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:	Orwell Private
Name of provider:	MCGA Limited
Address of centre:	112 Orwell Road, Rathgar, Dublin 6
Type of inspection:	Short Notice Announced
Date of inspection:	17 September 2020
Centre ID:	OSV-0000078
Fieldwork ID:	MON-0030461

About the designated centre

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

The designated centre is set in south Dublin close to local amenities such as bus routes, restaurants, and convenience stores. It is made up of a period premises that has been adapted and extended to provide nursing care and support through a number of units. The units provide bedroom accommodation alongside communal areas including sitting and dining areas and a kitchenette that are homely in design. Bedroom accommodation is a mix of single and double rooms, in the new areas of the centre the bedrooms are en-suite. Additionally on the premises there is a full time hair dressers, cafe, gym, library and training rooms. The provider is registered to offer 170 beds to male and female residents over the age of 18. They provide long term care, short term care, brain injury care, convalescence care, respite and also care for people with dementia.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	148

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
Thursday 17 September 2020	09:00hrs to 19:00hrs	Michael Dunne	Lead
Thursday 17 September 2020	09:00hrs to 19:00hrs	Deirdre O'Hara	Support

What residents told us and what inspectors observed

On entering the designated centre the inspectors had their temperatures taken and were asked to adhere to a range of infection prevention and control processes. On entering the garden area leading to the centres entrance inspectors observed family members meeting with relatives in a designated area which observed social distancing requirements.

The centres hairdressing salon, shop and café were shut in order to comply with public health guidelines. These facilities were now used to store seating which had been moved to comply with social distancing requirements.

In addition pictures had been removed from walls to comply with infection prevention and control measures as they were non wipeable. The provider mentioned that the loss of all these facilities had impacted negatively on the residents and on the provider's ability to provide a homely environment.

The inspectors met with residents throughout the inspection and all residents spoken with said they were happy with the service they were receiving. One resident said that they were content with their bedroom and added that it was well maintained by the cleaning staff.

Some residents told the inspector that they were happy with the care staff and felt that their health and social care needs were met,while another resident said there was not much activities happening due to the restrictions resulting from the outbreak of COVID-19.

Inspectors observed that some residents were in their rooms while others were seen to be engaged in a socially distanced activity. In one unit where a number of residents were COVID-19 positive, it was observed that these residents were separated from the rest of the unit with each area staffed by their own staffing cohort.

Capacity and capability

The registered provider entity is a limited company called MCGA limited and is also the registered provider entity of one other designated centre in the Dublin area. The provider proactively acquired sufficient supplies of personal protective equipment (PPE) to meet the needs of the staff team during the pandemic.

This risk inspection was prompted due to the occurrence of significant outbreak of COVID-19 in the centre including concerns relating to the management of the

outbreak. Inspectors followed up on advice given to the centre by public health and found that the provider had made changes to comply with infection prevention and control measures which included the cohorting of detected cases. Inspectors also followed up on concerns relayed to the office of the chief inspector by the provider themselves where four residents transferred to a convalescence unit did not receive health and social care support for a period ranging from 8am until 2pm. Inspectors also followed up on a number of unsolicited receipts of information regarding concerns around staffing, the availability of PPE, and arrangements for resident to receive visits.

Orwell Private experienced an outbreak of COVID-19 on 19 August 2020. During the outbreak 12 residents and 13 staff members had a diagnosis of cases detected for COVID-19. At the time of the inspection there were nine residents detected and five staff members detected. The nine detected cases were located in two units of the home, four in a convalescence unit and five located on a unit where these residents were segregated from the rest of the residents on that unit. Sadly the provider has reported the passing of five residents due to or related to COVID-19.

Inspectors found there were governance and management structures in place to monitor the delivery of quality services to the centres residents. There were however some areas that needed review including a refocus on staff training and development needs in relation to infection prevention and control training and a review of communication systems to ensure consistency across the service.

Inspectors found that while there were oversight systems to monitor the safety and quality of service in the centre, the provider's systems had failed to prevent a significant incident that impacted on the safety of four residents, which is discussed further under Regulation 23, Regulation 8 and Regulation 6 below.

Overall the centre was well maintained with each unit having its own dining and sitting room facilities. Areas of the centre that required decoration and upgrade are described under regulation 27. Access to communal facilities such as the shop, café and hairdressing were suspended due to COVID-19.

Inspectors found that not all information requested prior to the inspection visit was available for full review on the day. This resulted in the inspectors having to request additional information throughout the day. It was noted that the provider did submit requested information post inspection.

The training roster indicated there were gaps in Infection prevention and control training with 18% of staff requiring updated training. The provider submitted a training matrix for Infection, prevention and control training post inspection.

Regulation 15: Staffing

There was a recruitment drive in place with a focus on recruiting care personnel to the centre. Inspectors noted that the provider had already recruited a number of

permanent staff comprising of a director of nursing, clinical nurse manager, staff nurses and health care assistants had been recruited since March 2020. Information provided to inspectors regarding staff retention showed that there was no increase in staff turnover since the beginning of the pandemic. Details presented to the inspectors comprised of data related to permanent staff who had left the centre and did not include staff who did not pass their probationary period.

The designated centre had encountered significant levels of staff sickness since the announcement of the pandemic in March 2020, however, this had improved over recent months with the centre engaging with recruitment agencies to cover staff absence as well as using their own bank staff.

All units seen on the day of the inspection had a staff nurse as part of the staffing complement. Inspectors were informed that the provider had arranged for the transfer of staff from another unit to cover a unit in order to maintain a safe staff to resident ratio. There was an issue regarding a convalescence unit which was not staffed for a period of six hours which will be discussed further under Regulation 8 regarding protection.

Judgment: Compliant

Regulation 16: Training and staff development

Inspectors reviewed training records which were supplied after requests. These records indicated that there were good attendances at mandatory training such as fire safety training, moving and handling and safeguarding. There was a range of supplementary training which included access to training on medication, dementia, restrictive practice and food safety.

Records seen indicated that at least 18% of staff required Infection prevention and control training. Inspections were informed that this training was scheduled for the week after the inspection. Records not available at the time of the inspection regarding this training were provided post inspection. Staff were supported to engage with online infection prevention and control training via HSEland with advice and information relayed to staff at handovers, at daily huddle meetings and monthly meetings which the centre referred to as town hall meetings.

Staff spoken with during the course of the inspection mentioned that they found training very useful in supporting their day to day work. All staff spoken with confirmed they had an induction and were supported through mentoring and by shadowing more experienced personnel. Inspectors noted that there were 10% of staff currently in the induction period of their employment. Arrangements for staff appraisal were in place and were held at six weeks, six months and on an annual basis.

The centre had a practice development nurse which augmented the training

schedule and provided practical and education support to the staff team.

Judgment: Substantially compliant

Regulation 23: Governance and management

There was a well-defined management structure in place with clear lines of responsibility and accountability. The director of care was supported in their role by a director of nursing and three additional assistant directors of nursing. A team of Clinical Nurse managers had responsibility for managing the centre's staff nurses and healthcare assistants.

The centre was well resourced however a unit located in Orwell required its décor to be updated. Inspectors were informed that a number of rooms would be updated with tracking for hoist use which would improve the moving and handling experience of residents. Inspectors noted that the provider had reassigned staff to two units on the day of the day of the inspection to maintain safe staffing levels.

The centre had maintained its stocks levels of personal protective equipment (PPE) and had arrangements in place to maintain appropriate levels to meet the requirements of the staff team.

Clinical audits were in place to monitor resident care needs with oversight arrangements maintained through multidisciplinary team meetings. There was an effective appreciation of risks present in the centre with the risk register subject to regular review.

While the provider had governance and management arrangements in place, inspectors found these assurance arrangements were not robust and failed to prevent or immediately identify a significant incident which occurred where residents in one part of the centre were unprotected, and were left without staffing support, meals and medication from 8am to 2pm. This occurrence significantly increased the risk to safety for residents during this time and fortunately for the residents involved, their famlies and the provider, the incident did not result in more serious harm for residents. This is discussed further under Regulation 8 below.

Judgment: Not compliant

Regulation 34: Complaints procedure

There was a current complaints policy in place which was updated in June 2020 and was located at various points throughout the building. The policy outlined the procedure to follow in registering a complaint, it also detailed the nominated person who would oversee the complaint and provided information on feedback and on

appeals should the complainant be unhappy with the outcome.

Records indicated that the centre had recorded 16 verbal and seven written complaints in quarter three with 23 complaints registered for quarter two which covered the months of April, May and June. Only two complaints were still at an open stage from quarter two with 21 complaints now closed.

There were seven open complaints registered during the months of July, August and September all of which were under investigation or nearing closure. The nature of complaints ranged from family members concerned about visiting arrangements to see their loved ones to concerns raised that residents were being asked to stay in their rooms. A number of complaints raised by residents and family members alike focused on poor communication from staff members.

There was evidence available to indicate that the centre was keen to learn from complaints received with complaints reviewed on a quarterly basis at the complaints governance meetings. Inspectors were informed that there was complaints training scheduled for later in the year.

Judgment: Compliant

Quality and safety

The inspection found that there were improvements needed to ensure that a good standard of care was delivered on a consistent basis. These included ensuring that all residents were protected from incidences of neglect and that their rights were protected by ensuring ongoing and timely access to care and welfare support from the staff team.

A review was required regarding the recording of activity support to residents. Whilst all care records seen showed that residents likes and dislikes regarding their activity preferences were recorded by the centre there were significant gaps in records relating to resident participation at activity sessions. In addition during the period of restricted visiting inspectors were unable to evidence the precise nature of the one to one activity support residents received.

Inspectors found that there was good access to external medical and healthcare services with arrangements in place to access GP services and specialist services such as psychiatric care and palliative care services. There were robust arrangements in place for timely access to speech and language therapists, dieticians, and tissue viability nursing. Input from these service were recorded in residents care records.

A review of the designated centres infection prevention and control protocols was needed. While it was acknowledged that the centre had made changes in ensuring that their infection prevention and control programme was effective on the ground

there were still elements of this programme that still required review. A focus on cleaning procedures, storage of items in an appropriate manner and the cleaning of clinical monitoring equipment required review with the latter also highlighted in the previous inspection.

Inspectors found that residents care plans were well written and were evidence based. There was evidence of input from specialists with care plans altered to take account of changes in treatment plans. Care input was monitored internally through a system of audits, key performance indicators and multidisciplinary team meetings.

There was evidence available to suggest that the centre kept families and residents updated on the pandemic. The provider remitted newsletters to residents and designated care personnel which contained information relating to changes in visiting routines, testing and the swabbing of residents.

Regulation 11: Visits

Inspectors reviewed the current visiting arrangements for families to the centre as a result of unsolicited information regarding visits, received prior to the inspection. On entry to the centre inspectors observed family members visiting their loved ones in the garden area. There were arrangements in place which adhered to social distancing and the appropriate wearing of personal protective equipment (PPE).

Inspectors reviewed records relating to visiting and were able to confirm that during the months of June, July and August an average of 21 visits were provided each day with each visit lasting 15 minutes in duration. Evidence seen on inspection noted that the provider had communicated with family members during the period of lockdown and had provided updates on visiting, testing and the swabbing of residents.

Where visits could not occur there was evidence to show that residents were supported to liaise with their loved ones via online platforms or through social media.

Concessionary visits were also catered for where residents were at end of life.

Judgment: Compliant

Regulation 26: Risk management

There was a risk management policy in place which detailed the responses the provider was required to undertake to reduce incidents of risk in the centre. This was done through process of risk assessment which evaluated risks and identified

measures to mitigate risks from a clinical and operational perspective.

There was good oversight in place with the risk register updated and reviewed on a regular basis. The centres safety statement was updated in May 2020. There was an emergency plan in place to respond to major incidents including COVID-19.

A comprehensive COVID-19 risk assessment had been completed and there were robust contingency controls in place which included workforce planning, resources, infection control and environmental hygiene, catering and visiting arrangements.

Judgment: Compliant

Regulation 27: Infection control

During this COVID-19 outbreak, records showed that there were formalised arrangements in place to manage the COVID-19 outbreak in the centre. The director of clinical services, person in charge and heads of department liaised closely with Public Health and frequent outbreak control meetings were seen in communication documentation between them. The Health Protection Surveillance Centre Interim Public Health, Infection Prevention and Control Guidelines on the Prevention and Management of COVID-19 Cases and Outbreaks in Residential Care Facilities guidance was available in the centre.

There was on-going monitoring of staff to identify signs or symptoms of COVID-19, which was documented before staff entered the building. A lack of records showing monitoring of staff did not give the provider assurances that all staff were being checked a second time during their work shift. Staff were aware of the local policy to report to their line manager if they became ill. Staff who spoke with inspectors were aware of atypical presentations of COVID-19 and the need to report promptly to the nurse in charge any changes in residents baseline. Visitors to the centre were also seen to be checked for symptoms of infection before they could enter the centre and there was personal protective equipment (PPE) available for their use.

There was appropriate infection prevention and control signs on display around the centre. Isolation areas were well signposted for staff entering this area. Social distancing measures were observed by staff when they were on break and seating arrangements in dining areas ensured a safe distance for residents. There was a uniform policy in place which directed staff to change into and out of work clothes at the start and end of a shift. Audits were undertaken to monitor compliance with the policy. Results showed there was 99% compliance by staff in the audit carried out in August 2020.

The person in charge had ensured that all staff working in the centre had been provided with the opportunity to attended the required training in infection prevention and control, however 18% of staff had not attended training. Inspectors were informed that training was scheduled in the weeks following the inspection. Training records showed that 10 staff were trained to take swabs for the detection

of COVID-19 in the centre.

There were good systems in place to ensure appropriate PPE was available in line with current guidance. Staff were observed donning and doffing (putting on and taking off) PPE in the correct sequence. Hand hygiene practice and correct use of PPE was good on the day of inspection.

There were safe laundry and waste management arrangements in place. Clean and dirty laundry were separated and laundry staff were knowledgeable about infection prevention and control.

Infection prevention and control audits had recently commenced in the centre. There were cleaning processes in place which was documented in cleaning sign off sheets. However, there were some gaps identified in labelling and inappropriate decanting of cleaning solutions. Spray bottles containing a detergent concentrate and tap water mixture used for general surface cleaning had not been emptied and washed out appropriately following previous cleaning sessions. Topping up spray bottles can encourage bacterial growth in the solution which may result in the dispersal of micro-organisms in particular gram negative bacteria into the clinical environment. Local processes should ensure that spray bottles are emptied, washed out and allowed to air dry at the end of each cleaning session.

Cleaning was overseen by the cleaning supervisor or deputy cleaning supervisor. Cleaning and nursing staff, who spoke with inspectors were aware of their roles and responsibilities and the cleaning processes needed for terminal cleaning. Staff knowledge refresher training was needed regarding the day to day cleaning of bedrooms and bathrooms and the standard operating procedure required updating to guide staff in correct cleaning procedures.

There was a legionella management programme in place and records maintained to show that bedpan washers were regularly serviced.

Following the advice of an infection control specialist nurse the provider had arranged to remove seating and other items that had surfaces which would not allow for effective cleaning. A large order had been placed to replace this furniture.

Other findings on the day of inspection identified the following areas that required review and strengthening, these include the following:

- The provision of splash backs behind clinical hand wash sinks, sinks in some residents rooms and sluice hoppers, where walls were seen to be damaged and could not be effectively cleaned.
- A large number of cleaning brushes were heavily worn and not clean.
- Shelving in store rooms were too low to allow effective cleaning and cleaning supplies were stored on floors which could lead to contamination.
- There was gaps in practice in the re-use of single use dressings, the cleaning and decontamination of blood glucose monitoring equipment, pill crushers, dressing trays and insulin pens were not labelled correctly. This was a finding at the last inspection.
- The door to a COVID-19 positive residents bedroom was left open.

- The provision of hand towels and soap in cleaners rooms.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Inspectors reviewed a number of care plans with a focus on resident falls and care plans for residents who required support with moving and handling. All care plans seen were based on an initial comprehensive assessment of resident's needs.

This document formed the basis of resident care plans with each care plan supported by an appropriate nursing tool or risk assessment, for example residents who were a falls risk had an appropriate assessment tool in place called a "Frase assessment" which indicated the level of risk and guided appropriate interventions to mitigate against this risk.

An internal audit of moving and handling was presented to the inspector prior to the inspection and included an action plan to improve staff performance in this area. The provider indicated that overhead tracking for hoist use was being introduced into a number of rooms.

Care plans seen were well written and clearly identified the interventions required to meet that particular need. Daily nursing notes were reflective of the care provided and consistent with the relevant care plan. Care plans were subject to regular review and those seen incorporated residents and families' wishes where appropriate.

Judgment: Compliant

Regulation 6: Health care

There was good access to a range of health care services for residents to use both internally and externally. There were regular visits from the centres GP with inspectors informed that currently GPs visit three times per week. There were arrangements in place for accessing input from dietitians, speech and language therapist who provide input for issues related to swallowing and from tissue viability nurses who provide input for wound care management such as ulcers.

There were three physiotherapists on the team as well as an occupational therapist. Resident care plans were seen to reflect guidance and input from medical professionals including in house recommendations made at multidisciplinary team meetings.

There were arrangements in place for residents who required specialist mental

health input through referral to community teams via the GP service. In addition where residents required palliative care input this was also routed through the GP service.

Notwithstanding this evidence of good practices, the very serious incident detailed under Regulation 8 means that for those residents, their healthcare needs were not met during that incident.

Judgment: Substantially compliant

Regulation 8: Protection

While the provider had arrangements in place to safeguard residents, these systems failed to prevent a significant safeguarding issue occurring when residents in one part of the centre were left without any support from when the night staff went off duty at 8am until 2pm when staff realised the residents had been left alone in that part of the centre without support or care. During this period, these residents were not administered their medication, they were provided with no food or snacks and their hydration needs were not provided for. Residents who required assistance with their personal care including continence care and assistance with using the toilet did not receive that support during those six hours.

Inspectors did find that once the provider became aware of this incident, they took immediate action to meet the needs of residents and to review their arrangements. In addition, they established an independent review to examine how this incident occurred and to prevent risk of recurrence. Inspectors were told on the day of inspection that this investigation was ongoing.

Inspectors reviewed other aspects of safeguarding and protection and found that there was a policy in place which outlined measures for the prevention, detection and response to abuse of residents. Discussions with members of the staff team indicated that they had received training in this area with all expressing confidence that they would be able to support residents by using appropriate referral procedures.

There was a restraints register in place which detailed areas of restrictive practice currently in use in the centre, which included the use of bed rails, posey alarms and the use of PRN (when required) medication. Where any of these measures were in place there was clear rationale for their use with the focus on using the least restrictive measures for the least amount of time. All restrictive practice measures were subject to regular review at multidisciplinary team meetings.

Judgment: Not compliant

Regulation 9: Residents' rights

Inspectors observed staff and residents interactions and found that staff were supportive of residents communication needs. Where residents encountered difficulties in expressing their needs staff deployed active listening skills and afforded residents time and space to make their views known. There was evidence of good rapport between staff and residents and it was clear that staff were aware of resident's needs. All residents seen on the day of inspection were well presented and were wearing appropriate clothing and footwear.

Residents told the inspector that they were supported to liaise with their families via telephone or via Skype calls during periods of restricted visits. The centre carried out an audit of family contacts to ensure visits and contact was recorded. At the time of the inspection, Inspectors observed visits being facilitated in the garden area with window visits also taking place.

There was evidence of good communication between the provider and residents through a range of mediums. Resident views about the service provided were accessed through one to one discussions and through resident satisfaction surveys. The Orwell news newsletter provided residents and family members with additional information about key events happening in the centre. Inspectors also reviewed communication from the provider to residents regarding the COVID-19 pandemic and saw that residents and family members were updated about testing and visiting arrangements including information on infection prevention and control protocols in operation in the centre.

Inspectors observed residents being offered choice about how they wished to receive their care support throughout the day and found that staff respected and promoted resident decision making. While the provider strived to ensure that residents rights were promoted in the centre an oversight in ensuring that a convalescence unit was sufficiently staffed resulted in four residents being unable to exercise their rights for a period of at least six hours.

Residents meetings has restarted with a residents committee meeting held in June 2020. The group activity programme which had been curtailed during the lockdown period was re-emerging with activities organised and planned to satisfy social distancing. Inspectors were informed that there were plans to reinstate the "men's shed" where residents could engage in crafts and gardening. There was a music session performed in the garden which residents said they enjoyed.

Inspectors reviewed a selection of resident's activation plans and found that resident's likes and dislikes were recorded in a document called "key to me". Resident's attendances at activities were recorded in a separate document however for a number of residents the last activity session attended was recorded in August 2020. Recording resident attendances at activities is important as it provides key information regarding resident participation, and also provides care staff with information to use in the care plan review process.

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 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Substantially compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Orwell Private OSV-0000078

Inspection ID: MON-0030461

Date of inspection: 17/09/2020

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: All staff working in the Centre have completed classroom training on Infection prevention and control since the inspection. Further one-to-one training on Infection prevention and control practices like hand washing techniques, use of alcohol based hand rub, safe use of mask,5 moments of hand hygiene, safe use of PPE's, Donning and Doffing of PPE's were provided to the staff by the IPC nurse, PDN and the CNM's. New staff members are provided with classroom training on Infection prevention and control by the IPC nurse on day 1 of the induction Programme. All staff are enrolled to an Infection Control course module in Orwell Academy where staff are asked to complete this within 6 weeks of commencing the employment.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The Provider is in compliance with Regulation 23. We are currently conducting a review of services as agreed with the Chief Inspector which will be forwarded to her in due course. The inspector has reviewed the provider compliance plan. This action proposed to address the regulatory non-compliance does not adequately assure the chief inspector	

that the action will result in compliance with the regulations.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
Any areas which needed to be retiled or need a splash back which action will be completed by end of November 2020.
The Accommodation Manager checks all the cleaning equipment every 3 months and items will be replaced as required.
All the cleaners store have adequate shelving units to store cleaning materials. There are alcohol-based hand sanitizers available in all the cleaning stores.

All nurses are informed of discontinuing the practice of single use items like dressing supplies at the daily huddles. Audits have been carried out on this following the inspection -compliance is now 100%. This is also checked weekly by DON in all the units and is reported via weekly report to DOC.

To improve effective management of glucometers, we have ordered the same brand of glucometer for all residents for their individual use. These are labelled with resident's full name and date of birth. There is also an "Emergency Glucometer" available in all the units to use in any medical emergencies.
All the insulin pens used by the residents are labelled with resident's name and date of birth, these are checked weekly by the DON to monitor the compliance.

Cleaning of medicine crushers and IV trays is assigned to the night nurses in each unit and signed after completing the task nightly on the Night staff checklist. This is validated by the night manager on duty and a monthly report on completion of this is submitted to the DON.

The inspector has reviewed the provider compliance plan. This action proposed to address the regulatory non-compliance does not adequately assure the chief inspector that the action will result in compliance with the regulations.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
Both the Stage 1 and Stage 2 reports as issued by the Inspectors on 28 October 2020

and in January 2021 on the Inspection of 17 September 2021 assessed the Provider to be fully compliant with Regulation 6.
The Provider understands that on 19 February 2021 the Chief Inspector revised the assessment of the Inspectors and instead assessed the Provider to be substantially compliant with Regulation 6 and requires the Provider since 1 April 2021 to provide a compliance plan by reference to Regulation 6.
Following the Chief Inspector's revision, the Provider conducted a review of its current practices, policies and procedures and following its review confirms its satisfaction that:

i (i) the entirety of the Centre's staff is trained in Safeguarding of Vulnerable adults as part of the induction programmes and attend refresher training every 3 years;
ii (ii) all the Centre's staff are encouraged and will continue to be encouraged to report any concerns they may have in relation to resident's safety and comfort; and
iii (iii) Residents of the Centre are encouraged to report any concerns which compromises their safety, privacy and dignity.

With a focus on ensuring effective continuing clinical oversight and supervision within our Centre, the Provider confirms that its practices now reflect a procedure whereby the clinical duty manager who is identified on the roster has responsibility physically to check ill residents in the Centre day and night and to check with the nurse on duty if there are any concerns. As part of these procedures, the manager who assesses each resident then completes the SBAR communication in Care Monitor and any concerns with regard to the resident's health and wellbeing are discussed with residents' GPs.

The Person in Charge of our Centre has the responsibility to ensure that SBAR communication is documented daily by the clinical nurse mangers, ADON and DON after resident assessment which demonstrates the changing needs of the resident and advice to reassess and evaluate residents care needs and assist in planning nursing interventions. The completion of SBAR for each month is reported and addressed at the Provider's monthly management meetings.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
The Provider is in compliance with Regulation 8.
All staff in the Centre are trained in Safeguarding of Vulnerable adults as part of the induction programmes and attends refresher training every 3 years. Staff are encouraged to report any concerns they may have in relation to resident's safety and comfort. Residents are also encouraged to report any concerns which compromises their safety, privacy and dignity.
We are currently conducting a review of services as agreed with the Chief Inspector which will be forwarded to her in due course.

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	17/11/2020
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	Red	17/11/2020
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	30/12/2020

	staff.			
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.	Substantially Compliant	Yellow	12/04/2021
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Red	30/12/2020