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:	Rathfredagh Cheshire Home
Name of provider:	The Cheshire Foundation in Ireland
Address of centre:	Limerick
Type of inspection:	Unannounced
Date of inspection:	24 February 2022
Centre ID:	OSV-0003449
Fieldwork ID:	MON-0036210

About the designated centre

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

Rathfredagh Cheshire Home consists of a large two-storey building and a smaller one-storey building located adjacent to each other in a rural area within a short driving distance to a nearby town. Both buildings are comprised of apartment style individual accommodations. The centre can provide for a maximum of 21 residents consisting of full-time residential support for up to 18 residents and respite support for up to three residents. Each resident in the centre has their own bedroom and other facilities throughout the centre include offices, bathrooms, dining rooms, kitchens, a laundry room, a prayer room and store rooms amongst others. The centre supports residents of both genders of both genders with physical, neurological or sensory disabilities. Residents are supported by care support staff, nurses, a community services coordinator and the person in charge.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	16

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
Thursday 24 February 2022	10:00hrs to 19:15hrs	Caitriona Twomey	Lead
Thursday 24 February 2022	10:00hrs to 19:15hrs	Conor Dennehy	Support

What residents told us and what inspectors observed

This unannounced inspection was focused on Regulation 27: Protection against infection only. As this inspection took place during the COVID-19 pandemic, enhanced infection prevention and control procedures were in place. Both inspectors and all staff adhered to these throughout the inspection. This designated centre consisted of a large two-storey building and a smaller one-storey building located on the same grounds on the outskirts of a town in county Limerick. Both buildings housed apartment style individual accommodation for people with physical, neurological or sensory disabilities. The centre was registered to accommodate 21 residents at any one time, 16 in the main house and five in the smaller building. The majority of accommodation provided in the centre was in the form of a long-term residential service with three rooms in the main house assigned to provide a respite service. The person in charge informed an inspector that one resident had moved within the centre from the smaller to the larger building earlier that month. On the day of this inspection there were 12 residents living in the main house and four in the smaller building.

On arrival at the reception area of the larger building, COVID-19 related signs were on display and hand sanitiser was readily available. Inspectors were asked to sign in and also had their temperatures taken and recorded before going any further into the building. Inspectors spent the initial period of the inspection reviewing this building primarily from an infection prevention and control perspective.

The ground floor of the main building included 20 apartment style living areas, a kitchen, a laundry room, a physiotherapy gym and a number of other communal areas and staff offices. It also had a hydro pool. When reviewing the building it was noted that the door to the pool area had a sign on it saying it was closed. During the inspection it was queried with some staff members on duty how long the pool had been closed. One staff member said it had been closed for two years, while another indicated that it had been closed for four years. When asked about this, one resident told an inspector that they could not remember the pool being open since they moved into the centre in 2016. Also when comparing the layout of this building against the floor plans submitted as part of the process to register the designated centre, inspectors observed a number of a differences. For example, a room described on the floor plans as a store room was an office, an area where it was indicated that there were three toilets was a store room and one accessible toilet. It was also noted that although it was indicated on the floor plans that there was a functioning door linking the sitting and smoking rooms, this was not the case in reality. The inspectors requested that updated floor plans be submitted to the Health Information and Quality Authority (HIQA).

The building was divided into different corridors with a number of apartments on some corridors, while another had a mix of communal spaces and accommodation, and another had communal rooms and rooms used by staff for administration, storage and therapeutic services. Each apartment had its own en suite bathroom.

Some apartments consisted of a bedroom and living area while others were smaller in size. Inspectors saw a sample of the apartments in this building. They were observed to be clean in most areas. It was noted that the quality of fittings and furnishings varied in different parts of the building. For example, the flooring along some corridors was noticeably chipped and worn in places while in contrast the flooring in other areas was in much better condition. It was also observed that on one of the corridors with worn tiles, the flooring in some rooms used by staff was in noticeably better condition than the floors in some residents' apartments. In the corridor leading from the reception area into the designated centre there was a large mat. The flooring immediately around and underneath this mat required cleaning.

There were a number of communal areas along one corridor of this building. An inspector met with one resident in the sitting room who was watching television. The communal rooms were observed to be decorated in a homely manner and appeared clean. Behind the radiators in some of these rooms required cleaning. Although three windows in the room were open there was a strong smell of tobacco smoke in the smoking room. While the inspector was in this room a staff member entered and adjusted the door leading to the corridor and other communal areas so that it would remain open. It was noted on the corridors that although the areas around them had been cleaned, a layer of dust was observed on some fire extinguishers. There was a lift on this corridor to facilitate access to the administrative and training rooms on the first floor. The lift was observed to be clean. A physiotherapy room was also located off this corridor. This was fitted out with a variety of equipment. Again this room appeared to be well maintained and visibly clean. At the time that an inspector first visited the dining room area, there were no residents present. Residents had already eaten their breakfasts and lunch was to be made available within an hour. A number of tables had not yet been cleaned since breakfast. Staff were observed cleaning these tables later in the inspection. A number of the chairs in the dining room were observed to have torn upholstery in many areas, including on the arm rests. As a result it would not be possible to effectively clean these chairs. It was also noted that one of the hand sanitiser units was empty while another required cleaning. A dustpan and brush stored in this area had not been emptied.

One of the apartments, designated to provide a respite service, had been identified to use as a COVID-19 isolation room if required. This room was vacant at the time of this inspection. A room that was ordinarily designated as a prayer room was being used as a staff meeting room given the increased space that it offered. The building also had its own dedicated laundry room that was used to launder the clothes and linen of residents living in this building. Inspectors were informed that staff worked in the laundry from Monday to Friday only. An inspector spent time in this room and noted that the layout promoted a system that kept clean and dirty laundry separate. It was also noted that the laundry had multiple washing machines and dryers. A system was in place for laundry to be returned to individual residents. One resident spoke with an inspector regarding this saying that laundry was washed and returned every day during the working week. At the weekends they said that laundry was taken away in bags and would be returned during the week. Just off this room was a sluice room. It was noted that parts of the sink in this area required

some further cleaning.

Throughout this building were wooden handrails on both sides of some corridors. It was observed by both inspectors that these handrails were marked, dented and chipped in places. Although staff were observed cleaning them, given the damage it would not be possible to effectively clean these surfaces. This applied to several areas throughout the building, including the corridors, toilets and dining room, where tiles, storage units and appliances were observed to be cracked or have damaged surfaces. At particular points in some corridors, there were supplies of personal protective equipment (PPE) such as gloves and aprons and bottles of hand sanitiser. In some areas these items were stored on handrails, and in others they were stored in wall mounted units. Inspectors were later informed that the reason for this was that some of the supplies received did not fit in the storage units. Some of the wall mounted hand sanitiser units had signs indicating they were no longer in use. Where this was the case, there was observed to be working dispensers nearby. Stocks of PPE and hand gels were available throughout this building and were noted to be in date. The only exception to this was an eye wash solution contained in the first aid box in the dining room. This required replacement. There were a number of relevant signs and posters on display referencing topics such as hand hygiene, respiratory etiquette and social distancing. Most bins in the building were pedal operated bins although some bins were noted not to be. These included swing bins in a toilet area and living room. When discussed with staff, inspectors were informed that these were used exclusively by residents unable to physically operate a pedal bin.

There were two rooms in the centre used to store cleaning products and equipment. The housekeeping and provisions manager explained to one inspector that there had previously been one room but that it was decided early in the pandemic to assign each half of the building to one cleaning staff member. Separate store rooms had then been set up to facilitate the storage of the equipment and products used by each of these staff so as to limit cross contamination. Each store had shelving and housed a cleaning trolley and equipment including mops, vacuum cleaners and a floor buffing machine. These rooms were noticeably different to each other. One was very cramped and the cleaning trolley had a large number of items on it, including a duster and sweeping brush that were not clean. This room also contained non-cleaning items such as artificial flowers. There was a folder of safety data sheets stored in this rooms. On review, it was noted to be incomplete. Later the housekeeping and provisions manager provided another folder which contained all of the required information. The other room was more ordered and spacious. The cleaning trolley stored in this room also had less items. There was a sign on the wall of this room stating that specific coloured mops were to be used in specific rooms. This sign was not observed in the other cleaning store.

Later on in the inspection, the smaller building that was part of this designated centre was visited by one of the inspectors. On arrival, the inspector was directed to sign a visitors' log and take their temperature. This building was comprised of some communal areas and five apartments. Each apartment had a bedroom with an en suite bathroom and a kitchen/dining area. The inspector looked into two of these apartments through open doors while a third was visited with the permission of the

resident living there. All three apartments were noted to be clean, very well maintained, homely and personalised. For example, one apartment had a number of posters and photographs on display related to the resident's favourite sporting team.

The communal areas of this smaller building were also reviewed. They were also noted to be very clean, with relevant signage on the walls and hand sanitiser gel readily available. The building contained a separate storage area for cleaning supplies but when in the dining area, the inspector saw a mop standing in a mop bucket. It was noted that the mop bucket was yellow, the mop handle was blue and the mop head, which was standing directly in water in the bucket, was green. This did not appear consistent with a colour coded cleaning system where specific coloured mops were to be used to clean specific areas so as to prevent cross contamination between different areas. The inspector also spent time in the communal kitchen which was found to be very clean. Facilities were available for hand washing and included soap and paper towels. However, it was observed that a sink clearly marked for hand washing only was full with dishes and plastic containers.

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

This designated centre was last inspected by HIQA in March 2020 where overall a good level of compliance with the regulations was found. Following that inspection, the centre's registration was renewed until August 2023. As part of a programme of inspections commenced by HIQA in October 2021 focusing on the National Standards for infection prevention and control in community services, it was decided to inspect this centre to assess adherence with these standards. Key areas focused on during this inspection included the monitoring and oversight by the provider of infection prevention and control practices, the leadership, governance and management systems, and the staffing in place in the centre.

The staff team providing direct support to residents included nurses and care support staff. These staff reported to a clinical nurse manager (CNM) who in turn reported to the person in charge of the centre. Other categories of staff also worked in the centre. There was a team of household staff who were primarily responsible for cleaning, laundry and kitchen duties including cooking. These staff reported to a head of housekeeping and provisions who in turn reported to the person in charge. It was indicated to inspectors that household staff were responsible for some cleaning in the centre and that staff supporting residents were responsible for other cleaning. Inspectors were told that the responsibility to complete certain cleaning tasks would depend on the nature of the cleaning required, for example, a member

of the management team advised that support staff would clean high-touch surface areas when leaving some rooms but cleaning of other areas such as floors was the responsibility of household staff.

Under the national standards, the roles and responsibilities of staff regarding infection prevention and control should be clearly defined. However, it was indicated to inspectors by a number of staff that there was a lack of clarity regarding whether members of the housekeeping staff or the staff directly supporting residents were responsible for completing some cleaning duties. Inspectors were also given contradictory information around the presence and activities of housekeeping staff during this inspection. For example, at the outset of this inspection inspectors were informed that the same household staff would not work in the kitchen and the laundry on the same shift but later a member of the household staff told an inspector that this could and did happen. Cleaning checklists and records reviewed indicated that staff responsible for cleaning completed specific duties on certain weekdays only. The person in charge told inspectors that two cleaning staff were rostered to work in the centre from Monday to Friday and one was rostered at weekends. Given the size of the building it was unclear if this weekend arrangement was sufficient, however other staff said that no cleaning staff worked at the weekends. Rosters for support staff and household staff were requested during this inspection but only rosters for the former were available to inspectors on the day.

When asked about some practices regarding cleaning and laundry management, some staff told inspectors that that was the responsibility of the household staff. This was of concern as in the absence of household staff, as was reported to occur at weekends and was the case in the early mornings, evenings and at night, other staff may be required to perform these tasks. Despite this, staff members spoken with during this inspection were generally very knowledgeable about infection prevention and control matters and had completed a broad range of IPC training. The majority of recent training had taken place online and was provided by both the Health Service Executive (HSE) and the provider's own national training hub. Inspectors reviewed records of audits completed monthly by nursing staff. These included observations of staff completing hand hygiene practices. Each support staff member had been observed washing their hands and assessed at least once in the previous 12 months. Records indicated that where areas for improvement were identified this was highlighted to staff and repeat assessments demonstrated improvement. Assessments were also completed that looked at catheter care, including aseptic techniques. A clinical nurse manger was responsible for oversight of these audits.

A system was in place where staff were to monitor and document their temperature twice a day when working in the centre. An inspector reviewed two months of these records and noted that on most days there was only one documented recording for many staff. Staff then informed the inspectors that there was a second log in use and that staff may have documented another temperature recording there. This arrangement did not lend itself to ensuring effective oversight of this system. When asked, staff were not clear if the recordings were monitored and were not aware of any gaps identified in the records. The records in place documenting residents'

temperatures were also reviewed and were found to be completed in full.

It was suggested that staff members were to be given information related to COVID-19 and infection prevention and control through emails and by documents in specific folders. It was also indicated that nursing staff would provide updates to care support staff as required. Particular emphasis was placed on the presence of an overarching COVID-19 document developed by the provider, which according to the centre's COVID-19 contingency plan, was to be available in hard and soft copies in the centre to reflect any updates. It was indicated to inspectors that this document was updated regularly.

Inspectors requested copies of relevant documents relating to COVID-19 and infection prevention and control. In total inspectors were provided with a total of eight folders which had COVID-19 or infection prevention and control or both in their titles. While such folders contained various guidance documents and relevant information, it was noted that there was a lot of duplication in these folders and some of the information contained within them was out of date. It was indicated to inspectors that specific folders contained the most recent information and guidance for staff to review but when inspectors viewed these folders it was seen that they also contained out of date information and documents that had been superseded. The version of the provider's overarching COVID-19 document given to inspectors was dated July 2021 and on the cover page stated it was to be reviewed in August 2021, six months prior to this inspection. A more recent version was not available and the one provided did not appear to take account of recent developments related to COVID-19 guidance.

This document made reference to the provider having a national COVID-19 team in place and it was seen that the provider did have structures in operation to escalate any concerns related to COVID-19. For example, in response to a recent COVID-19 outbreak which impacted the centre, the provider had established an outbreak control team whose membership contained those involved in the management of this centre as well as the provider's clinical and quality partners. This team met regularly during the outbreak, which was contained, and overall it was noted that since the start of the pandemic, there had been a low incidence rate of COVID-19 in the centre. It was also noted that within the centre generally, senior management team meetings and health and safety meetings took place regularly. A sample of notes from such meetings were reviewed which indicated that COVID-19 related matters were discussed regularly.

Direct support staff spoken with indicated that a member of nursing staff was always available to provide guidance on infection prevention and control. There was also an on-call service available for additional guidance and support if required. Some information on who to contact in the event of a COVID-19 concern arising was contained within the centre's COVID-19 contingency plan which had been reviewed in November 2021. This contained relevant guidance on how to respond to such matters although it was noted that aspects of this required updating. For example, the contingency plan outlined staffing levels for the centre at normal times and at time when the availability of staff would be impacted by COVID-19 but in some areas it was noted that the staffing figures for the latter were higher than for the

former.

Matters related to COVID-19 and infection prevention and control were considered by the provider's monitoring systems that were in operation. These included infection prevention and control audits, relevant self-assessments and provider unannounced visits carried out every 6 months. Inspectors also reviewed a sample of individualised cleaning checklists developed for residents. It was unclear if any member of the management team was responsible for oversight of these records. As will be detailed in the next section of this report, several gaps in completing this paperwork were noted. An inspector reviewed copies of reports for two provider unannounced visits conducted for the centre in 2021, both of which considered Regulation 27: Protection against infection. It was noted that such monitoring systems generally indicated a very good level of compliance in the areas of infection prevention and control. Although some areas for improvement were highlighted by inspectors during this inspection, these were not captured by the provider's own monitoring systems.

Despite this it was acknowledged that significant work had been undertaken by management and staff throughout the pandemic to reduce the potential for COVID-19 and other healthcare associated infections to impact this centre.

Quality and safety

During the initial period of this inspection when inspectors were reviewing the larger of the two buildings it was observed that many staff present were wearing surgical type face masks. No residents were observed at this time. As the inspection progressed during the day most staff were observed wearing respirator face masks both when in the presence of residents and not. National guidance requires that staff wear respirator face masks for all resident care activities. However, during this inspection it was observed that some staff were incorrectly wearing surgical masks, for example, some were observed to rest below staff members' noses, while others had not fitted respirator face masks correctly, as per recommended practice. There was reference in the provider's overarching document for the management of COVID-19 to guidance on facial hair and the use of respirator face masks. However when inspectors went to review the specified attachment which was to provide guidance, it was not available. Staff were unaware of what this guidance entailed and were unable to source the attachment referenced. It was therefore unclear if management had followed the provider's guidance in relation to the use of respirator masks by staff with facial hair. There was no evidence of risk assessments completed regarding this matter in the centre.

While some areas were observed to require cleaning, as referenced earlier in this report, overall it was noted that both buildings of the centre were clean. This was particularly notable for the larger building given its age and size. A housekeeping operational plan, specific to this centre, had been developed at the outset of the

pandemic to ensure that all local procedures were documented and available. An inspector reviewed this plan. The plan was very specific regarding some tasks, for example naming specific products to be used, and in other sections gave broad outlines of duties to be completed. Some tasks were to be completed as needed rather than at a specific frequency. Some omissions were also noted. For example, staff told inspectors and it was observed that kitchen staff were responsible for cleaning the residents' dining room. However this was not listed in the cleaning plan. It was also noted that some areas of the building were only cleaned on three named days. It was unclear who was responsible for cleaning these areas, if required, on the other four days of the week. There was no overall cleaning schedule in place for the centre, however cleaning checklist documents were available that indicated when cleaning tasks were completed. As with the differences noted in the cleaning supplies storage areas, different checklists were in use for the two sides of the building. It was not always clear from these records whether items were cleaned or cleaned and disinfected or which had been assessed as required. It was also noted that at times the same checklist was used for different rooms in parts of the building although items on the checklist were not always present in each room. Documents indicated that specific COVID-19 cleaning which included cleaning of commonly touched surfaces such as door handles and handrails was done twice a day and during the inspection a member of staff was seen carrying this out. However, while records reviewed indicated that this was being done, it was noted that such records did not explicitly state what items or surfaces had been cleaned with records containing broad statement indicating that all commonly touched items were cleaned on some days. Similarly, records indicated that all equipment in the physiotherapy gym was cleaned but each individual piece of equipment was not listed. Staff informed inspectors that individual cleaning records had been developed for each resident. These included items personal to each resident, and included the daily cleaning of wheelchairs and other mobility aids. Inspectors reviewed a sample of these and noted several gaps in the records. It was also noted that the provider's guidance document for the management of COVID-19 outlined that residents' mobility equipment was to be cleaned twice a day.

The person in charge informed inspectors that an external contractor had cleaned the centre at various intervals since the beginning of the COVID-19 pandemic. Regular 'deep cleaning' was also completed by the household staff. Similar to the findings regarding everyday cleaning in the centre, there was no deep cleaning schedule in place however records did indicate that additional cleaning tasks, such as cleaning of doors, windows and names apartments, were completed at times in the centre.

In addition, it also found during this inspection that there was some inconsistent information given around the use of colour coded cleaning equipment. A colour coded cleaning system involves designating colours to cleaning equipment for use in specific areas to help reduce the potential for cross contamination. In the larger building of the centre, some signage around the use of coloured coded cleaning equipment was seen relating to certain areas of the building but a staff member told an inspector that the same mop heads would be used when cleaning all areas of residents' apartments in that building. However, in the smaller building, when reviewing its cleaning folder an inspector came across a hand written note indicating

that particular colour coded items were to be used in certain areas of residents' apartments with a staff member present also confirming that this was the case. When reviewing the various COVID-19 and infection prevention and control folders provided during this inspection, inspectors did not come across any specific guidance on the use of colour coded cleaning equipment.

When speaking with residents, it was clear that they were aware of the enhanced infection prevention and control measures in place in the centre. Although not happy about the need for some of these measures, such as staff wearing masks, residents displayed an understanding of why they were in place. When reviewing the folders containing COVID-19 information in the centre, inspectors saw some information sheets prepared for residents. These included easy-to-read information on COVID-19 and a letter to each resident informing them of an outbreak in the centre and reminding them of precautions they could take to protect themselves and others. It was also noted that resident meetings continued throughout the pandemic, when possible, with smaller meetings arranged to ensure that residents could socially distance when attending.

Regulation 27: Protection against infection

Overall the provider had put in place systems which supported staff to deliver safe care and maintain a good level of infection prevention and control practice. However, this inspection did identify some areas where improvement was required. These included

- Further clarity was required regarding the roles and responsibilities of all staff working in the centre regarding cleaning and other infection prevention and control measures. This was required for when both support staff and household staff were present in the centre and also for the times when household staff were not on duty.
- Clarity was also required regarding the routine rostering of household staff to work in the centre throughout the seven day week.
- The information provided to staff regarding COVID-19 required review to ensure that the most up to date information was provided and was easily accessible.
- The centre's COVID-19 contingency plan required review to ensure that is was up to date and accurate regarding the number of staff that may be required in the event of an outbreak.
- Damaged surfaces on high touch areas such as torn upholstery on arm rests of chairs required repair. Damaged surfaces were also observed on handrails and large areas of flooring throughout the building, on storage units and some appliances. This visible damage prevented the ability to effectively clean these surfaces.
- The storage and cleanliness of cleaning equipment, including those stored in communal rooms, required review to ensure a high standard was consistent throughout the centre.

- In the absence of an overall cleaning schedule for the centre, the household operational plan and cleaning checklists required review to ensure the frequency of tasks to be completed was consistent with the provider's policies, that they were specific to the rooms/area concerned, were consistent throughout the centre and were monitored to ensure they were implemented as planned.
- Some areas of the premises required cleaning such as the area around and under the mat in the main entrance, behind some radiators, fire extinguishers and the sink/drainage board in the sluice room. This was a large centre and the majority of it was observed to be clean.
- Further clarity was required regarding whether a colour coding cleaning system was in use in the centre and if so, staff's adherence to implementing this system.
- Based on observations of the inspector and the provider's guidance documents and policies, the correct use and wearing of face masks in the centre required improvement. Clarity was also required on the guidance to be followed regarding facial hair and the use of respirator masks.
- The system regarding the recording of staff temperatures required review to ensure effective oversight was possible.
- Some hand sanitiser gel dispensers required cleaning and refilling. The majority were well maintained and supplied.
- One out-of-date product was noted in the first aid box stored in the dining room.

Judgment: Substantially 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	Substantially compliant

Compliance Plan for Rathfredagh Cheshire Home OSV-0003449

Inspection ID: MON-0036210

Date of inspection: 24/02/2022

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	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
Please see below details on areas identified in some areas where improvement is required and time scale for completion.

1. Further clarity was required regarding the roles and responsibilities of all staff working in the centre, regarding cleaning and other infection prevention and control measures. This was required for when both support staff and household staff were present in the centre and also for the times when household staff were not on duty.
A cleaning schedule is in place, and depending on the outbreak status, the CSWs would carry out the cleaning in the Covid Positive rooms, prior to vacating the room, to minimise cross infection within a small cleaning dept. This system worked well from March 2020 to March 2022 where we remained Covid free, with our first case of Covid-19 was contracted by a service user.
Touch surface cleaning is completed by all staff, depending on the area they work in e.g. the Courtyard staff touch surface clean their area and the gym is touch surface cleaned by the Therapies assistant. Records are in place to review this.
When it was required, the CSW would touch surface clean the bedrooms daily and the house-keeping staff would touch surface clean the corridors and communal areas, in line with all IPC guidelines and using the appropriate PPE. Records available on this cleaning, for review.
To ensure good Governance and monitoring of the cleaning records in accordance with Regulation 27, the cleaning records will be reviewed once weekly by the Head of House-keeping or designate to ensure no gaps in infection control occur.
- Time Scale for Completion - June 2022

2. Clarity was also required regarding the routine rostering of household staff to work in the centre throughout the seven-day week.
A historical roster of household staff is available for review and the seven-day household staff roster is prepared 5/6 weeks in advance.

3. The information provided to staff regarding COVID-19 required review to ensure that the most up to date information was provided and was easily accessible.
The Covid-19 information files will be streamlined and updated to contain only the most up-to-date live information for staff to access and the front cover of the Over-Arching document will be updated to reflect the times it is reviewed and updated accordingly.
· Time Scale for Completion - July 2022
4. The centre's COVID-19 contingency plan required review to ensure that is was up to date and accurate regarding the number of staff that may be required in the event of an outbreak.
The contingency plan staffing level which had been reviewed in December 2021, was reviewed following the recent inspection. The contingency plan was based on an outbreak situation and took into consideration less staff working overall, but for longer shifts to enable corridor isolation, no over-lap of staff within Rathfredagh and no cross over of staff within the Limerick Cheshire Service, to avoid cross infection in the event of an outbreak. Following review, the plan was amended to reflect more of the current Covid situation re: Vaccination uptake and in line with HSPC guidance on Outbreaks in Residential Settings.
· Time Scale for Completion - Completed
5. Damaged surfaces on high touch areas such as torn upholstery on arm rests of chairs required repair. Damaged surfaces were also observed on handrails and large areas of flooring throughout the building, on storage units and some appliances. This visible damage prevented the ability to effectively clean these surfaces.
The three chairs with torn arm rests, have subsequently been repaired.
The hand-rails have been repaired.
· Time Scale for Completion - Completed
There is a plan in place to repair the flooring in stages. The flooring repairs were scheduled, prioritizing the areas in most need of repair. This currently being facilitated.
· Time Scale for Completion – December 2022
All storage units and appliances are being reviewed and will be repaired or replaced as appropriate.
· Time Scale for Completion – July 2022
6. The storage and cleanliness of cleaning equipment, including those stored in communal rooms, required review to ensure a high standard was consistent throughout the centre.
New checklists have been developed to ensure consistency regarding the storage and cleanliness of cleaning equipment, including those in stored communal areas. These cleaning records will be reviewed monthly by the Head of House-keeping or designate to ensure no gaps in infection control occur.
· Time Scale for completion - Completed
7. In the absence of an overall cleaning schedule for the centre, the household operational plan and cleaning checklists required review to ensure the frequency of tasks to be completed was consistent with the provider's policies, that they were specific to the rooms/area concerned, were consistent throughout the centre and were monitored to ensure they were implemented as planned.
The cleaning schedules, which are based around the needs and wishes of our residents, have been reviewed and now include the frequency of tasks to be completed, with the understanding that some of the cleaning required in residents rooms will be completed with their consent, and may have to be rescheduled in line with their wishes.
· Time Scale for Completion - Completed

8. Some areas of the premises required cleaning such as the area around and under the mat in the main entrance, behind some radiators, fire extinguishers and the sink/drainage board in the sluice room. This was a large centre and the majority of it was observed to be clean.
The identified areas have been included in the revised cleaning schedule including the front Door Mat, fire extinguishers and the sink/drainage board in the sluice room.
A cleaning schedule has been developed to include quarterly behind-radiator cleaning using an air compressor.
These cleaning records will be reviewed Quarterly by the Head of House-keeping or designate to ensure no gaps in infection control occur.
· Time Scale for Completion - Completed
9. Further clarity was required regarding whether a colour coding cleaning system was in use in the centre and if so, staff's adherence to implementing this system.
A colour coding system is in use within Rathfredagh Cheshire Home and is currently being reviewed, including the updating our colour coded mop heads and mop handles, and up-to-date signage. The colour coding cleaning system to be discussed at all team meetings following this update.
· Time Scale for Completion – June 2022
10. Based on observations of the inspector and the provider's guidance documents and policies, the correct use and wearing of face masks in the centre required improvement. Clarity was also required on the guidance to be followed regarding facial hair and the use of respirator masks.
A risk assessment has been completed for the staff member with a beard. The HSE have been requested again to provide FFP2 mask fitting.
Staff will be required to refresh themselves regarding the donning and doffing of PPE on HSELand and same will be discussed at handovers.
· Time Scale for Completion – July 2022
11. The system regarding the recording of staff temperatures required review to ensure effective oversight was possible.
The staff temperature documentation has been amended to include am and pm temperature checking on the same recording line and the management team has commenced random weekly checking of this documentation for effective oversight.
· Time Scale for Completion - Completed
12. Some hand sanitiser gel dispensers required cleaning and refilling. The majority were well maintained and supplied.
The twice weekly checking and cleaning of sanitisers now included in the cleaning schedule.
· Time Scale for Completion - Completed
13. One out-of-date product was noted in the first aid box stored in the dining room.
The out-of-date product has been replaced. The First aid boxes are checked monthly and same documented. Historical check lists are available for review.

· Time Scale for Completion - Completed

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.	Substantially Compliant	Yellow	31/12/2022