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:	Hollybrook Lodge
Name of provider:	St James's Hospital
Address of centre:	St Michael's Estate, Bulfin Road, Inchicore, Dublin 8
Type of inspection:	Unannounced
Date of inspection:	30 November 2022
Centre ID:	OSV-0005053
Fieldwork ID:	MON-0038398

About the designated centre

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

Hollybrook Lodge provides residential care to 50 residents, with 46 resident beds and 4 respite beds. All residents and patients cared for in Hollybrook Lodge have access to specialist medical and nursing care, a wide range of support therapies including Physiotherapy, Clinical Nutrition, Medical Social Work, Speech & Language therapy and specialist aged-care services & treatments including Old Age Psychiatry, Bone Health, and Memory Clinic. Hollybrook is a secure, bright, purpose built two storey structure with stairs and a lift. There are two units, Robinson Unit on the ground floor, and the McAleese unit on the first floor. Each unit provides accommodation for 25 residents. There is an enclosed garden for resident's use adjacent to and behind the building. The family room is located on the first floor and there is an external designated smoking area for residents. The philosophy of the centre is to provide holistic person-centred care that promotes and safeguards the well-being and rights of each individual. The ethos of the centre is to create and maintain a suitable space for each resident ensuring individual privacy with space for their personal belongings and possessions in addition to facilitating recreational activities. The Hollybrook Lodge Residential Care Centre is managed by the Medicine for the Elderly Directorate of St James Hospital. The scope of the directorate services comprises acute in-patient, rehabilitation, out-patient, day care, transitional care, residential care and community outreach.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	45

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 30 November 2022	10:00hrs to 18:20hrs	Michael Dunne	Lead

What residents told us and what inspectors observed

From what residents and visitors told the inspector, and from what the inspector observed, residents were happy with the care that they received within the centre. Residents seemed content in the company of staff and inspectors observed many positive interactions between staff and residents during the inspection. The inspector observed a calm and relaxed atmosphere in the centre with residents in receipt of timely support from the staff team. Residents were smartly dressed and were found to be wearing suitable clothing and footwear.

Prior to accessing the centre, the inspector had a temperature check carried out by staff however the required checks on any signs and symptoms of ill health, hand hygiene and the wearing of PPE (personal protective equipment) were not completed.

Following an initial meeting with the person in charge the inspector carried out a tour of the centre where they met and spoke with residents and staff. The centre consists of two units located on the ground and first floors each providing accommodation for 25 residents. There were a range of communal facilities available for residents to use, which were suitable in size and appropriate for the number of residents living on each unit. Fixtures and fittings were well-maintained, the centre was tastefully decorated, and resident's were observed to be comfortable in their surroundings. There was unrestricted access to a secure garden area, which was available for residents and visitors to use.

The inspector spoke directly with a number of residents. Feedback from residents was positive, those who expressed a view said staff were kind, caring and that they were well looked after. All residents spoken with said that they felt safe in the centre, and also mentioned that if they had a concern or a problem that staff would sort it out for them. Some residents described the daily support provided by the staff team which consisted of personal care support and assistance to keep their rooms clean and tidy. Other residents described how staff come around with their tablets a few times a day.

Residents gave feedback on the meals service, and said that they liked the choice of food available in the centre. Residents were presented with options of meals on a daily basis and where these options was not suitable then an alternative meal could be provided. Residents also said that they could have their breakfast served in their bedrooms if they wished.

Residents who displayed responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment) had care plans in place to support and protect them from harm. It was clear from observing staff interventions that they had the skills and abilities to ensure that resident's were supported in a dignified manner and that residents were protected. The provider had arrangements in place to

allocate additional staff support where needed to maintain residents safety.

The inspector observed resident attendance at planned activities throughout the day. Residents were supported to engage in activities according to their capacities and capabilities. Where resident's were unable to participate in group activities then one to one support was provided and assistance given for residents to engage in activities suitable to them. Residents views on the activities provided was positive, they were content with the variety of things to do. Residents who expressed a view mentioned that they particularly like the musical bingo and the organised trips to local places of interest. The provider ensured that the centre maintained links with the local community with combined activities organised with local schools and community centres.

The inspector spoke with residents attending a residents committee meeting on the day of the inspection. Residents said that they had opportunities to discuss the quality of the service at these meetings. A review of records indicated that these meetings were well-attended with 21 residents observed to attend a meeting in March 2022. The annual review for 2022 had been completed by the provider and incorporated the views of residents and family members on the quality of the service provided.

The next two sections of this report will present findings of this inspection in relation to the governance and management arrangements in place and on how these arrangements impact on the quality and safety of the service provided.

Capacity and capability

This centre was well-managed with management systems in place ensuring that a quality person centred service was delivered to the residents. The management team were proactive in addressing issues that arose, however the inspector found non compliance with a number of regulations where actions were needed by the provider to ensure that the service was safe, appropriate, consistent and effectively monitored. This included improvements required under Regulations relating to Governance and Management, Training and Development, Records, Notifications and Complaints.

This was an unannounced inspection of Hollybrook Lodge to review on-going compliance with the regulations and to follow up on actions the provider had committed to take as part of their compliance plan from the previous inspection.. The centre is part of St. James's Hospital group, and had its own internal governance structures, as well as clearly defined links with the managers of St James's hospital. The well defined internal governance structure was maintained since the last inspection in November 2022. The Chief Executive Officer (CEO) and senior management team are responsible for the operational management of the services provided by Hollybrook Lodge. Feedback for this inspection was provided via zoom presentation post inspection as there were no members of the provider

team available to receive feedback on the day of the inspection. A number of records were required to be submitted post inspection as there were no managers available to make these records available to the inspector on the day.

The person in charge was in their current role since the last inspection and were suitably qualified to carry out their role. They reported to the CEO and the assistant director of nursing who were based in St. James's Hospital. The person in charge was supported by four clinical nurse manager's and a team of nurses,health care assistants, catering and ancillary staff. The housekeeping service was outsourced to an external contractor who monitored this service.

There was a dedicated staff team available in the designated centre to provide timely support to the residents. Residents who required assistance with their mobility or personal care support were assisted in an appropriate person centred manner. Staff were aware of the needs of the residents and this ensured that the support was tailored to residents individual needs.

Records relating to mandatory training which were provided post inspection did not provide assurances that staff were being facilitated to keep up to date with their mandatory training requirements in line with the centre's own time lines set by the provider. The records submitted to the inspector showed that a number of staff required updated training and this meant that staff may not be up-to date with current practice.

While there were a number of oversight and monitoring meetings which were well-established and well-documented there were areas of the service which were not reviewed in governance meetings. A review of governance meeting minutes found that complaints and fire safety issues relevant to the centre were not reviewed. This meant that learning opportunities to improve the service from complaints received and from feedback relating to fire safety were missed. There was an auditing system in place which monitored key service areas, where improvements were identified, quality improvement plans were found to be in place. The inspector was informed that audits relating to infection prevention and control were conducted by an IPC link practitioner in St James Hospital, who was provided with relevant information by the management team. From a review of storage arrangements found in the centre on this inspection and on the poor oversight of cleaning records this current method of audit review required amendment to ensure that areas of poor practice were being identified and addressed.

Generally complaints were well managed and were in line with the requirements of centre's own complaints policy however one complaint was not fully recorded or processed in line with this policy.

The inspector reviewed a range of clinical, procedural and operational records as part of the inspection and on balance they were well maintained However there were lapses in terms of accuracy and sufficiency found regarding the upkeep of records which are described under the relevant regulations.

While the provider was keen to ensure that restrictive practices were kept to a minimum in line with national guidance, not all practices that could potentially

impact on residents freedom to mobilise around the centre were recorded or referred to the Office of the Chief Inspector in line with Regulation 31.

Regulation 15: Staffing

The registered provider ensured that there were sufficient staffing levels and an appropriate skill-mix across both units of the designated centre to meet the assessed needs of the residents. The provider maintained rosters to identify where staff resources were being used in the centre, however there were some gaps identified where rosters did not identify the attendance or changes in staff working in the designated centre. This is discussed in more detail under Regulation 21 Records.

Judgment: Compliant

Regulation 16: Training and staff development

Records relating to mandatory and supplementary training were not made available for the inspector to review on the day of the inspection. The registered provider submitted training records post inspection, a review of these records submitted indicated that staff did not have access to appropriate training for example:

- A significant number of staff did not receive their annual training in fire safety.
- Records reviewed indicated that a number of staff required updated training in manual handing
- There were still a number of staff who required up-to date Infection Control training in line with the designated centre's policy.

Judgment: Substantially compliant

Regulation 21: Records

The registered provider did not ensure that records set out under Schedule 3 and Schedule 4, were accessible for the inspector to review on the day of the inspection.

A number of additional Schedule 3 and 4 records were not sufficiently maintained and therefore did not give an accurate account of current practice for example:

- The person in charge was not entered onto the designated centre's roster.
- One complaint was not completed in accordance with the centre's policy on

complaints.
- Not all notifications were submitted in line with the regulations.
- A care record did not give rationale or record reasons behind the issuing of a PRN (when required) medication to a resident.

Judgment: Not compliant

Regulation 23: Governance and management

There were a number of actions required on behalf of the registered provider regarding their monitoring systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored. This was evidenced by:

- Poor oversight regarding the monitor of training and development of staff. Training records provided post inspection showed significant gaps in the training provided for mandatory training such as fire and manual handling. The inspector was not assured in relation to the accuracy of the records received as there was a contradiction notes in records relating to staff attendance at safeguarding training.
- While there was management oversight and records relating to regular governance meetings, the agenda which did not include a review of complaints or the information review for fire safety
- Current arrangements for the auditing of infection prevention and control were ineffective and did not identify areas that required improvement.
- Oversight of cleaning records required review. Although the centre was found to be clean with no malodours present at the time of the inspection, cleaning records were found to be inconsistent with the levels of cleaning completed. For example, a store room which records indicated was cleaned daily was found to be not clean and tidy on the day of the inspection.
- Risk assessments were not in place to identify the hazards relating to the storage of Oxygen cylinders in the centre.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The registered provider had prepared and revised the statement of purpose which was found to be updated on 1st October 2022. The document had been revised to incorporate information set out under schedule one of the regulations.

Judgment: Compliant

Regulation 31: Notification of incidents

Not all incidents which required a written report to be submitted to the Chief Inspector on a quarterly basis were received in line with incidents set out under paragraphs 7(2) (K) t (n) of Schedule 4. For example:

- The use of sensor alarms which had the potential to limit residents free movement had not been notified to the Office of Chief Inspection in quarterly notifications.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

There was a complaints policy in place and this was updated in line with regulatory requirements. Records of complaints were generally well-maintained and the inspector observed that most complaints were investigated in accordance with the centres complaints policy. The recording of one complaint however required improvement. The description and details of this complaint were unclear and not signed by the staff member receiving the complaint. Details regarding whether the complainant was satisfied or not with the conclusions of the investigation were not recorded. The provider submitted additional details regarding the handling of this complaint post inspection.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

The registered provider maintained a suite of policies and procedures which met the requirements of Schedule 5 of the regulations. Oversight of policy development and update was now localised and maintained in house. Discussion with staff confirmed that they had access to all policies and procedures designed to guide and inform current practice.

Judgment: Compliant

Quality and safety

Overall, residents were supported and encouraged to have a good quality of life which was respectful of the rights, and where residents were assisted make informed decisions about all aspects of their care. There was evidence that the provider had developed forums to encourage and promote resident and family feedback on the quality of the service. There were however areas of service where actions were needed to ensure the service met the assessed needs of the residents. In addition actions were required in relation to infection control and premises as findings on this inspection indicated repeated non-compliance with the regulations.

There was well-organised access to medical services with a medical practitioner assigned to provide regular support to the designated centre. In addition geriatric and psychiatry of old age services were available upon request. Monthly MDT (multi-disciplinary team) meetings were held on a monthly basis to provide clinical oversight of residents care. Additional supports in place to assist in the delivery of quality care included physiotherapy,occupational therapy, social work and allied health care input from speech and language therapists and dietitians.

Resident Care plans were well written and reflected residents individual assessed needs. There were clinical and social care assessments in place which guided staff intervention. All care plans reviewed on inspection confirmed that care plans were reviewed at least every four months in line with the regulations or as and when there was a significant change in resident's needs. Residents were supported to engage in the review process with their views and preferences incorporated into the relevant care plan.

There was a dedicated member of the team leading on the provision of activities. On the day of the inspection there was an organised music event underway which was well-attended by resident's,. Information on key events and the activity schedule were advertised in prominent locations across the centre. A resident newsletter letter had recently been established and this provided valuable information for residents and their families on the upcoming events and on key information about the service provided in the centre.

A resident's committee meeting was being held the day of the inspection and was organised and co-ordinated by a clinical nurse manager based in St James Hospital. Records indicated that resident meetings were held on a quarterly basis, and there was evidence that residents were kept updated on topics discussed. The residents meeting agenda covered all aspects of the service that were important to residents such as activities, outings, catering and laundry service's. There was access to advocacy services available for residents and this was advertised in the designated centre.

There were no limits to visiting at the time of this inspection with visiting arrangements aligned with national guidance. The inspector observed family members attending the centre throughout the day.

The designated centre was generally well-maintained and clean. The designated centre comprises of two units, one on the ground and the other on the first floor, both providing accommodation to 25 residents. The designated centre was tastefully

decorated with Christmas decorations and there was a calm and relaxed atmosphere found on both units. There were no malodours found in the centre which was found to be well-ventilated.While inappropriate storage in assisted bathrooms had ceased since the last inspection the inspector found inappropriate storage in the storage units on both the ground and first floors. The doors to these units were open and could have been accessed by residents. In addition the storage in these units were unsafe due to the volume of items and the manner in which there were stored. For example, a range of clinical and non clinical were items were being stored in close proximity to each other, many of which were stored on the floor.

The inspector found that oxygen cylinders were been stored in a clean utility room. There was no indication or warning sign in place to inform staff entering this room of this potential hazard. Best practice indicates that oxygen cylinders be stored in a locked facility preferably in a locked cage containing the relevant hazard warning sign.

The inspector found a number of practices to promote effective infection control in the centre which included well- maintained sluice facilities, good adherence to standard precautions by staff members and a well-organised laundry service, however there were areas where improvement was needed, for example:

- The appropriate storage and segregation of clinical and non-clinical equipment to reduce the risk of cross contamination in the designated centre.
- More robust measures to ascertain visitors well-being status upon entry to the designated centre. This is standard practice and would assist in identifying visitors who may be unwell and pose an infection risk to the residents and staff in the designated centre.
- The monitoring of cleaning practices required improvement to ensure that all areas of the centre were cleaned to a good standard and that the cleaning records were accurately maintained.

Regulation 11: Visits

There were no restrictions to visits at the time of the inspection with current visiting arrangements in line with national guidance.The inspector met with visitors during the inspection and those who expressed a view were content with the current arrangements. Residents were observed to received visitors in their own rooms or in communal areas. Visiting risk assessments were maintained and updated by a designated staff member.

Judgment: Compliant

Regulation 17: Premises

Action was required to ensure compliance with regulation 17. This was evidenced by;

- Inappropriate storage of equipment, found in both of the units that comprise the designated centre. For example, storage areas contained resident mobility equipment, open incontinence products, resident hoist slings, furniture and boxes of PPE (personal protective equipment) stored on the floor, which impeded effective cleaning.
- The storage of oxygen cylinders in the clean utility was unsafe, there was no sign indicating that these items were being stored in this facility.

Judgment: Substantially compliant

Regulation 27: Infection control

Effective infection prevention and control measures were hampered due to:

- Poor segregation regarding the storage of clinical and non clinical items which increased the risk of cross contamination and infection spread in the centre.
- Lack of effective sympthom checking at the point of entry to the centre.
- Poor oversight of cleaning records.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Care planning documentation was available for each resident in the designated centre. Records indicated that all residents had an assessment of their needs carried out before being offered a place in the designated centre. This was carried out to ensure that the service available would be able to meet the assessed needs of the residents. Records reviewed indicated that residents were consulted about their care preferences and where this was not possible then consultation and collaboration was conducted with relevant family members.

Judgment: Compliant

Regulation 6: Health care

The registered provider had arrangements in place which ensured that appropriate medical and specialist healthcare supports were in place to address residents

medical requirements. Where interventions were required the person in charge co-ordinated access to these supports in a timely manner. There were systems in place to monitor the quality of healthcare provision such as audits and the monitoring of key performance indicators such as falls management, wound care and resident nutritional needs.

Judgment: Compliant

Regulation 9: Residents' rights

The registered provider ensured that residents individual health and social care needs were assessed prior to admission to the designated centre. Residents needs assessments also gathered key information in relation to residents religious, racial, cultural, linguistic and communication needs, in order to assist the provider develop person centred care plans with a focus on residents rights. There were opportunities available for residents to participate in activities in accordance with their interests and capacities.

There was a well-developed programme of activities which included both in-house activities and activities in the community which included visits to local libraries, parks, cafe's and other places of interest.

Residents were observed to have access to newspapers, radios, TV's and other media. On the day of the inspection a number of resident events were organised which included a resident's committee meeting and a music session activity which was enjoyed by the residents who attended.

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	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Substantially compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 27: Infection control	Substantially compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Hollybrook Lodge OSV-0005053

Inspection ID: MON-0038398

Date of inspection: 30/11/2022

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Liaise and work with education and training providers to ensure Hollybrook Lodge's staffs' mandatory training needs are addressed in a timely fashion. The training records of all staffs will be reported on and reviewed at the local monthly nurse management meet in Hollybrook lodge and then also discussed and verified at the bi monthly residential care operational and quality review group (RCOQRG) meet. Records will be actioned if and as appropriate and in a timely manner.	
Regulation 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: - PIC's duty roster printed weekly and readily available. - Requirement for the follow up of local complaints procedure reinforced with all CNMs - The use of sensory alarms will now be registered under NF39 A quarterly notification forms.	
Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management: Mandatory trainings records will be reviewed, discussed and actioned as appropriate at the monthly Nurse Manager meets and also the bi monthly RCOQRG meet forum. Risk issues, safety concerns and complaints will be tabled for discussion at the Nurse Management monthly meetings and also the bi monthly RCOQRG meet forum. Clinical and non-clinical items are now stored separately. Cleaning audit tool reviewed and updated to reflect the needs of the environment. Oxygen cylinder placement discussed with Fire Safety officer and appropriate area for storage decided upon with clear signage identifying same. Hygiene and safety assessment audit results for the Lodge to be discussed at the Nurse Management monthly meetings and also the bi monthly RCOQRG meet forum and actioned if and as appropriate in a timely manner.	
Regulation 31: Notification of incidents	Substantially Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: All sensory alarms will be recorded under NF39A quarterly notifications going forward..	
Regulation 34: Complaints procedure	Substantially Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: Requirement for the follow up of local complaints procedure reinforced with all CNMs. CNMs to review records on a weekly basis as part of their local documentation audit. Resident's feedback on complaints to be included and recorded in the local complaint log. The results of these audits will be discussed at the monthly nurse management meets and also escalated for discussion at the RCOQRG forum on a bi- monthly basis if and as appropriate.	

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Dedicated storage room is now allocated for clinical and non-clinical storage.
Linens to be stored in linen rooms only.
Oxygen cylinder placement discussed with Fire Safety officer and appropriate area for storage decided upon with clear signage identifying same.

The monitoring and audit of storage spaces will be included in the environmental hygiene and safety monthly audit going forward to ensure they are maintained and safe to meet the needs of the residents and staffs.
The results of both ward monthly audits will be discussed locally at the nurse management monthly meet and actions if required will be escalated as appropriate.
These results will also be discussed at the bi monthly RCOQRG meet.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
-Dedicated storage room is now allocated for clinical and non-clinical storage.
-Linens to be stored in linen rooms only.
-Upon entry to facility, security personnel are now tasked with completing a full infection prevention and control screen on entrance. Template for same has been revised and provided.
-Cleaning contract manager tasked to modify daily ward cleaning checklist to reflect appropriate tasks.
- Environmental hygiene assessment audit completed monthly by CNMs to be completed in liaison with the cleaning supervisor.

-CNMs to report at the monthly Nurse Manager meet on the results of their audits and actions if and as appropriate.
-Results for both ward areas for discussion at the bi monthly RCOQRG meet forum along with mandatory training records for Infection, prevention and Control for all staffs.

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	28/04/2023
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	24/02/2023
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	01/02/2023
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to	Not Compliant	Orange	01/02/2023

	be safe and accessible.			
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	28/04/2023
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 staff.	Substantially Compliant	Yellow	10/02/2023
Regulation 31(3)	The person in charge shall provide a written report to the Chief Inspector at the end of each quarter in relation to the occurrence of an incident set out in paragraphs 7(2) (k) to (n) of Schedule 4.	Substantially Compliant	Yellow	31/01/2023
Regulation 34(1)(f)	The registered provider shall provide an accessible and effective complaints procedure which includes an	Substantially Compliant	Yellow	01/02/2023

	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.			
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 recorded and that such records shall be in addition to and distinct from a resident's individual care plan.	Substantially Compliant	Yellow	01/02/2023