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:	Oakwood Private Nursing Home
Name of provider:	Oakwood Private Nursing Home Limited
Address of centre:	Hawthorn Drive, Athlone Road, Roscommon, Roscommon
Type of inspection:	Unannounced
Date of inspection:	11 January 2022
Centre ID:	OSV-0000372
Fieldwork ID:	MON-0034890

About the designated centre

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

The centre offers long and short term care for 56 adults over the age of 18 including people with a diagnosis of Alzheimer's disease or dementia. The centre is purpose built, single storey and has a safe cultivated garden for residents' use. All bedrooms are single with full en-suite facilities. They have good natural light, a functioning call-bell system and appropriate storage. The kitchen, dining and sitting room areas are centrally located. There are appropriately equipped sluice rooms. The centre is located a short distance from the town of Roscommon and is near restaurants, shops, pharmacies, doctors' surgeries as well as the local general hospital.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	54

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
Tuesday 11 January 2022	10:00hrs to 15:30hrs	Catherine Sweeney	Lead
Wednesday 12 January 2022	10:00hrs to 16:00hrs	Catherine Sweeney	Lead
Tuesday 11 January 2022	10:00hrs to 15:30hrs	Kathryn Hanly	Support
Wednesday 12 January 2022	10:00hrs to 16:00hrs	Ann Wallace	Support

What residents told us and what inspectors observed

Inspectors noted staff to be responsive and attentive without any delays in attending to residents' requests and needs. Staff were observed to be respectful and courteous towards residents. Staff spoken with were knowledgeable of the signs and symptoms of COVID-19 and knew how and when to report any concerns to the nursing staff. Staff knew the residents well and were knowledgeable about their care needs and preferences for daily routines.

An outbreak of COVID-19 had been declared in the designated centre on 07 January 2022. Residents and staff had undergone testing and a total of three cases of COVID-19 infection in residents had been identified at the time of the inspection. The provider had taken action to isolate residents and staff who were confirmed to have contracted COVID-19, and to commence containment measures to limit the spread of infection. The three residents that had tested positive for COVID-19 were being cared for with transmission-based precautions. However, inspectors observed staff crossover between residents that had tested positive for COVID-19 infection and residents that had tested negative. Although inspectors were informed that infection prevention and control measures were in place, this arrangement was less than ideal and did not ensure ongoing containment of infection.

Inspectors spoke with eight residents. All were very complimentary about the professionalism and dedication of staff. Some residents spoken with stated that the pandemic had had a negative impact on their quality of life. However, they were kept informed of and understood the reasons for the public health measures and restrictions.

Efforts had been made to de-clutter the centre following the previous inspection. The designated centre provided a homely environment and residents were out and about mobilising between their bedrooms and the communal areas on the day of the inspection. Inspectors observed that residents had personalised their rooms and had their photographs and personal items displayed. There was sufficient closet space, display space, and storage for personal items. There were appropriate handrails and grab-rails available in the bathrooms and along the corridors to maintain residents' safety.

New shower chairs had also been purchased since the last inspection. While the centre appeared visibly clean, inspectors were not assured that it was hygienically clean. Issues with equipment hygiene were identified. Incontinence wear continued to be disposed of in open bin in a resident's room. Incontinence wear was still stored on open shelving in communal toilets. Barriers to effective hand hygiene practice were also identified during the course of this inspection. The laundry facility did not support the separation of clean and dirty activities. Findings in this regard are further discussed under Regulation 27.

The social care of residents was observed to be of a high standard. Residents were

observed to be socially engaged in both scheduled and individual activities throughout the two days of inspection. A number of the residents who had not been detected with COVID-19 were observed visiting each other in their bedrooms and chatting in small socially distanced groups in the seating areas and in the main lounge.

The next two sections of the report will summarise the findings of the inspection and discuss the levels of compliance found under each regulation reviewed.

Capacity and capability

This was a two-day unannounced risk inspection by inspectors of social services to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). The centre had notified the Chief Inspector of an outbreak of COVID-19 on the 7 January 2022. This outbreak was on-going on the two days of the inspection. The lead inspector was supported by an infection control inspector on day one of inspection and reviewed the systems in place to manage the on-going COVID-19 outbreak in the centre. Public Health were providing support and oversight of the management of the outbreak and an outbreak control meeting had been held the day prior to the inspection. Line listings for confirmed COVID-19 positive residents and staff were maintained in line with the Health Protection and Surveillance Centre (HPSC) guidance.

Inspectors followed up on the action taken by the provider to address issues of non-compliance found on the last inspection in November 2021. The findings of this inspection were that while some improvement had been made to the overall governance and management of the centre, significant improvements were still required across all the regulations which were inspected. The provider had engaged the services of a nursing consultancy and a project plan had been developed to address the non-compliance's found on the previous inspection. Inspectors reviewed the plan and found that while some actions had been progressed, the majority of the plan had yet to be commenced. The provider had carried out a number of actions to bring the centre into compliance with Regulation 28 and the fire safety action plan submitted following the last inspection was ongoing at the time of the inspection. One outstanding structural work to widen the final exit doors along two corridors was scheduled to begin in the coming weeks.

Some changes had been made to the organisational structure of the centre since the last inspection. Two senior nurses had been promoted to the role of clinical nurse manager. The person in charge was supported in the centre by these two clinical nurse managers and an administrator. There was no other person participating in the management of the centre. From the repeated non-compliant findings of this inspection, inspectors found that the skills, competencies and experience of the management team required strengthening and that further improvement in the

oversight of the service was required to ensure the service delivered was safe and effective**.** A plan was in place to develop a governance and management framework which included the establishment of a clinical governance committee. Training for management staff had also been scheduled. While this was a positive development, inspectors found that little progress had been made to implement the action plan.

Inspectors found no staff or governance meetings had been held since the last inspection. This meant that there was no record of how the non-compliances from the last inspection and the subsequent improvement action plan had been communicated to relevant staff. The provider informed the inspectors that a staff meeting was scheduled for the day following the inspection.

Inspectors found that the needs of the residents had been poorly assessed and therefore, it was difficult to assess if the staffing levels were adequate to meet the actual care needs of the residents. However a review of the staffing roster found that staffing levels were not appropriate to meet the needs of the residents.The provider was in the process of recruiting nursing staff and had committed to increasing the nursing levels to two nurses at night. In the meantime, there was a system of on-call rostering each night so that a second nurse would be available in the event of an emergency. Notwithstanding the on-going recruitment and on-call system, nursing levels remained low, especially during night time hours. For example there was only one nurse on duty at night, the level of nursing staff did not facilitate the cohorting of positive and 'not detected' COVID-19 residents, in line with the centre's own contingency plan.

A review of the training matrix found that all mandatory training was up-to-date. This training included safeguarding of the older person, challenging behaviour management, fire safety and infection prevention and control. Since the last inspection nursing staff had received two training sessions in relation to assessment and care planning.

The documentation of resident's care remained poor and not in line with professional guidelines. A review of record keeping was required to ensure compliance with the requirements under Schedule 3 of the regulations.

A number of policies had been reviewed and updated since the last inspection including risk management, complaints and safeguarding. However, these policies were yet to be implemented. In addition the management of risk required review to ensure that it was in line with the centre's newly updated policy.

A review of the complaints policy found that the complaints procedure had not been updated to reflect the updated policy. The changes to the policy had not been communicated to the residents or staff , nor was the procedure displayed in a prominent place in the centre as required under Regulation 34.

Regulation 15: Staffing

The staff roster showed that one nurse was on duty in the centre from 9pm until 8am to monitor and care for up to 56 residents. This was not adequate to meet the care needs of residents, particularly during an outbreak of COVID-19. The number of nurses available on the roster did not reflect the total nurses hours committed to in the centre's statement of purpose.

Judgment: Not compliant

Regulation 16: Training and staff development

A review of the staff training records in the centre found that staff had appropriate access to training as required under regulation 16. Two clinical nurse managers had been appointed to supervise care and ensure care was documented in line with professional guidelines.

This was a completed action from the last inspection.

Judgment: Compliant

Regulation 21: Records

A review of the residents nursing notes found that the daily progress record for a sample of residents notes reviewed were incomplete and did not detail the following:

- a nursing record of the person's health, condition and treatment given in accordance with professional guidelines
- a record of medical assessment and referral. For example, a resident who was displaying signs and symptoms of COVID-19 did not have their test, both antigen and PCR, documented nor was the referral date to the doctor documented.
- a record of when the residents' last received a shower or a bath was not available in the residents' care records.

Judgment: Not compliant

Regulation 23: Governance and management

Whilst inspectors acknowledged that some progress had been made in the governance and management of the designated centre they were not assured that the provider had taken the necessary actions required to bring the centre into

compliance with Regulation 23. This was evidenced by:

- inadequate staffing levels
- poor communication with staff
- lack of quality improvement systems such as audits.
- inadequate nursing documentation.
- poor implementation and oversight of policies and procedures, particularly in relation to risk assessment and safeguarding.

Furthermore, risks identified by the management team, such as fire safety and COVID-19, had not been managed in line with the centre's risk management policy. There was no risk register in place and therefore identified risks had not been assessed and any action taken to mitigate these risks had not been documented. The lack of up-to-date documentation meant that risk assessments and action taken could not be reviewed, evaluated and revised, where necessary. In addition risks were not identified and dealt with by managers and staff on the day of the inspection. For example a power tool and sharp attachments were left unattended along a corridor. This posed a risk to residents passing by who may have picked the tool up. Staff were observed passing through the area but they did not identify the risk and did not report it to senior staff or remove the tool to a secure room.

Judgment: Not compliant

Regulation 34: Complaints procedure

The complaints policy had been updated and reflected the requirements under Regulation 34. However, the changes to the complaints policy had not been communicated to staff and residents and the complaints procedure was not displayed in a prominent place in the centre.

No complaints had been recorded in the complaints log since the last inspection in November 2021.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

The provider has updated the policies in relation to safeguarding, complaints and risk management since the last inspection. A plan was in place to review and update all policies and procedures required under Regulation 4 and this work was ongoing at the time of the inspection.

Judgment: Substantially compliant

Quality and safety

Overall, inspectors found that the daily, face to face care delivered to residents was of a satisfactory standard. Residents told the inspectors that they were well cared for. Staff demonstrated a good knowledge when speaking about or asked about particular residents. However, the continued failure of the provider to implement effective quality assurance and clinical oversight processes posed an ongoing risk to residents in the centre.

Inspectors found continued non-compliance under the following regulations

- Infection control,
- assessments and care planning,
- health care
- residents rights.
- fire safety precautions

Due to the current outbreak visiting restrictions had been reintroduced in line with Health Protection Surveillance Centre (HPSC) guidelines. Routine indoor visits had been suspended but window visits were facilitated. Indoor visiting on compassionate grounds continued to be facilitated.

There was a recently updated COVID-19 preparedness plan in place. However, inspectors found that the centre was not adhering to the cohorting arrangements outlined in this plan.

Inspectors were informed that overall accountability, responsibility and authority for infection prevention and control within the service rested with the person in charge. However, there was no formalised access to a specialist staff with expertise and qualifications in infection prevention and control and antimicrobial stewardship. For example, there was no access to an infection prevention and control nurse, to support, advise and educate infection prevention and control, as outlined in Standard 5.3 of HIQA's National Standards for infection prevention and control in community services.

There was a high uptake of COVID-19 vaccinations amongst the residents and the staff in the designated centre. However, the person in charge had not maintained records of staff's COVID-19 booster vaccine status. This information was necessary to effectively carry out risk assessments to identify and manage health and safety risks to staff and residents within the centre.

Online infection prevention and control training had been completed by all staff. Face-to-face training had also been attended by some staff. However, further on-site training and supervision was required in the areas of infection prevention and

control, and cleaning practices.

There were insufficient local assurance mechanisms in place to ensure that the environment and resident equipment was cleaned in accordance with best practice guidance. The findings identified, relating to environmental and equipment hygiene processes during the inspection, were symptomatic of the lack of a robust infection prevention and control auditing programme.

The centre had an infection prevention and control policy which covered aspects of standard and transmission-based precautions. However, the infection prevention and control policy lacked detail and required review.

Inspectors identified some examples of good practice in the prevention and control of infection. For example, staff were observed using alcohol hand gel after assisting residents. However, the registered provider did not ensure that procedures, consistent with the standards for the prevention and control of health care associated infections published by the Authority were implemented by staff. The lack of sufficient oversight to identify potential risks and opportunities for improvement, were identified in relation to standards: 2.1, 2.3, 2.3 and 3.1. Finding in this regard are detailed under regulation 27.

The risk management policy had been reviewed and updated since the last inspection. Inspectors found that the policy contained all the information required under Regulation 26, however, the content of the policy had not been implemented as discussed under Regulation 23.

The fire safety action plan submitted following the previous inspection was ongoing at the time of the inspection. The provider had installed a number of new fire doors in the centre and the inspectors were informed that the L1 fire alarm system was connected to all areas of the building. However a number of actions were still to be progressed at the time of this inspection.

While the face-to-face delivery of care was reported by the residents to be of a good standard, improvement was required in relation to the assessment and care planning process. A review of the electronic documentation system used to document resident care records found that while nurses had received two training session in relation to assessment and care planning, no improvement had been made to the quality of nursing documentation for each resident. Gaps in resident assessment were noted and care plans did not contain the information required to deliver person-centred care. This posed a significant risk to the resident in relation to ensuring consistent and appropriate care was being delivered in line with residents' assessed needs and preferences.

Residents had good access to their general practitioner (GP) and this was documented and evidenced within the resident's care notes. However, residents had limited access to some allied health care professionals. The poor quality assessment of residents resulted in delays in the referral process to services such as dietitian and speech and language therapy. Inspectors acknowledged that some residents had been referred to these services following the last inspection, however, poor assessment of resident's needs meant that some residents who were at risk of

malnutrition had not been referred to a dietitian.

Furthermore, the residents had reduced accessed to physiotherapy since the position became vacant prior to December 2021. The provider gave assurance that a private physiotherapy service could be sourced if required.

The provider had updated and revised the protection policy in the centre. A review of this revised policy found that it reflected the safeguarding of vulnerable person national guidelines.

Regulation 27: Infection control

Infection prevention and control practices in the centre were not in line with the National Standards for infection prevention and control in community services and other national guidance.

Cohorting arrangements were not in place for residents that had tested positive for COVID-19 infection in line with the centres own COVID-19 preparedness plan.

Environmental and equipment cleaning practices and processes required review. For example;

- Items of equipment including several nebuliser machines, two cleaning trolleys, two hoists, soap dispensers and a blood pressure cuff were unclean.
- Bleach was mixed with a detergent to make a two in one cleaning and disinfection product for floors. There was no evidence available to confirm that these products were either compatible or suitable as a two in one product. The same mop and water was used for up to six bedrooms. Mop buckets were emptied and refilled in resident's en-suite toilets and showers.
- Some surfaces of bed frames and lockers were worn and as such did not facilitate effective cleaning.
- Reusable nebuliser chambers were not rinsed with sterile water and stored dry after each use. The residual volume should be rinsed out with sterile water after use and reusable nebuliser chambers should be stored clean and dry between uses. Medication is delivered directly to the lungs and could, if contaminated, be a source of infection.
- Clean laundry was hung directly above a hand wash sink in the laundry which posed a risk of contamination.
- Used wash-water was emptied down residents' sinks and basins were rinsed in the residents' sinks which posed a risk of cross contamination.

Barriers to effective hand hygiene practice were identified. For example, there was only one clinical hand wash sink for staff use available in centre and that was situated within the 'dirty' utility (sluice) room. This stainless steel sink was visibly unclean and did not comply with current recommended HBN 00-10 Part C specifications. A separate sink for washing resident equipment was not available in this room so it was difficult to determine if the hand wash sink had a dual function.

Using sinks for both hand-washing and the cleaning of equipment should be discouraged as this will significantly increase the risk of hand and environmental contamination.

Open-but-unused portions of wound dressings were observed in the treatment room. Re-use of open but unused wound dressings is not recommended due to risk of contamination.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Improvement was required in relation to resident assessment and care planning. This was evidence by;

- A review of the files of a sample of four residents with a high risk of malnutrition found that they did not have an up-to-date nutritional risk assessment completed.
- Some assessments and care plans were not reviewed in line with regulatory requirements.
- Care plans were not informed by assessments, and therefore did not contain the detail required to deliver person-centred and effective care. For example, a resident who had recently lost weight did not have their assessment or care plan updated with the action to be taken to address the weight loss.
- There was no social care plans developed for residents.
- There was little evidence that care plans were developed with the resident.

This was a repeated non-compliance from the previous inspection.

Judgment: Not compliant

Regulation 6: Health care

The organisation of nursing duties did not ensure that residents received a high standard of evidence based nursing care in accordance with professional guidelines. For example there were two nurses on duty from 8am and throughout the day. However only one nurse was allocated to carry out the medication administration round for 56 resident in the centre. Inspectors were informed that this was managed by half of the residents receiving their morning medicines from the night nurse on duty and these were administered prior to 8am before the night nurse went off duty. This meant that these residents received their medications before the

prescribed time for administration.

The lack of appropriate nursing assessments and reviews meant that a number of referrals for specialist advice and care were delayed. A resident who had been assessed as being at high risk of malnutrition in September 2021 had not been referred to a dietitian and they remained at high risk of malnutrition at the time of this inspection. This was a repeated finding from the previous inspection.

Judgment: Not compliant

Regulation 8: Protection

Inspectors found that staff did not identify a potential safeguarding incident from a report made to them by a resident, and therefore did not follow the safeguarding procedure outlined in the centre's own policy.

Judgment: Substantially compliant

Regulation 9: Residents' rights

A plan to revise the resident meeting record had not been completed in line with the timescale committed to in the compliance plan from the last inspection. A residents meeting was held on day one of this inspection however the minutes of this meeting did not detail the feedback form residents in a way that improvements actions could be identified and shared with the relevant staff. This was not in line with the improvement action outlined in the provider's compliance plan submitted following the previous inspection.

The compliance plan also gave assurance that a bath in an assisted bathroom, that had been removed at the time of the last inspection, would be replaced. This action had also not been completed. This meant that residents did not have a choice in relation to having a bath or a shower.

Judgment: Not compliant

Regulation 28: Fire precautions

An additional fire door had been installed between the main corridor and the kitchen. However the existing fire door between the kitchen and the dining room was found to have intumescent strips that were damaged and coated in grime and did not form a complete seal along the height of the door. In addition the hinges on

this door were coated in grime and appeared to be leaking. The provider undertook to have the door reviewed by their fire safety competent person.

The works to widen the final fire door exits had not commenced at the time of the inspection due to a delay in obtaining planning permission for the structural changes. These works were scheduled to commence shortly.

The fire procedures to be followed in the event of a fire were not displayed in a prominent position throughout the designated centre.

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 15: Staffing	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 27: Infection control	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Not compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Not compliant
Regulation 28: Fire precautions	Not compliant

Compliance Plan for Oakwood Private Nursing Home OSV-0000372

Inspection ID: MON-0034890

Date of inspection: 12/01/2022

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 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Since the inspection, we have rostered a second nurse on night duty and an additional healthcare assistant for the morning shift. We are in the process of recruiting a person in charge to support the registered provider in the operation of the centre.	
Regulation 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: As per our action plan of 4th February 2022, we have implemented a system for recognizing and responding to clinical deterioration. Nursing staff completed training on recognizing and responding to clinical deterioration on Thursday 10th February 2022. We have arranged for a programme of mentoring by an external consultant for individual staff nurses in assessment, care planning and recording clinical practice. This will be completed in March 2022.	
Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management: Since the inspection, we have carried out the following: 1. Formalised written documentation to be completed at handover as outlined in the February 4th action plan. 2. CNMs have specific responsibility for monitoring residents' care daily as outlined in the February 4th action plan. 3. As part of the audit programme for the centre, auditing has commenced in infection prevention and control, including environmental hygiene, use of PPE and hand hygiene. Auditing of care plans had also commenced. 4. We have developed a clinical governance policy and framework for the centre. Key quality indicators for quality and safety monitoring have been established and data collection for same, commenced in February. Members of the clinical governance committee completed an introductory training session on clinical governance facilitated by an external consultant. A meeting of the clinical governance committee has been scheduled for the 22nd February. A standard template for these meetings has been developed and the initial two meetings will be facilitated by an external consultant to provide support and mentorship to the committee. 5. A risk management policy has been developed and an introductory risk management training session has been arranged for the 28th February 2022. 6. The risk register has been updated to reflect current clinical risks and risks related to Covid-19. A copy of the risk register has been placed at the nurses' station and staff will receive training on identifying hazards in the course of their work and the reporting of same. Hazards identified will ither be eliminated at the time or where this is not possible will be risk assessed by the person in charge or deputy and recorded in the risk register. 7. We continue to update our policies and procedures as per the previous action plan. Those completed have been disseminated to staff. Implementation of policies will be overseen by clinical nurse managers and the quality and safety coordinator at floor level as well as monitoring through our programme of key quality indicators auditing and reviewed at clinical governance meetings. 8. A staff meeting was held on the 11th February to discuss issues arising from inspections.	
Regulation 34: Complaints procedure	Substantially Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: The complaints procedure on display has been updated to reflect the complaints' policy for the centre. The updated complaints policy has been disseminated to all staff	

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
The programme for updating the written policies and procedures is in progress.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
1. The centre currently has access to an infection prevention and control specialist through the local public heath team.
2. We have made contact with and hope to engage an infection prevention and control specialist to support, advise and educate staff in infection prevention and control in the centre on an ongoing basis.
3. One of our CNMs has been identified as the IPC lead for the centre.
4. The infection prevention and control policy has been updated.
5. We have commenced specific infection prevention and control auditing on environmental hygiene, use of PPE and hand hygiene. A training session facilitated by an external consultant, on conducting these audits was completed by the person in charge and CNMs on Wednesday 9th February 2022.
6. Written detailed cleaning schedules have been developed and implemented for bedrooms and communal areas.
7. A cleaning schedule for resident equipment has been developed and we will install a clinical sink for same.
8. We will install additional hand hygiene sinks for staff use on bedroom corridors in consultation with IPC specialist.
9. We have upgraded our cleaning trolleys and changed cleaning practice so that mops are not used for more than one room.
10. The centre now uses a combined detergent and disinfectant product.
11. Housekeeping staff have completed refresher training on cleaning and appropriate use of chemicals.
12. We have identified a cleaners' room to be used for cleaners for emptying and refilling of mop buckets and storage of cleaning equipment.
13. Laundry staff have been informed that clean laundry must not be hung above the hand wash sink.
14. Nursing staff have been reminded to dispose of all opened dressings.
15. Additional record keeping by nursing staff has been introduced to monitor the use of antimicrobials in the centre.

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:
As outlined under regulation 21, we have arranged for mentoring of staff in assessment, care planning and recording clinical practice.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
The medication round has been rearranged so that two nurses are allocated to administration of medicines for separate areas in the centre each morning.

As outlined in regulation 21, additional measures have been put in place to monitor residents' healthcare needs on a daily basis and mentoring of nursing staff on assessment, care planning and recording clinical practice is scheduled for March 2022.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
The reference to an alleged safeguarding issue in the report was followed up, investigated and no safeguarding incident had occurred.
This issue and the overall need to comply with the current safeguarding policy was discussed with staff at a staff meeting held on the 11th February 2022.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:

The minutes for residents' meetings have been updated to include a record of all issues, concerns and complaints, actions to address same, responsible person and follow up of same. The bath referred to in the report has been returned to the assisted bathroom.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: New Fire exit fire doors are on order and are expected to be sited by April 1st. Replacement intumescent strips, repairs to fire doors and ironmongery are a work in progress and will be in place by 1st April. 2 copies of fire procedures are now on display on each corridor.

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 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	18/02/2022
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Not Compliant	Orange	30/04/2022
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the	Not Compliant	Orange	18/02/2022

	effective delivery of care in accordance with the statement of purpose.			
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	28/02/2022
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	01/04/2022
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Orange	01/04/2022
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape,	Not Compliant	Orange	30/04/2022

	including emergency lighting.			
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	30/04/2022
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	30/04/2022
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	30/04/2022
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	30/04/2022
Regulation 34(1)(a)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall make each resident and their family aware of the complaints procedure as soon	Substantially Compliant	Yellow	18/02/2022

	as is practicable after the admission of the resident to the designated centre concerned.			
Regulation 34(1)(b)	The registered 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.	Substantially Compliant	Yellow	18/02/2022
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.	Substantially Compliant	Yellow	01/04/2022
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Not Compliant	Orange	30/04/2022
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social	Not Compliant	Orange	30/04/2022

	care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.			
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	30/04/2022
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	30/04/2022
Regulation 5(5)	A care plan, or a revised care plan, prepared under this Regulation shall be available to the resident concerned and may, with the consent of that resident or where	Not Compliant	Orange	30/04/2022

	the person-in-charge considers it appropriate, be made available to his or her family.			
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.	Not Compliant	Orange	30/04/2022
Regulation 6(2)(c)	The person in charge shall, in so far as is reasonably practical, make available to a resident where the care referred to in paragraph (1) or other health care service requires additional professional expertise, access to such treatment.	Not Compliant	Orange	18/02/2022
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Substantially Compliant	Yellow	18/02/2022
Regulation 9(3)(a)	A registered provider shall, in so far as is	Not Compliant	Orange	18/02/2022

	reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.			
Regulation 9(3)(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	18/02/2022