

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Fermoy Community Hospital
Centre ID:	OSV-0000560
Centre address:	Tallow Road, Fermoy, Cork.
Telephone number:	025 31 300
Email address:	patrick.ryan1@hse.ie
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Patrick Ryan
Lead inspector:	John Greaney
Support inspector(s):	Mary Costelloe
Type of inspection	Unannounced Dementia Care Thematic Inspections
Number of residents on the date of inspection:	58
Number of vacancies on the date of inspection:	14

About Dementia Care Thematic Inspections

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor compliance with specific outcomes as part of a thematic inspection. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 19 September 2016 09:30 To: 19 September 2016 18:30

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

Outcome	Provider's self assessment	Our Judgment
Outcome 01: Health and Social Care Needs	Substantially Compliant	Non Compliant - Major
Outcome 02: Safeguarding and Safety	Substantially Compliant	Non Compliant - Major
Outcome 03: Residents' Rights, Dignity and Consultation	Substantially Compliant	Non Compliant - Major
Outcome 04: Complaints procedures	Substantially Compliant	Substantially Compliant
Outcome 05: Suitable Staffing	Substantially Compliant	Substantially Compliant
Outcome 06: Safe and Suitable Premises	Non Compliant - Moderate	Non Compliant - Major
Outcome 07: Health and Safety and Risk Management		Substantially Compliant
Outcome 09: Statement of Purpose		Compliant
Outcome 11: Information for residents		Compliant

Summary of findings from this inspection

Fermoy Community Hospital is located on the outskirts of the town of Fermoy. The centre comprises three units; 'Cuisle' (30 beds), 'Dochas' (30 beds) and 'Sonas' (12 beds). Due to insufficient staff numbers 'Sonas' was closed on the day of inspection and all residents were accommodated in the other two units.

The purpose of this inspection was to focus on the care and quality of life for residents with dementia living in the centre. This inspection report sets out the findings of a thematic inspection which focused on six specific outcomes relevant to dementia care. The inspection also addressed outstanding actions from the most

recent inspection that would not normally be covered during a thematic inspection such as this.

Ten of the 58 residents who were living in the centre on the days of the inspection had a formal diagnosis of dementia and another 12 residents were suspected of having dementia as they presented with signs of cognitive impairment. The provider had submitted a completed self assessment on dementia care to HIQA with relevant policies and procedures prior to the inspection. The judgments from the self assessment and the judgment of the inspectors are set out in the table above.

Overall, residents' healthcare and nursing needs were met to a good standard. Residents had access to medical, allied health and psychiatry of later life services. Staff interacted with residents in a kind and respectful manner and residents spoken with were complimentary of the care provided by staff. Significant improvements, however, were required in relation to the social care needs of residents. Despite some improvements in activities such as the introduction of a fireside chat, a visiting music group and one-to-one activities for some residents such as massage, there was a distinct lack of stimulating activities for residents. Residents did not receive an activity assessment to ascertain their interests and capacity to participate in activities. Most residents spent the day in their bedrooms, either in bed or on a chair at their bedside. There was minimal interaction with residents other than when care was being provided or when there were visitors present.

As part of the inspection, inspectors spent a period of time observing staff interactions with residents. Inspectors used a validated observational tool (the quality of interactions schedule, or QUIS) to rate and record at five minute intervals the quality of interactions between staff and residents in two communal areas. While there was some positive connective care, scores mainly indicated neutral care and protective and controlling care.

The use of restraint was not in compliance with recommended practice. Some residents had "safety vests" in place that involved residents being restrained to their chair. The restraint policy explicitly stated that this type of restraint is not to be used. Additionally, restraint was being used as a long-term falls prevention technique, which is also contrary to recommended practice, except in emergencies and only for a limited period.

Inspectors observed that, for most residents, meal times were functional rather than social occasions. There were inadequate dining facilities and the dining room in each of the two units could only accommodate 12 of the 30 residents in each unit. However, only four to six residents from each unit had their meals in the dining rooms. Most residents had all of their meals in their bedrooms.

There was limited access to a pharmacist and, due to time constraints, the pharmacist did not have access to residents' prescriptions in order to be part of a multidisciplinary review of residents' prescriptions. Other required improvements in relation to medication management included a number of stock medications were out of date and a record of the fridge temperature was only intermittently completed.

Additional required improvements included:

- care planning process
- pre-admission assessment
- privacy and dignity
- consultation with residents
- complaints process and records
- staffing levels
- staff training
- premises
- infection prevention and control

The action plan at the end of this report identifies where improvements are needed to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Standards for Residential Care Settings for Older People in Ireland.

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

Outcome 01: Health and Social Care Needs

Theme:

Safe care and support

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

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

Findings:

This outcome sets out the inspection findings relating to healthcare, nursing assessments and care planning. The social care of residents with dementia is comprehensively covered in Outcome 3. Inspectors focused on the experience of residents with dementia and they tracked the journey of a number of residents with dementia.

Residents were usually admitted through the public health nursing service. Inspectors were informed that a common summary assessment report (CSAR) was completed by a placement coordinator and other relevant healthcare professionals, detailing the health needs of each resident. However, a copy of this report was not routinely available in the centre. Pre-admission assessments were not routinely carried out on all residents prior to admission to the centre. Due to limited access to the CSAR and the absence of a pre-admission assessment, inspectors were not satisfied that the centre had appropriate measures in place to ensure they could meet the needs of residents prior to accepting the admission.

Inspectors reviewed a sample of residents' records and each one contained comprehensive biographical details. A process of collecting social care information, such as interests, hobbies, likes and dislikes, had commenced but this had only been completed for a small number of residents. Inspectors examined a sample of records of residents who were transferred to hospital from the centre and found that appropriate information about their health and medications were included with the transfer letter. There was also adequate information shared by the hospital with staff of the centre when the resident was discharged from acute care.

Residents had access to a number of general practitioners (GPs) that visited the centre regularly and records indicated that residents were reviewed on a regular basis. Out-of-hours GP services were also available. There was also access to allied healthcare services including dietetics, physiotherapy, occupational therapy, speech and language therapy, psychiatry of later life, and chiropody.

Comprehensive nursing assessments were carried out using the activity of daily living model. This was supported by the use of validated assessment tools for issues such as risk of falling, risk of developing pressure sores, mental status and for the risk of malnutrition. Care plans in the form of problem identification sheets were developed for issues identified on assessment and some of these were personalised to individual residents. Some care plans, however, were generic. For example, some care plans stated that staff should ascertain the resident's preferences rather than detailing what those preferences were. Additionally, care plans were not developed for all issues, such as end-of-life care, when it was evident that residents were on an end-of-life pathway. For example, the care plan of one resident did not adequately detail the palliative care needs of the residents and there was no care plan to guide the management of a syringe driver. Care plans did not always reflect the communication needs of residents, however, staff members spoken with were knowledgeable of the communication needs of individual residents.

There were written policies and procedures in place for end-of-life care. Staff provided end-of-life care to residents with the support of their GP and the community palliative care team, to which there was good access. Religious preferences were documented and there was evidence that they were facilitated. Most residents were Catholic and a priest visited the centre each Wednesday to celebrate mass, which was rotated to each unit. Mass was also celebrated three times each week in a chapel on the grounds of the centre. The needs of other denominations were respected and supported. A single room had been identified to be the designated palliative care and end-of-life room and plans were in place to decorate the room appropriately. Nineteen of the 72 residents were accommodated in single rooms and 52 residents were accommodated in multi-occupancy bedrooms, so the option of a single room was not always available. An additional bed was located in an open area close to a nurses' desk that would not be suitable for end-of-life care. There were two relatives' rooms that had reclining chairs, a bathroom and tea and coffee making facilities should relatives or friends wish to remain overnight.

There were policies and procedures to guide practice in relation to the management of nutrition. There were systems in place to ensure residents' nutritional needs were met, and that they did not experience poor hydration. Residents were assessed for the risk of malnutrition on admission and at regular intervals thereafter using a validated tool. Residents were weighed regularly. Where there was evidence of weight loss or difficulty in swallowing food, residents were appropriately referred to dietetics or speech and language therapy. There was an effective system of communication between nursing and catering staff to support residents with special dietary requirements.

There was a small dining room in each of the occupied units, with seating accommodation for 12 residents in each. All residents had breakfasts in their bedrooms and only a small number of residents had their lunch and supper in the dining rooms. Meal times were functional and there was minimal evidence of a positive dining experience. Most residents had all meals in their bedrooms while in bed or at their bedside. While it was accepted that the limited dining space contributed to the lack of dining experience, it was further evidence of the lack of focus on the social care needs of residents. This is discussed in more detail under Outcome 3. Residents that required

assistance with their meals were assisted by staff in a respectful and dignified manner. Choice of food was available at mealtimes, including for residents prescribed modified diets. However, residents were asked the previous day what they would like for lunch and supper for the following day. Meals appeared to be nutritious and were attractively presented.

There was a centre-specific medication policy with procedures for safe ordering, prescribing, storing and administration of medicines. All residents had photographic identification in place on their prescription and medication administration record. The supply and administration of scheduled controlled drugs was checked and was correct against the drug register, in line with legislation. Two nurses checked the quantity of these medications at the start of each shift. The nurse spoken with by inspectors displayed a good knowledge of the requirements in the area of controlled drugs and the responsibilities of the registered nurse to maintain careful records.

At the last inspection, it was identified that the centre held a large stock of medication in a central pharmacy without an appropriate procedure in place to monitor stock levels and to ensure that all medicines were in-date. Inspectors were informed that a stock record was maintained by a pharmacist that visited the centre; however, this was not available in the centre on the day of inspection. The pharmacist was only available for six hours each week and had no clinical input in relation to the management of residents' medicines. Inspectors found a medication that was out-of-date in the central pharmacy. Records indicated that residents' prescriptions were reviewed regularly by their GP. There was, however, no multidisciplinary review. For example, a pharmacist was not involved in reviewing prescriptions. A procedure had been put in place to monitor stock levels at ward level, which involved a stock count fortnightly. Inspectors found a small number of antibiotics that were out-of-date in one of the wards. Medication requiring refrigeration were stored appropriately and the fridge temperature was monitored, however, the fridge temperature was only recorded intermittently. There were also some liquid medications that did not have a date to indicate when they were opened.

This outcome was judged to be substantially compliant in the self assessment, and inspectors judged it as major non-compliant.

Judgment:
Non Compliant - Major

Outcome 02: Safeguarding and Safety

Theme:
Safe care and support

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

Findings:

There was an up-to-date policy in place that addressed prevention, detection, reporting and investigation of allegations or suspicions of abuse. Records available indicated that all staff had up-to-date safeguarding training. A sample of staff spoken with by inspectors were knowledgeable of what action to take if they witnessed, suspected or had abuse disclosed to them. Residents spoken with were complimentary of the care provided and stated that they felt safe. Relatives of residents spoke highly of the care provided by the staff and their caring attitude. There were no reported allegations of abuse.

There were policies in place about meeting the needs of residents with responsive behaviour (also known as behavioural and psychological signs and symptoms of dementia) and restrictive practices. Policies were seen to give clear instruction to guide staff practice. These policies, however, were not always implemented in practice. For example, records were not always maintained of triggers for particular behaviours, how the behaviour presented and consequences of the behaviour. There were care plans in place identifying how to support residents with responsive behaviour, however, they contained inadequate detail. This action is addressed under Outcome 1. Staff spoken with were knowledgeable of each resident's behaviour, including how to avoid the situation escalating.

There was a policy in place to guide practice in relation to the use of restraint. Inspectors, however, were not satisfied that restraint practice complied with this policy. For example, a number of residents had "safety vests" in place that prevented residents from leaving their chairs. Based on discussions with staff and a review of records, it was clear that, for at least one resident, this restraint was used as a falls prevention measure. This is not in keeping with relevant guidance that states that restraint should not be used as a falls prevention measure, unless the risk is immediate and restraint is only used as an emergency measure. Additionally, the centre's own policy states that restraint in the form of a vest should not be used. While residents had been reviewed by an occupational therapist for their speciality chairs, the assessments did not recommend the use of these vests for postural support purposes. At least one resident with a safety vest in place could walk with the aid of a frame and under the supervision of one member of staff. It was not clear from discussions with staff or available records if the resident was assisted to mobilise other than when transferring to the toilet or bed.

A significant amount of work had been done since the last inspection on risk assessments prior to the use of restraint and in particular prior to the use of bedrails. This was predominantly in response to an investigation into injuries sustained by a resident, which were diagnosed during radiological tests carried out following a fall from of bed. An action plan had been developed incorporating the recommendations from the report and records indicated that some of the recommendations were fully implemented and others were in the process of being implemented. Residents were risk assessed prior to the use of restraint and safety checks were in place when restraint was in use. Records indicated that restraint in the form of bedrails was used following a risk assessment. However, where risk assessments directed the assessor to explore alternatives to the use of bedrails, records did not demonstrate that this was always done. There were records of safety checks while restraint was in place.

Inspectors reviewed incident reports in relation to residents' behaviour and records confirmed the information given to inspectors that there were no recent significant behavioural related incidents. There were adequate records in place on the management of residents' finances.

This outcome was judged to be substantially compliant in the self assessment, however, inspectors judged it as major non-compliant.

Judgment:
Non Compliant - Major

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:
Person-centred care and support

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

Findings:
Inspectors observed staff interacting with residents in an appropriate and respectful manner. A number of residents were observed having their hair done in the hairdressing salon on the day of inspection. Residents confirmed that their religious and civil rights were supported. The preferences of all religious denominations were respected and facilitated. Religious ceremonies were celebrated in the centre that included a weekly mass for Catholic residents, usually on Wednesdays and at other times in the chapel on the grounds of the centre. Residents were facilitated to vote in local and national elections and the returning officer visits the centre to facilitate residents to vote.

Residents had access to an advocacy service. There was a notice on prominent display that outlined the purpose of advocacy and included details of how to make contact with an advocate. Details of the confidential recipient were also on display. Residents were consulted through residents' meetings that were held every six-to-eight weeks. Records indicated that some of the issues raised at these meetings were addressed; however, there was no action plan to identify progress in addressing other issues. For example, card games had been introduced and a chiropodist had been sourced following queries raised at residents' meetings. However, it was not clear if other issues raised could be or would be addressed, such as access to pet therapy. Another request was that relatives could make a cup of tea or coffee, and while this was available in the visitors' rooms, these were usually only used by relatives of residents that were at end of life. There was a residents' and relatives' survey, most recently completed in May 2016.

As part of the inspection, inspectors spent a period of time observing staff interactions with residents. Inspectors used a validated observational tool (the quality of interactions schedule, or QUIS) to rate and record at five minute intervals the quality of interactions

between staff and residents in two communal areas. The scores for the quality of interactions are +2 (positive connective care), +1 (task-orientated care), 0 (neutral care), -1 (protective and controlling), -2 (institutional, controlling care). An overview of these observation periods is detailed below.

Observations were recorded in two sitting rooms. As many of the residents spent a significant amount of time in their bedrooms, there was limited opportunity for inspectors to carry out the observation. The total observation period was 60 minutes, which comprised two 30 minute periods. For rating purposes, there were 12 five minute observation periods. One score of +2 was given when a staff member was seen to interact with a resident and explain in detail what activity was about to take place. Four scores of +1 were given when staff interacted with residents to determine if they were okay and to assist them with drinking. Four scores of 0 were given when staff were seen to enter the room but did not interact with the residents. Three scores of -1 were given when residents were left unsupervised in the sitting room, some of whom were restrained to their chairs and one of whom was seen attempting to stand without success.

Overall, inspectors were not satisfied that the social care needs of residents were adequately addressed. Residents did not have a meaningful activities assessment and there was no care plan in place to address the social needs of residents. Some improvements had been made to the programme of activities in the recent past. An activities person visited the centre for six hours each week to provide one-to-one and group activities, such as massage, card games and exercise to music. "Around the fireside" was held every Friday, whereby residents got together to share stories from the past. A group visited the centre on alternate Fridays to play music, which was well received by residents. Mass was included as an activity on four days each week, however, this was available in the chapel on the grounds of the centre on three of those days and it was not clear to what degree it was attended by residents. Despite these improvements, there continued to be a distinct absence of stimulating activities for residents for significant periods of time. Residents that were in the sitting rooms were seen to be sitting in their chairs with minimal interaction. The majority of residents spend their day in their bedrooms either in their beds or on chairs and the only interaction was when care was being provided or when there were visitors present. One resident stated that he found the day "as long as a wet week". This resident also stated that he liked watching television, especially sport, however, there was no television in the room in which he was sitting. The resident confirmed that he was provided with a newspaper every day.

Some improvements were required to the premises to support privacy and dignity. Bedroom doors had a glass panel and some of these had an opaque adhesive film or blinds in place to prevent others from seeing directly into the bedroom when the doors were closed. However, this was not in place on all bedroom doors and it was possible to see into the bedroom. The adhesive film had been partially torn in at least one glass panel. Additionally, a number of residents were accommodated in multi-occupancy bedrooms of two, three and four beds. There appeared to be adequate space between the beds and overhead hoists in each of the bedrooms meant that it was not necessary to manoeuvre manual hoists between beds. However, on one occasion inspectors came upon a resident sitting in his assisted chair in the corridor. The resident stated that he

was "put out here". This was confirmed by staff who stated that while there were transferring another resident to bed there was insufficient space due to the size of the assisted chairs, so one of the residents was moved out to the corridor while this task was being completed.

There was a lack of storage space for residents' clothing in some of the multi-occupancy bedrooms. Some residents had clothes stored in a store room, which meant that they were inaccessible to them. Some clothes that were to be laundered were stored in a bathroom and in a sluice room.

Residents were seen to be wearing glasses and hearing aids, to meet their communication needs.

This outcome was judged to be substantially compliant in the self assessment and inspectors judged it as major non-compliant

Judgment:
Non Compliant - Major

Outcome 04: Complaints procedures

Theme:
Person-centred care and support

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

Findings:
There was a system in place to ensure that the complaints of residents or their representatives were listened to and acted upon. There was a complaints policy that identified the person responsible for managing complaints and also included an appeals process. The complaints process, however, did not contain details of the person responsible for oversight of the process to ensure adequate records were maintained and that complaints were responded to. The complaints procedure was on prominent display in the centre and summarised in the residents guide.

Throughout the inspection it was clear that residents were familiar with all members of staff and management. It was apparent to inspectors that residents would find staff easy to approach with any concerns or complaints.

Inspectors viewed the complaints log that contained details of complaints, the investigation of each complaint and the outcome of the investigation. Records did not detail whether or not the complainant was satisfied with the outcome of the complaint.

This outcome was judged to be substantially compliant in the self assessment, and

inspectors judged it as substantially compliant.

Judgment:
Substantially Compliant

Outcome 05: Suitable Staffing

Theme:
Workforce

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

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

Findings:

Inspectors observed staff providing care in a respectful and caring manner. Residents appeared to be familiar with staff. An actual and planned roster was maintained in the centre, with any changes clearly indicated. The person in charge was supported in her role by an assistant director of nursing. There was also a clinical nurse manager 2 and a clinical nurse manager 1 assigned to each of the units. Inspectors reviewed staff rosters, which showed there was a nurse on duty at all times. There was a regular pattern of rostered care staff.

Inspectors were informed at the beginning of the inspection that Sonas unit was closed due to insufficient numbers of staff. A recruitment programme had recently concluded and it was anticipated that the unit would reopen in October 2016.

The staffing complement in each of the units on the day of inspection comprised three nursing staff from 08:00hrs until 18:00hrs and two nursing staff from 18:00hrs until 08:00hrs, with a change of shift at 20:00hrs. There were three multi-task attendants (MTAs) providing care from 08:00hrs until 18:00hrs and two multi-task attendants from 18:00hrs until 08:00hrs, with a change of shift at 20:00hrs. There were also two MTAs who were responsible for catering on duty in each of the units during the day. Additional staff included an assistant director of nursing and administrative staff. There were no separate housekeeping staff and cleaning duties were assigned on a daily basis to one of the MTAs in each of the units. While inspectors were informed that protected cleaning time was provided, some staff members stated that at times they had to assist with care provision during allocated cleaning time. This did not adequately provide for separation of duties and did not comply with good infection prevention and control practice.

There was a varied programme of training for staff. In addition to mandatory training, the training programme included training on issues such as end-of-life care, food safety, cardiopulmonary resuscitation and open disclosure. Some improvements, however, were required in relation to training as a significant number of staff had not attended up-to-date training on responsive behaviour or on dementia care.

Inspectors reviewed a sample of staff files and found that some improvements were required. For example, there was not always a full employment history for all staff with satisfactory explanations for any gaps in employment. There were adequate records in relation to volunteers with their roles and responsibilities set out in writing, supervision arrangements and satisfactory Garda vetting.

This outcome was judged to be substantially compliant in the self assessment and inspectors judged it as substantially compliant.

Judgment:
Substantially Compliant

Outcome 06: Safe and Suitable Premises

Theme:
Effective care and support

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

Findings:
Fermoy Community Hospital is located on the outskirts of the town of Fermoy. The centre comprises three units 'Cuisle' (30 beds), 'Dochas' (30 beds) and 'Sonas' (12 beds). Due to insufficient staff numbers, 'Sonas' was closed on the day of inspection and all residents were accommodated in the other two units.

The centre was generally well maintained, bright, clean and comfortable. The exterior of the centre had been recently painted. New external doors had been fitted to some areas, wall surfaces in some bathrooms had been upgraded and locks had been fitted to the doors of cleaning stores. There was a variety of communal day spaces that were appropriately furnished and comfortable.

While the centre was bright and clean, it was not designed to meet the needs of residents with dementia. There was some new signage to assist residents to navigate around the centre, however, further enhancement was required. There was also a distinct lack of contrasting colours to distinguish various areas of the centre. There was inadequate dining space for residents. The dining room in 'Dochas', a 30 bed unit, had dining spaces for 12 residents. The dining room in 'Cuisle', a 30 bed unit, also had dining spaces for 12 residents. There was inadequate facilities and space for storage of equipment. Equipment was stored inappropriately in several areas of the centre including corridors and bathrooms.

While there were no residents accommodated in Sonas on the day of inspection, it was due to reopen in October 2016. Since the last inspection in June 2015, there were no significant improvements to the layout of the centre. Some of the bedrooms did not

have natural light, there was an inadequate partition between some of the bedrooms, and there was a bed located beside the nurses' station in an area used as a thoroughfare by staff, residents and visitors.

There were a number of four-bedded rooms. These multi-occupancy rooms impinged upon the privacy and dignity of residents residing in these bedrooms. This is discussed in more detail under Outcome 3.

An internal courtyard that had previously been identified as poorly maintained had been power washed, had hand rails installed around the perimeter, and had recently been painted. As the work was not yet complete, it was inaccessible to residents. There was a new enclosed garden with raised plant beds, shrubbery and a walkway at near completion. This area was developed to a high standard. However, as it was not yet complete, it also was inaccessible to residents.

There was appropriate assistive equipment provided to meet the needs of residents, specialised beds, overhead hoists, specialised mattresses and wheelchairs. The inspectors viewed the maintenance and servicing contracts and found the records were up-to-date.

This outcome was judged to be moderate non-compliant in the self assessment and inspectors judged it as major non-compliant.

Judgment:

Non Compliant - Major

Outcome 07: Health and Safety and Risk Management

Theme:

Safe care and support

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

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

Findings:

At the last inspection it was identified that the risk management policy and associated risk register did not adequately address the items listed in the regulations and a number of risks were identified that were not included in the risk register. It was also found that the emergency plan did not provide for the safe placement of residents in the event of a prolonged evacuation. These items were satisfactorily addressed on this inspection. For example, doors to areas such as kitchenette, housekeeping room and sluice rooms were now key coded. However, some windows in Sonas did not have window restrictors in place.

Some improvements were required in relation to infection prevention and control.

Cleaning equipment such as mops were not stored appropriately, in line with best practice. Staff stated that they found it difficult to carry out thorough cleaning as there were no dedicated cleaning staff and the care needs of residents were appropriately given priority. Some personal clothing that was due to be taken home by relatives for laundering was stored in a sluice room and there was no satisfactory explanation as to why it was stored there.

Judgment:
Substantially Compliant

Outcome 09: Statement of Purpose

Theme:
Governance, Leadership and Management

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

Findings:
The statement of purpose was updated since the last inspection to adequately address all the items listed in the regulations.

Judgment:
Compliant

Outcome 11: Information for residents

Theme:
Governance, Leadership and Management

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

Findings:
At the last inspection it was identified that the terms and conditions relating to residence in the centre were not included in the residents' guide. Residents are now given a copy of the contract of care in conjunction with the guide.

Judgment:
Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

John Greaney
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	Fermoy Community Hospital
Centre ID:	OSV-0000560
Date of inspection:	19/09/2016
Date of response:	27/10/2016

Requirements

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

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

Outcome 01: Health and Social Care Needs

Theme:

Safe care and support

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

Due to limited access to the CSAR and the absence of a pre-admission assessment, inspectors were not satisfied that the centre had appropriate measures in place to ensure they could meet the needs of residents prior to accepting the admission.

1. Action Required:

Under Regulation 05(2) you are required to: Arrange a comprehensive assessment, by

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

an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to the designated centre.

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

1. The Community Placement Co-Ordinator completes the comprehensive assessment on all continuing and convalescent care residents prior to admission to ensure the centre can meet the individual's needs. There is further discussion twice a month at an MDT meeting which includes the input of the PHN.
2. A copy of the CSAR for all our current continuing care residents will be provided by the Placement Co-Ordinator and on all new admissions prior to admission to the facility going forward.
3. The CSAR form will be discussed at the next MDT meeting, to see if it comprehensively assesses the health, personal and social care needs of the person who intends to become a resident of the centre, as required by Regulation 5(2). If it is deemed inadequate, the form will be modified, or a separate assessment will be developed by the Person in Charge, to be completed prior to the residents' admission.

Proposed Timescale: 30/11/2016

Theme:

Safe care and support

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

Improvements were required in the care planning process. For example:

- a process of collecting social care information, such as interests, hobbies, likes and dislikes had commenced but this had only been completed for a small number of residents.
- some care plans were generic
- care plans were not developed for all issues, such as end of life care, when it was evident that residents were on an end of life pathway
- care plans did not always reflect the communication needs of residents
- records were not always maintained of triggers for particular behaviours, how the behaviour presented and consequences of the behaviour.

2. Action Required:

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

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

1. All continuing care residents to have a comprehensive personalised assessment to include "My day My way" and " A key to Me" completed.
2. New Care Plans have been developed, in co-ordination with the Nursing and Midwifery Development Unit, and the Cork Community Hospitals, and have been commenced on 1st October 2016.
3. A Practice Development Co-Ordinator has been sanctioned for the Cork Community

Hospitals, and should be in place within the next 3 months. She will liaise with Fermoy Community Hospital, to assist Nursing staff with the new documentation, including guidance on gathering social information.

4. Careplans will detail the Communication needs of the resident.

5. Training in Responsive Behaviours will be prioritised, and made available to all staff.

6. Records will be kept of triggers to responsive behaviours, specific behaviours, and the consequences of behaviours using the A.B.C. charts, as deemed necessary.

Proposed Timescale: (1) 30th November 2016 (2) 31st January 2017

Proposed Timescale: 31/01/2017

Theme:

Safe care and support

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

Improvements were required in relation to medication management. For example:

- the record for monitoring stock medicines this was not available in the centre on the day of inspection
- some out-of-date medicines were found in stock cupboards a medication that was out-of-date in the central pharmacy
- medications requiring refrigeration were store appropriately and the fridge temperature was monitored, however, the fridge temperature was only recorded intermittently
- there were also some liquid medications that did not have a date to indicate when they were opened.

3. Action Required:

Under Regulation 29(6) you are required to: Store any medicinal product which is out of date or has been dispensed to a resident but is no longer required by that resident in a secure manner, segregated from other medicinal products and dispose of in accordance with national legislation or guidance in a manner that will not cause danger to public health or risk to the environment and will ensure that the product concerned can no longer be used as a medicinal product.

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

1. Completion of daily refrigerator temperature checklist has been included as part of the change of shift medication checklist
2. Weekly checks of medication stock held at ward level and return to pharmacy any expired medication for safe disposal in place.
3. Label provided for all liquid medication to be completed and attached to bottle to by RGN opening the medication, to identify the date they are opened. CNM2's to educate all staff on procedure.
4. Pharmacist to meet with DON, to reduce to a minimum the number of stock items required to be stored in unit.
5. Pharmacist to manage this on a weekly basis initially, reducing to monthly, when established.

6. Itinerary of stock items to be kept in pharmacy, and Nurses to document when they remove a stock item.
7. Any item found to be out of date, or no longer required by a resident is placed in secure box within Pharmacy, for weekly collection by Pharmacist.

Proposed Timescale: 31/10/2016

Theme:

Safe care and support

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

A pharmacist was only available for six hours each week and had no clinical input in relation to the management of residents medicines.

4. Action Required:

Under Regulation 29(1) you are required to: Make available to the resident a pharmacist of the resident's choice or who is acceptable to the resident.

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

1. Ongoing negotiations with Pharmacist, DON and General Manager to ensure a medication management system in place to comply with HIQA,NMBI
2. Access to a pharmacist is provided by the hospital but residents also have the choice to access a pharmacist of their own choice

Proposed Timescale: (1) 30th November 2016 (2) completed

Proposed Timescale: 30/11/2016

Theme:

Safe care and support

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

Records indicated that residents prescriptions were reviewed regularly by their general practitioner (GP). There was, however, no multidisciplinary review, for example, a pharmacist was not involved in reviewing prescriptions.

5. Action Required:

Under Regulation 29(2) you are required to: Facilitate the pharmacist concerned in meeting his or her obligations to a resident under any relevant legislation or guidance issued by the Pharmaceutical Society of Ireland.

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

1. Ongoing negotiations with Pharmacist, DON and General Manager to ensure a medication management system in place to comply with HIQA,NMBI
1. Pharmacist has been informed that she will have to be part of the 3 monthly MDT

review of the residents medication

Proposed Timescale: 30/11/2017

Outcome 02: Safeguarding and Safety

Theme:

Safe care and support

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

The management of restraint was not in compliance with best practice. For example;

- a number of residents had "safety vests" in place that prevented residents from leaving their chairs. Based on discussions with staff and a review of records it was clear that, for at least one resident, this restraint was used as a falls prevention measure
- records indicated that restraint in the form of bedrails was used following a risk assessment. However, where risk assessments directed the assessor to explore alternatives to the use of bedrails, records did not demonstrate that this was always done.

6. Action Required:

Under Regulation 07(3) you are required to: Ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.

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

1. MDT Review of residents utilising Safety Vest to identify alternate safety measure, to include The Consultant Geriatrician, the Occupational Therapist, the Physiotherapist, the Next of Kin, the DON and CNM2 and RGN
2. Re audit of restraint documentation for compliance with local policy and re education of staff post audit
3. Increase in supervision of resident to ensure safety.
4. Plan and implement appropriate activity schedule to suit resident needs.
5. Engagement with Falls Prevention Officer to explore alternatives to use of vests.

Proposed Timescale: 31/10/2016

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

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

There was a distinct absence of stimulating activities for residents for significant periods of time. Residents that were in the sitting rooms were seen to be sitting in their chairs with minimal interaction. The majority of residents spend their day in their bedrooms

either in their beds or on chairs and the only interaction was when care was being provided or when there were visitors present. One resident stated that he found the day "as long as a wet week".

7. Action Required:

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

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

1. Education for all staff will be provided on the importance of communicating with the person with dementia.
2. All staff will be encouraged to work with each resident as an individual, allowing them as much choice as possible, and to make each interaction with the resident a positive one.
3. Staff will encourage residents to vacate the bedrooms during the day, to attend various activities.
4. The Careplans will be updated by a named Nurse, to include the Residents interests, hobbies, likes and dislikes, in co-ordination with a named Healthcare Assistant. They will be in charge of disseminating this information to the team, to help the team get to know the resident on a personal level.
5. The named Nurse and HCA will be responsible for personalising the residents' room or bed area, in co-ordination with the resident and/or their families.
6. A member of staff is allocated to Activities on a daily basis.
7. Volunteers will be encouraged, but these will require supervision, and support.
8. Funding will be made available for a group such as Elderwell, who provide activities on a sessional basis, until our sessions are more established.
9. Expertise in hand massage, aromatherapy, or other therapies will be actively sought out, and offered to residents.

Proposed Timescale: 31/10/2016

Theme:

Person-centred care and support

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

Improvements were required in relation to the privacy and dignity of residents, for example:

- there were clear glass panels on the doors of some bedrooms
- one resident in an multi-occupancy room was left sitting in the corridor so that care could be provided to another resident.

8. Action Required:

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

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

1. Contact in place or blinds on doors and glass panels of all bedrooms. (Completed)

2. The room from which the resident was removed, will be assessed, to see if it is large enough to provide for the assessed needs of the current residents, and measures to reduce the number, or the dependency of the residents will be undertaken, to ensure that a resident is not required to leave his/her bedroom to facilitate moving and handling of another resident.

Proposed Timescale: 27/10/2016

Theme:

Person-centred care and support

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

It was not clear if all issues raised at residents'/relatives' meetings could be or would be addressed, such as access to pet therapy. Another request was that relatives could have make a cup of tea/coffee, and while this was available in the visitors rooms, these were locked and only available to relatives of residents that were at end of life.

9. Action Required:

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

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

1. Residents meetings will continue to be held every 4 weeks, facilitated by the Advocate. Minutes from this meeting will be forwarded to DON within one week. DON will address any issues of concern with Management team, and will reply to the Advocate, within one week of receiving the minutes. DON will meet with residents on a daily walkaround, and am available to meet with the residents either individually, or as a group. Decisions made following the Residents meeting will be communicated to the residents verbally, with minutes on display on the Activity Notice Board, and will also be communicated at the next Resident meeting. Decisions made will be communicated to the staff via Handover, and at Staff Meetings.
2. The tea/coffee making facilities in both units will be accessible to residents and their relatives, but a coded access will be put in place to prohibit access by a cognitively impaired resident, who may sustain injury/burn from kettle.

Proposed Timescale: 27/10/2016

Theme:

Person-centred care and support

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

There was limited personal storage space in some of the multi-occupancy bedrooms.

10. Action Required:

Under Regulation 12(c) you are required to: Provide adequate space for each resident

to store and maintain his or her clothes and other personal possessions.

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

1. This will be addressed as part of the re design of the unit
2. Maintenance Dept will be asked to review the bedrooms to see if any improvements can be made in the space available for storage of resident possessions, while waiting for upgrade works to be completed.

Proposed Timescale: 31/12/2018

Outcome 04: Complaints procedures

Theme:

Person-centred care and support

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

The complaints process did not contain details of the person responsible for oversight of the process to ensure adequate records were maintained and that complaints were responded to.

11. Action Required:

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

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

1. The Director of Nursing is the nominated person who deals with complaints and maintains the records. The registered Provider, Mr Paddy Ryan, oversees the process.

Proposed Timescale: 27/10/2016

Theme:

Person-centred care and support

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

Complaint records did not detail whether or not the complainant was satisfied with the outcome of the complaint.

12. Action Required:

Under Regulation 34(1)(f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.

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

1.All complaints are dealt with as per regulation 34(1)(f)

Proposed Timescale: 27/10/2016

Outcome 05: Suitable Staffing

Theme:

Workforce

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

While inspectors were informed that protected cleaning time was provided to a designated MTA, some staff members stated that at times they had to assist with care provision during allocated cleaning time. This did not adequately provide for separation of duties and did not comply with good infection prevention and control practice.

13. Action Required:

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

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

1. Staffing is planned appropriately, and in advance to ensure adequate number and skill mix, appropriate to the needs of the residents, however, it is a dynamic process, and in times of unanticipated sick leave, measures have to be taken to ensure essential care is provided to residents.
2. Access to relief staff is utilised, but sometimes unsuccessfully.
3. Access to Agency Staff is sought in times of prolonged sick leave.
4. Admissions to unit are revised and may be reduced at times of high levels of sick leave.

Proposed Timescale: 31/10/2017

Theme:

Workforce

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

Some improvements were required in relation to training as a significant number of staff had not attended up-to-date training in on responsive behaviour or on dementia care.

14. Action Required:

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

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

1. Training dates for responsive behaviour and dementia training are secured for 14th November 2016 and 16th January 2017
2. Further onsite training dates requested from St Luke's Education Centre for February and March 2017.

Proposed Timescale: 30/04/2017

Theme:
Workforce

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

There was not always a full employment history for all staff with satisfactory explanations for any gaps in employment.

15. Action Required:

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

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

1. All staff requested to complete and return employment history form by 30th November 2016

Proposed Timescale: 30/11/2016

Outcome 06: Safe and Suitable Premises

Theme:
Effective care and support

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

Required improvements in relation to the premises included:

- inadequate dining space
- inadequate storage
- outdoor space was inaccessible on the day of inspection
- multi-occupancy room did not support privacy and dignity
- there was no screen for some glass panels on bedroom doors
- there was a distinct lack of contrasting colours
- signage required upgrade

16. Action Required:

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

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

A design team will be appointed and progress preliminary drawings in order to comply with the requirements of the recently issued new 2016 HIQA standards (as published 3rd May 2016) and the amendment to the Regulation (S.I. No. 293 of 2016). Once the preliminary drawings are available I will forward them on with our time line for completion of the project.

In the interim:

- (a) Contact has been applied to the glass panels on the bed room doors to enhance residents privacy
- (b) Pictures, unique to our residents are in the process of being applied to their bedroom doors for ease of identification.
- (c) Signage is in the process of being upgraded
- (d) Continuing care residents are accommodated on the premises in areas which conform to the matters set out in schedule 6.

Proposed Timescale: (a) Complete, (b, c & d) December 1st 2016

Proposed Timescale: 01/12/2016

Theme:

Effective care and support

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

Some of the bedrooms did not have natural light, there was an inadequate partition between some of the bedrooms, and there was a bed located beside the nurses station in an area used as a thoroughfare by staff, residents and visitors and some windows did not have restrictors in place.

17. Action Required:

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

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

A design team will be appointed and progress preliminary drawings in order to comply with the requirements of the recently issued new 2016 HIQA standards (as published 3rd May 2016) and the amendment to the Regulation (S.I. No. 293 of 2016). Once the preliminary drawings are available I will forward them on with our time line for completion of the project.

Interim Action:

- (a) Bed located beside the Nurses station has been removed
- (b) Restrictors are now in place on all windows

Proposed Timescale: December 2021 (a) Complete (b) Complete

Proposed Timescale: 31/12/2021

Outcome 07: Health and Safety and Risk Management

Theme:

Safe care and support

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

Some improvements were required in relation to infection prevention and control. For example:

- cleaning equipment such as mops were not stored appropriately, in line with best practice
- staff stated that they found it difficult to carry out thorough cleaning as there were no dedicated cleaning staff and the care needs of residents were appropriately given priority
- some personal clothing that was due to be taken home by relatives for laundering was stored in a sluice room and there was no satisfactory explanation as to why it was stored there.

18. Action Required:

Under Regulation 27 you are required to: Ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.

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

1. Staff asked to store cleaning equipment appropriately (Immediate action)
2. Separate teams for Patient care and housekeeping to be initiated with new roster
3. New individual laundry bags for residents on order and protocol for management of same currently being devised. All staff to be aware of new protocol
4. All HCA and MTA staff to complete revision course on Infection Control procedures within Hospital, to be facilitated by CNM11, in co-ordination with Infection Control Officer.

Proposed Timescale: (2) January 2017 (3)(4) 30th November 2016

Proposed Timescale: 31/01/2017