Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Adults).

Issued by the Chief Inspector

Name of designated centre:	Pinegrove
Name of provider:	Health Service Executive
Address of centre:	Sligo
Type of inspection:	Unannounced
Date of inspection:	28 January 2022
Centre ID:	OSV-0002605
Fieldwork ID:	MON-0035414

About the designated centre

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

Pinegrove is a centre run by the Health Service Executive and is located on a campus setting a few kilometres from a town in Co. Sligo. The centre provides residential care for up to 8 male and female residents, who are over the age of 18 years and have a moderate to profound intellectual disability. The centre comprises of single and shared bedroom accommodation, shared bathrooms and communal areas and access to a garden area. Staff are on duty both day and night to support the residents who live there.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	8

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (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
Friday 28 January 2022	10:00hrs to 17:35hrs	Alanna Ní Mhíocháin	Lead
Friday 28 January 2022	10:00hrs to 17:35hrs	Christopher Regan-Rushe	Support

What residents told us and what inspectors observed

This inspection was an unannounced inspection to review the infection prevention and control measures that had been put in place by the provider, in line with the relevant *National Standards on infection prevention and control in community settings*. Inspectors met and spoke with residents and staff throughout the inspection. In addition, the inspectors observed the lived experience of residents by observing daily interactions and practices in the centre.

The centre was part of a congregated setting on a large campus. The centre was located over two floors in a large building that also housed other designated centres and offices. The residents' bedrooms and two shared bathrooms were located on the upper floor. Where doors into residents' bedrooms were open, inspectors noted that each room was decorated in individual styles. Two sitting rooms, two dining rooms, two shared bathrooms, a store room with sluice and the nurses' office were located on the ground floor. The centre did not have its own kitchen as meals were cooked in a central kitchen and delivered to the dining rooms. However, a small kitchenette was located off one sitting room. Residents' laundry was taken to a central location on campus to be washed. However, there was a washing machine in an unused bathroom for washing residents' clothes protectors. The rooms in the centre were spread over a large area. Residents moved between their bedrooms and the living areas of the centre by means of two lifts or a staircase. Residents and staff had to pass bedrooms from other centres and through publicly accessible corridors when moving from bedrooms to living rooms. Since the last inspection, a door had been installed at the entrance to the main living area of the centre to prevent the hallway from being used as a thoroughfare.

Residents appeared relaxed and at ease in their home. Residents were noted relaxing in the sitting rooms watching television. Residents were supported by staff to move to the dining room of the centre at lunchtime. The dining rooms had hand hygiene sinks with soap and paper hand towels available. Residents were unable to verbally communicate and were supported by staff to engage with inspectors. Staff were friendly in their interactions with residents. They were respectful when they spoke about residents and knowledgeable of the supports needed by residents in their daily routine.

At the door into the centre, the provider had set up a hand sanitisation station and sign-in sheet to allow for contact tracing in the event of an outbreak of COVID-19 in the centre. However, it was noted that the hand-sanitiser provided was out of date. Also, a bin was not provided at the station for discarded masks. This was immediately rectified by staff when highlighted by inspectors. There were notices and posters throughout the centre that gave information in relation to hand hygiene, mask wearing, and coughing and sneezing etiquette. Picture-based and some easy-to-read notices in relation to infection prevention were available on notice boards. Some social distancing markers were placed on the floor in the centre. Staff were observed wearing face masks throughout the inspection. There were sufficient

arrangements and facilities in place to support good hand hygiene. In addition to the hand-washing sinks, hand sanitiser dispensers were located at various points on the walls in the centre. All of these were stocked with hand gel except one dispenser in a bathroom.

Inspectors conducted a walk around of the centre and observed that the centre was largely clean and tidy. However, significant improvements were required in some areas. Some sinks, furnishings and corners of flooring required a more thorough cleaning. Used personal hygiene items were found on a windowsill in a bathroom. Inspectors noted an opened, unlabelled sharps bins stored on the floor in two bathrooms containing used razors. There were also improvements needed in practices relating to the cleaning of equipment. For example, inspectors observed a shower chair and wheelchair that were used by residents with visible dirt, staining and damage. Some items of furniture were also worn or damaged and needed to be replaced. Further details of this part of the inspection will be discussed later in the report.

During the inspection, it was noted by inspectors that two residents had moved to new bedrooms. These bedrooms were not on the existing floor plan of the centre and the provider had not applied for an application to vary the registration conditions to accommodate this change. This was brought to the attention to the person in charge and senior management. Residents returned to their original bedroom and the provider assured inspectors that an application would be submitted to the Chief Inspector in a timely fashion to vary the conditions of registration of the centre.

Overall, it was noted that the provider had taken steps to implement infection prevention and control measures for residents, staff and visitors. The centre was generally clean but inspectors noted areas that required attention to ensure that the environment and facilities were maintained in optimum condition.

The next two sections of the report will outline the governance and oversight arrangements in the centre regarding infection prevention and control and how this impacted on the quality of the service delivered to residents.

Capacity and capability

The provider had developed policies and procedures for the management, control and prevention of infection. Risk assessments were developed to assess and evaluate the risks associated with infection prevention and control. However, improvements were required in the systems to oversee the implementation of policies and risk control measures.

The provider had clear governance structures and reporting relationships regarding infection prevention and control. There was a guidance document on serious incident escalation and review. The provider had an infection prevention and control

team who could be contacted by staff, as required. The provider had developed a plan should an outbreak of COVID-19 occur in the centre. This plan guided staff on their actions in response to cases of suspected or confirmed COVID-19. It outlined how staff could be redeployed from other areas to the centre and information on supporting residents to self-isolate. It identified who to contact to arrange additional staffing, if required. However, the plan required more specific information in relation to the centre. For example, it did not contain information on how the centre could be divided into zones to allow residents to self-isolate, where personal protective equipment (PPE) should be put on or removed, and how to access additional stocks of PPE.

The provider had a range of policies in the centre in relation to the prevention and control of infection. These policies were comprehensive and gave clear instruction to staff on the procedures and practices required to reduce the risk of infection to residents. The provider had an infection prevention and control manual that clearly outlined the precautions that should be taken by all staff when supporting residents. This manual provided guidance on a range of infection prevention practices, including hand hygiene, the use of PPE, cleaning, clinical waste management, managing laundry and sharps management (how used needles are disposed). The provider had made recent public health guidance information available to staff in a COVID-19 information folder.

In addition to the policies, a range of risk assessments were developed for the centre in relation to infection prevention. These assessments outlined the risks to residents and staff and identified control measures that should be implemented to reduce the risk. A review of these documents found that the control measures identified in the risk assessments were in keeping with the guidance issued in the provider's policies. The provider had also identified infection risks specific to individual residents. A review of these risk assessments found that not all had been reviewed to reflect the changes in the residents' circumstances. For example, one risk assessment in relation to the impact of COVID-19 restrictions on a resident had not been reviewed since September 2020 to reflect changes to public health guidelines that had occurred after this date.

The provider had developed a number of audit tools and checklists to support adherence to policies on infection prevention and the implementation of the control measures outlined in the risk assessments. These audits included environmental audits, an audit on the use of PPE, staff temperature and symptom checks, and cleaning checklists. However, inspectors noted that there were significant gaps in the completion of checklists which indicated that the provider's policies and procedures were not fully implemented in practice. For example, certain cleaning tasks were not checked as having been completed in line with provider's guidelines. Also, it was noted that staff temperature checks were not always recorded at the times specified by the provider. Inspectors noted one recent incident where a staff member had not recorded a temperature check at any point on their shift.

Further, the centre's recent six-monthly unannounced audit completed by the provider had not identified some of the issues that had been observed by inspectors. For example, inspectors identified three opened sharps bins in the centre. Two of

which were stored in bathrooms and one in the staff office. None of the bins were labelled or stored in accordance with the provider's policy or in line with the control measures identified on the centre's risk assessment relating to sharps. This indicated that the audit procedures in the centre were not effective at identifying issues and therefore, risks to residents' safety were not fully addressed.

Inspectors also reviewed the overall effectiveness of checklists used to provide assurances that tasks were completed. Inspectors found that the checklists used to record routine cleaning tasks and enhanced cleaning tasks did not provide assurances that these tasks were completed in line with the provider's guidelines. One checklist was kept for the entire centre and information recorded was too broad and generic to ensure that cleaning practices were implemented fully. This was also not in line with the provider's policy which stated that area-specific cleaning checklists should be implemented. Also, the records kept in relation to the cleaning of residents' personal equipment was too broad. For example, personal equipment, such as wheelchairs, were included as one item in the general cleaning list for night staff. It was not possible to identify if a specific piece of equipment had been cleaned or by whom. Furthermore, items that required decontamination and specific cleaning were not listed on cleaning records. For example, a reusable bedpan and urinal bottle were located in a bathroom but it was unclear how these were cleaned and reprocessed for use by residents.

A review of the staff training matrix found that staff were offered training specific to infection prevention and control. This included training in relation to hand hygiene, standard precautions and COVID-19 specific training. However, a review of the recording of information on the training matrix and staff training certificates found that dates on training certificates did not, in all cases, match the dates on the matrix. Also, it was unclear what training had been undertaken by individual staff members and when they would require refresher training. In conversation with staff, they were knowledgeable on the procedures that should be followed when supporting residents with different tasks. They were knowledgeable on the specific PPE that was required for certain tasks, cleaning protocols and where to access additional information, if required. There was an appropriate skill-mix among staff and adequate numbers to meet the assessed needs of residents and complete additional cleaning tasks. Household staff were also employed on a full-time basis to complete routine and some enhanced cleaning duties.

Quality and safety

The overall standard of cleanliness and practice in relation to infection prevention and control required improvement in this centre. This was brought to the attention of the provider throughout the inspection.

There was sufficient signage in the centre to guide staff, residents and visitors on

good practice in relation to hand hygiene, mask wearing and awareness of symptoms of COVID-19. Signs and posters with picture support were located throughout the centre. Posters on appropriate hand washing or use of hand sanitiser were on display at hand hygiene sinks and hand gel dispensers. Some easy-to-read documents were located on noticeboards in the centre for residents. There was signage throughout the centre to remind visitors of the need to wear masks and to avoid entering the centre if they had any symptoms of COVID-19. Staff reported that residents had been supported with mask wearing in public, if possible, particularly when attending hospital or medical appointments. Staff reported that residents had been supported by familiar staff when attending vaccination or testing appointments for COVID-19. Staff sat with residents and offered verbal reassurance during these appointments. Staying safe from COVID-19 was included as an agenda item on residents' meetings.

The standard of cleaning in the centre required improvement. While large surfaces were visibly clean, cleaning in harder to access places required improvement. Inspectors noted soap residue on bathroom walls, showers and in sinks. A shower chair in one bathroom had black staining on the backrest and residue in the folds of the backrest, indicating that it had not been thoroughly cleaned. Some of the furniture in the day rooms had visible staining. Practices in relation to the placement of waste bins required improvement. One bathroom contained an open clinical waste bin without a lid while one hand hygiene sink did not have any soap. Access to a hand hygiene sink was blocked in the nurses' office. Inspectors noted that there was no waste disposal bin available at the hand sanitisation station, which was a designated area for putting on and removing PPE located at the sign-in desk at the front door into the centre. Where possible, these issues were immediately addressed by staff when highlighted by inspectors.

Overall, the centre was in a good state of repair. However, some items in the centre were noted to be worn or damaged. Some couches and armchairs were damaged and the person in charge reported that they were due to be replaced. The medication trolleys for the centre were rusted and worn around the lock. This impacted on the ability to fully clean and wipe them down as needed. Worn or damaged items were reported to the maintenance department for repair or removal.

Storage of cleaning equipment was mainly in a store room that also contained a manual sluice. It was reported that this sluice was not in use. Mops were colour coded. Mop head were dried but mop buckets were not stored in an inverted position, in line with the provider's policy.

Residents' personal plans contained information to guide staff on certain tasks that caused a risk of infection. For example, residents' personal plans contained intimate care guidelines. Residents were routinely monitored for signs of infection and symptoms of COVID-19. Throughout the course of the pandemic, the provider had reported suspected and confirmed cases of COVID-19 in line with the regulations. There was no outbreak of COVID-19 in the centre and no resident had tested positive at any time.

Regulation 27: Protection against infection

Information regarding infection prevention and control was made available to residents and staff. Residents were supported to follow public health guidance in line with their own abilities.

The centre was largely clean and tidy. However, the overall level of cleanliness required improvement, particularly in relation to the cleaning of residents' equipment, for example, wheelchairs and shower chairs. Furniture and pieces of equipment with visible wear required replacement.

Staffing numbers and skill-mix were appropriate to protect residents from infection. Staff had received training in relation to infection prevention and control and were knowledgeable on protocols to protect residents from infection. However, the recording of training completed by staff was not accurate and it was unclear what staff required refresher training in infection prevention and control.

The provider had a range of policies, guidelines and protocols in place to guide staff on good practice in relation to infection prevention and control. The provider had assessed the risks in relation to infection and identified control measures to reduce the risks. However, throughout the inspection, it was noted that adherence to the provider's policies and control measures required improvement. For example, inspectors noted that staff did not always record temperature checks in line with the provider's control measures and policy.

The provider had a range of tools to monitor the implementation of infection prevention and control practices. However, audit tools and checklists did not effectively identify areas of improvement required in service delivery. Recent audits completed by the provider had not identified areas of risk that had been noted by inspectors, for example, the labelling and storage of sharps bins. In addition, some completed checklists and audits did not provide assurances that the tasks recorded had been completed in line with the provider's guidelines.

As a result, the provider was unable to adequately demonstrate that they had implemented the national standards for infection prevention and control in accordance with regulation 27.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Quality and safety	
Regulation 27: Protection against infection	Not compliant

Compliance Plan for Pinegrove OSV-0002605

Inspection ID: MON-0035414

Date of inspection: 28/01/2022

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

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 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
To ensure compliance with Regulation 27 the following actions have been undertaken

• The centre's contingency plan has been reviewed and updated and now reflects the current arrangements in place for each individual to be able to self-isolate .The plan includes specific arrangements with zoned areas outlined for each individual in the event of an outbreak.
• Specific arrangements are now outlined in the contingency plan for the procuring of PPE Stocks and the responsible person for this task .The plan also includes details of the location of PPE stock and the items required in the event of an outbreak.
• Staff Temperature checklists have been revised in line with the contingency plan. The PIC will ensure compliance with these safety checks through visual daily checks and completion of a weekly audit of the checklist .This information will be communicated to all staff through staff weekly meeting.
• All individual risk assessments have been updated in line with national guidance. The risk assessments' outline the current controls in place and any additional requirements necessary to manage and control the spread of infection Completed 7-2-22
• The cleaning checklists have been reviewed and updated and now reflect all individual pieces of equipment, the frequency of the cleaning and the responsible grade of staff to undertake this cleaning. There are also cleaning checklists developed for each room outlining the specific cleaning required, frequency and the responsible person. There is also a procedure in place when damaged or soiled furniture and equipment is identified which includes the replacement or repair of this item immediately. Items identified throughout the inspection have been removed, e.g. three cloth armchairs and two couches have been replaced There replacements are washable and impervious to moisture ,one damaged wheelchair has been removed from the centre and sent for repair and two new drug trolleys have been ordered .There is also two new shower commode chairs. Completed 14-2-22
• The auditing of Regulation 27 Infection Prevention and Control is now undertaken

using the MEG audit system .The areas audited include;
- Environmental Cleaning of each room
- Equipment Cleaning and Maintenance
- Training
- Sharps Management
- Healthcare Waste Management
- Hand Hygiene Facilities
- PPE
- IPC Compliance

These audits will be completed monthly initially and then proceed to quarterly. All actions identified will be closely monitored through the centres QIP and will be completed in a timely manner. Completed 21-2-22

• The training schedule for all staff has been reviewed by the person in charge. All staff have been informed of the required training to undertake appropriate to their role and in line with national guidance using the AMRIC recommended training. The uptake of training will be closely monitored by the PIC to ensure all staff are appropriately trained in the area of Infection Prevention Control.

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 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Not Compliant	Orange	31/03/2022