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:	Acorn Lodge
Name of provider:	Acorn Healthcare Limited
Address of centre:	Ballykelly, Cashel, Tipperary
Type of inspection:	Unannounced
Date of inspection:	21 June 2023
Centre ID:	OSV-0000188
Fieldwork ID:	MON-0040129

About the designated centre

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

Acorn Lodge is a single storey, purpose-built centre established in 2001, and the registered provider is Acorn Healthcare Limited. The centre is registered to accommodate 50 residents both male and female over the age of 18 years. Residents are accommodated in single bedrooms, each containing en suites. Bedroom accommodation is provided in two wings and each wing also accommodates a linen room, sluice room, a non-assisted bathroom and a nurses' station.

The aim of the centre is to provide person centred care and services to residents, and caters for residents of all dependencies; low, medium, high and maximum care needs. These include persons requiring extended or long term care as well as those who require respite care or convalescence, dementia and cognitive impairment; residents with physical and sensory impairments and residents who may also have mental health needs. In addition, the centre caters for residents requiring Percutaneous Endoscopic Gastrostomy (PEG) feeds or special diets, subject to and in conjunction with, the support of the residents' General Practitioner (GP). There is 24-hour care and support provided by registered nursing and health care staff with the support of housekeeping, administration, catering, and maintenance staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	49

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 21 June 2023	09:10hrs to 17:30hrs	Mary Veale	Lead
Wednesday 21 June 2023	09:10hrs to 17:30hrs	Catherine Furey	Support

What residents told us and what inspectors observed

This was an unannounced inspection which took place over one day. Based on the observations of the inspectors, and discussions with residents, staff and visitors, Acorn Lodge was a nice place to live. There was a welcoming and homely atmosphere in the centre. Residents' rights and dignity were supported and promoted by kind and competent staff. Residents appeared to enjoy a good quality of life and had many opportunities for social engagement, meaningful activities and they were supported by a kind and dedicated team of staff. The inspectors spoke with 3 visitors and 10 residents living in the centre. All residents and visitors were overwhelmingly complimentary in their feedback relating to the standard of care and the staff who provided the care. Residents' stated that they were well looked after and that the staff were always available to assist with their personal care.

On arrival the inspectors were met by a member of the centres activities team and were guided through the centres infection control procedures before entering the building. A senior staff nurse provided the inspectors with information at the introductory meeting and the person in charge joined a short time after the meeting began. The inspectors were accompanied by the person in charge on a tour of the centre. The inspectors spoke with and observed residents in communal areas and their bedrooms.

Acoon lodge was situated near Cashel, Co. Tipperary. The centre was a large single storey building with 50 single bedrooms with en-suite shower, toilet and wash hand basin facilities. The design and layout of the premises met the individual and communal needs of the residents. There was a choice of communal spaces. For example, a day room, a dining room, a visitors room, a library, a drawing room and oratory. The environment was homely, clean and decorated beautifully. Armchairs were available in all communal areas. The drawing room had a fireplace, large television and a piano. The multi-function room on Dualla had a television, large tables and was a space in which residents' could read the newspaper, listen to music or partake in activities. The dining room tables were covered with white cloth table clothes and had a fine dining room atmosphere. Residents' bedrooms were clean, tidy and had ample personal storage space. Bedrooms were personal to the residents, containing family photographs, art pieces and personal belongings. Pressure-relieving specialist mattresses, cushions and falls prevention equipment were seen in some of the residents' bedrooms.

Residents had access to a secure garden area and the doors to this area were open and were easily accessible. Residents had access to garden areas to the front of the building. Inspectors were informed that residents were encouraged to use the garden spaces. A pendant alarm necklace was available for residents who could used the garden areas which was linked to the centres call bell system. The inspectors were informed that the pendant alarm necklace provided independence and security for the residents who could alert staff if needed. The garden areas were attractive and well maintained with raised flower beds, seating areas and

decorative animal ornaments.

Residents were very complimentary of the home cooked food and the dining experience in the centre. Residents' enjoyed homemade meals and stated that there was always a choice of meals, and the quality of food was excellent. Many residents told the inspectors that the dessert trolley was a speciality in the centre. The daily menu was displayed outside the dining room. There was a choice of two options available for the main meal. Jugs of water and cordial were available for residents. The inspectors observed home baked pastries and scones been offered to residents outside of meal times. One resident said that they "loved the cakes that are baked daily", describing the cakes as "fresh and tasty". A second resident said the food was "just beautiful, the type of thing I would have at home".

Personal care was being delivered in many of the residents' bedrooms and observation showed that this was provided in a kind and respectful manner. The inspectors observed many examples of kind, discreet, and person-centred interventions throughout the day. The inspectors observed that staff knocked on resident's bedroom doors before entering. Residents very complementary of the person in charge, staff and services they received. Residents' said they felt safe and trusted staff. Residents' told the inspectors that staff were like family to them and were always available to assist with their personal care. One resident told an inspector that the staff would go beyond their role to help them, for example; a staff member called after their shift to fix their television and a staff member had returned from the Bloom garden festival with an ornament for the resident who tended to raised beds in the centres garden.

Residents' spoken to said they were very happy with the activities programme in the centre. The weekly activities programme was displayed in all residents' bedrooms. Seated exercises and short story telling was observed taking place in the day room on Dualla on the day of inspection. In the afternoon a group of residents met independently for a poetry recital. The inspectors observed staff and residents having good humoured banter during the activities.

The centre provided a laundry service for residents. All residents with whom inspectors spoke with on the day of inspection were happy with the laundry service and there were no reports of items of clothing missing.

The universal requirement for staff and visitors to wear surgical masks in designated centres had been removed on the 19 April 2023. Residents, visitors and staff expressed their delight since the masks had been removed. Staff felt the removal of the mask mandate signaled a return to normalcy which would in turn lead to improved socialisation for residents. A small number of visitors said that they had opted to continue wearing surgical masks to protect themselves and their loved ones. It was evident that staff encouraged residents to receive visitors, and inspectors observed visitors entering the centre throughout the day, and meeting with residents in the privacy of their bedrooms, in communal areas, and outside. Visitors who spoke with inspectors were unanimous in their praise for the staff, the premises, and the overall care provided. One visitor said that they were confident

that their loved one was safe and well-cared for.

The next two sections of this report will present findings in relation to governance and management in the centre, and how this impacts on the quality and safety of the service being delivered.

Capacity and capability

This was an unannounced risk inspection carried out to monitor ongoing compliance with the regulations and standards. The inspectors found that this was a well-managed centre where the residents were supported and facilitated to have a good quality of life. The provider had progressed the compliance plan following the previous inspection in June 2022, and improvements were found in Regulation 4: Written policies and procedures, Regulation 21: Records and Regulation 27: Infection prevention and control. On this inspection, the inspectors found that actions was required by the registered provider to address Regulation 5: Individual assessment and care planning, Regulation 16: Training and staff development, and Regulation 29: Medicines and pharmaceutical services. Areas of improvement were required in Regulation 23: Governance and management, Regulation 27: Infection prevention and control, and Regulation 31: Notification of incidents.

The registered provider had applied to renew the registration of Acorn Lodge. The application was timely made, appropriate fee's were paid and prescribed documentation was submitted to support the application to renew registration. On the day of inspection, the inspectors observed residents records securely stored in a shed to the rear of the centre. The provider was requested to submit additional information to include the shed as part of the designated centre in updated floor plan and statement of purpose following the inspection.

Acorn Healthcare Limited was the registered provider for Acorn Lodge. The registered provider representative was also the person in charge who worked full time in the centre. The person in charge was supported by a team of consisting of an assistant director of nursing, registered nurses, health care assistants, kitchen staff, housekeepers, activities staff, administration and maintenance staff. There were clear reporting structures and staff were aware of their roles and responsibilities. There was a stable management team in the centre and overall there was good oversight of the service and its current risks.

There were sufficient staff on duty to meet the needs of residents living in the centre on the day of inspection. The centre had a well-established staff team who were supported to perform their respective roles and were knowledgeable of the needs of older persons in their care and respectful of their wishes and preferences.

Improvements were required in the oversight of training needs in the centre. While there was an extensive list of mandatory training in place to support staff such as fire safety training, infection prevention and control and the management of

behaviours that are challenging. On the day of inspection it was evident that not all training was up to date. This is discussed further under Regulation 16; staff training and development.

Records and documentation, both manual and electronic were well presented, organised and supported effective care and management systems in the centre.

Management systems in place to monitor the centre's quality and safety required review. Since the previous inspection, a small number of audits had been completed in the centre, for example; infection prevention and control audits, observational audits, falls management audits and a medication audit. Audits viewed identified improvements and had action plans. There was no evidence of wound management, restrictive practices or care planning audits carried out since the previous inspection. There was evidence that meetings took place in the centre. There was records of management meetings with staff. Meetings took place quarterly in the centre. Meeting agenda include items such as fire safety, infection prevention and control, training, staffing and KPI's (key performance indicators). However, improvements were required in the management of audits and the centre's annual review which is discussed further in this report under Regulation 23: governance and management. The annual review for 2022 was submitted following the inspection. It set out the improvements completed in 2022 and improvement plans for 2023.

Inspectors examined the records of incidents and accidents occurring in the centre. For the most part, there was good information documented in the incident forms, including the factors contributing to the incident and follow up actions taken. However, some incidents were not subject to rigorous documentation, for example, it was unclear whether a resident had absconded from the building as there was no detail on how long the resident had been outside, or what measures it took to bring the resident back into the centre. This meant that this incident, which requires notification to the office of the Chief Inspector, was not submitted as required.

Registration Regulation 4: Application for registration or renewal of registration

All documents requested for renewal of registration were submitted in a timely manner.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge worked full time in the centre and displayed good knowledge of the residents' needs and had a good oversight of the service. The person in charge was well known to residents and their families.

Judgment: Compliant

Regulation 15: Staffing

Staffing was found to be sufficient to meet the needs of the residents on the day of the inspection.

Judgment: Compliant

Regulation 16: Training and staff development

Not all staff had access to appropriate training to support them to perform their respective roles. For example, training records made available on the day of inspection and following inspection to the inspectors indicated that 15 staff required updated training in safeguarding.

Judgment: Substantially compliant

Regulation 19: Directory of residents

A directory of residents was maintained on the centre's electronic information management system, which was made available for review by inspectors. The directory contained the information required by Schedule 3 of the regulations.

Judgment: Compliant

Regulation 21: Records

All records as set out in schedules 2, 3 & 4 were available to the inspector. Retention periods were in line with the centre's policy and records were stored in a safe and accessible manner.

Judgment: Compliant

Regulation 22: Insurance

There was a valid contract of insurance against injury to residents and additional liabilities.

Judgment: Compliant

Regulation 23: Governance and management

Management systems required improvement to ensure that the service provided was safe, appropriate and effectively monitored. For example;

- Clinical audits such as wound management, restrictive practices and care planning were not routinely completed since the previous inspection, which lead to actions being required to achieve compliance in a number of regulations including care planning and medication management.

Judgment: Substantially compliant

Regulation 24: Contract for the provision of services

A sample of residents' contracts of care were reviewed. These were agreed in writing with the resident, and where appropriate, their representative. Contracts contained all of the required information, including the fees to be charged, and the terms related to the bedroom to be provided.

Judgment: Compliant

Regulation 3: Statement of purpose

Amendments were made to the centre's statement of purpose during the inspection. The statement now contained all of the information set out in schedule 1 of the regulations and in accordance with the guidance.

Judgment: Compliant

Regulation 30: Volunteers

A volunteer attended the centre to enhance the quality of life of residents. The

volunteer was supervised and had a Garda vetting disclosure in place. Their roles and responsibilities were set out in writing.

Judgment: Compliant

Regulation 31: Notification of incidents

Two incidents, which met the criteria for notification to the office of the Chief Inspector within three working days of occurrence, had not been submitted.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

The registered provider had prepared policies and procedures on the matters set out in Schedule 5 of the regulations. These were updated at intervals not exceeding three years.

Judgment: Compliant

Quality and safety

The findings of this inspection evidenced that the management and staff strived to provide a good quality of life for the residents living in Acorn Lodge. Residents health, social care and spiritual needs were well catered for. Improvements were required in relation to Regulation 5: Individual assessment and care planning, and areas of Regulation 27: Infection prevention and control, and Regulation 29: Medicines and pharmaceutical services.

Residents' health and well-being was promoted and residents had timely access to general practitioners (GP), specialist services and health and social care professionals, such as psychiatry of old age, physiotherapy, occupational therapy, dietitian and speech and language, as required. The centre had access to GP's from local practices and the inspectors were informed that GP's called to the centre regularly. Residents had access to a consultant geriatrician and a psychiatric team. Residents had access to local dental and optician services. Residents who were eligible for national screening programmes were also supported and encouraged to access these.

There was no restriction to visits in the centre and visiting had returned to pre-

pandemic visiting arrangements in the centre. Residents could receive visitors in their bedrooms where appropriate, the centres communal areas or outside areas. Visitors could visit at any time and there was no booking system for visiting.

The overall premises were designed and laid out to meet the needs of the residents. A schedule of maintenance works was ongoing and the centre had been painted since the previous inspection. The centre was cleaned to a high standard, alcohol hand gel was available in all communal corridors and bedrooms. Bedrooms were personalised and residents had sufficient space for their belongings. Overall the premises supported the privacy and comfort of residents. Residents had access to call bells in their bedrooms, en-suite bathrooms and all communal rooms. Grab rails were available in all corridor areas, toilets and en-suite bathrooms.

The centre was cleaned to a high standard, with good routines and schedules for cleaning and decontamination. Bedpan washers had been replaced since the previous inspection. The management team completed infection control and environmental audits. Used laundry was segregated in line with best practice guidelines and the centres laundry had a work way flow for dirty to clean laundry which prevented a risk of cross contamination. Risk assessments had been completed for actual and potential risks associated with COVID-19 and the provider had put in place many controls to minimise the risk of harm to residents and staff. There was a high uptake of COVID-19 vaccination among residents and staff and procedures were in place to facilitate testing and isolation of residents should the need arise. Some required improvements in infection control procedures are detailed under Regulation 27: Infection control.

The centre had a risk management policy that contained actions and measures to control specified risks and which met the criteria set out in regulation 26. The risk registered contained site specific risks such as risks associated with individual residents and centre specific risks, for example; risk of medication errors, individual residents risk of chocking and bed rail associated risks.

Residents had adequate space to store their personal possessions and belongings. Residents had access to a wardrobe, drawers and bedside locker in which to store all of their belongings. The centre did not act as a pension agent for any of the residents. Residents had access to and control over their monies. Residents who were unable to manage their finances were assisted by a care representative or family member. A laundry service was provided in the centre for residents.

There were effective systems in place for the maintenance of the fire detection, alarm systems, and emergency lighting. The provider had made improvements to fire safety containment since the previous inspection. The provider had replaced all the bedroom doors and had completed containment works in the attic of the centre. All doors to bedrooms and compartment doors had automated closing devices. All fire doors were checked on the day of inspection and were in working order. Fire training was completed annually by staff. There was evidence that fire drills took place monthly in the centre. There was evidence of fire drills taking place in each compartment with simulated night time drill taking place in the centres largest compartment. Fire drills records were detailed containing the number of residents

evacuated , how long the evacuation took, and learning identified to inform future drills. There was a system for daily and weekly checking , of means of escape, fire safety equipment, and fire doors. All fire safety equipment service records were up to date. All escape routes were assessable, free from obstructions and the assembly point was accessible. The centre had an L1 fire alarm system. Each resident had a personal emergency evacuation plan (PEEP) in place which were updated regularly. Staff spoken with were familiar with the centres evacuation procedure. There was evidence that fire safety was on the agenda at meetings in the centre. On the day of the inspection there were no residents who smoked. The inspectors were informed by the person in charge that the centre would remain a smoke free campus, however; the centre had a visitors room which had access to a call bell, fire blanket, and fire extinguisher which could be utilised as a smoking room in the future if required. There was fire evacuation maps displayed throughout the centre.

A detailed individual assessment was completed prior to admission, to ensure the centre could meet residents' needs. Residents' needs were comprehensively assessed by validated risk assessment tools. Care planning documentation was available for each resident in the centre. Further improvements were required to residents care plans which is discussed under Regulation 5: individual assessment and care planning.

There was a rights based approach to care in this centre. Residents' rights and choices were respected and promoted. Residents were actively involved in the organisation of the service. Residents met regularly and informal feedback from residents informed the organisation of the service. The inspectors were informed that there was no record of the residents meetings or a record of any feedback from the residents. Suggestion and comment cards were available in all bedrooms on the day of inspection. A resident informed an inspector that a staff member met with the residents on a monthly or six-weekly basis to gather any suggestions or comments from the residents. There was no record of this information which was a missed opportunity to inform quality improvements in the centre. The person in charge informed the inspectors that any issued raised by residents were sorted locally. The centre promoted the residents independence and their rights. The residents had access to an independent advocate who called regularly and SAGE advocacy services. The advocacy service details were displayed in the reception area and activities planners were displayed in all residents bedrooms. Residents has access to daily national newspapers, weekly local newspapers, Wi-Fi, books, televisions, and radios. Mass took place intermittently in the centre but was available daily for residents. Mass was live streamed from local parishes or residents home parish. Musicians attended the centre regularly.

Regulation 11: Visits

Visiting had resumed in line with the most up to date guidance for residential centres.

Judgment: Compliant

Regulation 12: Personal possessions

The person in charge ensured that residents had access to and retained control of their personal property, possessions and finances. There was a system in place to ensure that residents' clothing was safely laundered and returned to the resident without delay. All bedrooms contained sufficient space to store clothing and other belongings.

Judgment: Compliant

Regulation 17: Premises

The premises was appropriate to the needs of the residents and promoted their privacy and comfort.

Judgment: Compliant

Regulation 26: Risk management

There was good oversight of risk in the centre. Arrangements were in place to guide staff on the identification and management of risks. The centre's had a risk management policy which contained appropriate guidance on identification and management of risks.

Judgment: Compliant

Regulation 27: Infection control

Overall, the environment was clean and safe for residents. Some improvements were required to ensure that the centre was in full compliance with the regulation;

- a sluice room did not have an adequate dirty to clean flow; clean basins were stored on a shelf directly above the bedpan washer, thereby posing a risk of cross-infection
- the regime in place to mitigate the risk of *Legionella* bacteria by flushing of water outlets required review. Staff were unaware of the correct procedures,

and associated sign-off sheets did not direct staff to these correct procedures. There was no evidence to show that intermittently used outlets were subject to the *Legionella* flushing regime.
- a number of pieces of furniture had worn or scuffed surfaces which hindered effective decontamination and cleaning. The provider had identified this deficit and a plan was in place for the repair or replacement of this furniture
- none of the hand hygiene sinks in the centre were compliant with current recommended specifications.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The provider had good oversight of fire safety. Annual training was provided and systems were in place to ensure fire safety was monitored and fire detection and alarms were effective in line with the regulations. Bedroom doors had automatic free swing closing devices so that residents who liked their door open could do so safely. Evacuation drills were regularly practiced based on lowest staffing levels in the centre's largest compartment.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

The centre's medication management policy outlines that transcribing of medicines should only be done in an emergency. The inspector found evidence that this policy was not followed, and that nurses were operating outside of best-practice guidelines:

- the transcribed Kardex were not always checked by a second nurse
- the transcribed Kardex were not always signed by the GP
- new medicines were transcribed onto the Kardex, with no signatures to indicate who had completed the transcribing

The procedure for checking and administration of controlled drugs required review to ensure that best-practice guidance was followed.

- the count of controlled drugs was not always conducted by two staff
- controlled drugs were not always administered by two staff

A small number of medicines which were no longer in use were retained on the drug trolley. This presents a risk of errors occurring.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

A sample of assessment and care planning documentation was reviewed by inspectors. There was evidence of non-compliance with the regulation as follows;

- a number of assessments and care plans had not been reviewed for six months, despite changes occurring in the residents' condition
- new residents did not always have a care plan prepared within 48 hours of admission to the centre
- Body Mass Index (BMI) was not always calculated on admission and therefore the risk of malnutrition was not assessed. This presented a missed opportunity to gather baseline information from which to assess deviation in the future
- three clinical risk assessments had been completed for a resident on admission, however, no care plans had been devised following this assessment
- social care assessments were not completed for a number of residents. As a result, no documented social care plan was put in place to address the residents' social needs.

Judgment: Not compliant

Regulation 6: Health care

There were good standards of evidence based healthcare provided in this centre. GP's routinely attended the centre and were available to residents. Allied health professionals also supported the residents on site where possible and remotely when appropriate. There was evidence of ongoing referral and review by allied health professional as appropriate.

Judgment: Compliant

Regulation 8: Protection

The registered provider had taken all reasonable measures to safeguard residents from abuse. Measures included strong recruitment processes including Garda (police) vetting of all staff prior to commencement of employment. Staff were knowledgeable regarding safeguarding and were aware of their responsibility to report any allegations, disclosures or suspicions of abuse. Staff were familiar with

the reporting structures in place. Residents who spoke with inspectors confirmed that they felt safe in the centre.

Judgment: Compliant

Regulation 9: Residents' rights

Residents' rights and choice were promoted and respected within the confines of the centre. Activities were provided in accordance with the needs' and preference of residents and there were daily opportunities for residents to participate in group or individual activities. Facilities promoted privacy and service provision was directed by the needs of the residents.

Judgment: 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	
Registration Regulation 4: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 30: Volunteers	Compliant
Regulation 31: Notification of incidents	Substantially compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Acorn Lodge OSV-0000188

Inspection ID: MON-0040129

Date of inspection: 21/06/2023

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Training has commenced for all staff in safe guarding and is on-going.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: A care plan audit was in progress during the inspection which the inspector had been informed of. This audit has been completed. An audit plan will be developed to include areas for audit and the timeframes for the completion of same. The annual review for 2022 had been completed and was submitted to the inspector on 23rd June 2023.	
Regulation 31: Notification of incidents	Substantially Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: Going forward all incidents will be submitted within the statutory timeframes.	

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
Shelving in the sluice room has been moved so is no longer located above the bedpan washer.
Records related to flushing of water outlets to minimize legionella has been reinstated.
A plan was in place to replace or refurbish furniture and work is being completed in accordance with this plan.
New hand hygiene sinks compliant with current recommended specifications have been ordered and are awaiting delivery and installment to replace existing sinks.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
The medication Management Policy and Procedures will be updated to align with practice in the centre. Auditing of transcribing will be included in the Centre's audit plan going forward.

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:
A care plan audit was being completed at the time of the inspection. An action plan was generated to address improvements needed in care planning. Staff are aware and have been reminded of the need to complete initial care plans within 48 hours of admission and to update same no less frequently that 4 monthly or where there is a significant change to the residents' care or condition. Any gaps in care plans have been addressed. Social care needs are included in residents' activities care plans and daily records are maintained regarding attendance and engagement of individual attendance at activities. Since the inspection, monthly narrative entries are being completed for each resident in

more detail evaluating their activity programme.

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.	Substantially Compliant	Yellow	31/10/2023
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Substantially Compliant	Yellow	31/07/2023
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	Substantially Compliant	Yellow	31/10/2023

	staff.			
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	20/08/2023
Regulation 29(6)	The person in charge shall ensure that a medicinal product which is out of date or has been dispensed to a resident but is no longer required by that resident shall be stored in a secure manner, segregated from other medicinal products and disposed of in accordance with national legislation or guidance in a manner that will not cause danger to public health or risk to the environment and will ensure that the product concerned can no longer be used as a medicinal product.	Not Compliant	Orange	20/08/2023
Regulation 31(1)	Where an incident	Substantially	Yellow	21/07/2023

	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.	Compliant		
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Not Compliant	Orange	24/07/2023
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Not Compliant	Orange	24/07/2023