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:	TLC Centre Santry
Name of provider:	TLC Spectrum Limited
Address of centre:	Northwood Park, Santry, Dublin 9
Type of inspection:	Unannounced
Date of inspection:	25 February 2021
Centre ID:	OSV-0000184
Fieldwork ID:	MON-0031993

About the designated centre

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

TLC Centre Santry is a designated centre located in north Dublin, registered to provide care for 128 men and women over the age of 18 years in single and twin bedrooms across four storeys. The ethos of TLC Santry is to promote an individualised person-centred approach to care for residents and their families who choose to live in the designated centre. TLC Centre Santry aim to ensure freedom of choice, promote dignity and respect within a safe, friendly and homely environment. All staff encourage residents to maximise their independence, achieve their potential and maintain interests. We support residents to develop new friendships and participate in activities appropriate to their needs.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	87

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 25 February 2021	09:00hrs to 17:35hrs	Niamh Moore	Lead
Thursday 25 February 2021	09:00hrs to 17:35hrs	Deirdre O'Hara	Support

What residents told us and what inspectors observed

Inspectors arrived at the centre and were met by the receptionist and person in charge who guided inspectors through the infection control measures necessary on entering the designated centre. Inspectors found that the provider had processes in place to ensure that visitors to the centre adhered to infection protection and control measures such as screening questions, the wearing of appropriate personal protective equipment (PPE), temperature monitoring and performing hand hygiene.

Residents were seen to be getting up at a time that suited them, this was confirmed in conversations with residents. There was sufficient staff to provide appropriate support in the morning, and nurse call bells were answered quickly.

Staff reported that they had recently received training in 'Nutritional challenges post COVID' and this helped them to guide their care delivery and provide better outcomes for residents who had lost weight.

An external courtyard was accessible to residents and this was suitable and safe for use by residents. There were raised beds and suitable seating provided and inspectors were told that this area was well used when visiting was allowed. The courtyard had a separate entrance gate to reduce traffic through the centre during visiting. There was a smoking shed outside for resident use and residents were seen to use this on the day.

Staff who spoke with inspectors said that they felt that they had come through a very challenging time and this experience had brought the team closer together which resulted in even better care for residents. They said that spirits in the centre had lifted greatly when the vaccine became available. Other staff said that because they had recovered from COVID-19 infections they had become more understanding of both residents and colleagues who were sick and the experience helped them in their work in caring for residents.

The centre had bedrooms across four floors which had single or twin occupancy. Residents reported to inspectors that they were happy with their bedrooms.

One staff member was a Eucharistic minister. They gave communion to residents, facilitated anointing and gave residents ashes on Ash Wednesday. Inspectors observed respectful and friendly interactions between staff and residents. Residents were seen to freely walk up and down corridors and spend time in communal areas. Residents told inspectors that they enjoyed looking out at the views from the windows on the third floor of the building.

The centre had a weekly itinerary for activities displayed in communal areas. On the day of inspection, there were planned activities such as a magic table taking place within the different floors of the centre. This was to allow for appropriate segregation of residents into groups to minimise the risk of the infection spreading

throughout the centre during the COVID-19 pandemic.

Inspectors observed that there was COVID -19 guidance advertised in key locations throughout the centre reminding people to observe social distancing, to wash hands regularly and to observe guidance in relation to the wearing of personal protective equipment (PPE).

Staff who spoke with inspectors said that they felt supported by management throughout the COVID-19 pandemic.

The next two sections of the report present the findings of the inspection and give examples of how the provider has been supporting residents to live a good life in this centre. It also describes how the governance arrangements in the centre effect the quality and safety of the service.

Capacity and capability

TLC Spectrum Limited is the registered provider for TLC Centre Santry. The centre had an established and clearly defined governance and management structure. The person in charge (PIC) was appropriately qualified and experienced for the role. The PIC worked full-time in the centre and was supported in their management role by two assistant directors of nursing.

The centre was experiencing an outbreak of COVID-19 on the day of inspection, which was first notified to the chief inspector in late November 2020. During this time, 71 residents and 61 members of staff had tested positive for COVID-19, and sadly 11 residents had passed away. Inspectors acknowledged that this was a difficult and challenging time for the management, residents and staff within the centre.

The centre had experienced two previous outbreaks of COVID-19 since the start of the pandemic, in April and September 2020. During these two outbreaks a further 16 residents and 17 members of staff had tested positive for COVID-19.

While there were systems in place to review incidents related to clinical governance, oversight needed to be strengthened to include time bound action plans,and learning from audits.

Records viewed by inspectors showed that there were arrangements in place to manage the COVID-19 outbreak in the centre. An outbreak control team (OCT) was set up with members of management and staff in attendance. Records showed that the OCT group met regularly during the outbreak. The registered provider had a clear pathway in place for testing and receiving swab results to detect the presence of a COVID-19 infection.

Inspectors reviewed the staffing rosters and found that there was sufficient nursing

and health care assistant staffing rostered to meet the care needs of the residents on the day of inspection.

Inspectors saw evidence that staff were facilitated to attend mandatory and supplementary training. Refresher training for fire safety was scheduled to take place shortly after the inspection.

The provider was seen to have taken the necessary steps in relation to restricting visiting as part of COVID-19 infection preventative measures. Visiting had been restricted in line with public health guidance. Families were facilitated to visit on compassionate grounds, such as at end of life.

Inspectors reviewed a sample of personnel records which evidenced that staff had all information required under Schedule 2 of the regulations including evidence of identification, qualification, and clearance by An Garda Síochána. Improvements were required to ensure that resident files were consistently stored securely.

There was a policy and procedure for people who wished to make a complaint. This procedure was visible throughout the centre and residents spoken with said they would feel comfortable making a complaint.

Regulation 15: Staffing

The provider had continued to provide a full staffing compliment during the recent outbreak with little use of agency during this time. The staffing compliment on inspection day was sufficient to support residents and ensure that appropriate care was available while they were recovering from COVID-19.

A staff team was allocated to each floor in the centre. They were made up of nursing staff and health care assistants. There were at least five nurses on duty at any one time in the centre. There were also household staff, and kitchen staff in sufficient numbers to meet resident needs. The provider had also had a large number of bank staff available when required and these staff were familiar with the centre and residents.

Judgment: Compliant

Regulation 16: Training and staff development

Staff were supervised in their roles by the assistant director of nursing and four nurse managers. There was a clinical nurse manager available in the centre twenty four hours a day to provide oversight of care to residents and support staff in their work.

A review of training records indicated that there was a comprehensive programme of training and staff were supported and facilitated to attend training relevant to their role. Nursing staff were trained to take swabs for the detection of COVID-19 infection.

While all staff working in the centre had received up-to date mandatory training which included infection prevention and control and moving and handling, a small number of staff were overdue fire safety and safeguarding training.This training had been delayed due to the recent outbreak and was to take place in the weeks following inspection. Staff who spoke with inspectors were familiar with fire safety measures and safeguarding the residents from abuse.

A sample of other training available to staff included restrictive practice, wound management, responsive behaviours and pressure ulcer management which enhanced the care that residents received.

Judgment: Compliant

Regulation 23: Governance and management

Inspectors found that there was a clear management structure in the centre. The registered provider representative, director of clinical services, person in charge, two assistant directors of nursing and four clinical nurse managers actively participated in the operation of the centre. Inspectors found that the centre was adequately resourced to ensure the effective delivery of care.

The provider had prepared a contingency plan for COVID-19 which had recently been reviewed based on the learning from the current outbreak. This contingency plan was available to ensure the intended response strategies could be easily followed and all relevant information and contacts were located together. The contingency plan detailed succession planning if key management personnel were unable to attend work, and to ensure the centre remained sufficiently resourced with staff and equipment.

The person in charge had a clear pathway in place for testing and receiving swab results to detect the presence of a COVID-19 infection.

There was a system of audit in place with meetings set up to provide oversight such as clinical governance meetings. However records reviewed did not sufficiently detail action plans with time bound improvement plans identified to respond to all risks or trends. For example, there was three incident analysis documents for 2020 reviewed by inspectors. One of these documents identified an action plan with time bound actions. One document identified learning outcomes but had no time bound actions, while the other document did not identify any learning outcomes or have an action plan. As a result, improvements were required to ensure the quality and safety of care and residents' quality of life was effectively monitored. The person in charge informed inspectors that new systems were being developed to allow for tracking

and monitoring of incidents within the centre with oversight from management.

There was an annual review of the quality and safety of care delivered to residents in the designated centre for 2019. The person in charge told inspectors that the annual review for 2020 was in progress but had been delayed due to the COVID-19 outbreak within the centre. The centre had commenced the consultation process with families and residents with surveys issued.

Judgment: Substantially compliant

Regulation 24: Contract for the provision of services

All the required information was seen in three records of contracts of care reviewed by inspectors. They included information with regard to fees, room numbers and the services available to residents.

Judgment: Compliant

Regulation 34: Complaints procedure

There was a complaints procedure in the centre which had been updated in November 2020. The PIC was identified as the complaints officer. The director of clinical services was the nominated person to ensure complaints were responded to. The registered provider representative was the nominated appeals officer.

There was information displayed on how to make a complaint in prominent positions throughout the centre.

The provider maintained a log of complaints received. Inspectors reviewed the log for 2020 and one complaint received for 2021. This log outlined the issues raised, the outcome of the investigation and recorded the satisfaction level of the complainant.

Staff were aware of how to respond to complaints and said that they would bring any issues to the attention of the complaints officer if they we not able to resolve the concern themselves.

Judgment: Compliant

Regulation 21: Records

The records required by the regulations were maintained in the centre. Staff records were reviewed and contained the necessary documentation. Resident files contained the required information. However, on two floors, resident files were stored in a manner that meant that they were not fully secure. This was addressed on the inspection day.

There was evidence of active registration with the Nursing and Midwifery Board of Ireland seen in nursing staff records viewed.

Judgment: Compliant

Quality and safety

Inspectors spent time within communal areas, observing and speaking with a number of residents and staff. Observations were that staff were patient, respectful and friendly with residents. Residents informed inspectors that they were supported with their assessed needs.

While resident's well-being and welfare was impacted during the COVID- 19 outbreak, dedicated staff in the centre worked diligently to provide care to residents at the height of the outbreak. When staff were sick or unavailable for work, they were replaced by bank staff who knew the residents and the layout of the centre. This ensured the provision of a good standard of evidence-based care and support. Staff who had been off work said they were pleased to have returned to work.

Infection prevention and control and health and safety audits were on-going in the centre. However the gaps identified in infection control during this inspection were not identified in the infection control audit tool being used to give the provider assurances that best practice was in place and was effective. For example: there was damaged furniture that could not be cleaned effectively, inappropriate use of single use dressings and medicine and I.V. trays were not clean.

All staff were following public health guidance in the use of PPE in the centre and ample supplies of PPE were available. Hand hygiene stations were set up and good hand hygiene techniques were observed however staff were seen to wear nail varnish and hand jewellery which meant that they could not effectively clean their hands.

Care plans seen were person centred and residents had comprehensive access to medical and allied health services. Records showed that where medical and allied health practitioners made recommendations for care these were implemented.

Inspectors found that residents had opportunities to participate in activities in accordance with their interests and capacities. However resident council meetings did not take place in 2020 and improvements were required to ensure residents had

opportunities to be consulted with and participate in the organisation of the centre.

Separate staff rooms, rest rooms and changing rooms were organised, so that staff working in separate floors did not mingle. The staff uniform policy included mandatory changing of uniform when coming on and off duty.

The design of the facilities supported residents to self- isolate in their rooms but the maintenance of the premises required improvement with regard to paintwork of doors. Flooring in areas of the centres were marked and stained. The provider told inspectors that upgrades to these areas had been identified before the pandemic but were still outstanding due to restrictions imposed by COVID-19 control measures.

Inspectors found that improvements were required within multi-occupancy bedrooms which is further discussed under Regulation 9. The provider informed inspectors that they were aware of the issues and had plans for further renovations to reduce the occupancy within these bedrooms.

The centre had a health and safety statement and a risk management policy in place to mitigate against identified risks including COVID-19.

Regulation 17: Premises

The premises was appropriate for the needs and number of residents in accordance with the statement of purpose.

While the premised was of sound construction improvements were required in the following areas which impacted on cleanliness and the safety of residents.

- Splash backs were required behind sluice hoppers and hand hygiene sinks where walls were seen to be damaged or not clean.
- Seals behind some sinks were not intact which would not facilitate adequate cleaning.
- The paintwork of walls, skirting, radiators covers and door frames were chipped or damaged throughout the centre, which meant that these surfaces could not be effectively cleaned.
- Window sills and flooring in clinical rooms were either not clean or were damaged.
- A number of chairs in the centre was seen to be worn, with damaged surfaces, impacting on effective cleaning.
- Carpets were seen to be heavily marked in areas such as the dining room and some bedrooms, and there was carpet in the physiotherapy room. Requests for the replacement of flooring in specific rooms was seen in correspondence and many had been changed. National guidelines recommend that the use of carpet in resident bedrooms and care areas should be avoided..
- Radiator covers were seen to be hanging off the walls in the activity room.

The provider informed inspectors that that upgrades to décor and carpets had been

identified and was part of a program to improve the environment for residents but delays had occurred due the COVID-19 pandemic and outbreaks in the centre.

Judgment: Substantially compliant

Regulation 26: Risk management

There was a comprehensive risk management policy in place, and it contained or referenced all the risks and appropriate controls, as required by the regulation. Risk identified were reviewed when they occurred and at management meetings. Staff were provided with the appropriate information to prevent or manage risks. Improvement was required in the centres risk register to identify individual staff responsible for specific measures when managing risks.

The provider had a plan in place to respond to major incidents likely to cause disruption of services or serious damage to property.

Judgment: Compliant

Regulation 27: Infection control

Infection prevention and control strategies had been implemented to effectively manage and control the outbreak. These included but were not limited to:

- Implementation of transmission based precautions for residents where required.
- Staff temperature checks twice daily in line with current guidance.
- Ample supplies of PPE available. Staff were observed to use PPE in line with national guidelines.
- There was increased cleaning and disinfection of all residential units. Inspectors were informed that there were sufficient cleaning resources to meet the needs of the centre.

A seasonal influenza vaccination programme had taken place and the COVID-19 vaccination program had commenced, with further vaccination sessions booked in the weeks following inspection. Vaccines were available to both residents and staff. There had been a high uptake of the vaccines among residents and staff.

While there was evidence of good infection control practice outlined above there were issues fundamental to good infection prevention and control practices which required improvement:

- Where the terminal cleaning of bedrooms that been signed off as being clean (when a resident had vacated the room and would not return) inspectors saw

in three rooms that wardrobes and drawer units were not clean and personal items belonging to another resident were stored in these en-suites bathrooms. Examples seen were items of clothing, personal hygiene products and assistive equipment.

- Staff did not evidence understanding of the symbol which identifies an item as single use and sterile dressings were not used in accordance with single use instructions.
- Two insulin pens were not labelled and one blood sugar monitor was not clean.
- Staff hand hygiene practices required review as some staff were seen to wear watches, stoned rings and nail varnish which meant that they could not effectively clean their hands.
- Some cleaners' rooms did not have hand soap or alcohol based hand rub.
- Medicine cup holders and four medicine trays seen were not clean which could lead to cross infection.

Judgment: Substantially compliant

Regulation 28: Fire precautions

On the day of inspection, inspectors followed up on areas of non compliance relating to fire precautions from the previous inspection which were found to have been addressed. Examples of this included records of recent fire drills and personal emergency evacuation plans (PEEPs). Residents PEEPs were found to be reviewed on a monthly basis or when a change occurred.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Inspectors reviewed a sample of care plans and found that they were personalised to individual needs.

Care plans reviewed related to COVID-19, falls and wound management. Inspectors found that care plans were prepared no later than 48 hours after the residents' admission to the designated centre. Care plans were based on a range of assessment tools that identified residents' health and social care needs. From these assessments, care plans were developed that used evidence based best practice to ensure the delivery of safe care.

Care plans were formally reviewed at intervals not exceeding four months. There was evidence that where a change occurred in between the formal review, care

plans and nursing documentation had been updated.

Where a medical need was identified, appropriate referrals to services such as physiotherapy and tissue viability nursing took place. Nursing notes reviewed showed that input from multi-disciplinary teams was recorded and their recommendations had been adopted by staff.

Judgment: Compliant

Regulation 6: Health care

The centre had good access to General Practitioners (GPs), with visits to the centre by their local GP clinic three times a week. Inspectors reviewed records of communication with GP's within residents' electronic files.

Referrals were available to consultant and nurse specialists such as Gerontology, Psychiatry of Old Age and Palliative care to provide additional expertise and support when needed.

The centre had a physiotherapist available on site Monday to Friday. Inspectors observed resident's attending the physiotherapist on the day of inspection.

Access to allied health professional services were available to residents and included occupational therapy, speech and language therapy, dietitian and tissue viability nursing.

The centre had referral pathways to access a dentist, optical services and podiatry. Residents were seen on the day of inspection to be supported to attend the dentist. Residents who were eligible availed of the National Screening Programme.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

The centre had a restraints policy which was reviewed in November 2019, to guide staff in the safe and appropriate use of restraints. Inspectors found that for residents who had a physical or environmental restraint such as a bed rail, security bracelets or posey alarm that care plans were in place to evidence the rationale for their use.

Consent forms and documentation were reviewed for the use of physical or environmental restraints. Records showed that discussions with residents and family members, if appropriate, were included within the consent process. Records also evidenced that there was a multi-disciplinary approach when using a restraint, with

signatures seen from resident or their family members, GP, physiotherapist and a member of nurse management.

Inspectors reviewed records relating to PRN (taken when required) medication and found that care plans were person centred and detailed to guide staff with regard to managing responsive behaviour. Inspectors found in one residents records where a PRN had been administrated, that the impact of the PRN medication had not been documented. All other records viewed showed that alternative methods and reassurance were trialled prior to issuing PRN medication.

Judgment: Compliant

Regulation 9: Residents' rights

At the time of inspection, visiting had been fully restricted due to COVID-19 level five restrictions, with the exception of compassionate visiting. Compassionate visits were seen to take place on the day of inspection. Video calls were available for residents to keep in touch with family members.

Records of family communication throughout the recent outbreak within the centre was reviewed and found that family members were regularly updated on the outbreak, swabbing, visiting arrangements and the vaccination schedule.

Residents stated they were happy with their bedrooms. Inspectors reviewed some multi-occupancy bedrooms and found that residents within these bedrooms shared a double wardrobe. A twin bedroom which was vacant on the day of inspection, had no facility to provide privacy curtains or partition. Inspectors requested this was reviewed prior to any resident being admitted into this room. Inspectors recommended that consideration was given to ensure residents within twin bedrooms had sufficient storage and their privacy maintained.

Inspectors found that residents had meaningful activity assessments to guide the completion of activity care plans. These care plans were seen to be person centred and reflected individual residents' preferences for activities. For example, one care plan referred to a residents religious preferences, how they enjoyed spending their day with particular books and their individual preferences for how they took their tea.

There was a weekly activity schedule available for residents to review. Activities were available seven days a week. Activities were facilitated in different floors of the building with suitable facilities in place to allow residents to comply with social distancing requirements. Residents told inspectors that they enjoyed the activities available.

Inspectors found that resident council meetings did not take place in 2020 and therefore residents did not have the opportunity to be consulted with or to participate in the organisation of the centre. The person in charge informed

inspectors that following their outbreak, which was due to close in the coming weeks, that the provider planned to organise a resident council meeting.

There was documentation seen in communal areas regarding an advocacy service available for residents.

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 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	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 21: Records	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for TLC Centre Santry OSV-0000184

Inspection ID: MON-0031993

Date of inspection: 25/02/2021

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 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: From March 2021, monthly incident analysis has been improved with the addition of time bound and specific action plans. Learning outcomes will be identified each month and shared with staff to reduce the risk of reoccurrence. From April 2021, all meetings held in the centre, including monthly governance, falls review meetings, health and safety meetings will have specific and time bound actions plans and appropriate follow up will be performed to ensure actions are addressed. The annual review of the quality and safety of care delivered to residents for 2020 is in progress and will be completed by 30th April 2021 and it will be issued to all families and residents in the facility upon completion.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: By the 22nd April, whiterock splash backs will be fitted to sluice room walls to facilitate easy cleaning and reduce infection control risks. An audit of all sinks in the building has been carried out and where defective seals are identified they will be removed and replaced with fresh seals. This work will be completed by the 15th of April 2021. Ongoing audit will identify these issues on a monthly basis and these issues will be addressed on a timely basis.	

By the 30th April 2021, the window sills and flooring in the clinical rooms will be replaced along with the flooring in these rooms.
An audit has been conducted on the furniture in the building and any chair found to be damaged or a risk to infection has been removed.

A painting schedule will be started to include all rooms and communal areas. Damaged doors, skirting boards and radiator covers will be repaired and painted. This work will be completed by June 2021.

The radiator covers in the activity have been repaired.

By July 2021, a schedule will be agreed for replacing the carpet in bedrooms, on a phased basis.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
A revised procedure has been implemented to verify terminal cleaning / deep cleaning after resident vacates the room. This procedure will be audited by the housekeeping manager. Complete
A weekly Glucometer audit has been put in place to ensure that the safe practice is followed by the staff nurses and education has been delivered to all nursing staff in relation to management and storage of insulin pens, glucometer and also wound management/single use dressings. Complete

Hand hygiene champions are assigned in every floor to promote good practice. Hand hygiene audits are carried out daily and the feedback is given to the floor on the same day. Staff training on IP&C (including the importance of adherence to the uniform policy) is ongoing and will be refreshed with staff at least twice a year. The daily IP&C audit checks that staff are complaint with uniform policy. Complete (and ongoing).

Wall mounted hand soap and alcohol-based hand rub installed in 4 cleaners rooms. Complete

A weekly medication trolley cleaning schedule is maintained by the staff nurses. Medication audits are carried out by Clinical Nurse Manager every month and this will include the cleanliness of all trolleys and equipment. The outcome of the audit is discussed with the staff nurses in the respective floors. Complete.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
The resident council meeting was conducted on 29th March 2021 and it will be held quarterly from now on. Complete

We are currently in the process of planning and designing an improvement to the centre including the reduction of double rooms, thereby improving choice for residents who prefer a single room.

An audit of bedrooms is carried out monthly and will ensure that curtains are in place in all shared rooms to maintain privacy for all residents. Complete

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 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	31/07/2021
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Substantially Compliant	Yellow	30/04/2021
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare	Substantially Compliant	Yellow	30/04/2021

	associated infections published by the Authority are implemented by staff.			
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned.	Substantially Compliant	Yellow	12/04/2021