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

Issued by the Chief Inspector

Name of designated centre:	Bandon Community Hospital
Name of provider:	Health Service Executive
Address of centre:	Hospital Lane, Cloughmacsimon, Bandon, Cork
Type of inspection:	Unannounced
Date of inspection:	30 June 2021
Centre ID:	OSV-0000557
Fieldwork ID:	MON-0033323

About the designated centre

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

Bandon Community Hospital, established in 1929, is a single-storey building which had been extensively renovated. The designated centre is a Health Service Executive (HSE) establishment. It consists of accommodation for 25 older adults set out in 21 single en-suite bedrooms and two twin en-suite bedrooms. Communal areas include the day room, dining room, Bandon Suite relaxation area and the quiet room. Residents have access to an enclosed courtyard and an enclosed walkway. The centre provides 24 hours nursing care for long-term, respite and palliative care residents. The centre is supported by the Friends of Bandon Community Hospital who have raised money for the day-room refurbishment and many other aspects of the care setting.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	21

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as 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
Wednesday 30 June 2021	09:30hrs to 18:00hrs	Ella Ferriter	Lead

What residents told us and what inspectors observed

The inspector arrived unannounced to the centre in the morning, and the administrator guided the inspector through the infection prevention and control measures necessary on entering the designated centre. These processes were comprehensive and included a signing in process, hand hygiene, face covering, and temperature check. The reception area was very welcoming and was decorated with comfortable armchairs, soft furnishings and a table.

After an opening meeting with the person in charge, the inspector was guided on a tour of the premises, where she met and spoke with residents in their bedrooms, on the corridors and in the communal rooms. The centre is single story building. Residents bedroom accommodation consists of 21 single rooms and two twin rooms. Residents were facilitated to personalise their bedrooms with memorabilia and photographs. There was adequate space in residents' bedrooms to store their personal possessions and clothing. Some bedrooms had double doors opening onto the garden. Residents were seen to use this facility, and told the inspector they really enjoyed having such easy access to the outdoors.

There were 21 residents living in Bandon Community Hospital on the day of this inspection. Residents appeared well-cared for, neatly dressed and groomed, in accordance with their preferences. The inspector observed interactions between the staff and residents throughout the day and found that they were warm, respectful and person-centred. The inspector spoke to a number of residents informally throughout the inspection and spoke to approximately six residents in more detail, to gain a better insight of their lived experience in the centre. Overall, residents reported a good quality of life in a homely environment and they were generally complimentary of the care in the centre. They also told the inspector that they had more activities available to them in the past few weeks, which made the days more enjoyable.

There was a relaxed atmosphere in the main sitting room, residents moved around to chat with their friends, others enjoyed reading the newspaper. There is two enclosed gardens in the centre, one a central courtyard and the second to the back of the building. On the previous inspection of this centre, residents told the inspector they would like more access to the outdoors. The garden to the back of the premises was not being utilised. The inspector observed that residents now had easy access to the gardens and saw numerous residents sitting out in the garden on the afternoon of the inspection, which took place on a warm day in June. The staff served residents ice cream and some residents read books and did puzzles. Gardens had recently been furnished with seating and some plants. One of the residents told the inspector that she loved to sit out in the garden as it was very peaceful and relaxing and the new furniture had been a great addition to the centre. The inspector observed a sun lounger had been purchased for one resident, who enjoyed lying out in the summer.

Communal accommodation was in the process of being redecorated, with the aim of making the centre more homely. Painting was being carried out and new curtains had been ordered. The large communal room was home to a very large screen wall mounted TV, music and comfortable seating, spaced out, to abide by social distancing requirements. Dining tables had been relocated to one side of this room since the previous inspection, where it had been found that there was not sufficient facilities to accommodate residents to dine outside of their bedrooms, and the dining experience for residents had lacked ambiance. The inspector was informed that the management team and staff were focused on ensuring that residents are afforded an enjoyable dining experience, and this area would be further developed and decorated in the coming months.

The residents were given the option of having their meals in the dining room, their bedroom or in the communal areas of the centre. The majority of residents commented that they were satisfied with the quality of the food and the choice offered. However, two residents stated they would like more variety and there had been a few occasions where food was not hot enough. A menu was on display on dining room tables, detailing lunch options. A review of minutes of residents meetings evidenced that residents had raised issues regarding the variety of food. In response to this, the management team were currently reviewing the process for taking meal orders from residents, enhancing menu options and had ordered new dinnerware.

Residents had a choice to socialise and participate in activities. The inspector observed both group and one-to-one sessions taking place. Mass was streamed daily from the local church and residents stated they enjoyed this morning event. The activity coordinator demonstrated a commitment and enthusiasm for the role and it was evident that she knew the residents well. Residents were observed getting hand massages, laughing and joking with staff.

There was a relaxed atmosphere within the centre. The inspector observed that residents seemed relaxed and content in the company of staff and that staff were respectful towards the residents at every interaction. Visiting to the centre had resumed, was being monitored, and visitors were appropriately screened. The inspector met with four visitors during the inspection, who praised the care and attention their loved one received in the centre. Two visitors expressed satisfaction with the enhanced outdoor space. They told the inspector that management had maintained contact and keep families updated with any changes during the various levels of the pandemic restrictions.

The centre was observed to be spotlessly clean throughout and there was sufficient cleaning staff on duty to maintain the high level of cleanliness. The inspector observed numerous examples of good practice in infection prevention and control throughout the centre and appropriate systems were in place to ensure and promote safe practices in infection prevention and control. Residents also described heightened anxieties and the difficulties brought on by the COVID-19 outbreak in the centre that had commenced in December 2021. Two residents told the inspector how they had experienced "the virus" and were so happy that it was all over. One residents reported that the physiotherapy sessions weekly were very beneficial to

them to improve their mobility and recovery.

The next two sections of this report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted the quality and safety of the service being delivered.

Capacity and capability

This was an unannounced risk inspection to monitor ongoing compliance with the regulations. The registered provider had submitted an application to renew the registration of the centre, and this inspection would also support the decision-making process for that application. The last inspection of this centre was in September 2020, which identified four regulations as non complaint and found urgent risk regarding fire precautions and the management of incidents within the centre. Following that inspection the registered provider representative of Bandon Community Hospital attended a meeting with the Office of the Chief Inspector, and conveyed how the provider would address the regulatory non compliance's identified, and presented a compliance plan. The findings of this inspection demonstrated that actions had been completed in relation to identified fire safety precautions, implementation of the risk management policy, and management of incidents. However, management systems required further attention in relation to care planning, the management of complaints and residents rights. There had been some improvements in the overall governance and management of the centre since the previous inspection and a number of systems had been commenced to ensure that the service provided is safe, appropriate, effective and consistently monitored. However, these systems were in the early stages of implementation and required ongoing development and review.

Bandon Community Hospital is operated by the Health Service Executive, who is the registered provider. Clearly defined management structures were in place, to enable accountability and responsibility for the service. The organisational structure within the centre was clear, with roles and responsibilities understood by the management team, residents and staff. The management team operating the day to day running of the centre consists of a person in charge and a Clinical Nurse Manager, both of whom had been appointed two months prior to this inspection. Support was provided by the the General Manager who was the registered provider representative (RPR), and the person in charge reported to the RPR. Off site there also the additional support of the clinical development coordinator, human resources and an infection prevention and control specialist.

This inspection took place during a national incident which compromised the information technology (IT) access in the centre. As a result the management team did not have access to their auditing system and had implemented a temporary paper based system. While these risk audits had identified areas of improvement, they did not always have a quality improvement plan developed. This meant that

there was no plan of action, delegated to a responsible person with an appropriate time lime, available for review.

Staffing levels were adequate to the size and layout of the centre. Staff understood their role, were knowledgeable of residents individual needs and were seen to engage with residents in a kind and caring manner, throughout the day of inspection. Training records indicated that all staff had completed infection prevention and control training in areas such as hand hygiene, personal protective equipment (PPE) and breaking the chain of infection. However, there were gaps seen in attendance at some mandatory training for a number of staff, which is discussed further under Regulation 16.

Residents and staff had been through a challenging time, having experienced a recent COVID-19 outbreak in the centre, which affected the majority of residents and a large proportion of staff working in the centre. Sadly, some residents had passed away. The outbreak was well managed, and the affected residents had supportive plans in place to promote a full recovery. The centre had successfully implemented their preparedness plan and had managed to substantially increase their staffing levels during the outbreak, with a combination of agency staff and redeployment of staff from other HSE centres in Cork. Records reviewed on the inspection indicated that the provider had actively engaged with Public Health and had implemented specific infection control advice. The outbreak had been formally declared over by Public Health on February 23rd, 2021. The inspector was informed that an outbreak report was currently being compiled by the provider, however, this was currently unavailable due to limited IT access. This would review what had worked well, and to identify learning from the outbreak.

Incident recording and complaint management processes were in place. All incidents had been reported to the Chief Inspector as required by the regulations. Improvements were required in the management of complaints, as a review of documents found that resident's complaints were not always recorded in line with the centre's complaints policy and were not always addressed in a timely manner.

In summary, this inspection found improvements were implemented since the previous inspection, however, opportunities for the consolidation and embedding of management systems was necessary to ensure a robust service was delivered to residents, which promoted a rights based approach to care delivery.

Registration Regulation 4: Application for registration or renewal of registration

The application for registration renewal was submitted to the Chief Inspector and included the information set out in Schedule 1 of the registration regulations.

Judgment: Compliant

Regulation 14: Persons in charge

There was a new person in charge since the previous inspection, who had commenced the post two months prior to this inspection. This person was a registered nurse who was full time in post, and had the necessary experience and qualifications as required by the regulations. She demonstrated good knowledge regarding her role and responsibility, and was articulate regarding governance and management of the service.

Judgment: Compliant

Regulation 15: Staffing

A review of the staffing rosters and the staffing levels on the day of the inspection found that staffing was adequate to meet the assessed needs of the residents and for the size and layout of the building. Improvements were noted in the allocation of staff to activities to ensure that residents social care needs were addressed.

Judgment: Compliant

Regulation 16: Training and staff development

Staff were supervised in their roles by the person in charge, who was supported daily by the clinical nurse manager. A review of the training records for staff found that there were gaps in mandatory staff training, for example:

- 50 % of training in managing behavior that is challenging had expired
- 10% of training in manual handling had expired.

Judgment: Substantially compliant

Regulation 21: Records

A sample of four staff files viewed by the inspector were assessed and complied with the requirements of Schedule 2 of the regulations. Garda vetting was in place for all staff, and the the person in charge assured the inspectors that nobody was recruited without satisfactory Garda vetting.

Judgment: Compliant

Regulation 23: Governance and management

There had been a number of changes to the governance and management team two months prior to the inspection. Improved management systems were in the early stages of implementation and required ongoing development and review, to ensure that the service provided is safe, appropriate, consistent and effectively monitored. Improvements were required in the following areas:

- Individual assessment and care planning.
- Oversight of fire precautions, namely daily checks.
- Management of complaints.
- Ensuring that a social activities programme is sustained.
- Although there was a risk register in place, this was required to be reviewed by the new management team to ensure risks were effectively monitored.
- Ensuring mandatory training was completed for all staff.

Judgment: Not compliant

Regulation 31: Notification of incidents

A record of incidents was maintained in the centre. Based on a review of incidents, the inspector was satisfied that all notifications were submitted as required by the regulations to the Chief Inspector.

Judgment: Compliant

Regulation 34: Complaints procedure

The system in place to manage complaints in the centre required review as it was found:

- there was evidence that some complaints were not managed in line with regulation 34, for example they did not always document if the complainant was satisfied
- the system for documenting complaints was inconsistent
- there was not always evidence that complaints were monitored by management
- some complaints from residents regarding food were not addressed and had

been left open for four months.

The management team acknowledged these findings on the day of inspection and informed the inspector that the current process was being reviewed.

Judgment: Not compliant

Quality and safety

The inspector found that overall, residents were supported and encouraged to have a good quality of life which was respectful of their wishes and choices. Residents' needs were being met through good access to healthcare services, opportunities for social engagement and a premises that met their needs. While good levels of compliance were found in most of the regulations and standards, there were some opportunities for further improvement in care planning and fire precautions.

Validated risk assessments were completed to assess various clinical risks including risks of malnutrition, pressure sores and falls. Based on a sample of care plans viewed appropriate interventions were in place for some residents' assessed needs, however, improvements were required in some care plans reviewed. This will be discussed further under regulation 5. Oversight of residents' health care needs was good. Residents' health care needs were promoted by ongoing on-site access to their GP and allied health professionals when required, for example, psychiatry of old age and access to a geriatrician

Visiting had recommenced and visits were scheduled and facilitated in the afternoons over a seven-day period. Staff demonstrated a commitment to facilitating visiting and accommodating visitors time schedules as well. This improvement was acknowledged since the previous inspection where visiting was found to be restrictive.

The centre was seen to implement best practice infection control guidelines, to ensure the ongoing safety of residents and staff, and had enhanced their cleaning regime during the pandemic. The provider had proactive measures in place to protect residents and others from risk of fire. Fire fighting equipment was available throughout the building. Emergency exits were clearly displayed and free of any obstruction. Daily and weekly fire safety equipment checking procedures were completed, however, there were some gaps noted. There was a preventive maintenance schedule of fire safety equipment, the fire alarm and emergency lighting in accordance with the recommended frequency.

A review of residents rights was required to ensure that all residents had appropriate access to opportunities for activity and social engagement, and that the new programme implemented was sustained. The activities schedule was of good quality, with a number of engaging and varied activities on offer seven days a week. Staff were seen to be supportive and encouraging in their interactions with

residents.

Regulation 11: Visits

On the last inspection of this centre, visiting was found to be restrictive and limited. This had been addressed and visiting was now taking place seven days per week. Visits were seen to take place in line with updated visiting guidelines. Many visitors were seen coming and going on the day, with visits taking place both indoors in residents rooms and in the garden. There was sufficient space and time allowed for residents receive their visitors in private. Visitors confirmed that they were communicated with by management in relation to any changes to the visiting procedures.

Judgment: Compliant

Regulation 27: Infection control

There was evidence that the centre had effectively managed the recent outbreak of COVID-19 and had a comprehensive preparedness plan in place, should another outbreak occur. The centre was seen to be very clean. An cleaning schedule was in place and specific named staff have responsibility for the completion of tasks. High use areas were cleaned frequently, and regular deep cleaning schedules had been implemented. Up-to-date training had been provided to all staff in infection control, hand hygiene and in donning and doffing of personal protective equipment (PPE).

Judgment: Compliant

Regulation 28: Fire precautions

On the day of this inspection there were upgrades to the fire alarm system taking place. There were adequate precautions taken to prevent against the risk of fire at the centre including fire fighting equipment, adequate means of escape, emergency lighting and regular servicing of these systems. Annual fire training was completed by staff at the centre. However, improvements were required in the following areas:

- ensuring that daily fire checks were complete as there were gaps in some days evidenced
- ensuring the evacuation of the largest compartment could be undertaken in a timely and safe manner, mindful of night duty staffing levels

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Some improvements were required in care planning to ensure that care plans were prepared and reviewed in line with regulations, for example:

- wound care documentation was inconsistent and not in keeping with evidence based practice.
- care plans were generic in some instances and did not detail individual care needs.
- care plans were incomplete regarding the aims and goal of care provision
- care plans were not always updated four monthly.

Judgment: Not compliant

Regulation 6: Health care

Residents had a choice of general practitioners GPs who visited the centre four days per week. Records evidenced that residents were appropriately referred, seen by GP when required and prescribed appropriate treatment. Physiotherapy, speech and language services, dietetics and tissue viability services were also available following a referral.The physiotherapist visited the centre on a weekly basis.

Judgment: Compliant

Regulation 9: Residents' rights

Residents had access to advocacy services, information on local events, notice boards, radio, and television. The activity programme ran seven days a week and the activity schedule was informed by the interests and activity preferences of the residents. However, improvements were required in relation to the following:

- on review of records and from conversations with residents and staff it was evident that activities had only become available to residents in the last 2-3 months. Findings of two previous inspections of this centre in December 2019 and September 2020 found that residents did not have sufficient access to activities.
- the complaints management system required review to ensure that residents complaints were addressed in all instances.
- a residents meeting had taken place in May 2021, however, the meeting prior

to this had been in July 2020.

- a satisfaction survey regarding meals had taken place in November 2020, however, there was no evidence that feedback from residents was acted upon.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 4: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 27: Infection control	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Bandon Community Hospital OSV-0000557

Inspection ID: MON-0033323

Date of inspection: 30/06/2021

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:

<table>
<tr><th>Regulation Heading</th><th>Judgment</th></tr>
<tr><td>Regulation 16: Training and staff development</td><td>Substantially Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 16: Training and staff development:
Staff training is essential to maintain optimal and safe practice. The PIC will ensure under Regulation 16, that all staff have access to appropriate and timely training and as outlined in the report and this training is appropriately supervised.a training matrix will be developed which will encompass all mandatory training and this maxrix will be reviewed on a monthly basis to ensure compliance

Nominations for training in Manual Handling have been submitted and will be scheduled in September/October of 2021.

Staff training in Responsive Behaviour will be provided by the on site responsive behavior trainer and this is scheduled to commence week beginning 09.08.21,it is anticipated all training will be completed within 6 weeks
.</td></tr>
<tr><td>Regulation 23: Governance and management</td><td>Not Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 23: Governance and management:
The management team consists of the Director of Nursing , Clinical Nurse Manager 2 . in their absence Senior Staff Nurses assume responsibility for the unit, the Nurse in Charge has access to a member of the management team at all times. The management team ensures that systems are in place to provide a safe, appropriate, consistent and</td></tr>
</table>

effectively monitored service as outlined in legislation, regulations and standards and policies. Sufficient resources are available to provide effective delivery of care. As outlined in report there is a clearly defined management structure in place to support the unit including support from infection control, Human Resources, and the General Manager office and who are available to the service at all times.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
Bandon Community Hospital supports the HSE's Your Service , Your Say policy on the management of complaints. There is an accessible and effective complaints system in place with a local and regional complaints officer and appeals procedure clearly displayed.
All complaints are documented consistently and appropriately and reviewed by the PIC and responded to in a timely manner in order to close the loop. Residents are informed of the outcomes. SAGE and the Patient Advocacy Service are available for all residents as needed.
All complaints and concerns are listened to and acted upon in a timely, supportive and effective manner and outcomes are communicated to the resident.
The local complaints procedure has been reviewed and a new recording book introduced for all complaints and compliments.

Staff have been instructed in documenting complaints and the importance of highlighting all complaints to the management team in a timely manner.

Management review all complaints and document action plans and outcomes and ensure closure or the loop and keep residents informed of the outcome.

A monthly review of all complaints is submitted to the General Managers office
The Complaints officer for CHO4 is available to assist with all aspects of complaints.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Effective procedures are in place to minimize risk and protect residents in accordance with legislation.
All fire escapes and emergency lighting are serviced on a quarterly basis or more frequently should the daily fire checks identify a concern

A fire steward is identified each shift and the this person is trained in the completion of all fire check log and document same.

The fire alarm test is completed weekly and documented.

A fire evacuation drill is completed and documented monthly with emphasis on evacuation of the compartment with night shift staff number of 3. All areas within the centre are evacuated in a rotational basis

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 resident has an identified nurse who is responsible for the review of the Resident care plans, these care plans are reviewed every 4 months or less should the residents condition require same in consultation with the resident and where on the residents request their family may be invited to participate
Resident assessment and care planning in conjunction with the resident ensures that the health and well being of each resident is promoted and each resident is given the appropriate supports to meet their needs.

There is a monthly audit schedule that encompasses care planning in place ,using the online viclarity system,this audit tool is person centred and aims to ensure the care plans are person centred ,meaningful and resident focused,the audit tool has an inbuilt action plan component requiring timely review and completion.
All nursing staff are scheduled to receive audit training and will be participating fully in audits action plans and outcomes.

HSEland training is available for all staff online including resident assessment and documentation modules
Care plan and documentation training for all Nursing staff is scheduled for September 6th and 13th

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
The residents are included in the decision making process regarding their individual care and also the decisions and planning around the general running of the centre. The

Resident forum(meetings) are facilitated every 3 months with planned meeting dates to end of the year. These are facilitated by the Elderwell coordinator and attended and reviewed by the PIC. Any actions required are followed up by management and a response is issued to all residents.
A resident representative has been appointed since May 2021 and she meets with the PIC weekly and as needed to review and discuss any issues, concerns or suggestions which the residents may have. These meetings are documented and any actions required are managed by the PIC and a response is given to the resident representative.
The health and well being of each resident is promoted and each resident is given the appropriate supports to meet their needs.

Activities have been reinstated since April 2021 with Elderwell 2 days a week and in house activities on other days An activity coordinator has been appointed and together with Elderwell all residents have been assessed for their preferences and capabilities in activity and a combination of group and individual sessions are scheduled weekly.
There is a diverse activity program in place Activities are planned in coordination with residents assessed capacities and interests The activity schedule is reviewed by management and audited.
All activities are documented on individual files and individual assessments are included in the careplan.

Residents are encouraged to complete the satisfaction surveys on an ongoing basis and these are available throughout the unit and these are reviewed by the PIC

SAGE and Patient advocacy services are available to all residents.

Physiotherapist provides a group exercise class weekly and also provides treatment and review for individual residents.

The new patio areas and outside seating has provided a welcome alternative for all residents.

We also engage with local community groups and schools to provide entertainment and support. For example:-

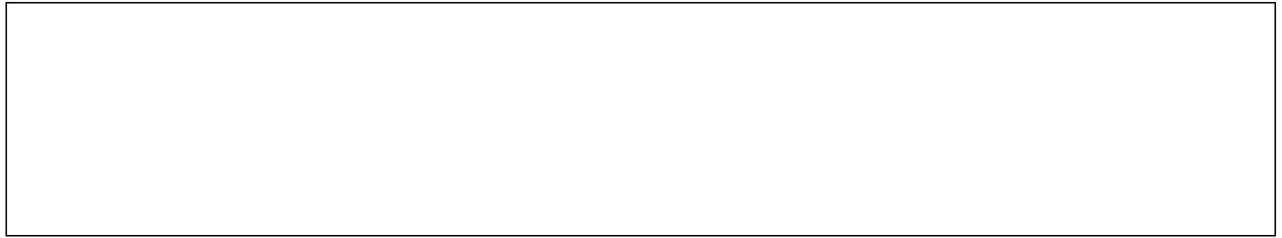
Mass on site every Tuesday with local preist attending and daily via TV.

Biweekly zoom call with Kinsale CH and Kinsale Mens Shed who provide entertainment in the form of music, song and poetry.

A recent outdoor concert given by students of Bandon Grammer School and presentation of lap rugs made by the students to the residents.

Ongoing connection to family and friends who are unable to visit via zoom and whats app calls.

We plan to continue to provide a range of activities for all residents and hope to begin group outings and volunteer group involvement in the near future.



Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	01/09/2021
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	Orange	01/09/2021
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.	Substantially Compliant	Yellow	01/09/2021
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and	Substantially Compliant	Yellow	01/09/2021

	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 34(1)(d)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall investigate all complaints promptly.	Not Compliant	Orange	01/09/2021
Regulation 34(1)(f)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall 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.	Not Compliant	Orange	01/09/2021
Regulation	The registered	Not Compliant	Orange	01/09/2021

34(1)(g)	provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall inform the complainant promptly of the outcome of their complaint and details of the appeals process.			
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Not Compliant	Yellow	01/09/2021
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	Yellow	01/10/2021
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in	Substantially Compliant	Yellow	01/09/2021

	activities in accordance with their interests and capacities.			
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned.	Substantially Compliant	Yellow	01/09/2021