Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

# Report of an inspection of a Designated Centre for Older People

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| Name of designated centre: | Kanturk Community Hospital |
| Name of provider: | Health Service Executive |
| Address of centre: | Kanturk,<br>Cork |
| Type of inspection: | Unannounced |
| Date of inspection: | 01 November 2018 |
| Centre ID: | OSV-0000572 |
| Fieldwork ID: | MON-0025349 |

## 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). It is located on the outskirts of the town of Kanturk, Co. Cork. The centre is a single-storey building and the layout comprises a long corridor with multi-occupancy wards on either side of the corridor. Bedroom accommodation comprises six single rooms with wash-hand basins and five multi-occupancy rooms with four to six residents. Toilet, shower and bath facilities are available throughout. Communal areas comprise a day room which is also the dining area, a conservatory, church, and a small quiet room and a secure garden area with seating. The service provides 24-hour nursing care to both male and female residents whose dependency range from low to maximum care needs. Long-term care, respite and palliative care is provided, mainly to older adults.

**The following information outlines some additional data on this centre.**

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| Number of residents on the date of inspection: | 29 |

## 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 |
|---|---|---|---|
| 01 November 2018 | 10:10hrs to 16:20hrs | Breeda Desmond | Lead |
| 01 November 2018 | 10:10hrs to 16:20hrs | Susan Cliffe | Support |
| 01 November 2018 | 10:10hrs to 16:20hrs | Niall Whelton | Support |

## Views of people who use the service

Inspectors met with several residents throughout the inspection. Feedback was positive regarding the kindness of staff and the quality of their meals. They reported that a new activities co-ordinator was appointed and while there was an increase in activities, the range and availability of meaningful activities could be better; inaccessibility to the outdoors was also highlighted.

## Capacity and capability

Poor findings and inadequate provider responses to the three inspections completed since January 2018 precipitated this follow up inspection. The findings from this inspection demonstrated that the Health Service Executive (HSE) had failed to address the deficits in governance and management identified on the previous inspections. The HSE did not take the necessary measures to ensure that the service was safe, appropriate, consistent and effectively monitored.

The absence of an effective system of governance was evident in:

- a failure to progress remedial works required to address fire safety risks
- a failure to take all necessary action to improve the privacy and dignity of residents
- a lack of involvement of and oversight by senior managers in plans to address both of the above issues
- a comprehensive review of occupancy levels was not carried out to inform the profile and number of residents who could appropriately be accommodated in the centre
- findings of repeated regulatory non-compliance over four inspections.

The inspection of the 08 August 2018 raised concerns about fire safety in Kanturk Community Hospital. On foot of these concerns the Office of the Chief Inspector referred the centre to the local Fire Authority for review. This inspection found a lack of urgency on the part of the HSE in responding to the issues raised and a failure of senior HSE managers with responsibility for the centre to take ownership of and implement the required measures. As a result, there was a fragmented approach to addressing those issues as evidenced by:

- the removal of an extra staff member rostered on night duty to assist in evacuation if necessary without referral to or advice from the fire safety officer
- the absence of a comprehensive plan on the day of the inspection (Thursday)

to underpin works to upgrade fire safety infrastructure due to commence the following Monday
- newly installed externally facing door handles to fire exit doors where staff may be required to assist with evacuation from the outside, were not working as intended.

Despite three inspections with findings of poor regulatory compliance since January 2018, the HSE had failed to implement their own compliance plan and to make the necessary improvements. For example:

- the provider had yet to recruit and formally appoint a director of nursing, the senior nursing position in the designated centre
- long-term residents continued to be accommodated in situations which adversely impacted their daily quality of life, privacy and dignity
- 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
- while staff training had been conducted, there was no system to determine if training to ensure the protection of residents was understood and implemented
- following a reduction in the number of residents accommodated in the centre, the registered provider had failed to ensure that the space created by the reduced number of residents was utilised to enhance the quality of life and privacy and dignity of the remaining residents.

The evidence of this inspection and documentation reviewed demonstrated the absence of a coherent approach on the part of the HSE in addressing fire safety risks while upholding and improving the privacy and dignity of residents living in the centre. Drawings produced on inspection to inform interim fire safety works were not discussed locally, and on review, did not appear to acknowledge the fundamental requirements of privacy and dignity of residents.

In conclusion the findings of this inspection were that the HSE had failed to take the necessary action to strengthen the governance and management of this centre for the purpose of improving the quality of life for residents and supporting the staff on the ground in striving to achieve greater regulatory compliance.

## Regulation 16: Training and staff development

Appropriate staff supervision was not evidenced:

- to enable and ensure the safe delivery of care
- to ensure that practice was in accordance with their policies
- ensure residents were protected from institutional practices.

Judgment: Not compliant

## Regulation 21: Records

Records required as listed in Schedules 2, 3 and 4 were not comprehensive. For example:

- a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 was not in place for five staff members (Schedule 2)
- drug administration records were incomplete in the sample reviewed, so it could not be determined whether residents yad received their prescribed medication
- medication errors were not recognised as such and so they were not recorded (Schedule 3).

Judgment: Not compliant

## Regulation 23: Governance and management

The registered provider failed to ensure that authority and accountability and responsibilities were executed in line with the defined management structure in place for this designated centre and the HSE's own scheme of delegation. The management systems in place did not empower local management to effectively govern and affect change.

The managements systems in place did not ensure that the service provided was safe, appropriate, consistent and effectively monitored as evidenced by:

- delays in addressing identified fire safety issues
- a failure to take all necessary action to improve the privacy and dignity of residents
- a lack of involvement of and oversight by senior managers in plans to address both of the above issues
- findings of repeated regulatory non-compliance over four inspections.

The annual review of the quality and safety of care delivered to residents to ensure that such care was in accordance with relevant standards set by the Authority under Section 8 of the Act was not undertaken in accord with the national standards.

Judgment: Not compliant

## Regulation 3: Statement of purpose

A statement of purpose relating to the designated centre was available for review. However the service provided did not reflect the aims, objects and philosophy of person-centred care advocated in the statement of purpose evidenced by the degree of institutional practices observed.

The statement of purpose stated that all practices in the centre would be informed by policies, procedures and guidance, whenever possible. Such a qualified commitment to adhering to policies and procedures is not in compliance with regulation 4 which states that matters set out in Schedule 5 are adopted and implemented.

The statement of purpose did not contain all required information including:

- the identity of the registered provider
- the reporting structure within the organisation to assist residents and family when reading this information booklet.

Some information included did not protect specific residents' privacy and dignity.

Judgment: Not compliant

## Regulation 31: Notification of incidents

Institutional practices were not recognised as such, and consequently, notifications were not submitted in accordance with the regulations.

Judgment: Not compliant

## Quality and safety

The findings of this inspection were that the registered provider had failed to implement the necessary changes to influence the prevailing culture of a nurse-led medical model of care to a social model of care to enable residents to have a fulfilled quality of life. While some staff understood and demonstrated a strong person-centred approach to care and interactions with residents, the prevailing culture was that of a hospital, focused on caring for 'patients'. Daily routines and practices did not reflect the fact that the centre was a person's home or recognise that while health impacts quality of life, it should not define quality of life

for residents.

As with previous inspections, institutional practices continued to negatively impact many aspects of each resident's daily lived experience. A small number of staff did embody a person-centred approach to care as evidenced in a staff-resident interaction over an un-eaten lunch. In that situation the staff member explored the reason why the resident wasn't eating and offered an alternative which the resident subsequently enjoyed. That staff member was later observed asking the resident if he wanted his dietary preferences updated so that he would not be offered the original meal again. However such interactions were in the minority with many residents unable to exercise personal choice in issues such as when they would get up, how they wished to attend to personal hygiene in the morning or whether they wanted to finish a meal. A significant number of residents remained in bed or sitting by their bedside for the duration of the inspection.

On a positive note, an activities co-ordinator had been appointed since the last inspection, however the range and availability of meaningful activities in accordance with peoples' interests and capacities was inadequate. Inspectors observed that some staff understood their role and responsibilities regarding normal socialisation and engaging with residents, nonetheless, further work was required to highlight the profile of activities as part of the role and responsibility of all staff.

Similar to previous inspections the privacy and dignity of residents was not assured:

- some residents did not have independent access to their personal possessions
- some residents did not have access to an individual wardrobe, rather they were required to avail of a small shelved locked room with residents' names on individual shelves, located outside their bedrooms and not amenable to independent access
- staff did not utilise available bed screening and window curtains to protect residents privacy when performing intimate care.

Inspectors noted the reduction in bed capacity from 40 to 33 beds, however the registered provider had failed to ensure that the additional space was used to enhance the living space of individual residents. Specifically, space was not re-allocated in multi-occupancy bedrooms to improve the living conditions for residents and enable people to have a wardrobe and comfortable chair alongside their bed; it was noted that space created by the removal of a bed was used to store bed tables no longer required. An immediate action issued for the removal of these tables was completed prior to conclusion of the inspection.

Procedures consistent with the national standards for infection control were not demonstrated.

While the provider had taken steps to identify remedial action required to improve the levels of fire safety, there was no meaningful progress made in the implementation of the required works. Inspectors were not assured that the provider had adequate arrangements in place to ensure that all residents could be safely evacuated. This was a repeat finding.

At the previous inspection, the main issue of concern to inspectors was the in-ability of staff to evacuate residents from large multi-bedded rooms, either out of the building or through to an adjoining compartment. To this end, the provider committed to and arranged for an additional staff member to be on duty at night, increasing from four to five staff. At this inspection, the staff roster confirmed this arrangement was in place from 13th August until 30th September, however for three separate weeks of this period a fifth staff member was not in the centre at night. Staffing levels subsequently reverted back to four on duty at night when the numbers of residents living in the centre reduced without review of the totality of the risk associated with evacuating residents from the multi-bedded rooms which still remained.

Improvements in relation to fire safety since the last inspection included the removal of an administration desk outside St Theresa's ward to allow more available space to evacuate beds and the inappropriate storage of oxygen cylinders had ceased. Certificates were now available to demonstrate that the fire detection and alarm system was an L1 category system. This provides adequate fire detection coverage to all parts of the building.

However the HSE had still not made adequate arrangements for the maintenance of means of escape. The findings of this and previous inspections relating to non-functioning exits and damaged or non-functioning fire doors indicated that the system of fire safety checks required review to ensure they were of adequate extent, frequency and detail. For example, a final exit door was difficult to open. Inspectors also observed an exit from one bedroom to be obstructed with a bin, a chair, a mobility aid and a laundry bin. In addition inspectors were not upon completion of the proposed works an effective evacuation strategy could be implemented as detailed under Regulation 28.

Limitations in risk management at the centre remain. For example there was a ramp along the main corridor where there was a change in floor level. Clear markings to help identify the change in floor level and to minimise the risk of falls were not in place. A risk assessment was not available when requested by inspectors.

The sample of care plans and assessments reviewed showed that documentation relating to residents was not comprehensive. They were not reviewed at intervals not exceeding four months. Care planning documentary evidence showed that records were blank regarding consultation with the residents or their next of kin (when appropriate). Consent forms were not in compliance with legal requirements.

Overall the quality and safety of care in this centre required significant review to improve the quality of life of residents living there.

## Regulation 12: Personal possessions

Appropriate personal storage facilities were not available to residents. Residents could not independently access locked rooms located outside their living space where their clothes were stored. The clothing of one resident was stored on the only chair beside their bed space. Another resident's wardrobe was not suitable for their specific needs and that resident had their clothes hanging off the door handle of their wardrobe.

Where wardrobe space was available it was so narrow it could hold very little and did not reflect the holistic approach to living, espoused in the statement of purpose.

Due to a lack of person space and personal storage afforded residents, people were unable to personalise their surroundings with mementos and photographs in keeping with a homely environment.

Judgment: Not compliant

## Regulation 17: Premises

Overall, the premises was not fit for purpose for the number of residents living there. The layout, multi-occupancy bedrooms, lack of separate dining and communal living space, limited quite space, all contributed to a premises that could not enable a holistic person-centred approach to living and being cared for with respect and dignity.

Judgment: Not compliant

## Regulation 26: Risk management

There was a ramp along the main corridor where there was a change in floor level. Clear markings to help identify the change in floor level and to minimise the risk of falls were not in place. This did not form part of the hazard identification and assessment of risks schedule.

Judgment: Not compliant

## Regulation 27: Infection control

The registered provider failed to ensure that procedures, consistent with the standards for infection prevention and control published by the Authority were implemented by staff. For example:

- cleaning staff were routinely used to replace sick leave among care staff resulting in 24 to 48 hour periods without cleaning in the centre
- residents had unrestricted access to clinical waste bins which contained wound dressings
- while there was adequate hand hygiene foam dispensers throughout, there was a lack of advisory signage to demonstrate best practice
- the hand-wash sink in the clinical room was inaccessible due to the volume of items stored there
- there was inappropriate storage of commodes, hoists and linen trolleys in toilets, shower rooms and bathrooms
- one sluice room remained out of order since before July 2018
- cleaning cloths were observed hanging from or lying on hand-wash sinks for an extended period of time.

Judgment: Not compliant

## Regulation 28: Fire precautions

The HSE had failed to take the necessary urgent action to address the many issues pertinent to fire safety in order to ensure the f=safety of the residents living there. Findings of non-compliance reported following the August 2018 inspection were repeated on this inspection 3 months later including

- Deficiencies to some fire doors, examples of which include doors not closing fully, heat and smoke seals partially missing and gaps around the door.
- The in-house fire safety checks required review to ensure they were of adequate extent, frequency and detail.
- The extent, size and location of fire compartments necessary for phased evacuation were not clearly defined on the drawings displayed around the centre.
- As a result of findings at the previous inspection, the provider had arranged for externally facing door handles to be fitted to exits where staff may be required to assist with evacuation from the outside. On this inspection, these handles were not capable of opening the exit doors. Furthermore, the panic bolt on the inside of one exit was not functioning correctly and the exit was difficult to open. This was a repeat finding for this particular door.
- Inspectors noted an improvement in the number of staff who had attended fire safety training, but there was still a cohort of staff who had not attending the required fire safety training in the previous twelve months.

The extent and size of compartments for evacuation was not clear. The registered

provider had commissioned a fire safety engineer to carry out a review of fire compartments in the centre. This review included drawings which showed 'St. Marys Ward' and 'St. Theresa's Ward' forming one sub-compartment, accommodating twelve residents. The report referred to guidance which indicated that where four staff were on duty, there should be a maximum of nine residents in a sub-compartment. However, the evacuation procedure explained to inspectors and detailed in the proposed evacuation strategy did not correlate with the above.

A drawing which detailed a proposed evacuation strategy for the multi-occupancy bedrooms upon completion of the remedial works was provided to inspectors. This drawing which was meant to underpin this evacuation strategy did not appear to consider the totality of furniture accommodated in the receiving room. This layout showed beds tightly fitting beside each other with no consideration for residents personal lockers, wardrobes or comfortable seating which would also be present in the area on any given day.

Judgment: Not compliant

## Regulation 5: Individual assessment and care plan

While all residents had assessment and care plans, the sample viewed showed that these were not comprehensively completed or updated in a timely manner as set out in the regulations. This was a repeat finding from previous inspections.

Judgment: Not compliant

## Regulation 8: Protection

While staff had completed training in relation to the detection and prevention and responses to abuse, this training had not resulted in improved outcomes for residents. This lack of protection was evidenced in the exposure of residents to institutional practices on a daily basis.

Judgment: Not compliant

## Regulation 9: Residents' rights

Institutional practices were observed throughout the inspection and following review of care documentation. Inspectors observed some normal human interactions that respected people's human rights, however, this was not always seen. Some staff

members showed kindness, offered choice, while others performed their duties in a perfunctory manner.

A review of the activities programme was proposed but this had not been completed at the time of this inspection to enable change and improve outcomes for residents. There appeared to be an over-reliance on the activities coordinator to socially engage with residents and it was not seen as the responsibility of everybody to engage and socially interact with residents.

Inspectors observed that just four people came to the dining room for their lunch, all other residents had their meal either in bed or by their bedside. Most residents were assisted with their meal in a respectful manner, however, poor practice was also observed that was not respectful.

Judgment: Not compliant

**Appendix 1 - Full list of regulations considered under each dimension**

| Regulation Title | Judgment |
|---|---|
| **Capacity and capability** | |
| Regulation 16: Training and staff development | Not compliant |
| Regulation 21: Records | Not compliant |
| Regulation 23: Governance and management | Not compliant |
| Regulation 3: Statement of purpose | Not compliant |
| Regulation 31: Notification of incidents | Not compliant |
| **Quality and safety** | |
| 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 8: Protection | Not compliant |
| Regulation 9: Residents' rights | Not compliant |

# Compliance Plan for Kanturk Community Hospital OSV-0000572

## Inspection ID: MON-0025349

## Date of inspection: 01/11/2018

**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:
A training needs analysis has been completed to inform the training needs for 2019.

A training matrix has been developed and clearly outlines the mandatory and desirable training achievements of staff and requirements going forward. This will inform a plan that ensures that:
1) All mandatory training requirements are planned for and achieved in a timely fashion.
2) A program to advance training requirements is included in individual staff plans.
The plan will include course details, training facilitators, and individuals identified for training. To date the key training requirements identified and scheduled include:
• Risk Management training 10th Dec,
• Incident management training Jan 8th & 9th,
• Medication Management 16 Jan,
• Safeguarding 15th & 22nd Jan
• National Dementia training 10th April & 15th May.

Expressions of interest have been sought from staff in the unit for additional training, eg National Dementia program, the Diploma in Gerontology and Fetac V Healthcare Assistant Course.

The safety pause now takes place in the morning (8am approx) with a follow up team talk in the afternoon (3pm approx). The team talk includes a reflective element to allow for discussion and observations around standards of care to be shared with the staff team. The HIQA Standards for Older Persons and clinical guidelines are being used to guide these talks. This allows those responsible to challenge any sub-standards of care and support and highlight good practice. The team talk also facilitates any changes to be shared with staff, such as updates to policies, sharing of preliminary audit findings or any communications received.

Two senior nurses are progressing performance appraisals following the recent completion of performance coaching training.

A performance appraisal schedule has been developed to outline the progress towards completion, identifying any follow ups/ reviews as required and progressing performance appraisals into 2019 as normal. Schedule for performance appraisal:
11 Completed by 21 Dec,
+36 to be completed in Jan and
+16 to be completed by 16th Feb.

The performance appraisals will help to inform a training needs analysis going forward.

The CNM2 or senior staff nurse in charge now provide increased supervision at ward level, and feedback provided to the compliance group. This has resulted in a post incident assessment on a no harm incident, and a risk assessment being completed. This has been shared with the staff at the pause meetings to ensure learning by all team members.
This is designed to ensure that best practice standards are maintained and to highlight areas where actions need to be addressed.

The appropriate segregation of duties is being actively progressed at present and the recruitment process has commenced to support the new roster introduction.

Official segregation of roles will commence on January 14th. This will involve appointment of Healthcare Assistants dedicated to care of residents, and a separate allocation of a Cleaner/Housekeeper role. These staff will receive in-house orientation on the responsibilities of the HCA, and will be appropriately supervised by a nurse. They will wear a different uniform. Residents and their families will be advised of this progress and the Jan 14th date provides time to facilitate effective engagement with residents and families in this regard.

| Regulation 21: Records | Not Compliant |
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Outline how you are going to come into compliance with Regulation 21: Records:
The statement of purpose has been reviewed and updated to accurately reflect the range of services provided in the unit.

Garda vetting records have been placed in a secure locked box onsite in Kanturk. The HR support to Social Care addressed the Director of Nursing meeting on 29th November to advise the Directors of Nursing in relation to the requirements and to promote discussion around recent learning.

A medication audit was conducted at the unit on 20th November. The audit identified

actions in relation to training, and highlighted the lack of reporting of errors. This has been communicated to the nursing staff, and appropriate incident forms are now in place to capture errors. All nurses have completed HSE Land training before 20th Dec 2018. This will be followed by a training day, onsite in January to include medication errors.

Further action taken includes a mechanism to ensure that all incidents are reviewed by ADON, CNM and the Clinical Project Manager with oversight by the Quality and Safety Advisor pending the imminent set-up of a local Quality and Safety Committee in the hospital, first meeting to be held on 16th Jan. Weekly medication audits are now being conducted with the CNM reviewing a medication chart each day.

A medication review will be conducted on a three monthly basis with input from the Pharmacist, the GP and nursing staff and will be formally recorded from Quarter 1 2019.

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| Regulation 23: Governance and management | Not Compliant |

Outline how you are going to come into compliance with Regulation 23: Governance and management:
A Quality Assurance Working Group has been established to progress actions arising from recent inspection reports and other action plans e.g. the Service improvement team report and any recent audits. This group is currently meeting on a weekly basis and will continue to meet weekly over the next month. The group comprises the General Manager, Director of Nursing, Clinical Project Manager, Quality and Safety Advisor, Practice Development and CNM2. The group drafted the terms of reference for a Quality and Safety Committee in the hospital which will take over from the working group when operational. The Quality and Safety Committee will provide oversight in relation to the quality and safety of care and support being provided to residents thereafter.

A mixture of formal and informal visits by the General Manager and/or representative has commenced in the unit. The General Manager has carried out a formal visit and will continue to do so on a monthly basis and also, attend and participate in Quality and Safety Committee meetings and attend more frequently if required. Informal, unannounced, visits will also take place to encourage consistency in service delivery in the hospital. The General Manager has been on site in Kanturk on Nov 26th, Dec 6th, 13th, 17th, 18th to date.

Director of Nursing (DON) meetings are being held monthly in the area to provide support to the DON of this hospital and facilitate peer discussions. These meetings facilitate strategic review (including of any changes in regulations, guidelines, standards) and include an operational component by providing a support network between DONs and allow for shared learning and planning (e.g. in relation to severe weather planning). Recent invitees to this meeting include infection control nursing (e.g. in relation to CPE) and Human Resources (in relation to the Garda Vetting process).

The Annual Review will be conducted in accordance with national standards and will be available to residents and their families. The annual review will be completed by the Director of Nursing, Clinical Project Manager and Quality and Safety Advisor.

A Clinical Project Manager, is presently on site 2 days per week and will continue until our practice development coordinator is available to the site. The recruitment process is well advanced and we are at Garda Vetting presently for the successful candidate.

The recruitment of the Director of Nursing has progressed in National Recruitment Service and was advertised on the HSE website on 13 December as well as national newspapers. In the interim an experienced Nurse Manager has been seconded to the unit from 7nd January 2019 and will participate in the Quality Assurance Working Group from Monday 4th Jan.

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| Regulation 3: Statement of purpose | Not Compliant |

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
The statement of purpose has been reviewed and updated to accurately reflect the range of services provided in the unit.

As the unit changes / updates the services which it provides the statement of purpose will be updated to reflect these developments.

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| Regulation 31: Notification of incidents | Not Compliant |

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
Safeguarding training is to be undertaken again by all staff in the unit, where guidance on what constitutes institutional abuse will be clearly outlined to all staff on Jan 15th and 22nd Jan. The incoming ADON is a designated officer for Safeguarding and will conduct this training. A memo will issue to all staff to raise awareness of the safeguarding policy and a copy of the policy will be circulated to all staff prior to training. This training will be provided by a safeguarding trainer. The training will be conducted in smaller than usual groups of 12- 15 staff to facilitate open discussion around safeguarding and institutional abuse and to ensure that all staff are clear in relation to expected standards of care from them going forward.

Supervision will be undertaken at ward level and time will be taken to ensure that the standards required are extremely clear and where the standards are not met it will be explained that any incident will / must be reported in accordance with HSE internal reporting requirements and in accordance with the Regulations to HIQA.

This will be completed by the end of January.

| Regulation 12: Personal possessions | Not Compliant |
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Outline how you are going to come into compliance with Regulation 12: Personal possessions:
Lockers and wardrobes with individual lockable space are available to all residents. All personal belongings are now fully accessible to residents. All engagement with the residents' personal possessions by a staff member is considerate. Eg. requesting permission to open a wash bag prior to opening the personal wash bag. A dedicated member of staff is assisting each resident to personalize their bed space with pictures or items of interest to them.

| Regulation 17: Premises | Not Compliant |
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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 regulations.

Remedial work commenced in the unit on the 12th November 2018 and phase 1-4 were completed on 10th Dec This includes wider bedroom doors to facilitate evacuation in the event of a fire.

An interior designer has been engaged to review the décor and to update the décor to promote resident comfort. The interior design plan for the Dayroom and bedrooms was circulated to the residents and their families for their input into the design and colour scheme on 18th Dec . Copies of designs are available in the day room.

Remedial works phase 5 and 6 will be completed after Christmas. This will cause a disturbance to residents for a maximum period of 1 week in total and will be aligned with the redecoration of the unit. This will be planned with the residents and communicated to them in advance.

The drawings for the new building are being progressed by the Estates Department and planning application is due for submission to the planning Department.

The Health and Wellbeing team are now being consulted in relation to the new design to ensure that the space provides the maximum benefit to both residents and their families and the staff, a follow up meeting is scheduled with Health & Welling being for 14th Jan.

| Regulation 26: Risk management | Not Compliant |
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Outline how you are going to come into compliance with Regulation 26: Risk management:
Advice and support has been provided to the Director of Nursing regarding review of the risk register and the site risk register review has been completed. The risk register now contains all identified risks and control measures.

A Health & Safety risk assessment of the premises has been conducted in conjunction with H.S.E. Health and Safety Advisor. Identified risks have been addressed and have control measures have been put in place.

Following this initial review, training in relation to risk management has been provided by a Quality and Safety Advisor on 10th December. This includes a procedure for notification of risks to the General Manager as required.

The Quality and Safety committee once established will have oversight of the risk register.

| Regulation 27: Infection control | Not Compliant |
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Outline how you are going to come into compliance with Regulation 27: Infection control:
An infection Control review was conducted in the unit on November 27, 2018 by an Infection Control Nurse. Recommendations have been made by the infection control nurse which are being implemented. The progress is monitored by the workgroup weekly.

New Cleaning schedules are being updated and are due to be completed by 21th December, and disseminated to all cleaning staff: and thereafter there will be daily visual checks in the unit and these checks will be recorded on the sheets provided.

All staff are engaging with infection control training, and this will be completed by December 31st. This is included as a mandatory training requirement in the Training Plan. In the first instance, training on HSELand will be completed, including hand hygiene and standard precautions. The CNM will facilitate training on standard precautions for all Healthcare Assistants and Multi task Attendants in early 2019.

A vacant Clinical Nurse Specialist Infection Control post is now at pre interview stage and once filled this post will provide ongoing infection control support to the unit.

The Quality and Safety Committee will ensure that there is oversight of infection control as part of it's terms of reference.

| Regulation 28: Fire precautions | Not Compliant |
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Outline how you are going to come into compliance with Regulation 28: Fire precautions: Following consultation with Cork County Council Fire Authority and the Fire & Safety Officer, Estates and the hospital management in relation to fire precaution, work has commenced to address building deficiencies identified during the consultation. The works have addressed identified issues concerning, fire doors, compartments for evacuation and the opening of exit doors. The planned works were completed, phase 1-4, on 10 of Dec.

Phase 5 will be completed pre Christmas, and includes replacement of kitchen door, and replacement of other internal doors. There will be minimal disturbance to residents.

Phase 6 will be commenced after Christmas, will be completed by Jan 20th. This involves upgrade of fire barriers in attic spaces. This will involve evacuation of St Theresa's ward for maximum of 3 days, and subsequent to that closure of the day room for maximum of three days.

A comprehensive Fire Safety Plan has been developed by the HSE Fire & Safety Officer for Kanturk Community Hospital which clearly outlines all fire safety and fire evacuation procedures to be followed in the event of a fire.

Fire safety checks have been reviewed to ensure that they are of adequate extent, frequency and detail. Fire exit checks are completed twice daily and these are being recorded.

All staff have received fire training on evacuation methods and use of fire safety and evacuation equipment.

The HSE Fire and Safety Officer has recently undertaken an evacuation training drill in which evacuation times were greatly improved. Further evacuation drills were carried out

over the last number of weeks to ensure that all staff were familiar with evacuation procedures during the building works. Monthly evacuation drills are now being carried out to ensure that all staff are familiar with evacuation procedures.

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

The relevant certificates confirming up to date maintenance and service checklist of the fire alarm, emergency lighting, fire equipment and electricity have been reviewed.

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| 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:
Each Nurse has received 1:1 refresher training to re-educate them on legislative and best practice requirements to completing an individualised comprehensive nursing assessment, care plan and formal evaluation and review.

A schedule of reviews has been developed and each nurse has been assigned responsibility for completing a formal evaluation and review.
In addition, each resident has been allocated two associate key workers (1 nurse and 1 Healthcare Assistant), to ensure the residents' preferences are captured, documented within the residents care plans and communicated to all relevant team members.

Monthly audits are being conducted to review care plans and the care plan audits will be included in the performance appraisal process in the unit.
The QPS Advisor surveyed a sample of care plans on Dec 18th, and recommendations arising have been communicated to nurses.
All nurses have been advised to ensure that care plans for their assigned residents are fully completed and up to date by January 4th.

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| Regulation 8: Protection | Not Compliant |

Outline how you are going to come into compliance with Regulation 8: Protection:
Increased clinical supervision is now in place where the CMN is actively supervising staff during the day, in addition to performance appraisals and daily reflective meetings which have commenced.

Safeguarding training is to be undertaken again by all staff in the unit, where guidance on what constitutes institutional abuse will be clearly outlined to all staff. This training will be provided by a safeguarding trainer in Jan 2019. The training will be conducted in smaller than usual groups of 12- 15 staff to facilitate open discussion around safeguarding and institutional abuse and to ensure that all staff are clear in relation to expected standards of care from them going forward.

Oversight of how safeguarding training is being implemented will be provided via supervision by nursing management, unannounced and announced visits by the General Manager, review of any feedback received from residents or their representatives and with the Quality and Safety Committee providing an oversight function in relation to the quality and safety of the care and support being provided in the hospital.

| Regulation 9: Residents' rights | Not Compliant |
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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 regulations.

A survey of resident's preferences around activities is being conducted, so that we can design an activity program which satisfies where possible their individual preferences.

Satisfaction surveys are being conducted routinely to assess our understanding of the residents requests and when dissatisfaction is identified the situation is reassessed to promote the resident's welfare and desires. Surveys were given to both residents and family members who attended the Christmas social evening on 17th Dec and have continued to be distributed since then.

Ways of promoting positive mealtimes and encouraging residents to come to the dining room are being actively discussed and trialed by the staff team. This includes making the dining room a more visually appealing environment (e.g. through the introduction of menus and table decoration) and exploring how best to facilitate social interaction at mealtimes for each individual resident. Supportive mealtimes group meeting is scheduled for December 19th. Outcome will be discussed at Working group meeting on Jan 4th.

Ipads and Wifi have been ordered for the unit to facilitate individual programs being shown to the residents to match their personal interests eg. gardening and news shows.

The Physiotherapist has been consulted with a view to developing personal exercise plans for the residents and to review existing plans where they exist.

An Occupational therapist has been consulted to advise in relation to activities and interests for residents (including for example meeting residents' sensory needs) and better use of outdoor space.

Voluntary groups have also been engaged with, in the local community eg. Men's shed in relation to promoting linkages in the community and promoting the groups to consider engaging with the community hospital when advancing community initiatives. The Men's shed have agreed to visit in Jan to progress.

Activities for residents are being promoted in accordance with the resident's preferences and supported by the staff. In the first instance, each resident's individual preferences and choices are being established via a survey and documented in their care plan. The care plan will outline what activities residents already enjoy, consider other activities that may be of interest to each resident and capture the residents experience of activities or interests to further inform individual care plans.

## 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 |
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| 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 | 12/12/2018 |
| 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 store and maintain | Not Compliant | Orange | 12/12/2018 |

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| | his or her clothes and other personal possessions. | | | |
| Regulation 16(1)(b) | The person in charge shall ensure that staff are appropriately supervised. | Not Compliant | Orange | 03/12/2018 |
| 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 | 17/12/2018 |
| 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 | 01/01/2022 |
| 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 | Orange | 09/11/2018 |
| Regulation 23(b) | The registered provider shall ensure that there is a clearly defined | Not Compliant | | 03/12/2018 |

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| | management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision. | | | |
| 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 effectively monitored. | Not Compliant | | 03/12/2018 |
| 26 (1) (a) | Ensure that the risk management policy includes hazard identification and assessment of risks throughout the designated centre. | Not Compliant | Orange | 20/12/2018 |
| 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 | 21/12/2018 |
| Regulation 28(1)(b) | The registered provider shall provide adequate | Not Compliant | Orange | 12/12/2018 |

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| | means of escape, including emergency lighting. | | | |
| 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 | Yellow | 12/12/2018 |
| Regulation 28(1)(c)(ii) | The registered provider shall make adequate arrangements for reviewing fire precautions. | Not Compliant | Orange | 03/12/2018 |
| Regulation 28(1)(d) | The registered provider shall 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. | Not Compliant | Orange | 03/12/2018 |
| Regulation 28(1)(e) | The registered provider shall ensure, by means | Not Compliant | Yellow | 03/12/2018 |

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| | of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire. | | | |
| Regulation 28(2)(i) | The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires. | Substantially Compliant | Yellow | 03/12/2018 |
| 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 | 03/12/2018 |
| Regulation 28(3) | The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place in the designated centre. | Substantially Compliant | Yellow | 03/12/2018 |
| Regulation 03(1) | The registered provider shall prepare in writing a statement of purpose relating to | Not Compliant | Orange | 07/12/2018 |

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| | the designated centre concerned and containing the information set out in Schedule 1. | | | |
| Regulation 31(1) | Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence. | Not Compliant | Orange | 31/01/2019 |
| 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 | 21/12/2018 |
| Regulation 8(1) | The registered provider shall take all reasonable measures to protect residents from abuse. | Not Compliant | Orange | 03/12/2018 |
| Regulation 9(2)(a) | The registered provider shall provide for residents facilities for occupation and recreation. | Not Compliant | Orange | 31/01/2019 |
| Regulation 9(2)(b) | The registered provider shall provide for | Not Compliant | Orange | 31/12/2019 |

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| | residents opportunities to participate in activities in accordance with their interests and capacities. | | | |
| 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 | 21/12/2018 |
| 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 | 12/12/2018 |
| Regulation 9(3)(c)(iii) | A registered provider shall, in so far as is reasonably practical, ensure that a resident telephone facilities, which may be accessed privately. | Not Compliant | Orange | 12/12/2018 |