**Health Information and Quality Authority**
**Regulation Directorate**

**Compliance Monitoring Inspection report**
**Designated Centres under Health Act 2007, as amended**

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

| | |
|---|---|
| **Centre name:** | Gorey District Hospital |
| **Centre ID:** | OSV-0000676 |
| **Centre address:** | McCurtin Street,<br>Gorey,<br>Wexford. |
| **Telephone number:** | 053 942 1102 |
| **Email address:** | Barbara.Murphy@hse.ie |
| **Type of centre:** | The Health Service Executive |
| **Registered provider:** | Health Service Executive |
| **Provider Nominee:** | Barbara Murphy |
| **Lead inspector:** | Ide Cronin |
| **Support inspector(s):** | None |
| **Type of inspection** | Unannounced |
| **Number of residents on the date of inspection:** | 18 |
| **Number of vacancies on the date of inspection:** | 5 |

## About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

▪ Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
▪ Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

▪ to monitor compliance with regulations and standards
▪ to carry out thematic inspections in respect of specific outcomes
▪ following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
▪ arising from a number of events including information affecting the safety or wellbeing of residents.

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.

Please note the definition of the following term used in reports:
responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

**Compliance 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 inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

**The inspection took place over the following dates and times**

| From: | To: |
|---|---|
| 27 June 2017 09:00 | 27 June 2017 16:00 |

The table below sets out the outcomes that were inspected against on this inspection.

| Outcome | Our Judgment |
|---|---|
| Outcome 01: Statement of Purpose | Compliant |
| Outcome 02: Governance and Management | Substantially Compliant |
| Outcome 05: Documentation to be kept at a designated centre | Substantially Compliant |
| Outcome 06: Absence of the Person in charge | Compliant |
| Outcome 07: Safeguarding and Safety | Compliant |
| Outcome 08: Health and Safety and Risk Management | Compliant |
| Outcome 09: Medication Management | Non Compliant - Moderate |
| Outcome 11: Health and Social Care Needs | Compliant |
| Outcome 16: Residents' Rights, Dignity and Consultation | Substantially Compliant |
| Outcome 18: Suitable Staffing | Compliant |

**Summary of findings from this inspection**

This was an unannounced monitoring inspection by the Health Information and Quality Authority (HIQA). This inspection took place to assess on going compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Standards of Residential Care Settings for Older People in Ireland (2016). The inspector also followed up on areas of non-compliance identified at the previous inspection which took place in July 2016.

HIQA had received unsolicited information prior to this inspection regarding aspects of general practitioner (GP) cover within the service. A provider led enquiry had been issued to the service provider in relation to this issue and it was found to be satisfactory. On this inspection the inspector found that the provider had met their legislative responsibilities and adequate GP cover was provided to residents.

The inspector observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files. The centre

provided care for short stay residents for example residents admitted for respite, convalescent, palliative care and residents waiting long stay placements.

This inspection found that there were robust and effective governance systems in place, safeguarding systems were evident and risk management procedures were satisfactory. The clinical nurse manager and staff demonstrated a comprehensive knowledge of residents' needs. Overall, the healthcare needs of residents were well met and residents had good access to general practitioner (GP) services and to allied health professionals.

Residents were very positive and complimentary regarding the care provided, the kindness and availability of staff and management, their ability to choose their own routines, maintain their independence and how safe they felt living in the centre.

The action plan at the end of this report identifies areas where some improvements must be made to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and the National Standards for Residential Care Settings for Older People in Ireland (2016).

**Compliance with Section 41(1)(c) of the Health Act 2007 and 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.**

***Outcome 01: Statement of Purpose***
***There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.***

**Theme:**
Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
As part of the inspection process the inspector reviewed the statement of purpose and found that it consisted of a statement of the aims, objectives and ethos of the designated centre and a statement as to the facilities and services which are to be provided for residents. It also contained all of the information required by Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended).

**Judgment:**
Compliant

***Outcome 02: Governance and Management***
***The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.***

**Theme:**
Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
Effective management systems were seen to be in place in the centre during the inspection. The inspector observed that there were sufficient resources in place to

ensure the delivery of safe and quality care to the residents with the current skill mix and staffing levels.

The inspector found that the management structure was appropriate to the size, ethos, and purpose and function of the centre. Appropriate resources were allocated to meet residents' needs. These included appropriate assistive equipment available to meet residents' needs such as electric beds, wheelchairs, hoists and pressure-relieving mattresses.

There was an organisational structure in place to support the person in charge which included two clinical nurse managers. There was a reporting system in place as observed by the inspector to demonstrate and communicate the service was effectively monitored and safe between the person in charge, the provider nominee and all staff.

Consultation with residents/relatives in relation to the existing systems of monitoring quality of care was available. An annual review of the quality and safety of care delivered to residents had taken place for 2016. Resident satisfaction surveys and food surveys been completed, the results of which indicated satisfaction with the service provided.

While some audits were being completed the inspector found that audits were not sufficiently detailed or broad enough to identify trends within all areas of clinical and non clinical risk. Some of the audits viewed included some learning and actions required to improve practice. However, documentation reviewed did not indicate who was responsible for ensuring corrective action plans were completed or checked to determine effectiveness which would ensure optimal outcomes for residents. The auditing process also required further development to include areas of all clinical risk such as restraint, falls and infection control.

**Judgment:**
Substantially Compliant

***Outcome 05: Documentation to be kept at a designated centre***
***The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.***

**Theme:**
Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
Only the component of records listed in Schedules 2,3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People), Regulations 2013 (as amended) were considered as part of this inspection.

Records listed in Schedules 2, 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People), Regulations 2013 (as amended) were available and a sample of records was reviewed by the inspector. These included records relating to fire safety, medicines management, staff recruitment and residents' care, as well as the centre's statement of purpose, policies and procedures.

Overall, records were maintained. However, the inspector observed that there was no photographic identification present for residents as required by Schedule 3 of the regulations. The inspector saw that policies did not reflect practices in the centre. For example the inspector observed a resident wearing a coloured identification bracelet which indicated a high risk of falls. This practice was not outlined in the centre's own policy on falls and it also does not reflect a person-centered approach to care.

**Judgment:**
Substantially Compliant

***Outcome 06: Absence of the Person in charge***
***The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.***

**Theme:**
Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
There were suitable arrangements in place for the management of the designated centre in the absence of the person in charge for more than 28 days. The person in charge worked full-time and was supported in her role by a clinical nurse manager. The person in charge was on leave at the time of this inspection.

The clinical nurse manager had been appointed in March 2017. A fit person interview was conducted during inspection and was deemed to be satisfactory. The clinical nurse manager has extensive experience in older person services and her mandatory training was up to date.

**Judgment:**
Compliant

***Outcome 07: Safeguarding and Safety***
***Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.***

**Theme:**
Safe care and support

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
Measures to protect residents being harmed or suffering abuse were in place. A policy on, and procedures for the prevention, detection and response to allegations of abuse was in place in accordance with Health Service Executive (HSE) procedures. The Trust in Care procedures and the Safeguarding Vulnerable Persons at Risk of Abuse documents were available and accessible to staff. All staff had received training on recognising and responding to elder abuse.

Staff who spoke with the inspector demonstrated a good understanding of elder abuse prevention and were clear about their responsibility to report any concerns or incidents in relation to the protection of a resident. Residents spoken with stated that they felt safe in the centre. There was a visitors log in place. Garda Síochána vetting was available for all staff members.

The policy on restraint was based on the national policy on promoting a restraint free environment. The use of bed rails had decreased since the previous inspection. Two residents were currently using bed rails at night. There were risk assessments completed prior to the use of the restraint and assessments were regularly revised. There was a policy on consent available. Some residents used bedrails as enablers to help them move in bed or to prop themselves up. However, staff would benefit from further education to ensure that they are clear when bedrails are in use at residents' request to prevent falls or used as enablers.

There was a policy outlining procedures to guide staff on the management of residents' personal property and possessions. Residents' finances were managed in line with the HSE, private property accounts procedures and subject to audit. There was a policy on management of behavioural symptoms associated with dementia dated October 2015. Some staff had received training in dementia care. The inspector saw that there was good access to mental health services and the community psychiatric nurse would regularly come to the centre and provide advice and support.

**Judgment:**
Compliant

***Outcome 08: Health and Safety and Risk Management***
***The health and safety of residents, visitors and staff is promoted and protected.***

**Theme:**
Safe care and support

**Outstanding requirement(s) from previous inspection(s):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
There were systems in place to promote and protect the safety of residents, staff and visitors to the centre. The inspector was satisfied that risks were generally well managed. Issues identified on the previous inspection had been completed.

There was an up-to-date health and safety statement which was dated 2017. A risk management policy that included the areas described in regulation 26(1) had been developed. There was information on general hazard identification and a risk register that outlined general and clinical risk areas. The inspector observed that the risk register was also informed by risk assessments from the clinical area. The inspector reviewed the emergency plan and found that it provided sufficient guidance to staff on the procedure to follow in the event of an emergency.

Emergency lighting and fire fighting equipment, directional signage and appropriate fire procedures were available throughout the building. A fire safety register and associated records were maintained and precautions against the risk of fire were in place.

Records confirmed that the fire alarm system and fire safety equipment including emergency lighting and extinguishers were serviced appropriately and serviced on a regular basis. Directional signage was visible in prominent places. Means of escape and fire exits were unobstructed as observed by the inspector. All staff were trained in fire safety and those who spoke with the inspector knew what to do in the event of a fire. Records of simulated fire drills were available which included day and night time scenarios when staffing levels were reduced. All residents had personal evacuation plans.

Personal protective equipment, such as gloves and aprons, and hand sanitizers were located throughout the premises. All hand-washing facilities had liquid soap and paper towels available. There were policies in place on infection prevention and control. Staff had completed hand hygiene training. Regular hand hygiene audits were conducted and the results of these audits were displayed in the front reception. Overall satisfactory procedures consistent with the standards published by HIQA were in place for the prevention and control of healthcare associated infection.

The training records showed that for the most part staff had up-to-date refresher training in moving and handling. There was sufficient moving and handling equipment available to staff to meet residents needs. Each resident's moving and handling needs

were identified and outlined in an assessment. There were contracts in place for the regular servicing of all equipment as observed by the inspector.

The inspector saw that accidents and incidents were reviewed and there were details of the situation and the actions taken at the time of an incident. There was a strategy in place to prevent falls whilst also promoting residents' independence. An evidence-based assessment tool was used to assess residents' risk of falls on admission. The inspector also observed that other satisfactory measures were in place to mitigate all risks associated with falls such as environmental measures, staffing ratios and physiotherapy.

**Judgment:**
Compliant

***Outcome 09: Medication Management***
***Each resident is protected by the designated centre's policies and procedures for medication management.***

**Theme:**
Safe care and support

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
There were written policies in place relating to the ordering, prescribing, storing and administration of medicines to residents. There were procedures in place for the handling and disposal of unused and out of date medicines. All nursing staff had completed medication management training. The inspector saw that medication management audits were completed.

The medicine administration records viewed by the inspector included the required information such as the resident's name and address, date of birth and GP. The GP signature was present for all medicines prescribed. The maximum amount of p.r.n (a medicine only taken as the need arises) to be given in a 24 hour period were outlined.

The inspector found that some practices in relation to administration recording and review of medicines did not meet with professional or regulatory requirements. Some residents were not sufficiently protected by medication management practices and procedures found in the sample of residents' records inspected, indicated that practices were not in accordance with relevant professional guidelines. For example there were nursing staff signatures missing in a sample of medicine administration records viewed by the inspector. Therefore it was impossible to ascertain if the resident had their medicines or not.

Records indicated that residents' prescriptions were reviewed regularly by the GP. There was, however, no multidisciplinary review. For example, a pharmacist was not involved in reviewing prescriptions or monitoring stock control. Adequate refrigerated storage

was in use for medicines that required temperature control and the temperature of the refrigerator was monitored. Staff told the inspector that a protocol was not in place to ensure that a pharmacist was facilitated to meet the obligations in line with guidance issued by the Pharmaceutical Society of Ireland.

Medicines that required strict control measures were managed appropriately and kept in a secure cabinet in keeping with professional guidelines. Nurses kept a register of all controlled drugs. The inspector confirmed that the stock balance was checked and signed by two nurses at the change of each shift. There were appropriate procedures for the handling and disposal of unused and out of date medicines.

**Judgment:**
Non Compliant - Moderate

***Outcome 11: Health and Social Care Needs***
***Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.***

**Theme:**
Effective care and support

**Outstanding requirement(s) from previous inspection(s):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
The centre had sufficient GP cover and an out of hour's service was also provided. A contract was in place with three GP practices in the local town. Each practice was responsible during a month period for assessing new admissions during that period. Residents were seen by a GP within 24 hours of admission. Records confirmed that residents were reviewed regularly by a GP which included regular medicine reviews and the GPs visited frequently if a resident was receiving palliative end of life care.

There were comprehensive assessments completed following admission and a range of evidenced based assessment tools were used to determine care interventions and risk in relation to areas that included falls, dependency level, moving and handling, pressure sore risk assessment, nutrition, and mental test score examination.

The arrangements to meet residents' assessed needs were set out in individual care plans. The care plans provided good guidance for staff and interventions outlined were being adhered to so that residents' welfare was protected. The inspector found that in areas such as end of life and nutrition management a good standard of evidenced based care was in place. There was routine access to medical and allied health professionals and assessments were undertaken when acute situations arose so that appropriate

interventions were outlined to guide the staff team.

The clinical nurse manager and staff demonstrated an in-depth knowledge of the residents and their needs and this was reflected in the care plans. There was evidence of resident/ relative involvement in the residents care and in care planning. Overall, the inspector was satisfied that facilities were in place so that each resident's well-being and welfare was maintained by an adequate standard of evidence-based care and appropriate medical and allied health care.

Given the resident profile there were some opportunities for residents to partake in activities. Healthcare assistants directed the activities on a daily basis which was informed by what the residents wanted to do on the day. The inspector formed the judgement that the activity programme required further development and structure to ensure that the needs of the resident profile were met. Staff told the inspector that they might not have time to carry out an activity as it would depend on the acuity of the centre that day. One resident told the inspector that they did not know if there were any activities on or not. This is actioned under Outcome 16. Residents had access to a secure sensory garden which was utilised on a daily basis weather permitting.

**Judgment:**
Compliant

***Outcome 16: Residents' Rights, Dignity and Consultation***
***Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.***

**Theme:**
Person-centred care and support

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
Only the component of activities was considered as part of this outcome. Given the resident profile there were some opportunities for residents to partake in activities. Healthcare assistants directed the activities on a daily basis which was informed by what the residents wanted to do on the day.

The inspector formed the judgement that the activity programme required further development and structure to ensure that the needs of the resident profile were met. Staff told the inspector that they might not have time to carry out an activity as it would depend on the acuity of the centre that day. The inspector observed that the activity timetable that was on display did not correlate with what actually went on. Staff also

confirmed this to the inspector. One resident told the inspector that they did not know if there were any activities on or not.

**Judgment:**
Substantially Compliant

***Outcome 18: Suitable Staffing***
***There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.***

**Theme:**
Workforce

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
The inspector formed the judgement through observation, speaking with staff and review of documentation that there was an adequate complement of nursing and care staff with the required skills and experience to meet the assessed needs of residents taking account of the purpose and size of the designated centre. Residents spoken with confirmed that staffing levels were good stating they never had to wait long for their call bell to be answered or their requested needs to be met. A staff rota was maintained with all staff that worked in the centre identified. Actual and planned rosters were in place.

A daily communication system was established to ensure timely exchange of information between shifts which included updates on residents' condition. There was evidence of regular staff meetings taking place. Good supervision practices were in place with the nurses visible on the floor providing guidance to staff and monitoring the care delivered to residents.

The inspector spoke with varied staff members and found that they were knowledgeable about residents' individual needs, fire procedures and the system for reporting suspicions or allegations of abuse Staff told the inspector that they were well supported by the management team.

Records reviewed confirmed that all staff had mandatory education and training in place. Staff had also been provided with education on other topics, such as basic life support, hand hygiene and medicines management.

The inspector reviewed a sample of staff files. All information as required by Schedule 2 of the regulations was made available to the inspector. A vetting disclosure was in place in all staff files reviewed and the clinical nurse manager gave verbal assurances that all staff working in the centre had a satisfactory vetting disclosure in place. There were no volunteers working in the centre at the time of this inspection.

**Judgment:**
Compliant

## Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

**Acknowledgements**

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

***Report Compiled by:***

Ide Cronin
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

**Health Information and Quality Authority**
**Regulation Directorate**

**Action Plan**

**Provider's response to inspection report**[1]

| | |
|---|---|
| **Centre name:** | Gorey District Hospital |
| **Centre ID:** | OSV-0000676 |
| **Date of inspection:** | 27/06/2017 |
| **Date of response:** | 27/07/2017 |

## Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

## Outcome 02: Governance and Management

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Audits that were reviewed did not indicate who was responsible for ensuring corrective action plans were completed or checked to determine effectiveness which would ensure optimal outcomes for residents. The auditing process also required further development to include areas of all clinical risk such as restraint, falls and infection control.

**1. Action Required:**

[1] The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.

Under Regulation 23(c) you are required to: Put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

**Please state the actions you have taken or are planning to take:**
Audits have named responsible person for conducting specific audits and take action for the outcomes. These now include clinical risk audits for example restraint, fall and Infection control.

**Proposed Timescale:** 31/07/2017

**Outcome 05: Documentation to be kept at a designated centre**

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Ensure that all policies reflect practices in the centre.

**2. Action Required:**
Under Regulation 04(1) you are required to: Prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.

**Please state the actions you have taken or are planning to take:**
Policies are reviewed on a ongoing basis and we will endeavour to ensure that what is written is reflected in the practices of the hospital. Orange arm bands are no longer worn by patients to denote falls risk. This is in line with a more person centred approach to care.

**Proposed Timescale:** 24/07/2017

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The inspector observed that there was no photographic identification present for residents as required by Schedule 3 of the regulations.

**3. Action Required:**
Under Regulation 21(1) you are required to: 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.

**Please state the actions you have taken or are planning to take:**
Photographic identification of all patients will be implemented as required by Schedule 3

with the exception of patients who are palliative. This will be placed on the patients drug kardex.

**Proposed Timescale:** 24/07/2017

**Outcome 09: Medication Management**

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Staff told the inspector that a protocol was not in place to ensure that a pharmacist was facilitated to meet the obligations in line with guidance issued by the Pharmaceutical Society of Ireland.

**4. Action Required:**
Under Regulation 29(2) you are required to: Facilitate the pharmacist concerned in meeting his or her obligations to a resident under any relevant legislation or guidance issued by the Pharmaceutical Society of Ireland.

**Please state the actions you have taken or are planning to take:**
Following discussion with the pharmacist in Wexford General Hospital, General Manager the pharmacists are keen to put an on-site clinical service in place as per HIQA requirements. The starting date for this service be 13 September 2017. This will meet HIQA regulations 29(2) and Pharmaceutical Society of Ireland.

**Proposed Timescale:** 30/09/2017

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There were gaps in a sample of medicine administration records viewed by the inspector.

**5. Action Required:**
Under Regulation 29(5) you are required to: 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.

**Please state the actions you have taken or are planning to take:**
Nursing staff will record with appropriate codes when patients refuse medication. It will also be highlighted to GP's to review medicines that are not taken by patients on a regular basis and advise to chart PRN. Medicines management audit is allocated to

specific Staff nurses to ensure all nurses who administer medication record their signature in the drug kardex.

**Proposed Timescale:** 04/07/2017

**Outcome 16: Residents' Rights, Dignity and Consultation**

**Theme:**
Person-centred care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The inspector formed the judgement that the activity programme required further development and structure to ensure that the needs of the resident profile were met.

**6. Action Required:**
Under Regulation 09(2)(a) you are required to: Provide for residents facilities for occupation and recreation.

**Please state the actions you have taken or are planning to take:**
The activities schedule is a guide for patients to choose what they would like to do. In order to provide a more structured programme of activities there will be three days a week where set activities are available to patients that is Tuesdays, Wednesdays and Friday. Outside of these specific days we will endeavour to provide activities as listed within the resources available and patient choice.

**Proposed Timescale:** 30/09/2017