staff. This is being facilitated by the Performance and Development Unit of HSE and will be held before 1st November 2018.

4. All mandatory training is provided primarily by in-house training and staff are also encouraged to identify their own training needs to management. This is facilitated through the Performance Coaching process. Nursing Staff have been introduced to the various HSELand online training programmes which are available. Nursing Staff have commenced training in the following via HSE Land: Medication Management, Children First, Pronouncement of Death etc.

5. Nurses have been facilitated in Delegation training – 16 staff have been trained with 4 staff yet to receive training on 7th October 2018. This will provide staff clarity on the roles that can be delegated to HCA role and what is their role as nurses.

6. All staff have been facilitated to attend Person Centred and Responsive Behaviour training (completed on 17th August 2018) with 46 staff trained. 7 staff remain not

trained as they are out on maternity/sick leave but will be facilitated on their return from leave.

7. All staff given hard copy of Hospital Safeguarding policy and provided with Safeguarding Training which has increased the awareness and the reporting mechanism on what they should do if they have a safeguarding concern.

8. A number of Multi-Task attendants do not have the FETAC 5 Healthcare course are being encouraged to complete same. Two staff are being facilitated to start their Fetac Level 5 training starting on the 15th October 2018.

9. Director of Nursing has completed a Certificate in Health Services Management from University of Limerick. A/CNM11 has completed the LEO Managerial Programme and is planning to do the First Line Manager Course in November 2018. These courses will assist in the supervision and mentoring of staff, and the management of performance issues.

10. Clinical Support Manger from the General Manager's office has been specifically assigned to work with the Management team in the past month – one day a week – to improve compliance with HIQA standards and support governance of the Centre.

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records

1. Complaints record and log are available to all staff and residents in the centre.

2. A review of all complaints and incidents for 2017, will be undertaken to identify if all complaints and incidents were properly recorded and ensure that all necessary actions were undertaken. This will be carried out by the General Manager's office by the 1st October 2018.

This compliance plan response from the registered provider did not adequately assure the office of the chief inspector that the actions will result in compliance with the regulation.

3. A comprehensive review of staff files is currently underway to ensure full compliance in relation to Garda vetting and disclosures. 31st October 2018

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

This compliance plan response from the registered provider did not adequately assure the office of the chief inspector that the actions will result in compliance with the regulation.

1. The Registered Provider has engaged the National Service Improvement Team to conduct a comprehensive review of the current management structures in Kanturk Community Hospital to ensure clear lines of authority and accountability and that the

service provided is safe, appropriate, consistent and effectively monitored. The Service Improvement Team carried out a two day inspection in July 2018 and its report is currently being reviewed with a clear commitment to implement the recommendations.

2. The recruitment campaign for a permanent Director of Nursing for the centre is with the HSE National Recruitment Service and is hoped that this competition will be advertised before 31st October 2018.

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3. A Management and Governance plan is currently being developed between Nursing Management and General Manager's Office. 30th September 2018.

4. The General Manager and the DON are currently engaged in clearly setting out the roles and responsibilities of the DON, CNM, and senior nurses. Job descriptions have been agreed and discussions with staff are planned in the next two weeks for agreement and implementation by 01/10/2018.

5. Full managerial cover is being provided to the centre. When the DON is not on duty a CNM2 or Senior Nurse will be in charge of the centre. This will be clear on the roster. When the CNM2 is not on duty a Senior Nurse will fill in for her absence. This will ensure clear and good governance to the centre at all times.

6. The DON and CNM2 will meet each morning to review each resident and also to deal with any issues that have arisen. Any actions that are agreed will be documented in their daily record. This provides a record and ensures that follow up of any actions are clear. The CNM2 is clear that it is her responsibility to inform the DON of any issues that have been reported to her are communicated to the DON at this meeting. Any issues that are outside of the control of local management will be escalated to the General Manager. At weekends there is a Senior Staff Nurse appointed to be in charge and they are now clearly documenting and informing the DON and/or CNM2 of any incidents, accidents and any other issues that may have arisen over the weekend. The DON has outlined to staff via the staff meetings and via the CNM2 the importance of reporting any incidents that occur and the importance of notification of these incidents in a timely manner. The CNM2 has started having a weekly staff meeting to encourage better communication between management and staff. The DON has held the first of the monthly meetings that she will have with nursing and support staff.

7. The process of reporting all incidents of concern will be reported to the Director of Nursing, and in her absence to the CNM11, or the Nurse in Charge of the shift. All incidents forms are being completed immediately after the incident has occurred by the person who witnessed the incident. Incident forms are given to the Person in Charge on the day of the incident. Any significant incidents are reported as per HIQA requirements.

8. In the absence of the CNM2, a nominated Senior Staff Nurse will be the person in charge for Day duty and at weekends. This is indicated on the nurses' roster. All issues of concern will be communicated through this Senior Staff Nurse. Director of Nursing now conduct "Walk around audits", three times of the day to monitor

staff/resident interactions and to manage any issues/concerns that she has.

9. CNM2 and some Nurses will continue audits of care using the quality metrics, areas of improvement recorded, collated, analysed and resolved in consultation with staff and resident. This process has commenced and monthly reviews are undertaken by nursing management and actions communicated to staff via ward meetings/safety pause meetings.

10. The CNM2 or Senior Nurse in charge on duty is clear that her role is to be visible in each of the wards throughout the day by being on the wards and communicating their expectations to staff as they go around. This will ensure that best practice standards are maintained and also highlight areas where actions need to be addressed.

11. A formal reporting mechanism has been developed, whereby Nurse in charge will meet with DON or CNM11, after any period of absence to communicate any relevant information. This meeting is also recorded to ensure follow up on any actions.

12. The Director of Nursing will support and guide the CNM2, in the management of clinical issues, complaints and concerns, in accordance with National policy, and local guidelines to ensure the delivery of high quality, evidence based safe care. This will be done through their daily meeting and the CNM's good communication with all staff grades.

13. All staff who care for the residents participate in the nursing handover to ensure that they are kept up to date with the residents condition and what care the resident requires during that day/night.

14. The ISBAR communication tool has been introduced to assist in communication of clinical events that occur and the ISBAR handover sheet will be implemented by 1st October 2018 to provide a communication tool for each staff member to ensure that they have all information about the resident and what their particular needs are.

15. The Safety Pause has been introduced daily, and is attended by all staff which provides staff with an update on changes in residents' condition, details of admissions and discharges, any actions that need to be implemented by staff and raises awareness of issues of concern.

16. Staff meetings have been introduced and will be held every week with the CNM2 and monthly with the DON to ensure all members of the team are aware of the best practice standards, and to address any issues or concerns. Minutes of these meetings are made available to staff in the staff room. Staff are encouraged to provide items for the agenda.

17. To meet the recreational needs of the residents, an Activities Co-Ordinator has been recruited to the Centre and they are working 30 hours per week. Elderwell, an activities company, will continue to provide a service, one day a week until such time as a review is carried out.

Regulation 24: Contract for the provision of services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 24: Contract for the provision of services: 1. All contracts of care have been revised to ensure that residents are clear on where their bed is situated in the hospital and that they are in a 2/3/4/5 bed multi-occupancy room. 2. All residents have received a copy of their contract of care and hospital booklet outlining the services provided in the Centre.	
Regulation 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: The A/DON and A/CNM11 clearly understand their role in relation to identification of notifiable events, and the timeframe for submission to HIQA. 1. The A/DON has now included in the quarterly return the use of chemical restraint (NF39's) and the importance of reviewing all residents on psychotropic medications and any other form of restraints. 2. Restraint log is held at the Centre and is updated with changes as they occur. 3. Review of the use of restraint is carried out on a monthly basis with the aim to reduce the use of chemical and physical restraint by using alternative methods. 4. Following a recent review by A/ DON she met with Medical Officers and requested review of patients medications. One resident has been referred for psychiatric review on 11th September 2018. 5. All staff in charge at weekends will discuss with A/DON/CNM2 any incidents that have occurred over the weekend to ensure that PIC is aware of incidents and can review them and if notifications or actions required they can respond within the 3 working days. 6. Any safeguarding incidents will be notified to HIQA within 3 working days as required in the timeframe for submission. 7. All staff are aware of the different types of incidents that are notifiable to HIQA within the 3 working days. To ensure that this occurs a daily meeting of A/DON and A/CNM2 all incidents will be reviewed on a daily basis and notification will be made, where required. 8. Review of incidents will be done by the CNM2 on a monthly basis and A/DON will be informed of any actions following the review. Staff will be informed of the results via the Safety Pause if urgent actions required or via the Staff Meetings each week. 9. Safeguarding Incidents will be prioritised to the A/DON and actioned immediately to ensure the safety of all residents.	
Regulation 11: Visits	Not Compliant
Outline how you are going to come into compliance with Regulation 11: Visits: ***This compliance plan response from the registered provider did not adequately assure the office of the chief inspector that the actions will result in compliance with the regulation.***	

1. A new space has been created for a sitting area for use by residents and their families.

2. In the context of the planned works due to take place around fire safety & evacuation risks at the end of September 2018, it is planned to carry out a review to identify further private spaces that could be made available for residents use and also to see if tea/coffee making facilities could be provided in the new sitting area.

3. At ward level, staff have been reminded to ask relatives to wait outside until personal care is completed and to encourage visitors to meet in the current quiet spaces available throughout the Centre.

4. As much as possible residents are encouraged to use the bathrooms for personal care and toileting needs
5. A Design Team has been appointed to progress with the Capital Project for the Centre. Progress is advancing and it is expected that preliminary drawings and estimated costs will be issued to HSE Estates for Stage 1 Capital Approval shortly. Pending Stage 1 Capital approval, it is anticipated that the project will advance to planning, Capital Approval Stage 2b in Quarter 4 2018.

Regulation 12: Personal possessions	Not Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:

This compliance plan response from the registered provider did not adequately assure the office of the chief inspector that the actions will result in compliance with the regulation.

1. All lockers now have a functioning locking mechanism.
2. In the context of the planned works due to take place around fire safety & evacuation risks at the end of September 2018, it is proposed that a review will take place to see if there is any further capacity to allow greater bed space for residents which will allow them to have their own wardrobe and locker within their bed space.
3. Residents are encouraged to bring personal items from home to personalise their bed spaces and make them homelike.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

This compliance plan response from the registered provider did not adequately assure the office of the chief inspector that the actions will result in compliance with the regulation.

1. A Design Team has been appointed to progress with the Capital Project for the Centre. Progress is advancing and it is expected that preliminary drawings and estimated costs will be issued to HSE Estates for Stage 1 Capital Approval shortly. Pending Stage 1 Capital approval, it is anticipated that the project will advance to planning, Capital Approval Stage 2b in Quarter 4 2018

Regulation 26: Risk management	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management:

1. All sluice rooms are locked and have keypad access for staff.
2. All oxygen cylinders are now being stored outside in an appropriate safe locked area.
3. The centre holds a Risk Register which records all risks which are actual and potential risks.
4. Any Risks that are rated 20 or above are escalated to the General Manager
5. A risk assessment will be completed in all reported incidents which have a potential risk to residents and ways of reducing the risk will be acted upon.
10. The HSE National Incident Management System is being used to document and incidents and also as a means of trending all incidents.
11. A review of all incidents for 2017 to be conducted by General Managers Office by 30th Sept. 2018.
12. All safeguarding incidents to be recorded, HIQA informed and Preliminary Screening form completed for Senior Social Worker in Safeguarding Team, all to be completed within 3 days of incident occurring.
13. Risk Assessments to be completed on any incident or safeguarding incident which has a potential risk to residents in the centre. All risks to be added to risk register and if risk rating above 20, notification to the General Manager must be made on the same day.
14. Auditing of all incidents will be carried out by the CNM2 on a monthly basis to ensure that all incidents were managed correctly. Any learning from incidents will be shared at the Safety Pause and the Staff meetings – a Safety Learning Sheet will be developed for use for staff by 15th October 2018.
15. Risk Register to be updated as each new risk is inputted.
16. Support from Quality and Safety Patient Manager to be sought when needed.
17. HSE has new Risk Manager for Community Hospitals recruited and this is a source of support for the management of the Centre to help to identify and reduce risks.
18. The development of a Health and Safety Committee is planned for October 2018 in the Centre to increase awareness and ensure the safety of residents and staff.
19. Recent recruitment of Practice Development Personnel for Community Hospitals will support the Centre in ensuring policies are updated and based on best practice.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:

This compliance plan response from the registered provider did not adequately assure the office of the chief inspector that the actions will result in compliance with the regulation.

1. Two sluices are now fully functional and a new bed pan washer is awaiting delivery on the 28th September 2018 for the third sluice.
2. All cleaning items are now stored in a locked area. There has been an introduction of the use of disposable cloths to reduce the risk of cross infection.
3. The storage of equipment will be further reviewed with the planned reduction of the bed capacity so that no equipment is stored in any of the bathroom areas. This will

be completed on the 27th Sept. 2018.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:

1. A development programme in relation to fire safety and emergency procedures has been developed and is being implemented in the Hospital with a number of measures already been put in place in terms of all staff completing fire safety training and simulated evacuation training.

2. A PEEP (Personal Evacuation Plan) has been put in place for each resident and will be reviewed on a monthly basis or when a residents' condition changes.

3. The relevant certificates confirming up to date maintenance and service checklist of the Fire Alarm, Emergency Lighting, Fire Equipment and Electricity have been reviewed. L1 certificate will be provided by Monday 17th September 2018.

4. In relation to the evacuation of residents, the HSE Fire and Safety Officer in conjunction with the Estates Dept and in consultation with the Fire Dept, Cork County Council has developed a plan which will greatly assist in the evacuation process. The planned work which is scheduled to commence on 27th September 2018 will involve the widening of doors in a number of wards. These works will necessitate an initial reduction of 7 beds. The fire door in the kitchen has also been identified to be replaced. The admission of respite patients has ceased and the removal of the associated empty beds has already commenced to allow for these works to commence.

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:

1. Each staff nurse has been allocated the responsibility of an individual residents' care plan. Refresher Training on Nursing Documentation is being given in September and October 2018 to all nursing staff to support this. Each residents' care plan will be reviewed on a four monthly basis and also when a residents' condition changes. The CNM2 now takes an active role in ensuring that all assessments, monthly weights, bloods etc are undertaken and that all new admissions care records are completed within 72 hours of admission.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights
This compliance plan response from the registered provider did not adequately assure the office of the chief inspector that the actions will result in compliance with the regulation.

1. To support the Residents' rights to choose to participate in different activities, the

Activities coordinator has met with each of the residents in asking them what activities they would like to be involved/or not involved in. The Activities Co-ordinator is currently developing an Activities Programme according to the resident's requests in relation to activities.

2. The Activities Co-Ordinator has met with all residents and explained to them the Complaints procedure: "Your Service, Your Say". This has provided the resident with an understanding on how they can have their say on how they live their lives in the centre.
3. The Activities Co-Ordinator met with each resident in a group and individually to discuss the Safeguarding Policy and how they might, as individuals, wish to report or be aware of any safeguarding issues.
4. The Hospital Booklet was given to each resident to provide them with information on the services that are provided to each of the residents here in the Centre.
5. The residents are provided with a menu choice on a daily basis so that they can choose from the menu their preferred choice. They also have the option of requesting other food choices.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 11(2)(b)	The person in charge shall ensure that having regard to the number of residents and needs of each resident, suitable communal facilities are available for a resident to receive a visitor, and, in so far as is practicable, a suitable private area, which is not the resident's room, is available to a resident to receive a visitor if required.	Not Compliant	Orange	30th September 2018.
Regulation 12(a)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that a resident uses and retains control over his or her clothes.	Not Compliant	Orange	30th November2018
Regulation 12(c)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that he or she has adequate space to	Not Compliant	Orange	30th November 2018

	store and maintain his or her clothes and other personal possessions.			
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	30th September 2018.
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30th September 2018
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.	Not Compliant	Orange	30th September 2018
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Orange	December 2021
Regulation 21(1)	The registered provider shall 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.	Not Compliant	Red	30th September 2018
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Not Compliant	Orange	30th September 2018.
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and	Not Compliant	Orange	30th September 2018

	effectively monitored.			
Regulation 24(1)	The registered provider shall agree in writing with each resident, on the admission of that resident to the designated centre concerned, the terms, including terms relating to the bedroom to be provided to the resident and the number of other occupants (if any) of that bedroom, on which that resident shall reside in that centre.	Substantially Compliant	Yellow	30th September 2018
Regulation 26(1)(a)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.	Not Compliant	Orange	30th September 2018
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Not Compliant	Orange	30th September 2018
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Orange	30th September 2018
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	30th September 2018
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	30th September 2018.

Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.	Not Compliant	Orange	30th September 2018
Regulation 31(3)	The person in charge shall provide a written report to the Chief Inspector at the end of each quarter in relation to the occurrence of an incident set out in paragraphs 7(2) (k) to (n) of Schedule 4.	Substantially Compliant	Yellow	30th September 2018
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Not Compliant	Orange	30th September 2018
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Not Compliant	Orange	30th September 2018
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Not Compliant	Orange	30th September 2018
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Not Compliant	Orange	30th September 2018
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Not Compliant	Orange	30th September 2018
Regulation	A registered provider shall,	Not	Orange	30th September

9(3)(c)(iii)	in so far as is reasonably practical, ensure that a resident telephone facilities, which may be accessed privately.	Compliant		2018