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:	St Gabriel's Community Hospital
Name of provider:	Health Service Executive
Address of centre:	Colla Road, Schull, Cork
Type of inspection:	Unannounced
Date of inspection:	12 December 2019
Centre ID:	OSV-0000600
Fieldwork ID:	MON-0028090

About the designated centre

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

St. Gabriel's Community Hospital is a 21 bedded residential care facility located on the outskirts of Schull village on well- maintained grounds with beautiful views over Schull harbour. A new single-storey wing consisting of 17 single bedrooms and two twin bedrooms, all of which were en suite, was added in 2012. The ground floor of the new wing also included extensive communal accommodation.

Communal accommodation is extensive and includes a large sitting or recreational room with an adjacent lounge which overlooked the garden and sea. There is a decked balcony outside the lounge area with seating and a bird table. Further communal areas include a dining room with a built in kitchen area. The ground floor of the old building is used for physiotherapy and occupational therapy, and it also contains a clinical room, a hairdressers room, kitchen and store rooms. The centre also provides a lovely visitors' room with a pull out bed and cooking and dining facilities if families wished to stay overnight (particularly if a family member was at end of life). An enclosed garden area opened off the dining room with plenty of tables, chairs, benches and plants for residents to enjoy.

The primary objective of the service is to support the needs of the population of the Mizen Peninsula catchment area by providing continuing care, respite care, palliative care, community support and convalescent care mainly to older people. The service also provides care to younger people over the age of 18 as required. It is a mixed gender facility catering for all dependency levels. Care is provided by a team of nursing and care staff covering day and night shifts. They are supported by chefs, household staff, medical officers and a multidisciplinary team.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	19

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 December 2019	09:15hrs to 18:20hrs	Ella Ferriter	Lead

What residents told us and what inspectors observed

The inspector met with all the residents present on the day of inspection and feedback was positive in relation to the care they received daily. Residents reported that staff were caring, respectful and pleasant. They knew the person in charge and described her as approachable and kind and stated they would talk to her if they had a concern. The residents spoke very positively about their surroundings and their comfortable bedrooms. They enjoyed the sea views over Schull harbour and the calm environment. The centre was well maintained, exceptionally clean, beautifully decorated for Christmas, homely and spacious. Residents told the inspector they enjoyed the days out on the mini bus and had the opportunity to visit some local attractions around West Cork last summer. They praised the quality of the food and home baking. The majority of the residents sat in the sitting room during the day which had comfortable furniture, a fish tank, a cinema screen and open doors onto a large conservatory overlooking the sea.

Capacity and capability

This was a one day unannounced inspection carried out to monitor ongoing compliance with the regulations. Overall, the findings on this inspection were that improvements were required by the registered provider, namely the Health Service Executive (HSE), in improving the management systems currently in place in St. Gabriel's Community Hospital. To ensure that the service provided is safe, of good quality and appropriate to the needs of the residents substantial improvements were required in training of staff, medication management, notification of incidents, risk management, provision of policies and procedures, management of behaviors that challenge and the provision of choice. Although the healthcare needs of the residents were met to a good standard the social care needs required further attention.

There had been two visits to the centre by the Registered Provider Representative (RPR) in 2019. Additional support to the centre is also available through a practice development coordinator. Although on the day of inspection, there was no evidence of regular management meetings the inspector was informed that contact with the RPR was available daily via phone or email and response was always timely. The person in charge also meets with the RPR on a monthly basis off site during operational management meetings which address the day-to-day operational running of the centre. Additional quality and patient safety meetings are chaired monthly by the RPR. These meetings are a forum for nurse managers from Cork and Kerry Community Hospitals to share ideas and learn from each other, with the aim of improving quality of care delivery.

Governance and management arrangements were interim in nature and the current person in charge was operating on a month-to-month basis in an acting capacity since agreeing to take on the position in September 2018. Although this nurse had experience working in the centre, there was no formal induction into this role evident. There was also no formalised nurse managerial support as the Clinical Nurse Manager II (CNM II) position had not been replaced and was vacant for over a year. The registered provider was depending on a loose arrangement whereby a senior staff nurse who works part time replaces the person in charge if she is required to attend meetings or is on annual leave. This often results in presenting for work on time off. A business case had been submitted to the HSE for a CNM II on the day prior to inspection. This arrangement was not suitable or sustainable.

There was an adequate number of nursing staff and care staff on the day of inspection to meet the assessed needs of the residents. Staff were observed to be caring kind and respectful towards residents .Staff engaged in a safety pause during the day and at each change of shift which focused on communicating residents care needs specific to that day such as information on falls, skin integrity, wandering risk , palliative care and environmental safety. However, there were no records of scheduled staff meetings. Communication in relation to quality improvements required and audit findings were opportunistic during these safety pauses.

There were substantial deficits in staff training which was also an area of non compliance on the previous inspection. Training in managing responsive behavior and safeguarding vulnerable adults had expired for all staff working in the centre, both of which are mandatory training required by the regulations. Over half the Registered Nurses training in basic life support was out of date. There were also substantial gaps in manual handling, hand hygiene, fire training and medication management.The person in charge informed the inspector that access to training was a challenge due to the remote location of the centre and recent cancellations of training programmes. This was not identified on the current risk register.

There were systems in place to monitor the quality and safety of the service. A new computerised audit system had been introduced the previous month which monitored falls, food and nutrition, medication management, and documentation. To date there was no formal arrangements to share findings of these audits with staff which would need to be further explored. Incidents occurring at the centre were being recorded appropriately; however, on review of all incidents occurring in 2019 the inspector noted that the Chief Inspector was not always given notice in writing of these incidents which is a legal requirement as per the regulations.

The process for management of complaints had required attention after the previous two inspections. The complaints log was reviewed and it demonstrated that formal complaints were recorded in line with the regulations. Complaints were investigated promptly, complainants were informed of the outcome and it was recorded if they were satisfied with the response to the complaint. On the last inspection the complaints policy did not identify the person responsible for dealing with complaints, this had been rectified and there was a named person to deal with complaints and the procedure to make a complaint was displayed in the centre. Policies and procedures legally required to be maintained in the designated centre were not all in

place on the day of inspection and some were outdated. Therefore assurances could not be given that care was being delivered according to best practice guidelines.

Regulation 14: Persons in charge

The centre was being managed by a full-time person in charge who was in an acting position since September 2018. She had previously held a management position in the centre. She had the necessary experience in management and in nursing the older adult that is required by the regulations. She knew each resident and was well informed in relation to their current clinical care requirements.

Judgment: Compliant

Regulation 15: Staffing

The staff complement and skill-mix was appropriate to meet the assessed needs of the residents on the day of inspection.

Judgment: Compliant

Regulation 16: Training and staff development

A training matrix was made available on the day of inspection and a review of the training records indicated that there were substantial deficits in all training. Mandatory training as required by the regulations in safeguarding vulnerable adults and managing responsive behavior had expired for all staff working in the centre. This had also been highlighted during the previous inspection where training and staff development was found to be non compliant. Deficits in training were also noted in people and manual handling, basic life support, hand hygiene and medication management for nurses.

Judgment: Not compliant

Regulation 23: Governance and management

There was an annual review of the quality and safety of care delivered. There had been an introduction of a new audit system to monitor falls, food and nutrition, medication administration and documentation. However, improvements were

required in the current management systems, to ensure that the service provided is safe, appropriate, consistent and effectively monitored. There was a requirement for increased oversight of medication management, staff training, fire precautions, risk management, the use of restraints and notification of incidents.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

Each resident had a contact of care. Contracts contained all the information as required by the legislation.This required to be addressed after the last inspection of May 2018.

Judgment: Compliant

Regulation 31: Notification of incidents

The inspector noted on review of incidents from 2019 that not all notifications required to be submitted to Chief Inspector were submitted as is required by legislation. The person in charge reported to the inspector that she had received training in notification of incidents in the past three months.

Judgment: Not compliant

Regulation 34: Complaints procedure

Complaints were discussed with the person in charge on inspection and records were reviewed. It was evident that an effective complaints procedure was in place.Residents' complaints and concerns were listened to and acted upon in a timely, supportive and effective manner. There was evidence that residents and relatives were satisfied with measures put in place in response to issues raised.

Judgment: Compliant

Regulation 4: Written policies and procedures

The centre did not have all of the written operational policies and procedures

in accordance with Schedule Five maintained in the centre. Of the 20 required under the legislation eight were not available or outdated. The inspector was informed that the centre was in the middle of a transition period, where new revised policies and procedures would be introduced.

Judgment: Not compliant

Quality and safety

Overall, the healthcare needs of residents living in St Gabriel's were met to a good standard. There was access to the local general practitioner (GP) seven days per week and an out- of-hours service if required. There was also access to psychiatry of older life at a local outpatient facility. The physiotherapist visits the centre three days per week and there was evidence of regular review. The community occupational therapist (OT) was reviewing residents on the day of inspection. OT assessment post referral was on average between two-to-three days. There was evidence that residents had access to Speech and Language Therapy (SALT), dental services, palliative care services, a tissue viability nurse, chiropody and ophthalmology. The inspector was informed and viewed recent correspondence from the HSE dietetic service via email informing the person in charge that there is an unavailability of a dietetics service to the centre due to a 'staffing crisis', The person in charge had continued to advocate for this service and had ensured that two residents that required a service had received an assessment.

Residents had personally decorated bedrooms and had adequate space to receive visitors and to store their personal possessions. Laundry was managed well and laundered by an external company. Residents expressed satisfaction with this service. The chef was knowledgeable about residents specific dietary requirements, textured diets and personal likes and dislikes. Residents in general spoke positively about the quality food provided. However on the day of inspection it was observed that limited choice was available to residents at dinner time with one meal on the menu. Times of meals were set by staff rather than residents. This was institutional practice and not person centred. Breakfast was served particularly early at 07:30 by staff on night duty, dinner was at 12:00 midday and tea at 16:30. There was no evidence of consultation with residents in relation to this.

Residents' medication was stored in a locked cupboard in individual bedrooms. The inspector reviewed a sample of medication records. Record keeping in relation to administration of medication and monitoring of controlled drugs required improvement as it was noted that there were gaps in signatures which could not assure the inspector that medication had been administered as prescribed. Recent medication audits at the centre had similar findings. Nurses also required updated training on medication management.

The person in charge had responsibility for maintaining a risk register which was

well maintained and contained both clinical and non clinical risks. This was updated annually or as new risks were identified. However, some risks identified and discussed on the day of inspection, such as the inability to access staff training and the withdrawal of the dietetics service, were not documented as risks.

The support required by each resident if a fire were to occur was documented on individual personal emergency evacuation plans (PEEP). Fire equipment was serviced appropriately and records were very well maintained. However, as noted on the previous inspection, regular fire evacuation drills were not taking place the most recent one being in April 2019 facilitated by a fire safety officer during training. It was also found that not all staff had up-to-date training on fire safety.

New care planning documentation had been introduced in the previous three months. The inspector viewed a sample of residents assessments and care plans and found that they were detailed, person centred and could direct individualised care. Validated tools were used to assess risk and inform care plans. They were updated four monthly as required or if the needs of the resident changed.

The centre's management on the use of restrictive practices was not in line with national policy. The inspector was informed that of the 19 residents residing in St Gabriel's on the day of inspection, 16 residents (84%) were using bed rails. Nine of these residents had been assessed as low dependency. The inspector found that this was a large percentage of bed rail use and required review. The inspector reviewed a sample of assessments and consent for the use of bed rails. Assessments reviewed did not consider measures or alternatives that could be taken to protect residents prior to using bed rails. Consent was also not obtained at all or obtained by a family member although the resident was deemed as having capacity. The staff focus appeared to be on safety checks twice daily of bed rails as opposed to assessing the suitability of them in the first instance and trialling alternatives. This incidence of high use of bed rails (63%) was also found on inspection at this centre in June 2017 which would indicate a culture of restrictive practice.

Residents were consulted on how the centre was run and areas for improvement through monthly residents' meetings which were facilitated by an outside company. The inspector reviewed documentation from these meetings where on average 60% of residents attended. Issues raised were addressed by the person in charge. Residents said they felt safe and were complimentary about the care they received. There were robust systems in place to monitor and protect residents' finances. Safeguarding training for all staff was outdated, with the last training being recorded as 2017, which could not provide assurances that staff were educated in relation to the detection, prevention and the response to abuse.

Links to the local community were maintained as students from the local school frequently visited and engaged with residents. There was a bus available at the centre for recreational outings. Trips this year had been to the beach, the local St. Patrick's Day parade, Schull pier and some residents went out for lunches in hotels around West Cork. Residents expressed their desire for more frequent trips out of the centre however the person in charge acknowledged there was a difficulty in the provision of staff for these outings. The inspector viewed personal life story

books that had been compiled about the lives of some residents and pictures of residents' activities on the centre's computer tablet. There was a Christmas mass and party planned for the following Saturday where families and the local community were invited.

Residents spoken to on the day of inspection were unaware of what activities were taking place and could not interpret the information board in the sitting room. The inspector observed that residents, on occasion, were not stimulated and left unsupervised in the sitting room. There was a lack of engagement in some instances where staff were task orientated. The inspector was informed that activities were also facilitated by care staff and the person in charge. Therefore care staff had responsibility for the delivery of personal care, cleaning the premises, serving food after 16:30 hrs and partaking in the social programme. There was a need for a clearer distinction in segregation of staff roles which would improve the time staff spent with residents outside of daily tasks.There was no assigned activities coordinator at the centre. Providing social activities to the residents was primarily allocated to an external company 13 hours per week. The inspector was informed that West Cork Arts for Health also visited the centre twice weekly.The residents had personal art work on display and valued this service. A musician was also employed at the centre once weekly. The activities schedule for the week was reviewed on the day of inspection.The programme was vague and did not provide information on times of activities and in some cases what activities were taking place.

Regulation 12: Personal possessions

Residents rooms were personally decorated and homely. Some had personal art work they had done in the centre and family pictures displayed. There was adequate storage space in each room and a locked wardrobe. Laundry was washed off site weekly and there were good systems in place to ensure it was well organised.

Judgment: Compliant

Regulation 18: Food and nutrition

There was daily communication between the nurses and kitchen staff in relation to the specific dietary needs of residents as per their individualised care plan. The assigned chef had a good knowledge of residents that required textured diets and their personal likes and dislikes. However, on the day of inspection it was noted there was a lack of choice available to residents at dinner time. The weekly dinner menu consisted of seven laminated pictures of a plate of food that would be served on that particular day. Mealtimes were also unreasonable in particular breakfast which was served by the night staff on duty at 07:30am. There was no evidence

of consultation with the residents on whether they chose to be woken at this time. The remaining meals were served at 12:00 (dinner), 16:30 (supper) and 19:30 (snack).The culture was reflective of a hospital rather than a home. The recent withdrawal of a dietetics service to St. Gabriel's Community Hospital could not assure the inspector that the individual dietary needs of residents as prescribed by dietetic staff could be met.

Judgment: Substantially compliant

Regulation 26: Risk management

The person in charge was responsible for maintaining a risk register which detailed centre specific risks, risk ratings, the controls implemented and an owner of each risk. It was updated annually or as new risks were identified and included clinical and non-clinical risks. However, risks identified on the day of inspection in relation to lack of availability of staff training and withdrawal of the dietetics service had not been recoded on the risk register.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Appropriate documentation was maintained for daily, weekly, monthly and yearly checks and servicing of fire equipment. The fire alarm system met the L1 standard which is in line with current guidance for existing designated centres. Annual fire training had taken place in 2019; however, not all staff had attended training. There was also no evidence of fire drills taking place to provide assurances that a successful evacuation could be completed in a timely manner especially when there is reduced staffing. This was also found to be an area that required attention on the last inspection.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Individualised medication for residents was securely stored in their bedrooms in locked cupboards and medications requiring special control measures were stored appropriately in the nurses station. However, it was noted on the day of inspection:

- A sample of administration records viewed showed gaps in cells which require

the signature of the administrator. This could not assure the inspector that medication had been administered in accordance with the directions of the prescriber. This finding was also evident in the centre's most recent medication audit of November 2019.

- A review of nurses signatures in the controlled drug record book which is checked at 08:00 and 20:00, showed that on the day of inspection it had been signed for both times in the morning. There were also gaps in signatures noted for other days which could not assure effective monitoring.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

There had been a recent introduction of new care planning documentation three months earlier in which all staff had received training. The inspector reviewed a sample of assessments which were completed using a range of validated tools. Care plans reviewed were personalised and sufficiently detailed to direct individualised care.

Judgment: Compliant

Regulation 6: Health care

The health needs of the residents were reviewed and it was evident that they were met to a good standard and they had access to a range of healthcare services. There was assessment by medical staff daily and timely access to allied health services. The withdrawal of the dietetics service for residents and the lack of professional expertise and access to treatment requires immediate attention and is addressed under Regulation 18 Food and Nutrition.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

The centre did not meet the requirements of this Regulation as the inspector noted the following:

- There was no policy in place to provide guidance to staff on the management of responsive behaviours.
- Training in responsive behaviour had expired for all staff working in the

centre.

- The centre had a high use of restrictive practices with 16 of the 19 residents (84%) on the day of inspection having bedrails in use. Nine of these were assessed as low dependency.
- Where bedrails were in use there was absence of assessments and consent and no alternative interventions had been applied.
- Care staff observed not responding to challenging behavior in a dignified manner.

Judgment: Not compliant

Regulation 8: Protection

Residents reported feeling safe in the centre and knew staff by name. They were complimentary about the care staff provided to them. Staff training in relation to the detection, prevention and response to abuse was out of date and ranged from last being completed in 2016-2018. This could not provide assurance that all staff had an awareness of how to respond if they witnessed abuse or had abuse reported to them.

There was a robust system in place for the management of residents finances. An employee from the HSE Patient Private Property Account project was in attendance at the centre on day of inspection. Her role was to review and monitor patient private property accounts as well as invoices and receipts. An electronic register for financial transactions was in place that could be accessed remotely.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Residents' meetings took place once a month and were chaired by external activities staff. The person in charge was made aware of issues raised and they were followed up on subsequent meetings. Residents had the option of attending the local day care centre if they chose to. The majority of activities were outsourced to an external company. The activities programme reviewed by the inspector found there were insufficient occupational and recreational activities available for residents and no schedule for weekends. The schedule did not provide residents with adequate information about what social activities were taking place on a particular day and at what time. Although care staff also had a responsibility for the social programme segregation of roles was unambiguous.

Times of meals were set by staff rather than residents was institutional practice and not person centred. Breakfast was served particularly early at 07:30 by staff on

night duty, dinner was at 12:00 midday and tea at 16:30.
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	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 12: Personal possessions	Compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 26: Risk management	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Not compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for St Gabriel's Community Hospital OSV-0000600

Inspection ID: MON-0028090

Date of inspection: 12/12/2019

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

<table>
<tr><th>Regulation Heading</th><th>Judgment</th></tr>
<tr><td>Regulation 16: Training and staff development</td><td>Not Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 16: Training and staff development:
Fire evacuation training commenced in house on 23/01/2020 and will continue on a monthly basis going forward.

Safeguarding Vulnerable Persons at risk of abuse was updated for 24 Staff on 21/01/2020.
Training for remaining Staff Members will take place 27th February 2020.

Hand Hygiene Training is in date for all staff Members.

New Digital Training Manikin purchased, AED training will take place in house and be completed for all Staff in March 2020.

Refresher training for managing Behaviour that is Challenging commenced 23/01/2020 and will be completed in January 2020.</td></tr>
<tr><td>Regulation 23: Governance and management</td><td>Not Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 23: Governance and management:
Current practice has defined Management Structure with organisational algorithm and reporting relationship in place.</td></tr>
</table>

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
Notification of incidents will be given to the Chief Inspector within three working days in line with statutory requirements.

Regulation 4: Written policies and procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
Schedule Five policies are now fully updated and in place.

Regulation 18: Food and nutrition	Substantially Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
Menus in the Kitchen are being revised and up dated and will be complete by February 2020.

We will consult with residents on admission and through our resident meetings and Dining audits, as is current practice, to ascertain if current meal times and food choices meet with their needs and preferences.

Dietitic referrals will be sent to the Dietetic Manager for West Cork as per her instruction until a Dietician is assigned to St Gabriels.

Regulation 26: Risk management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management: The paper risk record in relation to Dietitics service was updated. This risk was placed on our electronic risk register in November 2019.	
Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: Fire evacuation training has commenced on a monthly basis. This training will also be carried out using night duty staffing levels. All Staff will have updated their fire training by March 2020. Fire Alarm will be checked on a monthly basis. New record for in house fire training commenced 23/01/2020.	
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 nurses have undertaken Medication management training in Jan 2020. Medication Charts continue to be audited monthly and any issues addressed. Medication management included in daily safety pause.	
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: All Staff have received training in behaviour that is challenging.	

All Staff currently updating training which will be completed Jan 2020.
The use of bed rails is under review at St Gabriels and currently six of our sixteen Long term care residents are using bed rails.

Our bed rail use is also recorded on our daily safety pause.

All residents using bed rails are risk assessed.

Our bed rail documentation is in line with all of the Cork Kerry Community Hospitals.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
Twenty four Staff members received their refresher training on 21/01/2020.The remaining Eleven staff members will receive their refresher training on 27th February 2020.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
The times of activities have been added to the Notice Board in the Day Room.

Current practice and this is the normal practice based on individual choice and preference continues.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	
Regulation 18(1)(b)	The person in charge shall ensure that each resident is offered choice at mealtimes.	Substantially Compliant	Yellow	
Regulation 18(2)	The person in charge shall provide meals, refreshments and snacks at all reasonable times.	Not Compliant	Yellow	
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	
Regulation 26(1)(a)	The registered provider shall	Substantially Compliant	Yellow	

	ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.			
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the 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.	Not Compliant		
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	Not Compliant		

	practicable, residents, are aware of the procedure to be followed in the case of fire.			
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	Orange	
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	
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.	Not Compliant	Yellow	
Regulation 04(2)	The registered provider shall make the written policies and procedures	Not Compliant	Yellow	

	referred to in paragraph (1) available to staff.			
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Not Compliant	Yellow	
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	
Regulation 7(2)	Where a resident behaves in a manner that is challenging or poses a risk to the resident concerned or to other persons, the person in charge shall manage and respond to that behaviour, in so far as possible, in a manner that is not restrictive.	Not Compliant	Orange	
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated	Not Compliant	Orange	

	centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.			
Regulation 8(2)	The measures referred to in paragraph (1) shall include staff training in relation to the detection and prevention of and responses to abuse.	Not Compliant	Orange	
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	