Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People

Name of designated centre:	Skibbereen Community Hospital
Name of provider:	Skibbereen Community Hospital
Address of centre:	Coolnagarrane, Skibbereen, Cork
Type of inspection:	Unannounced
Date of inspection:	05 December 2018
Centre ID:	OSV-0000598
Fieldwork ID:	MON-0025164

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:	33

How we inspect

To prepare for this inspection the inspector or inspectors reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
05 December 2018	09:30hrs to 18:30hrs	Mary O'Mahony	Lead

Views of people who use the service

Residents with whom the inspector spoke said that they were happy and felt at home in the centre. They were located near to the town and to relatives and could be supported to go out, when required. They enjoyed a wide range of activities and said that the care was respectful and kind. Choice was facilitated and they could stay up late to watch favourite TV programmes if they wished. They knew the names of the people in charge and the staff who supported them. Residents said they felt safe and they were aware of the inspector's purpose in the centre. Residents attended advocacy meetings and spoke about the advocacy visits they had attended in November. They felt listened to and were aware of how to raise concerns. Residents said that they were happy with a number of improvements that had been made since the previous inspection, for example, the removal of one bed from each of the previous six-bedded wards and the provision of larger wardrobes. Friends and family were welcome to visit when they chose to and residents said that they were asked about the development of personal care plans. Some residents however, said that they would like more privacy, less noise and more storage space for personal items in the multi-occupancy rooms.

Capacity and capability

The findings of this inspection were that the registered provider, the Health Services Executive (HSE) had had not fully ensured that the service provided for residents in Skibbereen Community Hospital met the needs of the residents living there, particularly in terms of the arrangements for ensuring that Garda Vetting clearance was in place for all staff, personal privacy, personal space and storage provision. Non-compliance with the regulation which required that Garda Vetting clearance be available for all staff, resulted in the issuing of an urgent action plan to the provider which specified that evidence of the completed records be submitted to the office of the Chief Inspector within a set time-frame. The provider however, failed to submit timely evidence that these records were available.

Although a number of improvements, namely the reconfiguration of some bedrooms and the procurement of extra, larger wardrobes, had been completed, the provider had yet to adequately address the repeat aforementioned, regulatory non-compliances. Sufficient resources had yet to be employed to ensure the effective, safe and appropriate delivery of care in accordance with the statement of purpose. In particular, there were inadequate arrangements in place to meet the privacy and dignity needs of residents. Renovations and improvements, designed to address these issues were now planned to commence in March 2019. The negative impact of poor premises layout and lack of suitable storage was further discussed in the

quality and safety dimension in this report.

Improved audit and monitoring of the service provided had been maintained since the previous inspection.The inspector found that the quality of care and experience of residents was reviewed on an ongoing basis. Improvements were brought about as a result of learning from these reviews, according to minutes of staff meetings seen by the inspector. There was a clearly defined management structure in the centre which set out the lines of authority and accountability. There was evidence of consultation with residents and their representatives. Minutes of staff meetings were viewed and staff supervision and appraisals were on-going. The person in charge had the support of an experienced assistant person in charge and health-care team.

The statement of purpose was viewed by the inspector. It described the aims, ethos and services available in the centre. It contained the regulatory information. A directory of residents and a residents' information booklet were available and residents had been made aware of the planned renovations. The inspector found however, that a record of all visitors to the centre was not maintained on a daily basis as required. Complaints were reviewed. The inspector found that there were various methods of recording complaints and that all staff were not clear on how to record or deal with complaints and concerns. The person in charge undertook to provide a more comprehensive and cohesive record and method of investigation of all concerns and complaints.

The annual review of the quality and safety of care for 2017 was completed and available to the inspector. Staff had been afforded mandatory training. The person in charge informed the inspector, however, that there was no Garda (police) vetting clearance documentation on site for any staff member. In addition, eight staff were currently undergoing the process of acquiring renewed Garda vetting clearance as previous records had not been maintained by the Registered Provider.
This documentation was a requirement of Schedule 2 of the Regulations.

Regulation 14: Persons in charge

The person in charge met the requirements set out in the regulations for the person in charge of a designated centre.

Judgment: Compliant

Regulation 15: Staffing

The roster was maintained on a weekly basis and staffing levels were sufficient to meet the care needs of residents currently in the centre.

Judgment: Compliant

Regulation 16: Training and staff development

Mandatory and appropriate training had been attended by staff. However, a number of staff nurses had yet to attend updated medication management training.

Judgment: Substantially compliant

Regulation 21: Records

The required Garda (police) Vetting (GV) documentation was not available on-site for the staff employed in the centre. A number of GV applications were yet to be processed. A record of visitors had not been maintained. Not all medication incidents were recorded as errors; for example, when a syringe driver containing medicines had been interfered with by a resident.

Judgment: Not compliant

Regulation 23: Governance and management

Issues remained unresolved in relation to the regulatory requirements for the provision of a safe, consistent and appropriate service.

The arrangements for management support in the absence of the assistant person in charge had not been clarified.

Judgment: Not compliant

Regulation 3: Statement of purpose

This document contained all the required elements as set out in Schedule 1 of the Regulations.

Judgment: Compliant

Regulation 30: Volunteers

Volunteers had been provided with the required training and their files contained the regulatory documents.

Judgment: Compliant

Regulation 31: Notification of incidents

Incidents were notified as required.

Judgment: Compliant

Regulation 34: Complaints procedure

There was an inconsistent approach to recording concerns and complaints.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

Schedule 5 policies were maintained and adopted in the centre.

Judgment: Compliant

Quality and safety

Residents in the centre accessed the services of a team of GPs who visited residents when required or as requested. Residents who were on respite stay or in community support beds were facilitated to retain their own GP. Access to allied health professionals was evidenced by input from professionals such as dietitians, chiropody, physiotherapists and speech and language therapists (SALT). Specialist services were available for residents at end of life stage and subcutaneous fluids and palliative specialists were accessible to enable residents to stay in familiar surroundings. Clinical assessments were undertaken for those residents whose files

were reviewed. Personal care plans were developed following the assessments. Relatives and residents who spoke with the inspector confirmed that they were consulted in the development of care plans. The inspector found that the care plan files reviewed were very bulky, resulting in the use of communal files for the daily narrative notes for residents. The inspector found that the use of these communal files would not be required if each care plan file was properly individualised. For example, up to 12 or 14 blank sheets were stored in all files whether required for the particular individuals or not; blank wound care plans were stored in the care plans of residents who did not have a wound.

The inspector found that improvements and renovations had been carried out in the centre in response to previous inspection findings. The four single rooms in the newer section were now assigned to residents who resided in the centre on a long term basis. This improved their privacy and storage options. The single room allocation allowed for the rooms to be decorated in a homely manner. Items from home had been brought in by relatives to enhance the homely feeling. Two six-bedded multi-occupancy bedrooms had been converted to five-bedded rooms for the long term residents who resided in the centre. This meant that there was more bed space available in the bedrooms to allow for some personalisation. For example, the empty bed space in one room had been furnished with a Christmas tree and other seasonal decorations. An external door seal in one bedroom, had been repaired which had improved the temperature in that particular bedroom. However, some areas of the centre were noticeably cold which the staff member stated was an issue in some of the older sections of the building. The four bed multi-occupancy respite bedroom, St Teresa's, had been expanded to a six-bedded room. This had been nicely renovated and was now mainly used for respite admissions, who were only in the centre for a limited time. While there was still a negative impact on the privacy, space and dignity of residents in this bedroom the fact that residents were occupying the bedroom for a maximum of two weeks meant that the impact was not as prolonged or severe. Notwithstanding that fact however, one resident said that it was difficult to sleep due to the noise from the overhead hoist, used to move certain incapacitated residents, and that some residents called out repeatedly at night. As this room was now set up to accommodate six residents there was insufficient space for each resident and there was no room for a chair beside each bed without impeding the access to bedside lockers or encroaching on the space of the resident in the next bed. In addition, the design and layout of all multi-occupancy rooms had a significant negative impact on residents as they were unable to undertake personal activities in private or to meet with visitors in their bedroom in private. St Joseph's was still laid out as a six-bedded ward and while one of the three doors into the room had been fitted with a lock since the previous inspection it had an institutional, hospital-like appearance with the resultant negative impact on residents' privacy and dignity. The limited space and wardrobe availability in the five-bedded rooms also impacted on the availability of storage for residents' clothes and personal belongings. Clothes were still noted to be stored on a chair, in bags and a number of residents had no wardrobe yet. The inspector was present when a resident was directed to use a toilet located within a multi-occupancy room instead of an accessible communal toilet or a toilet within his own bedroom. This had an negative impact on the privacy of residents within that bedroom as well as on the dignity of the individual involved.

In the new wing of the centre the four-bed multi-occupancy rooms were found to be more spacious and residents who resided there were generally happier with the space available. The additional wardrobe and shelving areas which had been allocated following previous inspection findings were welcomed, with a request for additional personal storage from one resident who was seen to have a number of belongings in plastic containers. There was an adequate number of showers and toilets in the centre however, there was still no bath or assisted bath in the centre which was a requirement of regulations. This was planned in the proposed renovations. Sluice rooms had adequate storage and hand-washing facilities.

Visiting times were unrestricted and visitors were plentiful. Some residents had the opportunity to meet with their visitors in a number of smaller quieter rooms. Residents had access to televisions in the spacious, well decorated day rooms and the bedrooms. However, as identified in the previous inspection televisions in the larger bedrooms were not accessible for all to view or to choose a personal choice of programme, due to the layout of the multi-occupancy rooms and the location of the two TVs on opposing walls.

The negative impact of living in the restricted space afforded to residents in multi-occupancy rooms were similar to previous findings as follows:

-there was limited space to store clothes
-residents sitting by the bed had limited access to wardrobes as some chairs were located in front of the wardrobe due to limited space,

-not all residents could have a suitable chair located by the bed

-large chairs and wheelchairs were still stored in interlinked corridor areas between the multi-occupancy bedrooms
-residents and a staff member stated that residents find the six bedded units disturbing at night because of some residents calling out, the use of hoists and the use of commodes during the night

Residents and relatives who spoke with the inspector were praiseworthy of staff, the homely atmosphere and the care in the centre. Staff were aware of residents' preferences and life events. Social care plans were informative.Weekly advocacy services were available to residents. The contact information for the confidential recipient was on display in the centre if anybody wished to look for advice and a national advocacy service was advertised.

Risk assessments were specific to the centre and to individual resident's safety. The risk register was updated and maintained. Arrangements were in place for responding to emergencies. Suitable fire equipment was provided and checked. The fire alarm panel and emergency lighting were serviced regularly. Staff received training in fire safety. However, staff had not carried out fire drills involving external bed evacuation which was recommended for all residents. The inspector was informed by staff that they had not led or practiced fire drills without an external adviser being present. The inspector found that the personal evacuation

plans (PEEPS) for residents were not stored adjacent to their bedroom but were located in the care plans which were stored at a distance from each resident's bed. This was a risk in the event of fire where such records would indicate to staff what level of support was required to assist each resident to evacuate their bedroom. No staff member had attended fire warden training.

The procedures in place for the prevention and control of infection were satisfactory. For example, the centre was very clean, hand gels were plentiful and hand-wash facilities were accessible around the centre.

Medicine management was the subject of regular audit. A number of nursing staff had undertaken medication management training however not all staff had attended this which was significant in view of a number of recent medication errors. The inspector reviewed the documentation and records of controlled medicines and found that the records for one type of controlled drug were not clearly documented. This was addressed and a solution found following the inspection.

Regulation 11: Visits

Visitors were plentiful and stated that they were always welcomed.

Judgment: Compliant

Regulation 12: Personal possessions

Personal possessions were sometimes stored in bags and on chairs. Not all residents had sufficient storage space.

Judgment: Not compliant

Regulation 17: Premises

Premises layout and design impacted negatively on residents lived experience in the centre particularly in relation to personal bed space and the promotion of privacy and dignity.

Judgment: Not compliant

Regulation 18: Food and nutrition

Residents enjoyed varied, tasty food and were offered choice at each meal. Nutrition policies underpinned nutritional support and assessment.

Judgment: Compliant

Regulation 20: Information for residents

Residents were well informed of their rights and of developments in the centre. An information booklet and notice boards were available to them.

Judgment: Compliant

Regulation 26: Risk management

A number of risks had not been assessed.

-risk of choking for a particular resident

-risk of meddling with the syringe driver

-risk of open drug cupboards containing sedatives, needles and syringes within the clinic room

-risk of resident ingesting foreign bodies

-risk of resident taking medicines from open drug lockers

Judgment: Substantially compliant

Regulation 27: Infection control

The centre was very clean and staff were seen to adopt appropriate infection control practices such as correct hand-washing technique.

Judgment: Compliant

Regulation 28: Fire precautions

Not all the required documents were available to the inspector. A number of these were submitted retrospectively: the quarterly emergency lighting certificates were not available for the third quarter of 2018. Fire drills rills were not frequent enough and PEEPS plans were not suitably located. The inspector found that two fire extinguishers were not dated as having been serviced at the required interval.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

There were inconsistencies noted in the records maintained of controlled drugs. Not all medicine no longer in use had been returned to pharmacy. Some medicine for "stock" use was labelled with residents' names. Drug cupboards within the clinic room were not locked. A medicinal product no longer in use had not been returned to pharmacy.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Care plan information was sometimes stored in communal files. Some care plan information was stored at the end of residents' beds and was not secure. The care plan for a resident with the behaviour and psychological symptoms of dementia was not sufficiently detailed to guide staff in all aspects of the care required.

Judgment: Substantially compliant

Regulation 6: Health care

Medical and allied health care was accessed for residents. Their written input was seen in residents' files.

A large number of showers were seen too be unused on the day of inspection. It was unclear how many residents received a shower on a weekly basis.

Judgment: Substantially compliant

Regulation 8: Protection

Mandatory training was up to date. Restraint practices were monitored. Finances were managed in line with the HSE policy and procedures.

Judgment: Compliant

Regulation 9: Residents' rights

Residents' rights to privacy, dignity and personal space remained impacted on in a negative manner by the design and layout of the premises. Residents could not view personal choice of TV programme without impacting on other residents in the multi-occupancy bedrooms. Residents were impacted on by noise from other residents. Residents' dignity could not be protected when receiving intimate care in the multi-occupancy room where their only privacy protection was a curtain. In addition, other residents were enabled to access toilets within these rooms even though there were alternatives available. Not all language used in care plans was appropriate to older adult care, for example the use of "nappy", "bibs" and "patients" was not dignified to residents who were living in the centre as their home. There were no dedicated hours or staff allocation to the co-ordination of activities which led to inconsistent documentation.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 30: Volunteers	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Not compliant
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management	Substantially compliant
Regulation 27: Infection control	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Skibbereen Community Hospital OSV-0000598

Inspection ID: MON-0025164

Date of inspection: 05/12/2018

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • All staff will have completed the Medication management course by January 15th 2019. • One staff Nurse on Maternity leave will complete the Medication management course prior to recommencing work.	
Regulation 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: All staff have Garda Vetting documentation on site to show proof of no convictions. However 8 staff did not have the actual disclosures on site (these staff are vetted). There are currently 5 staff awaiting disclosures (17/01/19) and these are expected on site in the next two weeks The Visitors' book had been moved to accommodate the Christmas crib, therefore may not have been signed by all visitor's. It is practice for visitor's to sign in when visiting the hospital Education will be provided for staff on what constitutes a medication incident as opposed to an error and incidents such as the syringe driver being opened by a resident will be logged as a medication incident	

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• The assistant person in charge is replaced at all times for planned leave.
• In circumstances of unplanned leave such as unexpected sick leave, the assistant person in charge is replaced by a staff nurse where staffing levels allow. The person in charge also provides cover in such circumstances and when a staff nurse is not available to cover

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
• All complaints, both verbal and written are recorded in our complaints log. Written complaints are handed in to the Nurse in charge.
• The HSE your service / your say complaint forms are available throughout the Hospital.
• All staff have been made fully aware of this procedure and information regarding same is displayed in staff areas.

Regulation 12: Personal possessions	Not Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
• All residents have been provided with their own wardrobe beside their bed / in their room for storage of their clothes.
• They also have a locker beside their bed for storage of personal processions.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• A planning application for upgrade of the hospital premises was granted on 26/07/18. Tender documents for construction of an extension and refurbishment of existing wards are currently being worked on. Work is due to commence in March 2019 following confirmation of capital funding.

Regulation 26: Risk management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management:
• A choking assessment for residents at risk of choking is currently being introduced
• Company representative contacted regarding the safety issue of the resident opening the syringe driver. Awaiting a visit from the rep. Residents requiring a syringe driver will be monitored in the interim.
• All Hospital stock drugs are stored in the Hospital Pharmacy. The doors on all the cupboards in the Pharmacy are now continuously locked. The door to the clinical room where needles and syringes are stored is kept locked at all times. Access to this room is restricted to Nursing staff only. Cleaning staff only enter the room under supervision.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• Quarterly emergency lighting certificates have already been submitted
• The two fire extinguishers have been replaced
• The PEEPS plan for each resident is now located beside their bed
• Fire drills will take place quarterly using night duty staffing levels for evacuation

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
• All controlled drugs that come into the Hospital are signed into our controlled drug book. If a long term care resident is being transferred another Hospital, the controlled

drugs held in the Hospital are returned to the Pharmacy they came from and not transferred with the resident.
• Any medicines with a residents label on it is returned to Drinagh Pharmacy when no longer in use and not stored with our Hospital stock and this is documented on a ward register for medicines returned to pharmacy.
• A register of all medicines held as stock in the Hospital Pharmacy has been drawn up. Expiry dates have been highlighted.
• All drug cupboards within the Hospital Pharmacy are now locked at all times.

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
• All care plan information relating to the resident will now be kept in the residents care plan file.
• Care plans for each resident will be stored in a locked cupboard in their room.
• The care plan for the resident with behaviour and psychological symptoms of dementia is complete. A Responsive Behaviour Policy is also in place

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
• All residents are offered showers at care giving interactions and same is recorded on their daily flow sheet
• Care plans are reviewed at least every 8-12 weeks, or sooner if there is a change in a resident's condition

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• The issues of residents' privacy and personal space will be dealt by our new extension which is due to commence in March 2019.
• All residents are asked and advised to use the toilet facilities in their own rooms. There

is however the odd occasion when a resident who is walking around the Hospital may need to use the bathroom urgently. In such circumstances the nearest available toilet is used.
• All staff have been advised re: the use of non- person centred language in our care plans. A staff member has been nominated to take part in "Cultures of person centredness" programme being delivered by Practice Development for Cork Kerry Community Hospitals. She will then be an internal facilitator for the delivery of the programme within the hospital. The programme focuses heavily on the dignity of residents and the appropriate use of language.
• A named Activity Co-Ordinator will be identified from health care staff , and will be allocated one - two hours per week to co-ordinate the activities.

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 12(a)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that a resident uses and retains control over his or her clothes.	Not Compliant	Orange	02/01/2019
Regulation 12(c)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that he or she has adequate space to store and maintain	Not Compliant	Orange	02/01/2019

	his or her clothes and other personal possessions.			
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	15/01/2019
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.	Not Compliant	Orange	03/01/2019
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Orange	31/05/2020
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Not Compliant	Orange	30/01/2019
Regulation 21(2)	Records kept in accordance with this section and set	Not Compliant		15/02/2019

	out in Schedule 2 shall be retained for a period of not less then 7 years after the staff member has ceased to be employed in the designated centre concerned.			
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	02/01/2019
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Not Compliant	Yellow	02/01/2019
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	07/01/2019
Regulation	The registered	Substantially	Yellow	14/01/2019

26(1)(a)	provider shall ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.	Compliant		
Regulation 26(1)(b)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the risks identified.	Substantially Compliant	Yellow	14/01/2019
Regulation 28(1)(c)(iii)	The registered provider shall make adequate arrangements for testing fire equipment.	Substantially Compliant	Yellow	02/01/2019
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	08/01/2019
Regulation 28(2)(iv)	The registered provider shall make adequate	Substantially Compliant	Yellow	02/01/2019

	arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.			
Regulation 29(4)	The person in charge shall ensure that all medicinal products dispensed or supplied to a resident are stored securely at the centre.	Not Compliant	Yellow	03/01/2019
Regulation 29(5)	The person in charge shall ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.	Not Compliant	Yellow	07/01/2019
Regulation 29(6)	The person in charge shall ensure that a medicinal product which is out of date or has been dispensed to a resident but is no longer required by that resident shall be stored in a secure manner, segregated from	Not Compliant	Yellow	07/01/2019

	other medicinal products and disposed of in accordance with national legislation or guidance in a manner that will not cause danger to public health or risk to the environment and will ensure that the product concerned can no longer be used as a medicinal product.			
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.	Substantially Compliant	Yellow	21/01/2019
Regulation 34(2)	The registered provider shall ensure that all complaints and the results of any investigations into the matters complained of and any actions taken on foot of a complaint are fully	Substantially Compliant	Yellow	21/01/2019

	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.	Substantially Compliant	Yellow	28/01/2019
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.	Substantially Compliant	Yellow	02/01/2019
Regulation 9(3)(a)	A registered provider shall, in so far as is	Not Compliant	Yellow	02/01/2019

	reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.			
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	02/01/2019
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	Yellow	02/01/2019