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:	Acorn Lodge
Name of provider:	Acorn Healthcare Limited
Address of centre:	Ballykelly, Cashel, Tipperary
Type of inspection:	Unannounced
Date of inspection:	08 June 2022
Centre ID:	OSV-0000188
Fieldwork ID:	MON-0034555

About the designated centre

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

Acorn Lodge is a single storey, purpose-built centre established in 2001, and the registered provider is Acorn Healthcare Limited. The centre is registered to accommodate 50 residents both male and female over the age of 18 years. Residents are accommodated in single bedrooms, each containing en suites. Bedroom accommodation is provided in two wings and each wing also accommodates a linen room, sluice room, a non-assisted bathroom and a nurses' station.

The aim of the centre is to provide person centred care and services to residents, and caters for residents of all dependencies; low, medium, high and maximum care needs. These include persons requiring extended or long term care as well as those who require respite care or convalescence, dementia and cognitive impairment; residents with physical and sensory impairments and residents who may also have mental health needs. In addition, the centre caters for residents requiring Percutaneous Endoscopic Gastrostomy (PEG) feeds or special diets, subject to and in conjunction with, the support of the residents' General Practitioner (GP). There is 24-hour care and support provided by registered nursing and health care staff with the support of housekeeping, administration, catering, and maintenance staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	46

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
Wednesday 8 June 2022	09:00hrs to 17:00hrs	Mary Veale	Lead

What residents told us and what inspectors observed

Residents enjoyed a good quality of life and were positive about their experience of living in Acorn Lodge Nursing Home. There was a welcoming and homely atmosphere in the centre. Residents' rights and dignity were supported and promoted by kind and competent staff. Care was led by the needs and preferences of the residents who were happy and well cared for in the centre. Residents' stated that the staff were kind and caring, that they were well looked after, and they were happy in the centre. The inspector observed many examples of person-centred and respectful care throughout the day of inspection. The inspector greeted the majority of the residents and spoke at length with 12 residents. The inspector spent time observing residents' daily life and care practices in the centre in order to gain insight into the experience of those living in the centre.

On arrival the inspector was met by a member of the nursing team and guided through the centre's infection control procedures before entering the building. Following an introductory meeting with the person in charge the inspector was accompanied on a tour of the premises. The inspector spoke with and observed residents' in communal areas and in their bedrooms. The design and layout met the individual and communal needs of the residents'. The centre comprised of a single storey building with 50 single bedrooms. All of the bedrooms were en suite with a shower, toilet and wash hand basin. Residents' bedrooms were clean, tidy and had ample personal storage space. Bedrooms were personal to the resident's containing family photographs, art pieces and personal belongings. Many of the residents' bedrooms had fresh jugs of water, fresh fruit and flowers. The centres resident information booklet and weekly activities programme was available in all residents' bedrooms. Pressure reliving specialist mattresses and cushions were seen in residents' bedrooms.

There was a choice of communal spaces. For example, a multi- function room, a dining room, a library, a drawing room and oratory. The environment was homely, clean and decorated beautifully. Armchairs chairs were available in all communal areas. The drawing home had a fireplace, large television and a piano. The multi-function room had a television, large tables and was a space in which residents' could read the newspaper, listen to music or partake in activities. The dining room tables were covered with white cloth table clothes and had a fine dining room atmosphere.

Residents had access to enclosed garden areas, the doors to the garden areas were open and were easily accessible. The garden areas were attractive and well maintained with raised flower beds, seating areas and decorative animal ornaments. Residents were encouraged to use the centre's polytunnel, where seasonal fresh herbs and vegetables were grown.

Residents were very complimentary of the home cooked food and the dining experience in the centre. Residents' enjoyed homemade meals and stated that there

was always a choice of meals, and the quality of food was excellent. Many residents told the inspector that the dessert trolley was a speciality in the centre. The inspector observed the dining experience at lunch time and saw that there were two sitting for lunch. The first sitting was for residents who required assistance and the second sitting was for residents' who were independent. The lunch time meal was appetising and well present and the residents were not rushed. Staff were observed to be respectful and discreetly assisted the residents during the meal times.

Personal care was being delivered in many of the residents' bedrooms and observation showed that this was provided in a kind and respectful manner. The inspector observed many examples of kind, discreet, and person- centred interventions throughout the day. The inspector observed that staff knocked on residents' bedroom doors before entering. Residents very complementary of the staff and services they received. Residents' said they felt safe and trusted staff. Residents' told the inspector that staff were like family to them and were always available to assist with their personal care. Residents stated their call bells were answered in a timely manner.

Residents' spoken to said they were very happy with the activities programme in the centre. The weekly activities programme was displayed in the reception area and in all residents' bedrooms. Chair yoga was observed taking place in the multi- function room in the morning. In the afternoon some residents took part in a group activity of flower arranging and others played the card game bridge. The inspector observed staff and residents having good humoured banter during the activities.

The centre provided a laundry service for residents. All residents' who the inspector spoke with on the day of inspection were happy with the laundry service and there were no reports of items of clothing missing.

The inspector observed that visiting was facilitated. The inspector spoke with two family members who were visiting. The visitors told the inspector that there was no booking system in place and that they could call to the centre anytime. Visitors spoken to were very complementary of the staff and the care that their family members received. Visitors knew the person in charge and were grateful to the staff for keeping their family member safe during the pandemic.

The next two sections of this report will present findings in relation to governance and management in the centre, and how this impacts on the quality and safety of the service being delivered.

Capacity and capability

This was an unannounced inspection carried out to monitor ongoing compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) 2013 as amended. Overall this was a well-managed service with established management systems in place to monitor the quality and safety of the

care and services provided to residents. The provider had progressed the compliance plan following the previous inspection in November 2020. Improvements were found in relation to Regulation 15: staffing, Regulation 26: risk management, Regulation: 27 infection prevention and control, and Regulation 28: fire precautions. On this inspection, actions were required by the registered provider to address areas of Regulation 4: written policies and procedures, Regulation 16: training and staff development, Regulation 21: records, Regulation 27: infection prevention and control, and Regulation 34: complaints procedure.

The governance structure operating the day to day running of the centre consists of the person in charge (PIC) who was also the registered provider of the centre. The PIC was supported in their role by an assistant director of nursing, registered nurses, care staff, activities staff, catering, housekeeping, laundry and maintenance staff.

There were sufficient staff on duty to meet the needs of residents living in the centre on the day of inspection. The centre had a well-established staff team and turnover of staff was low. Several staff had worked in the centre for many years and were proud to work there. They were supported to perform their respective roles and were knowledgeable of the needs of older persons in their care and respectful of their wishes and preferences.

Improvements were required in the oversight of training needs in the centre. Staff had access to education and training appropriate to their role. There were, however, gaps identified in staff training matrix. This is discussed further under Regulation 16: training and staff development. Staff with whom the inspector spoke with, were knowledgeable regarding fire evacuation procedures and safe guarding procedures.

For the most part electronic and paper based records were well maintained. Requested records were made available to the inspector throughout the day and records were safe and accessible. Improvements were required in staff records and in the updating of Gardaí Síochána (police) vetting disclosures for some staff who had worked in the centre for a number of years. The provider was undertaking to review this and update these records. Policies and procedures as set out in schedule 5 were in place and required up dating and review, this is discussed further under regulation 4: written policies and procedures.

There were effective systems in place to monitor the quality and safety of care which resulted in appropriate and consistent management of risks and quality. There was evidence of a comprehensive and ongoing schedule of audits in the centre, for example; pressure sores, infection prevention and control, falls prevention and medication management. Audits were objective and identified improvements. For example; medication management audits completed identified actions were required to improve the recording of omissions of medication, and the crushing of medication. Following a review of the medication prescription sheet an additional column was in included for medications that required crushing. Records of management meetings showed evident of actions required from audits completed which provided a structure to drive improvement. Monthly clinical governance meeting agenda items included corrective measures from audits, key performance

indicators (KPI's) , visits, restrictive practice, refurbishment plans, and residents' activities. The annual review for 2021 was submitted following the inspection. The review was undertaken against the National Standards. It set out an improvement plan with time lines to ensure actions would be completed.

Incidents and reports as set out in schedule 4 of the regulations were notified to the Chief Inspector of Social Services within the required time frames. The inspector followed up on incidents that were notified and found these were managed in accordance with the centre's policies.

There was a complaints procedure displayed at the reception area of the centre and in the resident's information booklet which was available in all residents' bedrooms. There was a nominated person who dealt with complaints and a nominated person to oversee the management of complaints. There was no record of complaints received in the centre for the previous two years. The inspector was informed that concerns raised by residents were sorted locally, however there was no documentary evidence to confirm the investigation of these concern and the complainant's satisfaction of the concern raised.

Regulation 14: Persons in charge

The person in charge worked full time in the centre and displayed good knowledge of the residents' needs and a good oversight of the service. The person in charge was well known to residents and their families.

Judgment: Compliant

Regulation 15: Staffing

Staffing was found to be sufficient to meet the needs of the residents on the day of the inspection. There was a minimum of one nurse on duty over 24 hours and contingency arrangements were in place should additional staff be required to provide cohorted care to residents in the event of an outbreak of COVID -19.

Judgment: Compliant

Regulation 16: Training and staff development

Not all staff had access to appropriate training to support them to perform their

respective roles. For example, seven staff required training in Safeguarding, and five staff had not completed fire training in line with the centres mandatory training requirements.

Judgment: Substantially compliant

Regulation 21: Records

Improvements were required with staff records. In a sample of four staff files viewed, two of the staff files did not have evidence of relevant qualifications and one of the staff files had gaps in employment which was not in line with schedule 2 requirements.

Judgment: Substantially compliant

Regulation 22: Insurance

There was a valid contract of insurance against injury to residents and additional liabilities.

Judgment: Compliant

Regulation 23: Governance and management

Management systems were effectively monitoring quality and safety in the centre. Clinical audits were routinely completed and scheduled, for example, medication management, falls and pressure sores and these audits informed ongoing quality and safety improvements in the centre.

There was a proactive management approach in the centre which was evident by the ongoing action plans in place to improve safety and quality of care.

Judgment: Compliant

Regulation 24: Contract for the provision of services

The inspector viewed a number of contracts of care which outlined details of the

service to be provided and any additional fees to be paid.

Judgment: Compliant

Regulation 3: Statement of purpose

The statement of purpose contained all of the information set out in schedule 1 of the regulations and in accordance with the guidance.

Judgment: Compliant

Regulation 30: Volunteers

Volunteer's attended the centre to enhance the quality of life of residents. Volunteers were supervised and had Garda vetting disclosures in place. Their roles and responsibilities were set out in writing.

Judgment: Compliant

Regulation 31: Notification of incidents

Incidents and reports as set out in schedule 4 of the regulations were notified to the Chief Inspector within the required time frames. The inspector followed up on incidents that were notified and found these were managed in accordance with the centre's policies.

Judgment: Compliant

Regulation 34: Complaints procedure

Residents stated they could discuss any concerns with the person in charge or with any staff member. However the centre had not recorded any concerns or constructive feedback from residents in the last two year which was a missed opportunity to inform quality improvements in the centre.

The centre had a complaints policy and the procedure to follow was displayed in the day room area.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

Policies and procedures as set out in schedule 5 were in place and available to all staff in the centre. The centres schedule 5 policies indexed 1-14 had not been updated and reviewed in the last three years.

Updating of policies and procedures is important to ensure up to date evidence on best practice was available to guide staff.

Judgment: Substantially compliant

Quality and safety

Resident's well-being and welfare was maintained by a good standard of evidence-based care and support. There was a rights based approach to care, both staff and management promoted and respected the rights and choices of resident's within the confines of the service. Improvements were required in areas of infection prevention and control.

Visiting had returned to pre-pandemic visiting arrangements in the centre. There were ongoing safety procedures in place. For example, temperature checks and health questionnaires. Residents could receive visitors in their bedrooms, the centres communal areas and outside in the gardens. Visitors could visit at any time and there was no booking system for visiting.

The centre was not an agent for any residents pension. Residents had access to and control over their monies. Residents who were unable to manage their finances were assisted by a care representative or family member. All transactions were accounted for and double signed by the resident/representative and a staff member. There was ample storage in bedrooms for residents' personal clothing and belongings. Laundry was provided on-site for residents.

The centre was bright, clean and tidy. The overall premises were designed and laid out to meet the needs of the residents. A schedule of maintenance works was ongoing and a programme of decorative upgrades was in place, ensuring the centre was consistently maintained to a high standard. The centre was cleaned to a high standard and alcohol hand gel was available at the entrance to all bedroom doors.

The centre had recovered from a COVID -19 outbreak earlier this year. The centre had following the advice of Public Health specialists, and had put in place many infection control measures to help keep residents and staff safe. Staff were

observed to have good hygiene practices and correct use of personal protective equipment (PPE). Sufficient housekeeping resources were in place. Housekeeping staff were knowledgeable of correct cleaning and infection control procedures. The cleaning schedules and records had been reviewed since the last inspection. Intensive cleaning schedules had been incorporated into the regular weekly cleaning programme in the centre. The centre had reviewed its staff dining facilities since the previous inspection, and on the day of inspection the centre continued to have two separate staff dining facilities for each wing. Improvements were required in relation to infection prevention and control, this will be discussed further in the report.

The individual dietary needs of residents was met by a holistic approach to meals. A choice of home cooked meals and snacks were offered to all residents. Menus were varied and had been reviewed by a dietician for nutritional content to ensure suitability. The daily menu was displayed outside the dining room. Residents on modified diets received the correct consistency meals and drinks, and were supervised and assisted where required to ensure their safety and nutritional needs were met. Meal times varied according to the needs and preferences of the residents. The dining experience was relaxed. There was two sittings for meal times in the dining room. There were adequate staff to provide assistance and ensure a pleasant experience for resident at meal times. The catering assistant was knowledgeable about the residents' individual dietary requirements and liaised closely with the nursing team, ensuring any required changes to residents' diets were made.

The centre had a risk management policy that contained actions, and measures to control specified risks, which met the criteria set out in regulation 26. The centre's risk register was reviewed in February 2022, it contained information about active risks and control measures to mitigate these risks. Arrangements were in place for the identification, recording, investigation, and learning from serious incidents which included falls, injuries to residents, medication management and wounds/pressure ulcers. There were up to date COVID -19 risk assessments in place including the centres contingency plans for a COVID- 19 outbreak. The risk registered contained site specific risks such as risks associated with individual residents, risks associated with working in the kitchen and maintenance risks.

Effective systems were in place for the maintenance of the fire detection, alarm systems, and emergency lighting. Fire training was completed annually by staff. There was evidence that fire drills took place quarterly. There was evidence of fire drills taking place in each compartment, and of a simulated night time drill taking place in the centre largest compartment. Fire drills records were detailed containing the number of residents evacuated, equipment used, how long the evacuation took and learning identified to inform future drills. There was a robust system of daily and weekly checking, of means of escape, fire safety equipment, and fire doors. Weekly activation of the fire alarm system included staff response to the alarm. Each resident had a personal emergency evacuation plan (PEEP) in place which were updated regularly. The PEEP's identified the different evacuation methods applicable to individual residents for day and night evacuations, and their supervision requirements at the assembly point. Staff spoken to were familiar with the centres evacuation procedure. The centre had an nominated fire warden on duty

each day who was responsible for checking fire equipment and exits. There was fire evacuation maps and compartments maps displayed throughout the centre. There was evidence of regular fire meetings taking place in the centre.

The inspector saw that the resident's pre- admission assessments, nursing assessments and care plans were maintained on an electronic system. Residents' needs were comprehensively assessed prior to and following admission. Resident's assessments were undertaken using a variety of validated tools and care plans were developed following these assessments. Care plans viewed by the inspector were comprehensive and person- centred. Care plans were sufficiently detailed to guide staff in the provision of person-centred care, and had been updated to reflect changes required in relation to incidents of falls and restrictive practice usage. Care plans were regularly reviewed and updated following assessments, and recommendations by allied health professionals. There was evidence that the care plans were reviewed by staff. However; it was difficult to navigate the electronic system to determine if consultation had taken place with the resident or where appropriate that the resident's family review the care plan at intervals not exceeding 4 months.

There was policy in place to inform staff on the management of responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort with their social or physical environment) and restrictive practices in the centre. There was evidence that staff had received training in restrictive practice. For resident's with identified responsive behaviours, nursing staff had identified the trigger causing the responsive behaviour using a validated antecedent- behaviour- consequence (ABC) tool. There was a clear care plan for the management of resident's responsive behaviour. It was evident that the care plans were being implemented, and residents' had been reviewed by the psychiatry of later life team. There were five residents who used bed rails as a restrictive device. The use of bed rails had significantly reduced since the previous inspection. Restrictive practice risk assessments were completed, and the use of restrictive practice was reviewed regularly.

The centre had arrangements in place to protect residents from abuse. There was a site-specific policy on the protection of the resident from abuse. In addition the centre were using the national safeguarding policy to guide staff on the management of allegations of abuse. Safeguarding training had been provided to staff in the centre and staff were familiar with the types and signs of abuse and with the procedures for reporting concerns. All staff spoken with would have no hesitation in reporting any concern regarding residents' safety or welfare to the centre's management team.

There was a rights based approach to care in this centre. Residents' rights and choices were respected, and residents were actively involved in the organisation of the service. There was no record of resident meetings available on the day of inspection. However, there was evidence on the centres activity planner that a number of residents met each evening. The inspector was informed this was the time in which residents met to discuss care and service issues. Any issues discussed were raised with the PIC following these meetings. Residents had access to the

centres advocate and an independent advocacy if they wished. There was a varied and fun activities programmes. Residents were very complimentary about the centres activity programme.

Regulation 11: Visits

Indoor visiting had resumed in line with the most up to date guidance for residential centres. The centre had arrangements in place to ensure the ongoing safety of residents. Visitors continued to have temperature checks and screening questions to determine their risk of exposure to COVID-19 on entry to the centre.

Judgment: Compliant

Regulation 12: Personal possessions

Residents retained control of their personal belongings and finances. Each bedroom had an individual safe facility for residents' valuables. Laundry was well managed in the centre and there was ample storage space in bedrooms for clothing and personal possessions.

Judgment: Compliant

Regulation 17: Premises

The premises was meeting the needs of most residents and was decorated and maintained to a high standard. The premises conformed with all matters set out in schedule 6 of the regulations.

Judgment: Compliant

Regulation 18: Food and nutrition

The food served to residents was of a high quality, was wholesome and nutritious and was attractively presented. There was choices of the main meal every day, and special diets were catered for. Home- baked goods and fresh fruit were available and offered daily. Snacks and drinks were accessible day and night. Fresh water jugs were seen to be replenished throughout the day in residents' rooms and

communal areas.

Judgment: Compliant

Regulation 20: Information for residents

A guide for residents was available in every bedroom. This guide contained information for residents about the services and facilities provided including, complaints procedures, visiting arrangements, social activities and many other aspects of life in the centre. Specific information on additional fees was detailed in individuals' contract for the provision of services.

Judgment: Compliant

Regulation 26: Risk management

There was good oversight of risk in the centre. Arrangements were in place to guide staff on the identification and management of risks. The centre's had a risk management policy which contained appropriate guidance on identification and management of risks.

Judgment: Compliant

Regulation 27: Infection control

Some improvements were required to ensure the environment was as safe as possible for residents and staff. For Example;

- Two sharps bins containers in the treatment room did not have temporary closures in place.
- Two shower chairs contained rust.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The provider had good oversight of fire safety. Annual training was provided and systems were in place to ensure fire safety was monitored and fire detection and

alarms were effective in line with the regulations. Bedroom doors had automatic closing devices so that residents who liked their door open could do so safely. Evacuation drills were regularly practiced based on lowest staffing levels in the centre's largest compartment.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

The standard of care planning was good and described person-centred care interventions to meet the assessed needs of residents. Validated risk assessments were regularly and routinely completed to assess various clinical risks including risks of malnutrition, bed rail usage and falls.

Based on a sample of care plans viewed appropriate interventions were in place for residents' assessed needs.

Judgment: Compliant

Regulation 6: Health care

The standard of care planning was good and described person-centered care interventions to meet the assessed needs of residents. Validated risk assessments were regularly and routinely completed to assess various clinical risks including risks of malnutrition, pressure sores and falls.

Based on a sample of care plans viewed appropriate person-centered interventions were in place for residents' assessed needs.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

There was a centre-specific policy and procedure in place for the management of behaviour that is challenging. A validated antecedent- behaviour- consequence (ABC) tool, and care plan supported the resident with responsive behaviour. The use of restraint in the centre was used in accordance with the national policy. Staff were knowledgeable of the residents behaviour, and were compassionate, and patient in their approach with residents.

Staff were familiar with the residents rights and choices in relation to restraint use.

Alternatives measures to restraint were tried, and consent was obtained when restraint was in use.

Judgment: Compliant

Regulation 8: Protection

Measures were in place to protect residents from abuse including staff training and an up to date policy. Staff were aware of the signs of abuse and of the procedures for reporting concerns.

Judgment: Compliant

Regulation 9: Residents' rights

Residents' rights and choice were promoted and respected within the confines of the centre. Activities were provided in accordance with the needs' and preference of residents and there were daily opportunities for residents to participate in group or individual activities. Facilities promoted privacy and service provision was directed by the needs of the residents.

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 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 30: Volunteers	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 20: Information for residents	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 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Acorn Lodge OSV-0000188

Inspection ID: MON-0034555

Date of inspection: 08/06/2022

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 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 discussed during Feedback Session on date of inspection, Following Covid-19 interruption, all training will now return to face-to-face; in-house commencing July 2022. All courses will be Acorn Lodge Specific.	
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: Evidence of Certification now required will be requested from relevant staff members. CV to be updated.	
Regulation 34: Complaints procedure	Substantially Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: Day to day life in Acorn Lodge and how time is spent is dictated by our Residents and their profile. We have on-going feedback from our Residents on how to enhance and improve their quality of life and this is evidenced/represented in the Weekly Activity Schedule & Care Plans.	

Regulation 4: Written policies and procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 4: Written policies and procedures: Policies & Procedures will be reviewed & updated where required.	
Regulation 27: Infection control	Substantially Compliant
Outline how you are going to come into compliance with Regulation 27: Infection control: Offending Shower Chairs have been removed. Refresher / Reminder on safe use of Sharps Containers has been completed by all nurses.	

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)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	20/07/2022
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Substantially Compliant	Yellow	29/07/2022
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Substantially Compliant	Yellow	17/06/2022

Regulation 34(2)	The registered provider shall ensure that all complaints and the results of any investigations into the matters complained of and any actions taken on foot of a complaint are fully and properly recorded and that such records shall be in addition to and distinct from a resident's individual care plan.	Substantially Compliant	Yellow	13/07/2022
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Substantially Compliant	Yellow	31/08/2022