Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Skibbereen Community Hospital
Name of provider:	Health Service Executive
Address of centre:	Coolnagarrane, Skibbereen, Cork
Type of inspection:	Unannounced
Date of inspection:	29 September 2021
Centre ID:	OSV-0000598
Fieldwork ID:	MON-0034388

About the designated centre

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

The original Skibbereen Community Hospital was constructed around 1930, and was originally known as St. Anne's Hospital. More recently it is known as Skibbereen Community Hospital. The centre consists of a single-storey building located on a Health Service Executive (HSE) site. The centre provides long-stay, respite, community support and palliative care to the older population of Skibbereen and the surrounding area. The centre is registered to cater for the needs of 40 residents. Our multidisciplinary team under the guidance of the director of nursing (DON) aim to provide our residents with the most appropriate care which is evidence-based and person-centred. The primary objective of our service is to assure a high standard of care and welfare in order to guarantee a living environment that maintains resident`s independence and well-being. All our nursing staff are experienced in caring for the older adult. They are dedicated to providing a 24-hour quality nursing service to the residents. All staff receive continuous professional development on training needs. Male and female adults over 65 years make up the majority of residents. In exceptional circumstances some residents may be under 65 yrs e.g. residents admitted for designated palliative care or chronic young sick, following an appropriate assessment. If there is a need for an urgent community support bed, the DON will consider such circumstances on an individual basis. Potential new residents and their families can arrange with the DON or clinical nurse manager 2 (CNM2) to visit the hospital prior to admission. Every resident is encouraged to engage in a wide range of activities organised for them. Trips to local areas are organized with the local rural transport. Feedback is welcome from our residents or their representative on all aspects of care. An independent volunteer advocate attends the hospital on a weekly basis. Any issues/concerns raised are addressed. Mass is said by local clergy in the on-site chapel. Those who cannot attend mass, can hear it via our intercom system. Pastors from other denominations visit the hospital also. There are few restrictions on visiting other than that extra consideration is given when visiting in the morning and at meal-times. A visitors' room is available with tea/coffee making facilities where relatives can have private visits or stay if necessary.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	23

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 29 September 2021	08:30hrs to 18:00hrs	Ella Ferriter	Lead

What residents told us and what inspectors observed

This inspection took place over one day. The inspector met with all 23 residents living in Skibbereen Community Hospital, and spoke in detail with three residents. The inspector spent time observing residents' daily lives and care practices in the centre, in order to gain insight into the experience of those living there. It was evident that the provision of activities and aspects of social stimulation for residents was inadequate, with a large number of residents spending their day at their bedside or in one of the sitting rooms, with little to occupy them apart from daily care tasks and the television. There was evidence of institutional practices within the centre, some staff viewing the centre more like a hospital than a home for residents living in the centre.

The inspector arrived to the centre in the morning, unannounced. Following an opening meeting with the person in charge, the inspector was guided on a tour of the premises. The centre was laid out over one level and residents had access to two secure internal courtyards. Bedrooms accommodation was divided into named wards, depicting areas around West Cork such as Glandore, Fastnet, Abbey, and Ilen. There were five rooms with four beds, one three bedded room and 13 single bedrooms. Previous inspections of Skibbereen Community Hospital had found that the premises layout and design impacted negatively on residents lived experience in the centre, which was impacting on their quality of life. This was particularly due to the number of multi-occupancy bedrooms, the majority of which had accommodated six residents. In response to these finding the Health Service Executive had implemented a building and refurbishment project which involved reducing the occupancy of six bedded rooms to four bedded rooms, thus increasing personal space. A new wing had also been constructed, which comprised of seven single en suite bedrooms. The inspector saw that these new bedrooms were decorated to very a high standard, with flat screen televisions, ceiling hoists and en-suite facilities. They were bright and homely. However the inspector saw that despite the fact they were ready for use four months prior to this inspection, all of these newly constructed bedrooms were unoccupied, and 19 of the residents living in the centre remained in multi-occupancy bedrooms. The inspector observed the corridor of this new wing was being used to store old furniture and equipment.

The inspector was informed that residents living in Skibbereen Community Hospital had not been afforded with the opportunity to relocate to single en-suite bedrooms, if they chose to do so and that this was due to issues pertaining to staffing. Staff told the inspector they did not believe they had adequate resources to facilitate residents' relocation to these new bedrooms and therefore could not facilitate residents moving into single rooms. One member of staff told the inspector that it was more difficult to observe residents in these rooms, and much easier when they were in multi-occupancy rooms. Another member of staff told the inspector that these rooms would be more suitable for short stay respite residents. Two residents that lived in shared rooms told the inspector they looked forward to moving into a new single room when they could, and they were aware there were not open yet.

There was no record of consultation with residents or their families in relation to these new bedrooms in the centre. This is discussed further in the report.

The inspector saw that there were a variety of indoor communal space available for residents. A former six bedded room was now operating as a sitting room, and this was the main room used by residents throughout the day of this inspection. The inspector saw that the decor in this room was very minimal and it was not homely. There were tables on either side of the room, which were used during lunch, and a flat screen television in the corner of the room. There was a nice sitting room on Ilen ward, which was bright, homely and had nice decor and artwork on the walls. There was also access to a secure garden from this sitting room which had recently been refurbished. However, this room was not used during the day of this inspection and was primarily being used to store equipment such as specialised chairs. The third communal room was being used as a dining room for some residents. However, many residents were observed during the day of this inspection sitting beside their bed for the majority of the day.

The inspector observed that opportunities for recreation or activities were not available, and there was no staff member allocated to activities or social aspects of care. The inspector enquired regarding activities, and was informed that the day prior to this inspection a chiropodist had visited residents, and that essential healthcare was classed as the scheduled activity. There was no activity schedule visible, to allow residents to choose what was available to them on any given day. Staff confirmed there was no group activity plan, and activities only happened if there was time in the day. On the day of this inspection seven residents were observed in the afternoon being brought to the sitting room, the majority in specialised wheelchairs and being put in front of a television with country music being played. There was little or no engagement between staff and residents at this time, and there was limited supervision of residents in this sitting room.

The inspector observed that there were enough staff working in the centre, to respond to the needs of the residents in a timely manner. Although there were some positive interactions between residents and staff seen on the day of this inspection, when staff were assisting residents with personal care and meals, the inspector also observed that some care in the centre was task based. From speaking to some staff in it was evident that the centre was viewed by some as a hospital, rather than a home. For example, it was common practice for staff to refer to residents as patients. A large number of residents in the centre were living with a cognitive impairment (80%), and were unable to fully express their opinions to the inspector, these residents appeared to be content and relaxed in the company of staff, when observed throughout the day. Residents that spoke to the inspector said that staff were kind and came when they called.

The inspector observed the dining experience at lunch time. Residents had their main meal in either a sitting room, in the dining room or beside their bed. The inspector saw the food was appetising and well-presented and residents had choice. Staff sat with residents and provided assistance appropriately and engaged with residents at this time. However, the inspector found that at times care was task-orientated. Medications were administered during meals and some residents

received a hot dinner and ice cream at the same time, with no consideration regarding the suitability of this, as the dessert was nearly melted when the resident was ready to consume it. The inspector saw that other residents were handed out tubs of ice-cream and a spoon at the end of their meal and then returned to their room. There was little or no atmosphere in the dining room or sitting room when residents had their main meal.

The centre was generally clean throughout. Housekeeping staff who spoke to the inspector demonstrated a good knowledge of infection prevention and control practices relevant to their work. However, the oversight of cleaning processes by management required review, as discussed under regulation 27. Robust measures were in place to manage the risk of COVID-19. Staff were observed following infection control guidelines, with the correct use of personal protective equipment (PPE) and hand hygiene. There was signage at the entrance of the centre, reflecting the current guidance and all visitors entering the building had their temperature checked and a health declaration completed. Visiting arrangements were in place, in keeping with the current guidance. The inspector did not have the opportunity to meet with any visitors on the day of this inspection.

Overall, findings of this inspection were that residents' rights required immediate review. There was evidence of institutional practices within the centre, some staff viewing the centre more like a hospital than a home for residents living in the centre. The next two sections of the 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 by an inspector of social services, to monitor compliance with regulations, and to follow up on the actions from the previous inspection, of March 2020. This inspection found improvements were required regarding the oversight of management systems, to ensure a a safe robust service was delivered to residents, which promoted a rights based approach to care delivery. Significant improvements were required to enhance the lived experience of residents and to ensure clear and effective oversight of the service, to address residents rights, fire precautions, food and nutrition, care planning and the management of responsive behaviours.

The registered provider of this centre is the Health Service Executive. The organisational structure within the centre is 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. Support was provided by a General Manager, who

represented the provider. The person in charge reported to the general manager. Off site there also the additional support of a clinical development coordinator, human resources, and an infection prevention and control specialist. There was evidence of good communication and frequent quality and safety meetings, where topics such as incidents, risk, safeguarding, audits and infection control were discussed.

There were sufficient resources available to ensure that safe and effective care was provided to the residents. Resident occupancy in the centre had reduced, to facilitate reconfiguration and refurbishment of the premises, however, staffing compliment had not been reduced by the provider. A review of the training matrix found that all staff were due training in managing responsive behavior. This posed a risk to residents in the centre, whose assessed needs included management of complex behaviours, which is further discussed under regulation 7. All staff had completed training in fire safety, manual handling, safeguarding and infection control practice. Although there were systems in place to monitor the quality and safety of care, these were inconsistent and sometimes ineffective, which is further detailed under regulation 23.

The centre had a comprehensive complaints policy and procedure, which clearly outlined the process of raising a complaint or a concern, however, complaints were not always recorded in line with regulatory requirements, as discussed under regulation 34. Incidents were reported to the Chief inspector as required by the regulations.

There was evidence that residents meetings took place every three months. However, the inspector found that where suggestions were made, these were not always followed up on and used to inform continuous quality improvements. In summary, this inspection found improvements were required regarding the oversight of management systems, to ensure a a safe robust service was delivered to residents, which promoted a rights based approach to care delivery.

Regulation 14: Persons in charge

There was a newly appointed person in charge since the previous inspection. They had the required experience in management and nursing as required by the regulations. The person in charge worked full time in the centre.

Judgment: Compliant

Regulation 15: Staffing

There was an adequate number and skill mix of care staff available in the centre to meet residents' care needs. This included three registered nurses daily and four

healthcare assistants. However, staff allocated to the social care needs of residents was inadequate, which is addressed and actioned under regulation 9.

Judgment: Compliant

Regulation 16: Training and staff development

Training was being monitored by the management team. Training in fire, manual handling and safeguarding was in date for all staff. However, all staff were overdue training in managing responsive behaviors, as detailed and actioned under regulation 7.

Judgment: Compliant

Regulation 21: Records

A sample of four staff files were reviewed by the inspector. The majority complied with the requirements of Schedule 2 of the regulations. One staff file did not have a reference from the most recent employer. Garda vetting was in place for all staff, and the the person in charge assured the inspector that recruitment did not progress without satisfactory Garda vetting.

Judgment: Substantially compliant

Regulation 23: Governance and management

Overall, management systems required to be strengthened, reviewed and developed to ensure that the service provided is safe, appropriate, consistent and effectively monitored. An immediate action was issued to the provider in relation to fire precautions and Improvements were required in the following areas:

- ensuring that there was effective oversight and monitoring of diets provided to residents, as detailed under regulation 18.
- the auditing process within the centre was not being used effectively to drive quality improvement. For example audits were not always complete and did not always have associated action plans when deficits were identified. The auditing system was also not sufficiently robust as it had not identified some of the findings of this inspection and 100% compliance was found in the majority of areas audited.
- there was evidence of a lack of effective systems in place to monitor fire

precautions, managing responsive behaviors, food and nutrition, care planning and complaints which are all outlined further under the specific regulations.
- there was poor oversight and provision of activity provision and social care provision which was impacting negatively on the quality of life of residents.

Judgment: Not compliant

Regulation 31: Notification of incidents

The records of accidents and incidents which occurred in the centre were appropriately recorded. The inspector found that all had been managed and reported to the Chief Inspector as required by the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

As found on the previous inspection the complaints process required review and there was insufficient oversight of complaints within the centre. The complaints records did not included adequate detail of the complaint, the outcome of any investigations and the action taken. It also did not evidence if the complaint was satisfied. The inspector noted that the complaint record was being used inappropriately, as a method for resident feedback, for example, to ask if residents were satisfied with a meal, and if not it was logged as a complaint.

Judgment: Not compliant

Regulation 4: Written policies and procedures

The policies and procedures outlined in Schedule 5 of the regulations were available for review and had all been updated within the last three years.

Judgment: Compliant

Quality and safety

Residents received a good standard of health care and services were provided in line with their assessed needs. However, residents were not afforded an appropriate social and recreation programme in Skibbereen Community Hospital, and although the premises had been reconfigured residents were not afforded the opportunity to choose to relocate to a single bedroom, which would provide them with enhanced privacy and may improve their quality of life.

Each resident had an individual assessment and an overall care plan developed. A range of validated assessments tools to identify each residents needs, were completed on admission to the centre. Care plans reviewed were updated four monthly as required by the regulations. Some areas were identified that required improvement, which is discussed further under regulation 5. Residents were assessed as required by dietetics and speech and language therapists, however, increased monitoring of residents who had prescribed diets were required, as discussed under regulation 18.

Previous inspections of the centre highlighted the negative effect of living in six bedded rooms resulted in residents having limited space for personal possessions and receiving personal and intimate care in close proximity to a fellow residents. This impacted on residents human right to privacy and dignity. Due to this the Chief Inspector placed a restrictive condition on the registration of this centre which stated that design and layout of the centre must be reconfigured as per plan submitted, to ensure that all existing and future residents are afforded appropriate dignity and privacy through the provision of adequate personal space and ensure that the premises meets the needs of these residents.

In response to this the Health Service Executive had implemented a building and refurbishment project of Skibbereen Community Hospital. This project involved reducing the occupancy of six bedded rooms to four bedded rooms, thus increasing personal space. A new wing had also been constructed, which comprised of seven single en suite bedrooms. These new bedrooms were decorated to very a high standard, with flat screen televisions, ceiling hoists and en-suite facilities. They were bright and homely. They had been registered by the Chief Inspector in May 2021, four months prior to this inspection. However, on the day of this inspection the inspector noted that all of these newly constructed bedrooms were unoccupied, and 19 of the residents living in the centre remained in multi-occupancy bedrooms.

Overall the premises was clean and well maintained. As detailed above the registered provider had invested in an extensive reconfiguration of the premises. There was an infection prevention control lead in the centre and in general there were good practices regarding implementation of infection control guidelines in the centre. The inspector acknowledges that residents and staff, living and working in centre had been through a challenging time, due to the global pandemic. The centre had not experienced an outbreak of COVID-19. A contingency plan was in place, should the centre experience an outbreak. This inspection found that the daily oversight cleaning required to be addressed.

There was a preventive maintenance schedule of fire safety equipment, the fire alarm and emergency lighting were serviced in accordance with the recommended

frequency. Personal emergency evacuation plans were in place for each resident and updated on a regular basis. Staff had completed their annual fire safety training. However, further fire safety issues, one in which the provider was issued an immediate action for, required to be addressed which is detailed under regulation 28.

Regulation 11: Visits

Visiting to the centre was taking place in line with the Health Protection and Surveillance Centre guidelines. There was evidence that visitors were risk assessed prior to entering the centre.

Judgment: Compliant

Regulation 12: Personal possessions

Improvements were noted in relation to residents accessibility to their personal possessions. With the reduced occupancy of six bedded rooms, residents were now afforded more personal space. Residents had individual wardrobes and bedside lockers in close proximity to their bed.

Judgment: Compliant

Regulation 17: Premises

Significant improvements had been made to the premises since the previous inspection of March 2020. However, there was inadequate storage available for equipment such as specified chairs. Although there was a storage room within the centre, this was allocated to a physiotherapist.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Increased oversight was required to ensure that where residents who had dietary requirements prescribed by healthcare or dietetic staff, based on their nutritional assessment, had this plan of care implemented in practice and communicated to all staff. The inspector observed that one resident who had difficulty swallowing and

was at high risk of choking, was provided with the wrong consistency diet on the day of this inspection. This posed a significant risk of to the resident.

Judgment: Not compliant

Regulation 26: Risk management

The risk management policy was available for review and complied with the legislative requirements. A general risk register was in place which included hazard identification and control measures. It was reviewed on a regular basis and discussed at the governance and management meetings. Incidents were appropriately recorded and followed up.

Judgment: Compliant

Regulation 27: Infection control

Improvements were required to ensure that procedures consistent with the standards for the prevention and control of health care associated infections were implemented by staff. For example:

- daily cleaning schedules reviewed had numerous gaps, that identified that cleaning had not taken place in the identified room. Management were unaware of this on the day of this inspection, indicating inadequate oversight and monitoring of cleaning. Cleaning staff spoken with informed the inspector that identified rooms may not have been cleaned on that specific day, as there may not have been time.
- clinical hand washing sinks did not have signage to indicate they were dedicated for clinical use.

Judgment: Substantially compliant

Regulation 28: Fire precautions

An immediate action was issued to the provider in relation to fire precautions. From a review of fire drill reports in the centre and assessment of staff knowledge, the inspector was not assured that residents could be safely evacuated at all times, during the day and night by staff. The provider submitted records of fire drills post the inspection, which provided some assurances regarding compartment evacuations. However, ongoing drills are required so the provider is assured that all

staff are competent in fire evacuations of the largest compartments, simulating minimal staffing levels. This is to ensure that residents can be evacuated in a timely and safe manner.

Increased oversight was also required pertaining to daily and weekly fire checks. The inspector found on review of records that there were gaps in daily checks. Weekly checks had also not been completed from February 2021-September 2021.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Care planning in the centre required improvement, to ensure that there was an updated care plan in place for all residents' identified needs and to appropriately inform staff practices. For example:

- a resident who had an indwelling urinary catheter did not have detail pertaining to frequency of reinsertion.
- some end of life care plans were generic, and did not always refer to residents personal preferences.
- a resident on a weight reducing diet did not have this reflected on their care plan.
- communication care plans did not provide adequate detail pertaining to residents communication methods and strategies to enhance communication.
- a residents that required two hourly repositioning, did not have this reflected in their care plan.

Judgment: Not compliant

Regulation 6: Health care

Residents' healthcare needs were regularly reviewed by their general practitioner, who attended the centre four days per week. There was appropriate referral to allied health professionals and evidence of regular review and input from psychiatry of old age, a geriatrician, chiropody and physiotherapy. There was a low incidence of pressure ulcer formation within the centre.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

All staff in the the centre were due to receive training in managing responsive behaviours and the review of documentation on this inspection indicated that there was a deficit in staff knowledge in this area. The inspector found that in some care plans and incidents records, where residents displayed behaviors associated with dementia, they were not responded to appropriately and language was not person centred. There was also high bed rail usage in the centre, which was nearly 40%, and there was not evidence of alternatives being trailed.

Judgment: Not compliant

Regulation 8: Protection

The inspector was satisfied with the measures in place to safeguard residents and protect them from abuse. Records reviewed by the inspector provided assurances that any allegations of abuse were reported, addressed and appropriate action taken to protect the resident. All staff had Garda Vetting disclosures in place, prior to commencing employment in the centre.

Judgment: Compliant

Regulation 9: Residents' rights

Findings of this inspection were that residents residents rights required review, as it was found:

- there were inadequate facilities for occupation and recreation for residents in the centre and residents spent their day with little to do. The inspector saw a large number of residents spending their day at their bedside or in one of the sitting rooms, with little to occupy them apart from daily care tasks and the television.
- where residents satisfaction surveys identified areas residents requested to be addressed such as more time outdoors or menu changes, there was not always evidence that these were actioned. The same was found with residents meetings, although they took place, there was not always evidence that residents suggestions were acted upon. For example, many residents had requested confession and communion be provided in the centre, however, this had not been addressed.
- residents were not afforded the choice to relocate to new single rooms en suite bedrooms available in the centre and there was no evidence that residents had been consulted about the choice of relocating to single en suite bedrooms.
- assurances were not provided that mealtimes were a social event that

enhanced people's quality of life.

- the inspector was not assured that two residents with communication difficulties were facilitated to communicate freely and have specific communication plans implemented, which may improve their quality of life.

Judgment: Not 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	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Not compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Not compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Skibbereen Community Hospital OSV-0000598

Inspection ID: MON-0034388

Date of inspection: 29/09/2021

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:

Regulation Heading	**Judgment**
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: The staff file which did not have a reference from most recent employer has now been updated with same and reference is available.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: A more robust governance and management system has being put into place with immediate effect. Nursing Management have commenced daily surveillance of meals served to all residents to ensure that the correct diet as recommended by therapists such as Speech and Language Therapy (SALT) and Dietician are available to residents. The DON and CNM2 update all staff at daily safety pause with any change in dietary consistency. Training has been provided to staff by hospital Dietician. The Dietician attended the hospital on 21st October 2021 and has agreed to be part of Skibbereens Hospitals Nutritional Group. A request for up to date training has been submitted to SALT and a date for training will be confirmed shortly. Going forward all clinical audits will be undertaken by CNM2 and DON and non-compliances identified will have a corresponding action plan initiated. The DON and CNM2 will communicate the findings of clinical audits and ensure all action plans are completed. Trending will be undertaken by DON and CNM2 of all clinical audits to target quality improvement.	

Fire Precautions by Management are being adhered to with daily checks and weekly fire alarm activations been carried out. Fire drills are being conducted regularly. Records of same are being documented. Action is underway to change the orientation of the fire door opening in Ilen Suite to allow a faster more efficient evacuation time in the largest compartment. This work will be completed by 12th November 2021.

A plan of the day for activities has been initiated, dedicated health care workers have been allocated daily to undertake this plan. This plan is tailored to suit needs of our residents. The DON and CNM2 will oversee this activities plan on a daily basis and ensure that residents are meaningfully occupied according to their wishes. Skibbereen Hospital has welcomed Arts for Health back on site since 21st October 2021. This is incorporated in our activities calendar with an artist coming weekly and a second artist coming fortnightly. Local Musicians have providing music sessions and will entertain residents monthly commenced since 20th October 2021.Individual and group Activities are provided on a daily basis by Staff.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
Skibbereen Commuity Hospital has introduced a new complaints form to ensure adequate oversight of complaints. This complaint form includes details of the complaint and the action being taken to address the complaint, it also clearly documents if the complainer is satisfied. All Staff have been made aware that this form is not a resident feedback survey. A Separate Compliment Form has been devised and is in place. Going forward an audit of all complaints will be undertaken by management on a quarterly basis.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
An area that will be suitable for storage has been identified. The process of obtaining approval for use of this room as a storage room is underway necessary certificates are being sought. Approximate time for completion of this project is 16 weeks .A temporary storage area is being used in the interim.

Regulation 18: Food and nutrition	Not Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
The DON and CNM2 have commenced daily surveillance of meals served to all residents to ensure that the correct consistency diet is provided. Wycatt observations of meal times are being completed by management regularly to check that all residents are receiving the correct diet. The meal time experience has been enhanced for all our residents, residents who wish to dine on their own is being facilitated. The recently set up nutrition group within the center will ensure quality improvement in the area of food and nutrition

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
A new cleaning schedule has been introduced with daily oversight by Management. The DON or CNM2 will carry out weekly audits to ensure this cleaning schedule is adhered to.

Clinical Signage has been erected over hand washing sinks indicating sink dedicated for clinical use where appropriate signage had been absent

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
All staff members have completed fire evacuation of the largest compartment simulating night duty staffing levels and continue to carry out regular drills. Ongoing weekly fire drills in all compartments being carried out. Records of same are being maintained.

Action is underway to change the orientation of the fire door opening in Ilen Suite to allow a faster more efficient evacuation time in the largest compartment. This work will be completed by 12th November 2021.

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:
Nursing documentation education (including person centred language and the documentation relating to responsive behaviour) has been scheduled and commenced for all nursing team members Completed: 08th November 2021).

A review of all care plans is currently being undertaken by the DON/ CNM2 to ensure all residents' identified needs have appropriate care interventions to inform staff practices. (Expected date of completion: 20th November 2021)

All clinical audits will be undertaken by CNM2 and DON. All non-compliances identified will have a corresponding action plans initiated. The DON and CNM2 will communicate the findings of clinical audits and ensure all action plans are completed

All care plans of residents with 'indwelling catheters' have been reviewed to ensure the frequency of reinsertion is detailed in the 'Catheter Insertion and Change Log' (Form 025b). Completed: 05th November 2021

All 'Spirituality and End of Life" core care plans have been reviewed to ensure the residents personal preferences are detailed (in accordance with the resident's wishes). Completed: 08th November 2021

All 'Food and Nutrition' core care plans have been reviewed to ensure the residents specified diet is reflected to inform staff practices. Completed: 05th November 2021

All 'Communication and Cognition' care plans have been reviewed and updated to ensure individual communication methods and strategies are detailed to inform staff practices. Completed: 05th November 2021

All 'Skin Integrity' core care plans have been reviewed to ensure the residents repositioning requirements are detailed to inform staff practices. Completed: 05th November 2021

Regulation 7: Managing behaviour that is challenging	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
Management have ensured that all staff will have completed responsive behavior training by 4th December 2021. Three education sessions are planned for staff, 2 have been

completed one on 21st October 2021 and a second session on 04th November 2021. The final session will be on 04th December 2021.

All care plans will be reviewed to identify triggers, triggers will be documented and identified to staff to ensure a person centered approach to resident care management will continue to be pro-active in monitoring restraint reduction and use of chemical restraint.

An action group meeting was held on 19th October 2021 to assist in implementing a person centered model of care. A follow up meeting on Wednesday 3rd November 2021 was held to highlight roles and responsibilities of staff this meeting outlined targets and immediate action agreed by staff. Champions have been identified to promote person centered care with representatives from all sections including Management, Nurses, HCA, Multitask Attendants, Catering, and Housekeeping.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: Management will commit to ensuring that all residents will be meaningfully occupied according to their wishes and giving resident's choice of how they wish to spend their day. A plan of daily activities is in place and is being implemented. A monthly activity calendar has been drafted with residents input requested.

Action plan following from residents meeting on 04th November 2021 has been documented and requests will be implemented where possible. All satisfaction surveys will be actioned in future and where possible resident's requests to leave to go on organized trips will be addressed while adhering to HSPC Guidelines and on Risk Assessment locally. An organized bus trip to see Christmas Lights is scheduled for the 09th December 2021. Individual residents have been accommodated to go home since May and whilst adhering to HSPC Guidelines.

Seven of our residents are now happily accommodated in our newly built, en-suite single rooms since 29th October 2021.

Resident's likes and dislikes regarding menu choices have been communicated to catering staff and will be accommodated where possible. All staff are fully aware that during meal times no other non-essential tasks should be carried out in order to enhance the mealtime experience for residents. Compliance of protected mealtimes will be monitored by management and staff will be encouraged to support each other with this initiative.

Post discussions with local clergy residents request for in- house mass, communion and confession has been re-introduced effective 05th November 2021. Next celebration of Mass in Skibbereen Community Hospital will be 03rd December 2021 and monthly

thereafter as per HSPC Guidelines.

An advocate has been requested to visit two residents that have specific communication issues this advocate will confirm visit date by 11th November 2021. PA hours for one resident have been requested – update awaited. Communication aids have been given to resident with deficits in communication to help improve resident's quality of Life. SALT have reviewed another resident with communication difficulties on 05th November 2021 – await specific plan to assist this resident.

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 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	25/02/2022
Regulation 18(1)(c)(iii)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietetic staff, based on nutritional assessment in accordance with the individual care plan of the resident concerned.	Not Compliant	Orange	11/10/2021

Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Substantially Compliant	Yellow	06/10/2021
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	12/11/2021
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Substantially Compliant	Yellow	12/11/2021
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	12/11/2021
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the	Not Compliant	Orange	08/11/2021

	designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.			
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	25/10/2021
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4	Not Compliant	Yellow	08/11/2021

	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.			
Regulation 7(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.	Not Compliant	Orange	04/12/2021
Regulation 7(3)	The registered provider shall 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.	Not Compliant	Orange	15/11/2021
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Not Compliant	Orange	25/10/2021
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with	Not Compliant	Orange	25/10/2021

	their interests and capacities.			
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Not Compliant	Orange	29/10/2021
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Not Compliant	Orange	29/10/2021