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:	Bandon Community Hospital
Name of provider:	Health Service Executive
Address of centre:	Hospital Lane, Cloughmacsimon, Bandon, Cork
Type of inspection:	Unannounced
Date of inspection:	11 December 2019
Centre ID:	OSV-0000557
Fieldwork ID:	MON-0028403

About the designated centre

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

Bandon Community Hospital, established in 1929, is a single-storey building which had been extensively renovated. The designated centre is a Health Service Executive (HSE) establishment. It consists of accommodation for 25 older adults set out in 21 single en-suite bedrooms and two twin en-suite bedrooms. Communal areas include the day room, dining room, Bandon Suite relaxation area and the quiet room. Residents have access to an enclosed courtyard and an enclosed walkway. The centre provides 24 hours nursing care for long-term, respite and palliative care residents. The centre is supported by the Friends of Bandon Community Hospital who have raised money for the day-room refurbishment and many other aspects of the care setting.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	25

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 11 December 2019	08:30hrs to 17:30hrs	Breeda Desmond	Lead

What residents told us and what inspectors observed

Residents were very complimentary of the care they received and gave positive feedback about how helpful and kind staff were to them. They loved the Christmas decorations and how cheery it made the place.The inspector observed that residents were dressed very smartly in clothes and accessories of their choice.

Capacity and capability

A restrictive practice thematic inspection was undertaken in Bandon Community Hospital, however, following collation of the evidence accrued, it was necessary to change the purpose of the inspection to a risk inspection. Several risks relating to fire safety were identified for immediate attention on inspection; these were actioned on the day of inspection and are reported in 'Quality and Safety' below. Other findings identified as non-complaint are detailed in this report.

The general manager was registered provider representative who supported the service in promoting a restraint-free environment including encouraging and facilitating ongoing professional training and staff development, and facilitated setting up the quality and safety committee to provide better oversight of the service. The person in charge and CNM2 were responsible for the service on a day-to-day basis and were supported by clinical development co-ordinator.

While there were some policies in place in accordance with Schedule 5, many were out of date, for example, some were dated 2009, 2010 and 2011; an overarching centre-specific policy regarding medication management as detailed in the regulations was not in place. It was difficult to locate these policies as they were located in the 'Administration and Financial' folder. As policies and procedures were out of date and not updated in accordance with current legislation and best practice guidelines, implementation of current best practice as well as outcomes for residents could not be assured.

Minutes of the September 2019 staff meeting noted that a quality and safety committee was proposed to be set up. This was discussed with the person in charge who advised that this committee was in place with monthly meetings scheduled; and the person in charge, CNM2, nurse representative and quality patient safety officer were the committee members. They had identified that a programme of audit was necessary as there was little oversight of monitoring the service in accordance with the requirements set out in the regulations, and the inspection findings concurred with this. While the inspector was shown a proposed monthly programme of audit for 2020, the audit programme in place showed poor monitoring and oversight in both clinical and non-clinical matters to support development and

improve outcomes for residents as well as to ensure residents' rights were protected and promoted.

A folder with 'Your Service Your Say' was available in the main foyer but it was not identified as part of the complaints procedure; signage with names of relevant staff members with whom to relay complaints was displayed in a different location on corridors, however, the complaints procedure displayed did not refer people to 'Your Service Your Say'. The complaints log was reviewed and complaints were recorded as incidents in the HSE incident folder, consequently, complaints were not recorded or dealt with in accordance with the regulations. As complaints were located within the incident file folder, they were difficult to identify; the inspector was shown one complaint but the outcome and whether the person was satisfied with the outcome, was not recorded.

Staff had up to date training on safeguarding vulnerable adults, restrictive practice, dementia and enhancing and enabling well-being for persons with dementia. While care staff had up to date training completed on responsive behaviours, not all staff had not completed this training even though they would have constant daily contact and interaction with residents.

In conclusion, while a restraint-free environment was promoted to support residents, a rights' based approach to quality of life would enhance the positive steps taken regarding restrictive practice. The establishment of the programme of audit was imperative to identify deficits in care and quality of life along with non-clinical responsibilities. Staff supervision and resident supervision was required to ensure that people's fundamental human rights were promoted and upheld and that care was safe, appropriate, consistent and to a high standard in line with their statement of purpose. An appropriate complaints procedure in conjunction with up-to-date policies and procedures was necessary to support staff to deliver care in line with national policy, current legislation including human rights legislation.

Regulation 14: Persons in charge

The person in charge was full time in post. She was a registered nurse with the necessary experience and qualifications as required by the regulations.

Judgment: Compliant

Regulation 16: Training and staff development

Not all staff had not completed training relating to responsive behaviours even though they would have constant daily contact and interaction with residents.

Judgment: Not compliant

Regulation 23: Governance and management

There was poor oversight of the service. The quality and safety committee was set up after the 2019 September staff meeting and while a programme of audit was proposed for January 2020, there was little evidence that the quality of care and quality of life for residents was reviewed in accordance with the requirements of Regulation 23 to enable and ensure that residents' fundamental human rights were upheld.

Judgment: Not compliant

Regulation 34: Complaints procedure

Complaints were not recorded in line with the requirements set out in Regulation 34; for example, the outcome and whether or not the complainant was satisfied with the outcome.

The complaints procedure was not in an easily accessible format for residents.

Judgment: Not compliant

Regulation 4: Written policies and procedures

Schedule 5 policies and procedures were out of date and had not been updated in accordance with national policy, current legislation or best practice.

Judgment: Not compliant

Quality and safety

Residents had access to advocacy services and there were information posters displaying this information by main reception. The front entrance and door into the centre were unlocked which enabled residents and visitors to independently access the centre. The inspector observed that the enclosed courtyard could be freely accessed; access to the enclosed outdoor space was fob access only. This was

identified as a restrictive practice and the person in charge immediately requested that this mechanism be de-activated. There was some advisory signage on long corridors to orientate residents to areas such as the dining room and day room. The inspector observed that residents were dressed very smartly in clothes and accessories of their choice.

Some bedrooms were decorated with people's paintings and mementos from their homes; residents had remote controls for the televisions in their bedrooms. The day room and Bandon suite were decorated beautifully for Christmas and residents said that a healthcare assistant was responsible for decorating and she 'had a great eye and flair for the job'. Nonetheless, aspects of the premises required attention to ensure it reflected the ethos espoused in the statement of purpose; for example, the dining room and quiet visitors' room were almost devoid of décor and had a clinical appearance; the hairdresser's room was a room with a toilet, and a sink with an attachment for washing someone's hair, there was no décor, and did not provide an ambiance consistent with expectations of going to the hairdresser.

The inspector observed that meal times were not protected times as medications rounds were undertaken during meal times, which possibly restricted residents enjoyment of their dining experience. Staff actively engaged with residents, some social engagement was observed, nonetheless, all personal care and interactions were undertaken in a professional manner. The inspector spend some time in the day room in the morning chatting with residents where morning coffee was offered and residents read the newspapers, however, there was very little supervision and no activities at this time. While there was an activities programme in place, responsibility for this was outsourced, consequently, when these activity staff were unavailable, there was no alternative proposed, consequently, residents had long periods with little or no interaction to enhance their quality of life, and the inspector observed this on inspection.

Minutes of residents meetings were reviewed and these were facilitated by an external activities group. Minutes demonstrated that issues were not discussed with the person in charge as there was no feedback or acknowledgement of resolving issues or providing residents with pertinent information to the questions asked; one set of minutes showed that information in relation to accessing allied health professional service was not in keeping with the actual services provided or the information in the statement of purpose. The minutes did not facilitate residents to make choices and be actively involved in shaping the service they received and were not empowered to exercise their rights to achieve their personal goals, hopes and aspirations. As there was no oversight of the residents meetings, it could not be assured that the annual review of the quality and safety of the service delivered was completed in consultation with residents and their families as described in the regulations.

While this service promoted a restraint-free environment, the focus was on the restrictions associated with the physical environment rather than a resident-led social model of care associated with a rights-based approach, as detailed in many examples given throughout this report.

Issues identified on inspection relating to fire safety included:

1) spacing under some fire doors was significant
2) several doors were maintained open by door wedges, chairs and large dust bins
3) mobile bed-screen obstructed a fire door exit at the end of one corridor
4) mobile screen used outside one resident's bedroom to block out the light, especially at night – this screen was obstructing a fire door exit
5) two large trolleys obstructed a fire door exit from outside
6) bed on corridor by CNM2 office obstructing both fire exits on this corridor
7) floor plans were inadequate a) no point of reference b) the exit arrow strategy did not reflect practice
8) a review of previous daily fire safety check records along with inspection findings showed that fire safety issues were not being identified.

Immediate action was requested regarding these issues and they were actioned as follows:

1) maintenance personnel came on site to assess the spacing and advised that the height of some doors needed to be adjusted and this would be done by 12/12/19
2) an electrical contractor came on site to review the mechanism to attached to doors in communal areas of dining room, quiet living room and door to pantry to enable them be maintained open. Parts were ordered to enable this mechanism. The person in charge subsequently e mailed the office of the Chief Inspector with confirmation of this, to be completed no later than 11 January 2020.
3) the mobile screen was removed from the corridor
4) the person in charge gave assurances that dimmer switches would be installed to facilitate the lighting issue
5) trolleys were removed from outside the fire exit door
6) the fire officer was contacted and requested to review and update the emergency floor plans displayed
7) the person in charge gave assurances that additional fire safety training would be provided for those staff completing the daily fire safety checks as the issues identified on inspection were not being picked up.

As the programme of audit (clinical and non-clinical) was yet to be established, other issues were identified that required urgent attention as follows:

1) the water in the sink in the dining room had not been identified as scalding.

Immediate action was requested regarding these issues and they were actioned as follows:

1) the person in charge contacted the plumber to attend the centre on 12 December 2019. In the interim, the person in charge agreed to check all the sinks in the centre to determine whether the temperature of water throughout the centre was appropriate.

While there were two sluice rooms available, there was no storage in one sluice room; the hand-wash sinks in sluice rooms were not identified; hand-wash lotions and paper towels were over sluicing sinks rather than with the hand-wash sinks

which was not in keeping with the national standards.

Medical notes showed that residents had timely access to medical care as well as access to allied health professionals such as occupational therapy, dietician, speech and language therapy, psychiatry of old age and tissue viability nurse specialist.

New care planning documentation was rolled out in this centre. A sample of assessments and plans of care were reviewed; in the sample examined there was detailed person-centred information to inform individualised care; the information accrued following assessments including risk assessments such as mental test score, barthel and braden all informed the care planning process to enable a holistic approach to resident care. However, information available in residents' medical notes did not inform residents' end of life care plan, for example, there were resuscitation wishes and decisions available but these were not reflected in the end of life care plans seen. Participation in the care planning process was signed by the resident but not consistently signed and dated by the nurse involved in the process. While there was a restrictive practice bed-rail assessment tool in place it did not provide direction to enable staff make an evidence-based informed decision on whether to implement the restrictive practice, such as a bed rail. Written consent was sought for some procedures for example photography for documentation such as medication management, however, just verbal consent was obtained for restrictive practice such as bed-rail usage, and there was no consent form seen in another care plan reviewed. Consent forms were not consistently signed and dated by the staff member obtaining this consent.

Residents had access to a multi-disciplinary team (MDT) to help in their assessments including assessments of restrictive practices such as the occupational therapist assessments of specialist chairs. Residents had access to the GP, gerontology and psychiatry of old age to support them.

People had access to a wide range of assistive equipment (for example, low-low beds, half bed-rails, alarm mats and cushions, and sensor bracelets) to enable them be as independent as possible. Many aspects of the physical environment enabled independence regarding flooring and handrails. The inspector was satisfied that no resident was unduly restricted in their movement or choices due to a lack of appropriate equipment or technology. Nonetheless, residents reported that corridor lighting was too bright, especially at night time. Observation demonstrated that mobile screens were used on corridors to block lighting, but in doing so, they also obstructed fire safety exits. These along with other findings were not identified in the daily fire safety checks completed. This was discussed with the person in charge who gave the commitment to have dimmer switches installed to facilitate residents' wishes and preferences.

Regulation 11: Visits

Visitors were observed throughout the day calling to their relatives and friends in the

centre. They were know to staff and were welcomed.

Judgment: Compliant

Regulation 13: End of life

As information available in medical notes did not inform end of life care plans, it could not be assured that the end of life care delivered was in line with the expressed wishes of the resident.

Judgment: Not compliant

Regulation 26: Risk management

As clinical and non clinical audits were not undertaken, risk such as the scalding water in the dining room was not identified.

Residents personal emergency evacuation plans (PEEPS) were to be updated every six months, however, the PEEPS reviewed showed they were last updated 16 February 2019.

Judgment: Not compliant

Regulation 27: Infection control

While there were two sluice rooms available, there was no storage in one sluice room; the hand-wash sinks in sluice rooms were not identified; hand-wash lotions and paper towels were over sluicing sinks rather than with the hand-wash sinks which was not in keeping with the national standards.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Several fire safety issues were identified on inspection requiring immediate attention and these were actioned during the inspection; assurances were given that other fire safety issues would be remedied by 10 January 2020.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

While there was detailed person-centred information to inform individualised care, information available in residents' medical notes did not inform residents' end of life care plan, for example, there were resuscitation wishes and decisions available but these were not reflected in the end of life care plans seen.

Resident documentation including consent forms were not consistently signed and dated by nursing staff in line with best practice.

While there was a restrictive practice bed-rail assessment tool in place it did not provide direction to enable staff make an evidence-based informed decision on whether to implement the restrictive practice, such as a bed rail.

Written consent was sought for some procedures for example photography for documentation such as medication management, however, just verbal consent was obtained for restrictive practice such as bed-rail usage, and there was no consent form seen in another care plan reviewed.

Judgment: Not compliant

Regulation 6: Health care

Residents had timely access to medical and allied health professional services.

Judgment: Compliant

Regulation 9: Residents' rights

While this service promoted a restraint-free environment, the focus was on the restrictions associated with the physical environment rather than a resident-led social model of care associated with a rights-based approach as detailed throughout the report:

1) meal times were not protected times as medications rounds were undertaken during meal times, which possibly restricted residents enjoyment of their dining experience

2) while there was an activities programme in place, responsibility for this was

outsourced, consequently, when these activity staff were unavailable, there was no alternative proposed, and residents had long periods with little or no interaction to enhance their quality of life

3) there was poor oversight of residents meetings to facilitate residents to make choices and be actively involved in shaping the service they received; they were not empowered to exercise their rights to achieve their personal goals, hopes and aspirations. As there was no oversight of the residents meetings, it could not be assured that the annual review of the quality and safety of the service delivered was completed in consultation with residents and their families as described in the regulations

4) the dining room and quiet room were almost devoid of décor and had a clinical appearance; the hairdresser's room was bleak and did not provide an ambiance consistent with expectations of going to the hairdresser.

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 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Not compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 13: End of life	Not compliant
Regulation 26: Risk management	Not compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Bandon Community Hospital OSV-0000557

Inspection ID: MON-0028403

Date of inspection: 11/12/2019

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:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The 2 staff members who haven't completed responsive behavior training are now booked in for February 2020. The training policy has been updated to include all mandatory training and the ongoing monitoring and management of the training requirements for Bandon Community Hospital. One member of staff has just completed a 5 day dementia training programme and this staff member will roll out the person centred ethos in the Bandon Community Hospital. Management will introduce the QUIS tool to capture person centred moments or opportunities for learning. All staff have had education around the introduction of the Resident Care Record and Person Centred Care Planning.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: A schedule of monthly audits is in place to review quality and safety of care. A resident meeting was held in December 2019 and meetings are scheduled for March, June, September and December 2020. These meetings will be well publicised and resident participation encouraged. Resident meetings are facilitated by an external group, which is facilitated by Hospital	

Management and the Director of Nursing will make herself available to this meeting if required. A suggestion box is located at the entrance to Bandon Community Hospital and residents/families/visitors are encouraged to provide feedback. Resident satisfaction surveys are being distributed in Bandon Community Hospital to review the service and to provide guidance for future service improvements and considerations.

The Quality and Patient Safety Committee and the Health and Safety Committee were set up following the September 2019 staff meeting. These Committees meet bi-monthly to review incidents and to discuss in detail the concerns of the staff. The on-site QPS and Health and Safety meetings provide an update to the Cork Community Hospitals QPS meeting on a monthly basis as required.

The QPS and Health and Safety meetings provide updates for the on-site risk register in relation to all incidences or risks on site. The January QPS meeting took place on 15th January 2020 and the meeting schedule was agreed for the year.

The Schedule 5 policies have been reviewed and updating will be completed by 31st January 2020. These policies are now clearly identified and stored in the Nurses' Station readily available to all staff members.

The Statement of Purpose has been updated to clearly identify the Allied Health Professional input into Bandon Community Hospital. Signage in the unit has also been updated to provide clarity in relation to the complaints process and the Your Service Your Say Folder has been clearly identified as the HSE Complaints Procedure.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
The Bandon Community Hospital Complaints Procedure has now been reviewed and updated in line with the HSE complaints policy and regulatory requirements.

Complaints are now recorded in a separate log, clearly labeled. The log records details pertaining to the complaint such as the date the complaint was made, the details of the complaint, whether the complaint has been investigated, the outcome of this investigation, measures put in place to resolve complaint and whether or not the complainant was satisfied with the outcome.

The Statement of Purpose has been updated to reflect the updated complaints procedure. Signage in the unit has also been updated to provide clarity in relation to the complaints process and the Your Service Your Say Folder has been clearly identified as the HSE Complaints Procedure. The signage now also provides details of the Registered Provider Representative should the resident/families wish to lodge a complaint directly to that office.

There is an information folder in the residents' day room and the 2 seating areas. The contents of these folders include the statement of purpose, the complaints policy, the visiting policy, what facilities are available and menus for Bandon Community Hospital.

An audit of complaints is included in the audit schedule to ensure that all complaints are reviewed and to ensure that the complaint cycle is closed off. Residents also have access to SAGE, which is advertised throughout Bandon Community Hospital with the relevant contact details for that service.

Regulation 4: Written policies and procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
The Schedule 5 policies have been reviewed and updating will be completed by 31st January 2020. These policies are now clearly identified and stored in the Nurses' Station readily available to all staff members.

As per Schedule 5 Bandon Community Hospital has its own medication policy in place.

Regulation 13: End of life	Not Compliant

Outline how you are going to come into compliance with Regulation 13: End of life:
An audit was completed on 15/01/2020 on end of life care. Findings from same have informed and have been implemented into practice. Audit of end of life care is an ongoing component of the audit schedule for Cork Community Hospitals in 2020. It also includes a survey of our residents' families' experiences of end of life care in Bandon Community Hospital.

Care plans and medical note reviews has been completed with residents in conjunction with the multi-disciplinary team to indicate the preferences and wishes of the resident for end of life care. This aspect of care is incorporated into the metrics, which are reviewed on a monthly basis.

Regulation 26: Risk management	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management:
The audit programme has been introduced for 2020 and audits are now underway.
The updated Health and Safety Policy and Risk Policy in Bandon Community Hospital identifies the steps to be undertaken in order to identify and rectify any such risks. Staff training is scheduled for February 2020 in relation to the 2 policies to ensure that staff have a working knowledge of both policies.
Resident Personal Emergency Evacuation Plans (PEEP) have been updated and will be reviewed on a four monthly basis or as required.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
The signage for the hand wash sinks has been installed and the layout of the dirty utility rooms and storage within is scheduled to be reviewed by the Infection Control Team in February 2020.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Fire Safety Training is 100% up to date in Bandon Community Hospital. An additional fire safety briefing session was incorporated into the staff meeting on the 15th January 2020 to provide feedback to staff for issues identified in the HIQA inspection. The training matrix/schedule will ensure continued compliance with mandatory training in relation to fire.

All fire issues raised by the HIQA Inspector were addressed on the day of inspection and all works completed in December 2019.

Identified areas requiring dimmer lights, were reviewed and works are scheduled to be completed by 31/01/2020.

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
Clinical Development Co-Ordinator conducted an audit of Care Plans 07/01/2020 and ongoing as per the 2020 audit schedule. Feedback was given to both staff and Hospital Management on the day to inform improvements. The Resident Care Record was introduced to Bandon Community Hospital immediately prior to the inspection as part of the pilot introduction. The identified deficits and learning from the findings will continue to inform areas for improvement which are being addressed on an ongoing basis.

Care plans and medical note reviews has been completed with residents in conjunction with the multi-disciplinary team to indicate the preferences and wishes of the resident for end of life care. This aspect of care is incorporated into the metrics, which are reviewed on a monthly basis.

Management will introduce the QUIS tool to capture person centred moments or opportunities for learning. All staff have had education around the introduction of the Resident Care Record and Person Centred Care Planning.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
Following resident consultation, medication round timing has now been adjusted to ensure meal times are protected times maximizing resident enjoyment of their dining experience.

Bandon Community Hospital is undertaking resident satisfaction surveys and additional resident engagement to determine their preferences in relation to activities and the timing of same. Once resident preferences have been determined a comprehensive activity schedule will be built to reflect resident preferences and choices.

The residents are presently being engaged in relation to the interior décor within their personal spaces and the communal spaces in Bandon Community Hospital with a view to enhancing the homely feel of these spaces as identified by the clients' individual preferences. This engagement marks the continuation of a resident led service to continually address the changes in culture.

Bandon Community Hospital has close links with the community of Bandon and its surrounds. The Volunteer Groups provide a selection of activities which help address identified resident preferences in relation to their engagement e.g. Bingo.

Identified areas requiring dimmer lights, were reviewed and works are scheduled to be completed by 31/01/2020.

Resident meetings are facilitated by an external group, which is facilitated by Hospital Management and the Director of Nursing will make herself available to this meeting if required. A suggestion box is located at the entrance to Bandon Community Hospital and residents/families/visitors are encouraged to provide feedback. Resident satisfaction surveys are being distributed in Bandon Community Hospital to review the service and to provide guidance for future service improvements and considerations. The findings from this will inform the annual quality review in conjunction with audits of resident care to ensure a quality and safe service for the residents.

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 13(1)(a)	Where a resident is approaching the end of his or her life, the person in charge shall ensure that appropriate care and comfort, which addresses the physical, emotional, social, psychological and spiritual needs of the resident concerned are provided.	Not Compliant	Orange	31/01/2020
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	29/02/2020
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	Substantially Compliant		31/01/2020

	details responsibilities for all areas of care provision.			
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	31/01/2020
Regulation 23(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.	Not Compliant	Orange	31/01/2020
Regulation 23(e)	The registered provider shall ensure that the review referred to in subparagraph (d) is prepared in consultation with residents and their families.	Not Compliant	Orange	31/01/2020
Regulation 26(1)(a)	The registered provider shall ensure that the risk management	Not Compliant	Orange	31/01/2020

	policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.			
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Not Compliant	Orange	28/02/2020
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	11/01/2020
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	15/01/2020
Regulation 28(3)	The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place in the designated centre.	Not Compliant	Orange	13/12/2019
Regulation	The registered	Not Compliant	Orange	31/01/2020

34(1)(b)	provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall display a copy of the complaints procedure in a prominent position in the designated centre.			
Regulation 34(1)(f)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.	Not Compliant	Orange	31/01/2020
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 and properly	Not Compliant	Orange	31/01/2020

	recorded and that such records shall be in addition to and distinct from a resident's individual care plan.			
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	Orange	31/01/2020
Regulation 04(2)	The registered provider shall make the written policies and procedures referred to in paragraph (1) available to staff.	Not Compliant	Orange	31/01/2020
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	Orange	31/01/2020
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a	Substantially Compliant		31/01/2020

	resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.			
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Not Compliant	Orange	31/03/2020
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	Orange	31/01/2020
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned.	Not Compliant	Orange	31/01/2020