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:	Brabazon House
Name of provider:	The Brabazon Trust
Address of centre:	2 Gilford Road, Sandymount, Dublin 4
Type of inspection:	Unannounced
Date of inspection:	14 January 2021
Centre ID:	OSV-0000017
Fieldwork ID:	MON-0031300

About the designated centre

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

Brabazon House Nursing Home is a 51-bed centre providing residential and convalescent care services to males and females over the age of 18 years. The service is nurse-led by the person in charge and delivers 24-hour care to residents with a range of low to maximum dependency needs. Admissions are primarily accepted from people living in the sheltered accommodation apartments in Brabazon Court and Strand Road, although direct admissions to the centre are accepted, in exceptional circumstances, subject to bed availability. The building is an original Edwardian House (circa 1902) that has been extended and refurbished while retaining some of its older features. It is located in a quiet road just off the Strand Road close to the strand and Dublin Bay. Local amenities include nearby shopping centres, restaurants, libraries and parks and also the strand. Accommodation for residents is across two floors. The centre contains 40 single bedrooms of which 34 have en-suite facilities. There are also three twin and two three bedded rooms. Communal facilities include assisted shower bathroom and toilets, dining room, two sitting rooms, an activity room, sensory room and a library. There are small rest areas situated on the ground floor at reception and on the first floor outside the hairdressing room which residents and visitors can enjoy.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	40

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 14 January 2021	09:45hrs to 17:45hrs	Gearoid Harrahill	Lead

What residents told us and what inspectors observed

Overall, the inspector found that the residents in this designated centre were supported to enjoy as much of their usual routine as was possible. The inspector observed that the residents participated in the operation of the centre and that their needs and safety, led decisions made in the delivery of care and support.

The inspector met briefly with some of the residents throughout the day and observed supportive, positive engagement between staff members and residents. Residents were seen navigating the premises alone or with assistance, and where personal or intimate support was provided, this was done in a discreet manner which respected the resident's privacy and dignity.

Residents were supported to practice social distancing in communal areas through proper furniture spacing, but were still able to gather and socialise with their friends. Residents spent their day in their rooms or in living rooms, watching television, reading the daily newspaper, chatting among themselves and staff, and participating in recreational sessions on offer. Some residents had items to keep their hands occupied, and residents who would benefit more from sensory therapy sessions could avail of these during quieter times of the day. One of the primary communal areas had a large projector screen and residents were enjoying a film during the afternoon.

The centre had a relaxed atmosphere and there was little anxiety among residents about the impact of COVID-19 and the associated restrictions. Residents told the inspector that things had been difficult recently but that they felt safe and looked after. Residents were supported to stay in contact with their friends and families.

The provider sought feedback and suggestions on the operation of the centre during 2020 through satisfaction surveys, and had received 60 resident responses of a potential 110. Respondents in the surveys were highly complementary of the choice and temperature of food, and spoke positively about support from staff. Some of the residents who stated that they had made a complaint in the designated centre fed back that the response was delayed or that they felt the matter was not resolved.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impacted on the quality and safety of the service being delivered to each resident living in the centre.

Capacity and capability

Inspectors found that a culture of individualised and person-centred care and support directed the work of the designated centre. The provider had taken measures to respond to the challenges presented by the pandemic and associated restrictions in a manner which worked for this building, staff team and resident profile. However, assurance was required on how the centre-specific contingency plan could be given effect, in the event of the provider leadership being unavailable.

The service had had an outbreak of COVID-19 which was first notified to the chief inspector in late November 2020. During this time, as of the day of the inspection, 42 residents and 45 members of staff had tested positive for COVID-19, and regrettably six residents had passed away. The provider kept the chief inspector apprised of the situation and had sought support from relevant parties to mitigate the impact on the service. The provider had received support, guidance and additional staff training from community services, and had made efforts to retain an appropriate number and skill-mix of staff through multiple agencies.

The provider had established an outbreak control team consisting of provider management as well as representatives from the Department of Public Health and the Health Service Executive. This group met regularly to discuss and respond to aspects of the service such as where supplementary staff resources were required, whether cleaning schedules were effective, and which aspects of regular service could be reintroduced safely – for example re-opening communal living rooms. Regular meetings took place between local and provider level management to ensure that resources were sufficient, where actual or potential cases of COVID-19 were being detected, and coordination of serial swab testing for staff and residents. At the time of the inspection, the provider was preparing for the upcoming distribution of the COVID-19 vaccine for residents and staff in the centre.

While the provider had measures in place to respond to general risks associated with the pandemic, they had not composed a contingency and emergency preparedness plan to respond to a COVID-19 outbreak in this centre, and associated risks such as major staff depletion, interruption of supply lines and how to most effectively isolate and cohort residents and staff teams. Key members of the management team were among the staff members required to self-isolate during the outbreak, but had retained oversight of the service remotely. Without a centre-specific COVID-19 response plan, the inspector was not assured that somebody could fully deputise absent managers and have the up-to-date knowledge of response actions, contact details and risk contingencies, to continue with the intended strategy of the provider as per their advice from public health and other bodies.

The provider had retained an appropriate number and skill mix of staffing personnel during the outbreak and was receiving support from multiple agencies to supplement the absent employed staff members. The provider had continued to ensure that there were no fewer than two nurses onsite at any given time. The inspector spoke with and observed staff supporting residents and found them to be knowledgeable, friendly and respectful with residents in general and during support to mobilise or have meals.

Staff had been facilitated to attend training in the centre, with all staff having

attended fire safety training in the past 12 months. Recently recruited staff members had attended basic training in manual handling and safeguarding of vulnerable adults, as part of their induction until the next available formal training session. The inspector reviewed examples of probation and competence review by management to highlights areas of good practice, and to support staff with career development objectives and areas in need of improvement.

The inspector reviewed a sample of personnel records which evidenced that staff had all information required under Schedule 2 of the regulations including evidence of identification, qualification, and clearance by An Garda Síochána. The inspector reviewed the worked staff rosters for the centre, which required improvement to ensure that they accurately reflected all personnel who worked in the centre. The rosters reviewed did not include the shifts worked by personnel who were provided through an agency to cover absent regular staff.

The provider kept a complaints log of matters raised formally and informally by the service users and other parties. For entries in 2020, the details of the complaint were clearly outlined, however many of the complaints logged in the second half of the year had no record of actions taken, the outcome of the complaint and whether or not the complainant was satisfied with said outcome. So it was not clear from this record what conclusion or feedback to the resident took place. In a satisfaction survey issued by the provider, ten respondents indicated that they had made a complaint, and of these, three indicated that they received either no response, or a delayed reply to their complaint.

The inspector reviewed a sample of the ongoing quality improvement audits carried out in the service by the provider. This included an analysis of the common or recurring factors of incidents and accidents, timeliness of care plan reviews, staff appraisal, maintenance matters and punctuality of staff. Where actions or areas of improvement were required, they were assigned a responsible person and a time frame for the action to take effect. The key findings of these audits contributed to the annual review, which highlighted key achievements and developments in the services and where the focus would be in the year ahead. The annual review for 2019 did not feature meaningful reflection of the resident feedback and contribution which the provider had collected. The provider had collected information on resident satisfaction which would be analysed to contribute to the review for 2020 which was being drafted at the time of the inspection.

Registration Regulation 4: Application for registration or renewal of registration

The provider had submitted their application to renew the registration of the designed centre and this was accompanied by all associated documentation.

Judgment: Compliant

Regulation 15: Staffing

The provider had taken measures to retain an appropriate number and skill mix of staff in the designated centre to support the residents' assessed needs. Nursing staff were available at al times of the day and night.

Judgment: Compliant

Regulation 16: Training and staff development

The structures for staff induction, probation and appraisal were in effect to support staff development. Staff were facilitated to attend training mandatory to their respective roles.

Judgment: Compliant

Regulation 21: Records

Worked rosters for the designated centre required review to ensure that they accurately reflected the personnel on duty, including recording when and where agency personnel worked shifts in the designated centre.

Judgment: Substantially compliant

Regulation 23: Governance and management

The provider had engaged their outbreak control team and sought support where required from external organisations such as the Public Health to ensure that resources and safety practices were sufficient to manage the centre during the COVID-19 pandemic and centre outbreak.

However, the provider had not composed a preparedness and contingency plan for COVID-19 which could be used in the absence of the management team to ensure the intended response strategies could be easily followed and all relevant information and contacts located together.

The provider had continued with their internal audits structure to review and develop the quality improvement of the designated centre and the delivery of

support for residents' needs.

The annual report did not reflect the information gathered on the residents' experiences and feedback regarding the operation and support delivered by the designated centre.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The provider had composed a statement of purpose which contained all information required under Schedule 1 of the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

The provider maintained a log of complaints received which outlined the issues raised, however the outcomes, learning and complainant satisfaction from issues raised were not recorded for a number of these complaints.

Judgment: Not compliant

Quality and safety

The inspector reviewed assessments of need for a sample of residents in the designated centre, and the care and support plans which were generated from these ongoing assessments. Overall, the inspector found the care and support plans to be concise, detailed with valuable, individualised information on the residents, and reflective of the residents' wishes, choices and preferences in how their support needs were met.

The inspector found good examples of person-centred data describing what residents liked to do with their day, their meal preferences and dietary requirements, preferred sleep times, the people with whom they wish to stay in frequent contact, and where they choose not to use prescribed aids such as glasses and hearing devices. For activities of daily living including dressing, washing, grooming, eating, getting around the building, and using the bathroom, support plans were highly specific to reflect the areas where assistance was required, and the areas in which the resident was independent and neither required nor wanted

any help.

Residents had advanced care directives in place which were kept under review by their doctor. Details on the residents' wishes regarding transfer or resuscitation were very clear. Arrangements for end-of-life care were written in a respectful and dignified manner to reflect each person's wishes related to their comfort, family, cultural and religious observances. The inspector read daily notes for residents who had recently passed away and found that staff had followed plans to support and care for the resident as per their stated wishes.

Residents had retained access to their doctor and other health care professionals as required during the year. The residents' general practitioner had been attending the centre weekly, and conducting reviews remotely since the start of the outbreak. The frailty team from the associated hospital were also engaging regularly with residents about whom they were concerned. The residents also retained regular and as required access to services including physiotherapy, speech and language therapy, dentistry, and dietician review. The input of these professional was recorded in the review notes of the respective assessments and care and support plans.

The seasonal influenza vaccine had been distributed in recent months, with 100% of the residents and 75% of staff availing of this. The provider had also been given an expected date for receiving doses of the COVID-19 vaccine, and was working on attaining consent from residents and staff who wished to receive it. Residents who met specific age and gender criteria were also supported to avail of the national screening service.

Some residents had sensor devices in place to respond to risks such as falling or leaving the building and getting lost. For these residents, the rationale for retaining these devices were kept under regular review to ensure that they were the least restrictive measure necessary to respond to the relevant risk and where it was no longer required, was removed. Some residents in the sample reviewed exhibited expressions of frustration or agitation which would cause a risk to themselves or others, and had been prescribed prn (administered as needed) medication as a last resort option to support the person to return to their usual behaviour. For these residents, improvement was required to ensure that there was clear guidance for staff on what form the expressions take, what de-escalation techniques to attempt first, and at what point it is necessary to use medication.

The provider in discussion with public health had recognised the challenge that the design and layout of the building presented in providing a designated zone for staff to use when coming and going from their shifts to protect themselves and others from COVID-19 transmission risk. In response the provider had erected a large rented marquee in the garden which could safely be used to store stock of personal protective equipment (PPE) and provide changing facilities for staff before entering the building. Staff were diligently checking for temperature and symptoms to allow for prompt identification of actual or potential cases, and the service was availing of routine testing of all staff and residents. Staff were observed following proper practice around hand hygiene and the use of face coverings and other PPE, and were supporting the residents to practice social distancing while still being able to

converse and socialise with their friends.

While the building overall was clean and in a good state of maintenance, the inspector identified some areas in need of improvement to ensure good infection prevention and control. Toiletries and other items belonging to residents had been left behind in toilet and shower areas used by other residents, including towels, nightwear, bar soap, shampoo, toothbrush and toothpaste. A cleaner store downstairs was small and cluttered, and contained inappropriate items such as staff belongings in the hand sink and a vacuum cleaner sitting in the drain for emptying buckets. The inspector also found potential contamination risk associated with dirty and clean items being stored together, with bags of laundry and rubbish from bins resting against open trolleys of clean linen and continence wear. A number of bottles of hand sanitizer were sitting on handrails, creating a potential contamination risk from people using the rails.

The inspector found good examples throughout the day of how residents were supported to attend social and recreational opportunities in a safe manner. The activities coordinators told the inspector that they were supported by their colleagues and by the manager to provide an activities programme that catered to residents who enjoyed group activities, those who enjoyed quiet, relaxed or sensory-based engagement, and those who were happy to go about their own day. Arrangements were in place for residents to stay in contact with their friends and families, and residents were provided with opportunities to attend mass and prayer services remotely.

Regulation 13: End of life

Residents' wishes and preferences regarding their end-of-life care was collected and written up in a dignified manner, and the inspector found evidence of how the residents' wishes were being respected and honoured.

Judgment: Compliant

Regulation 26: Risk management

The provider had a register of risk controls outlined to reduce the risk of people contracting COVID-19 in the centre, but did not have a risk control strategy outlined for responding to risks related to an outbreak, such as what to do in the event of major staff depletion, interruption of supplies, isolation and cohorting of residents, and contacts in the absence of key managers.

Judgment: Substantially compliant

Regulation 27: Infection control

Some improvement was required to the environment of the designated centre, particularly regarding placement and storage of items which could create potential infection transmission risk including:

- Resident belongings and toiletries left behind in shared-use bathrooms.
- Dirty items such as bin bags and laundry bags left with uncovered trolleys of clean linens and incontinence wear.
- Hand sanitising equipment sitting on handrails
- Inappropriately stored items blocking easy access to sinks and drains in utility rooms.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Assessments were conducted with input from the residents and their health care professionals. Care and support plans were individualised, person-centred and reflective of the needs, personalities, interest and choices of the residents.

Judgment: Compliant

Regulation 6: Health care

Residents retained a sufficient level of access to their doctor and other health care professionals through the pandemic. Residents had advanced care directives in place where required which reflected the input and review of the resident and their doctor. Residents were supported to receive treatments and vaccines in line with their wishes and consent.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Improvement was required on the support plans for residents who exhibited behaviours that posed a risk to themselves or others. There was insufficient guidance in these plans to advise staff on how the resident behaviour manifests,

what may trigger an incident, how to de-escalate the risk, and at what point it may be required to utilise prn (administered as required) medication to support the resident to return to their baseline behaviour.

Judgment: Not compliant

Regulation 9: Residents' rights

Residents were supported to avail of social and recreational opportunities in a manner which was safe and adapted to continue as much of the regular routine as possible.

Resident privacy, discretion and dignity was respected in the delivery of general and personal care and support.

Resident feedback on the designated centre and its service was invited and collected through regular use of council forums and satisfaction surveys.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 4: Application for registration or renewal of registration	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 13: End of life	Compliant
Regulation 26: Risk management	Substantially compliant
Regulation 27: Infection control	Substantially compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Not compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Brabazon House OSV-0000017

Inspection ID: MON-0031300

Date of inspection: 14/01/2021

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 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: The introduction of an Agency Roster, appended to our normal working roster will now ensure that records are more concise and easily understood and legible. This will also demonstrate more effectively the rostered skill mix at all times. Given this very difficult experience and wanting to avoid a repeat we are working with our IT consultants to explore how better to include these additions and the availability of more effective records. Due to the fact that our nursing home was still suffering the effects of a Major Outbreak of COVID19 on the day of inspection, emergency changes to personnel were necessary which also included changes involving agency staff which were often last minute additions on the Roster. Handwritten changes were made to the Printed Roster. This does not reflect the usual recording process in our home. The January roster was clear and legible as our own staff returned to work. It was a further two weeks from the inspection that Public Health declared our outbreak closed. We rarely use agency staff and if we do it is in small numbers not the huge level we managed during this time. Contrary to the concern we were operating short of staff we were in fact well-staffed albeit professionals not known to our residents.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and	

management:
We had a Contingency Plan prepared and available on the day of the inspection. It was completed on 1st April 2020 and readily available in the nurses' station. The template used was taken from the HIQA website. A new Contingency Plan has been prepared. This new plan is available on site and a copy is readily available at our nurses' station for guidance and instruction.

Our Annual Report 2021 will include a section which will reflect the information gathered on the residents' experiences and feedback given. Residents and their families are asked to complete our annual Service Satisfaction Survey and all comments are reviewed and managed as appropriate. All feedback is discussed at our Residents' Committee meetings and Minutes of these meetings are circulated and published on our Notice Board.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
Following a thorough review of the Complaints procedure we will now upgrade our procedures with the introduction of digital complaints module on our Epic care system. This module will assist us in recording, logging, monitoring and managing all complaints.

As well as complaints, concerns and compliments will now be recorded digitally on Epic by the Complaints Manager.

The Complaints Manager maintains a digital 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 including any appeals procedure.

Staff have been reminded of the importance of writing up the resident's satisfaction level when a complaint is dealt with and the issues resolved.

Training has been provided for staff in relation to the importance of the Complaints Management Process on Epic care, particularly relating to the documentation of complaints through to resolution stage. This element will also be included in our new staff induction presentation.

DON/ADON/CNM meetings to include review/feedback/progress on any complaints recorded.

Complaints will continue to be discussed at staff meetings both formal and informal in the future. The issue is not that complaints are inadequately dealt with but that the paperwork is not completed.

Monthly complaint audits will continue.

Residents will be invited to take part in a Service Quality Satisfaction Survey 2021 and a timely review will follow by Management with all findings dealt with as appropriate.

Complaints Policy has been reviewed to reflect the use of the digital system on Epiccare.

Regulation 26: Risk management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management:
The Risk Register Controls outlined measures to reduce the risk of Covid19 in our home and has been reviewed and updated and includes a risk control strategy for responding to risks related to an outbreak.

Contacts and Key Managers: - A contact list for CEO/Management, Deputy Personnel, HSE Emergency Outbreak Team, CHO6 Contacts, GP's, HIQA, is included in the Risk Register and available in Nurses Station and Administration office.

Interruption of Supplies: -
An external company is contracted to supply catering services and responsible for all supplies.
PPE gear supplies received from HSE as required.

Isolation and Cohorting of residents: -
We are not in a position to safely cohort residents. Therefore, our plan would be to cohort staff. Staff will be allocated to care for positive or negative residents to reduce cross infection. Brabazon House does not have capacity to vacate residents from their rooms due to the layout of the building.

Negatively tested residents were cocooned and socially distanced.
Smaller groups of residents were cohorted.
Residents remained in their rooms at recovery stage.
Recovered residents were socially distanced in a day room who was supervised by staff in full PPE or who have recovered from COVID

Major Staff Depletion: -
Through the HSE and OCT assistance was given with the provision of contacts and names of agencies which proved very useful.
Clonskeagh staff, Dalkey Community Unit, Alzheimer's Society staff were provided through the HSE.
Daily updates provided to HIQA Portal and telephone.

Staff who are part-time in the home, were asked of their willingness and availability to work additional shifts. All Annual Leave was suspended.
Remote working is facilitated.
We are liaising and engaging with the local CHO Chief Officer.
Assistance is available from Palliative Care/Frailty Team, St. Vincent's University Hospital.

A detailed COVID19 Contingency Plan is included and appended to our Risk Register Document 2021.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
Staff have been reminded to be vigilant regarding infection control and cross infection of resident belongings left behind in bathrooms. Residents with varying stages of cognitive impairment are encouraged in the independence but some may require assistance and prompting to collect their toiletries/belongings once they have used the bathroom, staff have been instructed to be observant.

Hand sanitising equipment had been placed outside each room on handrails as per advice from infection control CHO7, for the duration of the Outbreak.

Hand sanitizing equipment will soon be available outside each room and a bottle holder attached to the wall above the handrail eliminating the potential for contamination for rail users. While the order for these is in progress we have reverted to using the many hand sanitisers normally on the corridors. All staff have been using individual hand sanatisers which are worn as part of their uniform. Individual hand sanitisers have always been used in Brabazon.

During morning care the trolleys are placed in an alternative area. This provides a greater space so there is no risk of cross contamination. All trolleys are emptied and sanitized before and after each period of use.

Staff have had additional Infection Control training during the COVID outbreak. They are advised to be mindful of their training in infection prevention and control at all times when on duty. Hand hygiene and waste management audits are carried out.

Refresher training is ongoing and provided to all staff.

Regulation 7: Managing behaviour that is challenging	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
Refresher training has been scheduled and commenced in relation to PBS/Challenging Behaviour and use of prn medication. All other control measures are applied to deescalate issues before prn medication is used. Staff have been reminded of the importance of clear and concise documentation at all times.

Staff have been reminded of the importance of clear and concise documentation of all episodes of Challenging Behaviour and the process followed to deescalate any situation.

New signage has been adopted to remind staff of their duty to document accurately.

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 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.	Substantially Compliant	Yellow	10/03/2021
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	30/04/2021
Regulation 23(e)	The registered provider shall ensure that the review referred to in subparagraph (d) is prepared in consultation with residents and their families.	Substantially Compliant	Yellow	30/04/2021

Regulation 26(2)	The registered provider shall ensure that there is a plan in place for responding to major incidents likely to cause death or injury, serious disruption to essential services or damage to property.	Substantially Compliant	Yellow	01/03/2021
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	01/03/2021
Regulation 34(1)(f)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.	Not Compliant	Orange	06/03/2021

Regulation 34(1)(g)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall inform the complainant promptly of the outcome of their complaint and details of the appeals process.	Not Compliant	Orange	06/03/2021
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	31/03/2021
Regulation 7(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.	Not Compliant	Orange	27/03/2021