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:	Short Notice Announced
Date of inspection:	12 March 2020
Centre ID:	OSV-0000598
Fieldwork ID:	MON-0028858

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:	31

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
Thursday 12 March 2020	09:00hrs to 16:45hrs	Ella Ferriter	Lead

What residents told us and what inspectors observed

The inspector spoke with a number of residents during the inspection of Skibbereen Community Hospital. All residents spoke highly of the staff, describing them as very committed, caring, kind and helpful. Residents reported they felt safe, and staff were available when they needed assistance. Staff were observed treating residents with dignity and respect during all interactions.

Residents commented positively about the quality and choice of food. They stated they were given choice and there were adequate quantities of food. The building work taking place on the day of inspection had resulted in limited communal space for residents, as one of the day rooms had been closed. Residents and staff spoke positively and were enthusiastic in relation to the additional space that would be afforded to the residents on completion of the work. Visiting was restricted during on the day of inspection, for infection control purposes and residents were well informed in relation to this temporary change.

Capacity and capability

This was a one day inspection carried out to monitor compliance with the regulations. The Registered Provider Representative (RPR) and the person in charge were made aware of the inspection, the day before it was carried out. This was due to a temporary change in HIQAs processes, to to determine whether there has been any suspected or confirmed case or an outbreak of COVID-19.

There were extensive building works and refurbishment being carried out on the day of inspection. The Chief Inspector had placed a restrictive condition on the registration of this centre. This condition was time bound, and a date for implementation had been mutually agreed. The condition stated that the physical environment in the current designated centre shall be reconfigured, and an extension to the existing building completed as outlined in the plans submitted to the Chief Inspector in June 2018. On completion of these works no bedroom in the designated centre will accommodate more than 4 residents. This condition was to address the privacy and dignity of residents, which was compromised due to six bedded rooms and minimal storage space for personal belongings. Renovations to the building had commenced in August 2019 with a projected end date of January 2021. On completion of the work living arrangements will comprise of four bedded rooms (6), one three bedded room and 13 single bedrooms. To facilitate the work, on the day of inspection it was apparent that one day room had been closed, and bed capacity had been reduced from 40 to 31 residents.

Overall, it was found that a good service was being delivered to the residents of

Skibbereen Community Hospital and residents reported they were happy living there. Residents and staff spoke positively about the improvements planned for the premises and the additional space that would be afforded to residents. There was a clearly defined management structure, and clear reporting arrangements to support the day to day operation of the centre. Overall, care provided to residents was of a good standard and the inspector found that the management team and staff were committed to providing a quality service for residents. Some improvements, however, were required in the area of incident reporting, complaints management, care planning and in further development of a social programme for residents. Ensuring that garda vetting was in place for all staff working in the centre also required to be addressed, this was also found on the previous inspection of December 2018.

The person in charge reported to the RPR, who was available for consultation daily by phone and email. Formal management meetings took place monthly off site, where incidents, accidents, risk, quality improvement and staffing was discussed. The person in charge also had the additional support of a clinical development coordinator. The person in charge attends monthly quality and patient safety meeting chaired by the RPR which are also attended by nursing manager colleagues working in other Cork/ Kerry Community Hospitals. This was a forum for sharing ideas and learning from each other, to improve quality of care delivery. Meetings between the person in charge and staff were held at various times throughout the year. Minutes of these meetings were maintained and viewed by the inspector.

The staff compliment and skill mix was adequate to meet the care needs of the 31 residents on the day of inspection. The inspector observed good communication between staff and residents, and staff were seen to be caring and responsive to residents needs. Staff meetings and communication at shift handovers ensured information on residents' changing needs were communicated effectively. There was a comprehensive programme of training, and all staff had attended up-to-date training in mandatory areas, such as responsive behaviour, safeguarding and fire safety. Volunteers had their roles and responsibilities set out in writing as required by the regulations. However, the inspector found that not all volunteers had garda vetting in place.

Good systems of information governance were in place and the records required by the regulations were maintained effectively. Records and documentation as required by Schedule 2, 3 and 4 of the regulations were securely controlled, maintained in good order and easily retrievable for monitoring purposes. A review of the complaints log indicated that although complaints were being recorded, as found on the previous inspection there was an inconsistent approach to investigating complaints. The procedure for closing off complaints also required review. A record of incidents occurring in the centre was maintained, however not all incidents were reported to the Chief Inspector as required by the regulations. There were organised systems and processes in place to monitor the quality and safety of care received by residents. A new computerised auditing system had been introduced, which captured information on areas such as falls, skin integrity, food and nutrition and medication management. Findings of audits were discussed at staff meetings and

used to inform and improve practice.

Regulation 14: Persons in charge

There was a full time person in charge employed in the centre that had the qualifications and experience required by the regulations. He was well supported in his role by the registered provider representative, a Clinical Nurse Manager and team of staff.

Judgment: Compliant

Regulation 15: Staffing

There were adequate staffing levels for the size and layout of the centre to meet the assessed need of residents. Residents spoke very positively of staff and indicated that staff were caring, responsive to their needs and treated them with respect and dignity. There had also improvements noted in addressing segregated staff roles which was ongoing. There was now a clearer distinction between the multi-task attendant and the healthcare attendant.

Judgment: Compliant

Regulation 16: Training and staff development

Records viewed by the inspector confirmed that since the previous inspection, there was an adequate level of staff training provided with numerous training dates scheduled for 2020. Mandatory training was ongoing and all staff had completed mandatory training in areas such as fire safety, manual handling, safeguarding, dementia care and the management of behaviours that challenge.

Judgment: Compliant

Regulation 21: Records

Residents' records were reviewed by the inspector who found that they complied with Schedule 3 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. The records listed in Schedule 4 to be kept in a designated centre were all maintained and made

available to the inspector.

Judgment: Compliant

Regulation 23: Governance and management

There was a clearly defined management structure with clear lines of authority and accountability. The person in charge was supported in his role by a registered provider representative. There were sufficient resources available to ensure the effective delivery of care. There were management systems in place to ensure that service delivery to residents was safe and effectively monitored. This was enhanced by the implementation of a computerised auditing system. However, increased oversight was required in relation to ensuring garda vetting was in place for all staff, complaints management and incident reporting.

Judgment: Substantially compliant

Regulation 30: Volunteers

All volunteers working in the centre had a memorandum of understanding which outlined their roles and responsibilities, however a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 was not in place for all volunteers.

Judgment: Not compliant

Regulation 31: Notification of incidents

A record of incidents occurring in the centre was well maintained. However, not all incidents and allegations had been reported in writing to the Chief Inspector as required under the regulations within the required time period.

Judgment: Not compliant

Regulation 34: Complaints procedure

There was a complaints management policy in place and a nominated person responsible for dealing with complaints. However the inspector found that the

complaints management system required review. This was also found on the previous inspection of December 2018. There was not evidence that all complaints had been investigated, what the outcome of the complaint was and whether or not the complainant was satisfied.

Judgment: Not compliant

Regulation 4: Written policies and procedures

The policies of the designated centre were reviewed and found to be in compliance with Regulation 4, Schedule 5.

Judgment: Compliant

Quality and safety

The inspector found that the overall healthcare needs of the residents were well met and that they had access to appropriate medical and allied healthcare services. Residents' quality of life could be further enhanced through increased access to social activities. The inspector viewed a number of residents' records and found that care delivered was based on a comprehensive nursing assessment completed on admission, involving a variety of validated tools. There was timely access to general practitioner (GP) services. An out of hours service was also available. There was evidence of regular medical reviews and referrals to other specialist services, as required. There were processes in place to ensure the safe admission, transfer and discharge of residents to and from the centre. There was evidence that staff provided care in accordance with any specific recommendations made by medical and allied health professionals. Improvements were required in care planning, as it was found that pertinent information relating to some residents care needs was not included in some instances. This would enable better outcomes for their care. There was a reported low incidence of wound development and the inspector saw that the risk of same was assessed regularly and appropriate preventative interventions including pressure relieving equipment were in use. There were no residents with a pressure ulcers at the time of inspection.

Management and staff recognised the impact of the current premises on the quality of life for residents. This posed a challenge in assuring residents had adequate personal space and were afforded dignity when receiving care especially in five and six bedded rooms. Improvements were seen in fire safety since the last inspection. Residents now had personalised emergency evacuation plans (PEEPS) in place. There were adequate procedures in place to ensure that fire safety equipment was functioning appropriately and that emergency exits were not obstructed. There was

evidence of regular fire drills being preformed, and learning from drills informed improvements in practice.

Improvements were also seen in medication management since the last inspection. More robust procedures had been put in place for the storage and disposal of medication. Medicine management practices were reviewed and policies were in place to support practice. There was a system in place to ensure that all medicines were reviewed on a regular basis by a general practitioner (GP) and t It was also evident that medication management systems were regularly audited.

Residents nutritional status was kept under review. Food appeared to be nutritious and staff paid particular attention to ensuring that modified consistency food was attractively presented and appetising in appearance. Residents had a choice of food at mealtimes and there was access to drinks and snacks between meals. However, mealtimes were found to be particularly early, which was based on staffing levels as opposed to resident choice.

Similar to findings on previous inspections, activities were found to be limited . Overall, the activities programme required review, to ensure that all residents had opportunities for social engagement. Observations of the inspectors indicated that many residents had limited access to activities. The inspector found that measures were in place to protect residents from harm or suffering abuse and to respond to allegations, disclosures and suspicions of abuse.

Regulation 12: Personal possessions

Improvements had been made since the previous inspection, all residents were now provided with their own wardrobe. They also all had a locker beside their bed for personal possessions.

Judgment: Compliant

Regulation 13: End of life

A policy for end-of-life care was in place. Staff were knowledgeable about the procedures in relation to end-of-life care. Staff spoken to described how residents and families are supported in a person-centred and respectful manner. The centre is supported in the delivery of end of life and palliative care by the local hospice team who visit the centre as required. Family and friends were supported to remain with residents as they approached end of life and there were facilities for families available which included a room with couches and a kitchenette.

Judgment: Compliant

Regulation 17: Premises

It was acknowledged that upgrades to the premises would ensure that no room had an excess of four beds. However, the current premises did not conform to the matters listed in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. Examples of this included:

- multi-occupancy bedrooms of five and six beds did not support residents' privacy and dignity
- there was inadequate storage space for residents personal property and possessions
- residents were not always afforded space to have a chair beside their beds
- access to outside communal space was inadequate

Judgment: Not compliant

Regulation 18: Food and nutrition

Overall, residents nutritional and hydration needs were adequately met and residents weights were monitored on a regular basis, as appropriate. A recognised nutritional assessment tool was used and there were corresponding nutritional care plans in place. Appropriate referrals to allied health were documented. Residents were very complementary about the food provided which was cooked on site and served in the dining room or in residents bedrooms. The inspector spoke with the chef who demonstrated an excellent knowledge of the residents individual likes and dislikes. She had been working in the centre for over 30 years and was very enthusiastic about her role. She had an in-depth understanding of specialised and modified diets and the particular recommendations of Speech and Language Therapist (SALT) and dietetics. There was a four week rolling menu plan in place which offered choice. However, meal times were found to be particularly early, which was a routine practice to facilitate staffing levels. For example breakfast was served at 07:30 am and lunch on the day of inspection began at 11:50 for some residents on the day of inspection.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Improvements were seen in fire precautions since the last inspection. The registered provider had taken suitable measures to protect residents, staff and the premises against the risk of fire. Suitable fire fighting equipment and means of escape were available, and these were regularly tested, serviced and maintained. Personal Emergency Evacuation Plans (PEEPS) were now in place for all residents. Staff had up-to-date fire safety training including attendance at fire evacuation drills in the centre. Evacuations were timed and learning from drills informed improvements in practice. Appropriate documentation was maintained for daily, weekly and monthly fire checks.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

There were robust procedures in place for medication management. Improvements had been required following the previous inspection. Residents had access to pharmacy services and the pharmacist was facilitated to fulfil their obligations under the relevant legislation and guidance issued by the Pharmaceutical Society of Ireland. Medication administration charts and controlled drugs records were maintained in line with professional guidelines. There were procedures in place for medications no longer in use, to ensure they were returned to pharmacy and there was documentation to support this.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

A review of the assessment and care planning documentation was required to ensure that the documentation appropriately guided staff and reflected the quality of care delivered. For example on the day of inspection it was found:

- responsive behaviour care plans did not identify person-centred information relation to the triggers that may cause a responsive behaviour, and how a trigger may be avoided or managed with regard to the personal needs of the resident.
- risks identified in the incident logs had not informed the resident's care plan
- a resident with diabetes had no evidence of this in her care plan

Judgment: Not compliant

Regulation 6: Health care

The health needs of residents were reviewed and overall they had access to a range of healthcare services. All residents had access to a general practitioner (GP) services five days per week. There was an out-of-hours GP service available if a resident required review at night time or during the weekend. There was evidence of regular review by GP's as well as regular reviews of medications by the pharmacy. There was access to allied healthcare professionals including physiotherapy, dietetics, speech and language therapy, tissue viability, and podiatry services. A physiotherapist visited the centre 1-2 days per week.

Judgment: Compliant

Regulation 8: Protection

There were systems in place to support identifying, reporting and investigating allegations or suspicions of abuse. For example, there were organisational policies in place in relation to the prevention, detection, reporting and investigating allegations or suspicions of abuse. Training records confirmed that all staff had received training in relation to responding to incidents, suspicions or allegations of abuse. All staff who spoke with the inspector were knowledgeable of what constituted abuse and of steps to take in the event of an incident, suspicion or allegation of abuse.

Judgment: Compliant

Regulation 9: Residents' rights

Residents said they received good care and support from all staff. There was evidence of regular residents meetings which were facilitated by an external advocate and a detailed record of these meetings were reviewed. Residents had the option of attending the local day care facility which was in the same building. There was a church in the centre and mass was facilitated weekly. Meal times in the centre were found to be scheduled around staffing as opposed to being resident led which was institutionalised practice.

The activities schedule was discussed on the day of inspection and it was found that it required review. The inspector acknowledged that the closure of the second day room was challenging for residents and staff due to limited communal space, this resulted in many residents spending the day by their bed. Activities were provided by an external company 13 hrs per week as well as being supported by West Cork Arts for Health, external musicians, pet therapy and religious services. The management team also informed the inspector that staff working in Skibbereen Community Hospital facilitated bingo once a week and hand massage. The CNM outlined how "life story books" had been developed for some residents, compiled to

capture memories and experiences about a their lives. These books also gave staff a good insight into residents living in the centre. On the day of inspection the external company facilitator was providing one to one sessions with some residents. There was limited opportunity for all residents to have access to activities. The inspector was also informed that weekly musicians visiting the centre had been curtailed over the past few weeks due to limited finances, thus resulting on no activities scheduled on Mondays. The inspector was informed that the activities programme was currently being reviewed, this was supported by information obtained from minutes of staff meetings.

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	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 30: Volunteers	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Not compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 12: Personal possessions	Compliant
Regulation 13: End of life	Compliant
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Skibbereen Community Hospital OSV-0000598

Inspection ID: MON-0028858

Date of inspection: 12/03/2020

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 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Garda vetting is in place for all staff. No staff member commences employment without Garda vetting being in place. A new complaints template will be put in place which records the investigation process, outcome of the complaint and whether the complainant was satisfied or not. All incidents are reported on the NIMS system and where applicable they are reported to HIQA also.	
Regulation 30: Volunteers	Not Compliant
Outline how you are going to come into compliance with Regulation 30: Volunteers: Roles and responsibilities are outlined to volunteers when they commence in Skibbereen Community Hospital. They are also mentored by one of our senior volunteers and six monthly meetings are held to review the role. All volunteers are Garda vetted prior to commencing their role as a volunteer.	
Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents: All incidents are reported to the Chief Inspector as per regulation. Failure to report one previous incident was an oversight.	
Regulation 34: Complaints procedure	Not Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: A new complaints template will be put in place which records the investigation process, the outcome of the complaint and whether the complainant was satisfied or not. The complaints log is reviewed on a regular basis by Hospital Management and during QPS meetings.	
Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: Construction work commenced in August 2019 to upgrade the premises to meet regulation 17. When complete in January 2021 there will be 13 en-suite single rooms, six x four bed en-suite rooms and one x three bed en-suite, a separate dining room. Sitting room, a quiet room, recreation room and adequate storage space. Status: Completion date at risk due to Covid 19 restrictions	
Regulation 18: Food and nutrition	Substantially Compliant
Outline how you are going to come into compliance with Regulation 18: Food and nutrition: A re-organisation of our rosters will take place where by breakfast will not commence before 08:00 hours, Dinner will not commence before 12:15. This will be kept under review.	

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: We have transitioned from our own care plan to the Cork Kerry Community Hospital care plan recently. A complete review of our current care plans will take place to ensure that risk assessments are included in the new care plan	
Regulation 9: Residents' rights	Not Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: There is a comprehensive activities schedule in place. Activities on a Monday were curtailed at present due to a bereavement rather than finances. The activities review is currently on hold due to the COVID 19 situation at present.	

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.	Not Compliant	Yellow	31/01/2020
Regulation 18(2)	The person in charge shall provide meals, refreshments and snacks at all reasonable times.	Not Compliant	Yellow	13/04/2020
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.	Substantially Compliant	Yellow	30/03/2020
Regulation 30(c)	The person in charge shall ensure that people	Not Compliant	Orange	30/03/2020

	involved on a voluntary basis with the designated centre provide a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012.			
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence.	Not Compliant	Yellow	13/03/2020
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	13/04/2020
Regulation 34(2)	The registered provider shall ensure that all	Substantially Compliant		13/04/2020

	complaints and the results of any investigations into the matters complained of and any actions taken on foot of a complaint are fully and properly recorded and that such records shall be in addition to and distinct from a resident's individual care plan.			
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	16/03/2020
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Not Compliant	Yellow	
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Not Compliant	Yellow	31/01/2021

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	Yellow	31/01/2021
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		31/01/2021
Regulation 9(3)(c)(ii)	A registered provider shall, in so far as is reasonably practical, ensure that a resident radio, television, newspapers and other media.	Not Compliant		31/01/2021