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:	CareChoice Finglas
Name of provider:	CareChoice Finglas Limited
Address of centre:	Finglas Road, Tolka Valley, Finglas, Dublin 11
Type of inspection:	Unannounced
Date of inspection:	07 October 2021
Centre ID:	OSV-0005307
Fieldwork ID:	MON-0034329

About the designated centre

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

The designated centre provides long term residential care, transitional/respite care and convalescent care for persons, male and female, aged 18 years or over.
The premises can accommodate up to 89 residents in five units located over five floors; Tolka, Rivermount, Farnham, Claremont and Bellevue. There are two passenger lifts between floors. All bedrooms are en-suite with additional assisted shower and bathroom facilities on Rivermount and Claremont units.The majority of bedrooms are single occupancy. At least one twin room is available on each unit except on Bellevue. Each unit has its own lounge and dining area and there are additional quiet seating areas available for residents to meet with their visitors in private. Outside garden space is situated on the ground floor of the premises in a secure garden area to the rear of the building. Outside space is also available in a covered patio area which accommodates the resident smoking area and is accessed from the communal lounge on the ground floor. The centre is located in north Dublin close to local shops and amenities and is served by local transport routes.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	70

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 7 October 2021	09:20hrs to 18:30hrs	Michael Dunne	Lead
Thursday 7 October 2021	09:20hrs to 18:30hrs	Deirdre O'Hara	Support

What residents told us and what inspectors observed

This was a good centre where residents were enjoying a good quality of life. From what residents told us and from what the inspector observed, residents were happy with the care they received within the centre and were observed to be content in the company of staff. Care was seen to be given in a positive, respectful and warm manner.

When the inspector arrived at the centre they were guided through infection prevention and control measures necessary on entering the designated centre. These processes were comprehensive and included a signing-in process, hand hygiene, the wearing of face masks, and checking for signs of COVID-19. Inspectors observed the same process being implemented with visitors throughout the day.

The designated centre is registered to accommodate 89 residents, located over five floors which were accessed by lifts. All bedrooms were en-suite with additional assisted shower and bathroom facilities located in two of the units. The majority of bedrooms were single occupancy. Each unit had its own lounge and dining area and there were additional quiet seating areas available for residents to meet with their visitors in private. There were two enclosed gardens and a covered patio area which accommodated the resident smoking area and was easily accessed from the communal lounge on the ground floor. These areas were suitable furnished with tables and chairs and contained colourful well-kept raised flower beds.

Inspectors met with a large number of residents during the inspection, who spoke about their experience of living in the designated centre.

Overall feedback shared by residents was positive. Residents could do what they wished with their day, including going out into the community. Resident spoke positively about the staff and they felt well looked after, and knew they could get help or assistance when needed.

Residents said they liked their bedrooms and said that the premises met their needs and that they were warm and comfortable. Residents privacy and dignity was maintained in bedrooms by the use of curtains with staff knocking on doors and seeking permission before entering resident rooms. Residents had access to TVs in their own bedrooms, and large screens in the communal rooms. Residents looked well and were able to exercise choice with regard to their clothing and possessions and how they spent their day. Residents were supported and encouraged to personalise their bedrooms with family photographs, favourite ornaments, personal possessions and memorabilia that were important to them.

Residents were satisfied with their menu choices and enjoyed the meals served in the centre. Resident meetings took place four times each year. Following feedback from residents, new pictorial menus were due to be launched at the next resident meeting to show the meals that were presented. Meals were seen to be well

presented and residents who required assistance with drinks, meals or snacks were assisted in a supportive and discrete manner.

Residents reported they had enough to do, and enjoyed the weekly planned activities. There was a calendar on display which showed the activities on offer. For example bingo, arts and crafts, Sonas therapy, baking, singing and dancing, movie afternoons and reminiscence therapy. There was newspaper reading daily and newspapers could be delivered to those who requested them. 'Happy hour' was part of the activities on offer during the inspection day,where games were played and prizes won. There was good attendance and participation seen during this activity. Some of the activity staff were trained to deliver fit for life exercise classes, which took place every Wednesday.

Mass could be viewed on T.V.'s and a priest visited once a month to celebrate mass in person. There was also one-to-one sessions for residents who could not or did not wish to take part in group activities. Residents also told the inspectors that the provider had hired a bus for outings, and in particular they enjoyed the recent trips to Howth and the Botanical Gardens. Pictures were displayed on walls showing summer party celebrations.

There was sufficient space for residents to meet visitors in private within the designated centre. The residents had requested a new shelter which had been constructed in one of the enclosed courtyards, and heaters were being installed on the inspection day.

Inspectors also spoke with residents' family members, who spoke positively about the service, and indicated that they could visit their relatives in resident bedrooms, and stated that they could leave the centre with peace of mind regarding the care provided to their loved ones in the centre. Residents commented that they were delighted to have visiting return to somewhere near normal and compassionate visits were seen to be sensitively supported by staff. There were electronic devices in use for residents to stay in contact with friends and family abroad if they chose.

Residents felt safe in the centre, and knew who they could go to if they were concerned or dissatisfied with any aspect of living in the centre, and that such matters would be taken seriously.

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 the quality and safety of the service being delivered.

Capacity and capability

The inspectors found that residents received good care and support from staff that was person-centred in nature and facilitated them to enjoy activities of their choice on a daily basis. Overall this was a well managed centre with systems of oversight in

place to ensure that residents health and social care outcomes were achieved according to individual need. There were however some improvements required in areas such as governance and management, training and staff development, notification of incidents and measures to protect against the risk of infection.

Care Choice Finglas Ltd is the registered provider for Carechoice Finglas. There were well defined management structure in place with identified lines of authority and accountability. The person in charge worked closely with the registered provider who monitored overall performance of the designated centre and they were also supported in their role by the assistant director of nursing (ADoN),a quality and safety manager, nursing, activity staff, health care assistants, maintenance,household staff and volunteer.

This was an unannounced inspection to monitor compliance with the regulations and to follow up on the concerns raised through the receipt of unsolicited information which highlighted low staffing levels in the designated centre. Inspectors found that due to the movement of residents between floors staffing levels were being monitored by the person in charge to ensure that there was sufficient staff in place to ensure that the needs of residents were met.

At the time of the inspection the registered provider had submitted an application to renew the registration of the designated centre and was proactive in submitting the required information to the Office of the Chief Inspector. Inspectors found that there were systems in place to monitor the quality of the services provided. These included an audit programme which reviewed falls, medication management,infections wound care and responsive behaviours. The registered provider was keen to use information collected to further improve services provided as was seen in notes of clinical governance meetings, health and safety committee meetings, floor meetings and infection prevention and control committee meetings.

While there were systems in place to review and monitor services and care given, the audit tool used to give the provider assurances that infection control met the required standard did not identify deficits found by inspectors. This is discussed under Regulation 27: Infection Control.

Records reviewed and discussions with the staff team indicated that they had received regular mandatory training in areas such as fire safety, safeguarding, manual handling with 100% attendance rate observed by inspectors. Additional training provided included Infection prevention and control, cardio pulmonary resuscitation (CPR), restrictive practice, wound care and medication management. Staff were able to discuss how they incorporated learning from this training into their current work roles. New staff were also supported by means of an induction programme which covered key areas including the prevention of abuse, care needs of residents and communication. There was an appraisal system in place for existing staff to monitor their performance and identify opportunities for continuous development however inspectors found that appraisal records required updating to ensure that they provided a clear picture of staff performance.

However,improvement was seen from the last inspection with regard to the roles

and responsibilities for volunteers which was clearly defined in records reviewed and included vetting by An Garda Síochana.

While the Chief Inspector had been notified by the person in charge, of incidents required under Regulation 31, they had not included all incidences when restrictive practice had been used. The use of sensor alarms had not been included in the latest quarterly returns however this arose due to a misunderstanding which was explained by the person in charge. The inspectors provided clarity on this matter.

The designated centre encountered an outbreak of COVID-19 which ran from 17 March 2020 until its closure by public health on the 18 May 2020. Inspectors acknowledged that this was a difficult time for staff and residents in the designated centre. Inspectors reviewed information regarding the designated centres response to the risk of COVID-19 and found that there was a COVID-19 contingency plan in place to guide staff should an outbreak occur. Records reviewed by inspectors indicated that contingency plans were kept under review with the last review noted on the 27 August 2021. An infection prevention and control committee provided additional oversight to ensure measures in place to prevent the spread of infection were kept under review.

Residents were invited to resident meetings which were held quarterly and residents were also consulted in the running of the centre in regular conversations and feedback with senior management. Improvements seen, which impacted positively on the lived experience for residents, showed that there had been a visiting pod erected, and an improved labelling system for residents' laundry and more trips to areas of interest.

An annual review of quality and safety for 2020 was prepared in consultation with residents and families and included key information gathered from resident surveys, resident committee meetings and general feedback received throughout the year.

There was an up-to-date complaints policy available and a complaints procedure prominently display in the centre. Fourteen complaints had been received in 2021. They were all closed and were seen to be dealt with in a timely manner with the outcome and satisfaction levels of the complainant recorded and lessons learnt from these complaints were used to improve the lives of residents

Regulation 15: Staffing

There were sufficient numbers of staff with the required skill mix available to meet the assessed needs of the residents' having regard to the size and layout of the designated centre.

Judgment: Compliant

Regulation 16: Training and staff development

There was an appraisal system in place which supported staff supervision and continuous professional development. Records reviewed by inspectors indicated that appraisal documentation required updating to ensure that it presented an updated analysis of staff performance and support needs.

Judgment: Substantially compliant

Regulation 23: Governance and management

While there were a range of management systems in place to monitor the quality and safety of the services provided, inspectors found the following areas required strengthening to ensure a consistent approach was maintained across the service.

- The oversight of human resource processes required review to ensure that staff appraisals were happening on an annual basis and in line with the centres policy.
- The auditing system to monitor service provision and to identify areas for improvement did not identify deficits regarding the storage of equipment and areas relating to infection prevention and control.
- Systems and processes for identifying incidences of restrictive practices required strengthening in order to ensure that they were accurately recorded and submitted to Office of the Chief Inspector as set out under regulation 31.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

There was a statement of purpose in place which had been updated by the provider. The statement of purpose gave an accurate account of services and facilities available in the designated centre.

Judgment: Compliant

Regulation 30: Volunteers

The designated centre had arrangements in place to access volunteers which were

seen to support the activity staff deliver the comprehensive programme of activities. This service was available Monday to Friday. Volunteer roles and responsibilities were recorded and were available for inspectors to review. Volunteers were supported and supervised in their work by the designated centre's activity staff.

Judgment: Compliant

Regulation 31: Notification of incidents

Improvement was required to include all occurrences of when restrictive practice were used to protect residents, such as the use of bed and chair sensor alarms in the designated centre.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

There was an accessible and effective complaints procedure and they were responded to promptly and was overseen by the management team.

Judgment: Compliant

Quality and safety

Overall, residents' wishes and choices regarding their care and quality of life were respected and were central to service provision in the designated centre. The management team ensured residents had the opportunity to feedback on the service they received. There was evidence of good consultation with residents and arrangements were in place to ensure their social care and nursing care needs were being met with appropriate access to timely medical services and good standards of nursing care and support. Improvements were required with regard to premises and infection control which are discussed in detail under the relevant regulations.

Admission assessments were comprehensive and informed the development of individual care plans. The care plans seen were person centred, and incorporated feedback and consultation with the resident and/or their family where appropriate. Evidence based tools were used to assess resident conditions and informed the care plans which were reviewed regularly and updated if incidents had occurred or the residents' needs changed. There were monitoring procedures in place to ensure any deterioration in residents' health or well-being was identified without delay. End of

life care plans were developed in consultation with residents, their families and medical staff, to ensure that residents received appropriate care and to ensure they detailed residents wishes and preferences.

Residents were assisted to be as independent as possible through good health care provision, encouragement and assistive mobility equipment. Residents were referred to specialist services as they required it. If residents required review by psychiatry of old age or geriatrician services, this was seen to be well supported by teams from a nearby hospital and local community services. National health screening was available to those who were eligible

Where residents were seen by specialists their recommendations were actioned and integrated into care plans. For example specialist tissue viability and additional nutritional requirements to enhance the quality of life for residents were addressed in a timely manner.

Evidence was seen that indicated the service was striving to understand residents' responsive behaviours and respond appropriately and in a person centred way. Staff mainly used a combination of de-escalation techniques and communication techniques to help residents who were experiencing responsive behaviours. Where restrictive practices were used, they were assessed and monitored, and alternative measures had been trialled. Restrictive practices were part of a review and audit process and a register was maintained.

Staff were knowledgeable on the different forms of abuse which can occur in a nursing home setting, and were clear on how to prevent, identify and report incidents of suspected, alleged or actual incidents of abuse. Residents stated that they felt safe and would talk to staff if they became concerned. Any safeguarding investigations were seen to be addressed properly, with appropriate measures in place to protect residents.

There was an advocacy service available if residents wished to access supports. Residents had access to a residents meeting to air their opinion and give feedback on the service they received. In records seen they showed that one of the advocates attended this meeting. Residents had access to recreational facilities and an activity programme that helped promote their engagement and enjoyment.

Residents were enabled to maintain their friendships and relationships with their families as visitors were welcomed in the centre. Visiting was seen to take place in resident bedrooms, as rooms were mostly single occupancy and there were also facilities to enjoy private visits outside of their own accommodation.

There was clear risk management policy in the centre, which detailed the aspects of risk management as required by the regulation. There was a plan in place to manage emergencies and evidence was seen that incidents were reviewed and lessons learned. Residents clinical risks were well known to staff, and controls were in place to ensure a positive risk taking approach to residents needs was taken.

Regulation 11: Visits

Infection prevention and control measures were in place which allowed residents to receive visitors safely. The Inspector saw that the person in charge ensured that the up-to-date guidance from the Health Protection Surveillance Centre was being followed and was communicated to residents and families.

Judgment: Compliant

Regulation 13: End of life

End of life care plans seen, detailed resident wishes in relation to their physical, social and spiritual needs and preferences. There was evidence that residents were consulted when developing these plans, and where appropriate, family members were consulted.

Judgment: Compliant

Regulation 17: Premises

Improvements were required in the following areas which impacted on cleanliness and safety of residents:

- Oxygen cylinders were not stored securely in treatment rooms.
- Access to fire extinguishers were obstructed by drug trolleys, sharps bins and an I.V stand.
- Linen trolleys and linen skips were seen to be stored in assisted bathrooms.

Judgment: Substantially compliant

Regulation 26: Risk management

There was a detailed risk management policy in the centre. The risk register was maintained and the operational risks were clearly defined and controls described to manage the risk. Clinical risks were identified in care planning. Incidents were recorded and reviewed as and when they occurred and were subject to analysis to identify any learning opportunities to improve the service..

Judgment: Compliant

Regulation 27: Infection control

There were issues important to good infection prevention and control practices which required improvement:

- Staff hand hygiene practices required review as staff were seen to wear watches, stoned rings, and nail varnish. This meant that they could not effectively clean their hands.
- There was lack of clinical hand hygiene sinks and hand hygiene sinks seen did not meet the national standards.
- There were ample supplies of PPE available however a number staff were seen not to use PPE in line with national guidelines. For example staff were seen to regularly touch the front of their face masks and were found to wear gloves inappropriately.
- The monitoring records of staff for signs of COVID-19 infection were not in compliance with Public Health guidelines.
- Many sharps boxes were stored on floors in treatment rooms and the temporary closure mechanism was not engaged when they were not in use
- The gate of the external waste compound was unlocked and one clinical waste bin was not locked to prevent unauthorised access.
- Sterile dressings were not used in accordance with single use instructions, they were stored with unopened dressings which could result in them being re-used.
- Intravenous trays inspected were not clean with liquid or dust residue seen
- Equipment cleaning processes required review to ensure that I.V. trays, dressing trolleys and blood pressure cuffs were cleaned before disinfection.
- The storage of cleaning trolleys in sluice rooms could result in cross infection in the centre.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

A comprehensive assessment of residents' needs was completed on pre-admission and again within 48 hours of their admission. These assessments were used to develop care plans that were seen to person-centred and reviewed regularly as required.

Judgment: Compliant

Regulation 6: Health care

Residents had access to a general practitioner, who attended to them frequently in the centre, and to other allied health and social care professional services based on their assessed needs. A high standard of evidence-based nursing care was provided as evidenced by the use of regular clinical risk assessments using validated tools.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Staff delivered care appropriately to residents who had responsive behaviours. The least restrictive practice was seen to be used in accordance with national policy as published on the website of the Department of Health.

Judgment: Compliant

Regulation 8: Protection

There was a safeguarding policy available and all staff training was up-to-date with regard to safeguarding vulnerable adults.

All residents who spoke with the inspector said they felt safe and protected while living in the centre and that their rights were respected.

Judgment: Compliant

Regulation 9: Residents' rights

The inspectors reviewed residents' access to recreation. Facilities were available throughout the building to facilitate residents to attend activities. Residents were observed participating in many activities during the inspection. Residents' visitors were also facilitated semi-private visits in the enclosed gardens if they wished to meet their visitors outside of their bedrooms.

Judgment: Compliant

Regulation 12: Personal possessions

There were well defined systems in place to support residents access their finances and personal possessions. These systems were transparent and were supported by policies and procedures which were monitored and reconciled at regular intervals.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 30: Volunteers	Compliant
Regulation 31: Notification of incidents	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 13: End of life	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management	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	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant
Regulation 12: Personal possessions	Compliant

Compliance Plan for CareChoice Finglas OSV-0005307

Inspection ID: MON-0034329

Date of inspection: 07/10/2021

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: As and from October 11th 2021 HR have compiled an updated spreadsheet which now shows all staff appraisal due dates and analysis. All documentation will be reviewed by the Director of HR and will be aligned with the policy.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • As and from October 11th, 2021 HR have compiled an updated spreadsheet which now shows all staff appraisal due dates and analysis. All documentation will be reviewed by the Director of HR and will be aligned with the policy. There is an employee management system in place which is configured to alert line managers when appraisals are due and the person in charge monitors appraisal notifications. The HR generalist in the home supports the Person in charge to monitor and ensure all appraisals are completed as per policy. • The current auditing schedule involves the monthly unit IPC audit, internal annual IPC audit, quality IPC audit and the external regulatory audit which reviews the storage of equipment. Additionally, the clinical management team monitors and conducts regular spot checks. Further review of the audits will take place which will monitor the storage of linen trolleys and linen skips.	

• All incidences where restrictive practice has been used which includes the use of sensor alarms and the external front door will be included in the quarterly returns next due January 31st 2022

Prior to the inspection a restrictive practice audit was completed, and all sensor alarms were considered as part of a falls prevention strategy with the alarm alerting staff on the unit and not in the residents bedroom. However, on the day of inspection following further discussion and as requested by the inspectors, sensor alarms shall now be deemed as a psychological restraint. The PIC will continue to monitor the use of restraint. There is a restraint register in place and this will continue to be reviewed on a weekly basis

Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
• All incidences where restrictive practice has been used which includes the use of sensor alarms and the external front door will be included in the quarterly returns next due January 31st, 2022

The PIC will continue to monitor the use of restrictive practice. There is a restraint register in place and this will continue to be reviewed on a weekly basis.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• As and from October 11th 2021 the Oxygen cyclinders were removed and re located to the oxygen storage area

• As and from October 11th the fire extinguishers have been relocated to a single wall in the clinical room. Shelves have been added to the clinical rooms which now store the sharps bins . The IV stand has been relocated to the equipmemt room

• The linen rooms on each floor have been reorganised and as and from November 8th 2021 the linen trolleys will be stored in the linen room on each floor. The linen skips will be stored in the sluice room on each floor.

Daily monitoring of the above will take place by the clinical management team.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:

• Staff are not permitted to wear nail polish or watches and stoned rings whilst on duty and have been reminded of same. Management will monitor this. The Clinical management team will continue with education for all departments on hand hygiene and will carry out regular hand hygiene audits on individual staff.

Additional training on hand hygiene is planned for the week of November 22nd 2021 for all clinical/non clinical staff which will be carried out by an external clinical nurse advisor. The IPC policy has been reissued to all staff.

• The provider has developed an improvement expenditure plan to enhance IPC measures by carrying out the following works which will be completed on or before 30th March 2022:

· Additional clinical hand hygiene sinks will be installed on each floor.
· Existing sinks in clinical areas will be upgraded to meet the national standards

Additional hand gel units were installed throughout the building on November 3rd 2021 which included all residents bedrooms, the kitchen, lift and stairwell areas, corridors, offices, all communal areas and the waste bin area.

• The clinical management team will continue with education for all departments on the correct use of PPE and this will be monitored closely. A PPE assurance sign off sheet is in place which is now completed by a member of the clinical management team on a daily basis. Futher education has been rolled out on the correct use of PPE.

• This was discussed with all staff on the day of the inspection and at the clinical governance meeting which took place on November 3rd 2021. Staff temperatures are checked and recorded on each floor twice on a shift. As and from October 11th the checking of staff records which monitor signs of Covid -19 infection has been added to the daily clinical management team huddle and will continue to be monitored.

• As and from October 11th 2021 shelves have been added to the clinical room to store the sharps bins. Monitoring of the tempory closure mechanism will continue by the clinical management team. This was discussed on the day of inspection and will be discussed at all floor meetings in November 2021 and at the nurses meeting in December 2021

• On the day of the inspection the gate of the external waste compound was unlocked and one clinical waste bin was not locked. This was addressed on the day of inspection and is monitorerd daily by the maintainance staff on duty. This was discussed at the daily heads of department huddle.

• Monitoring of the use of sterile dressings will continue by the clinical management team. Once opened any unused surplus dressings will be discarded. This was discussed

on the day of the inspection and will be discussed at all floor meetings in November 2021 and at the nurses meeting in December 2021

• On the day of the inspection the Intravenous trays inspected were not clean with liquid or dust residue seen. This was addressed on the day of the inspection and is now added to the daily cleaning schedule. This will be discussed at all floor meetings in November 2021 and at the nurses meeting in December 2021. The clinical management team will continue to monitor

• The auditing system will be reviewed and will include the monitoring of storage of equipment and equipment cleaning processes which includes IV trays, dressing trolleys and blood pressure cuffs.

• The storage of cleaning trolleys has been reviewed with the PIC and the facilities manager. Alternative storage options were reviewed to allow additional storage capacity. The provider has developed an improvement expenditure plan to enhance IPC measures for the provision of a storage area for the housekeeping trolleys. These works will be completed on or before 30th March 2022.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/05/2022
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	08/11/2021
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	31/05/2022
Regulation 27	The registered provider shall ensure that procedures,	Substantially Compliant	Yellow	31/03/2022

	consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.			
Regulation 31(3)	The person in charge shall provide a written report to the Chief Inspector at the end of each quarter in relation to the occurrence of an incident set out in paragraphs 7(2) (k) to (n) of Schedule 4.	Substantially Compliant	Yellow	31/01/2022