Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Delvin Centre 1
Name of provider:	Muiríosa Foundation
Address of centre:	Westmeath
Type of inspection:	Unannounced
Date of inspection:	31 January 2022
Centre ID:	OSV-0003955
Fieldwork ID:	MON-0035631

About the designated centre

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

This designated centre comprises of three bungalows located in close proximity to the nearest small town. The centre offers a full time residential service to eleven adults with intellectual disabilities and there are no gender restrictions. The first house has five bedrooms with a kitchen / dining area, utility room, bathroom, shower room and toilet. There is a garden to the front and an outdoor seating area to the back. The second house has six bedrooms one which has an en suite bathroom, a kitchen / dining area, sitting room, a bathroom and a shower room. There are gardens to the rear and front of house. The third house has four bedrooms with a kitchen / dining room, a sitting room, a bathroom, shower room and lawns to the front and rear of the house. The three houses have transport available for the residents. There is a full-time person in charge in place for the designated centre.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	11

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Monday 31 January 2022	10:50hrs to 18:30hrs	Karena Butler	Lead
Monday 31 January 2022	10:50hrs to 18:30hrs	Amy McGrath	Support

What residents told us and what inspectors observed

This inspection was carried out to assess the arrangements in place in relation to infection prevention and control (IPC) and to monitor compliance with National Standards for Infection Prevention and Control in Community Services (2018) and the associated regulation (Regulation 27: Protection against infection). This inspection was unannounced.

The centre was made of up three separate houses within nearby locations of each other. The inspectors met and spoke with the person in charge and staff who were on duty throughout the course of the inspection, and met with eight of the eleven residents who lived in the centre. Inspectors also observed residents in their homes as they went about their day, including care and support interactions between staff and residents.

On arrival at the first house, the staff member on duty guided the inspector through the infection prevention and control measures necessary on entering the designated centre. There was a dedicated IPC station in the porch. The process included temperature checks, completing a symptom check form, hand hygiene in the form of hand sanitiser, and clean face masks available for use. The staff member confirmed that there were no staff or residents with signs or symptoms of COVID-19 in the centre. This process was the same for the other two houses.

Inspectors observed the majority of staff appropriately using personal protective equipment (PPE), in line with national guidance throughout the course of the inspection.

The inspectors completed a walk-around of the premises. Each resident had their own bedroom with adequate storage facilities. There were adequate numbers of bathroom facilities in each house to cater for residents, staff and visitors. Some residents had an en-suite bathroom and others had shared facilities. While the houses appeared to be visibly clean and well-maintained in most areas, some premises risks were identified during the walk-arounds that were highlighted to the person in charge. These will be discussed further in the course of this report.

Staff employed in each of the houses were responsible for the cleaning and upkeep of the premises on a day-to-day basis. This was with regard to both the routine and enhanced cleaning tasks that were implemented at the start of the COVID-19 pandemic.

The centre had vehicles which were used by residents to attend appointments and activities and there was a cleaning protocol in place for the vehicles.

The inspectors found that while there were arrangements in place for hand hygiene to be carried out effectively, such as warm water, soap and disposable hand towels, they were not always in place in each hand hygiene area in each location. There

were a number of hand-sanitising points located throughout each of houses and all were in good working order.

Residents were supported throughout the COVID-19 pandemic to undertake safe leisure and recreational activities of interest to them and since government restrictions were lifted residents had started to re-engage in other activities. For example, on the day of inspection one resident went to have a massage.

Residents' rights were seen to be promoted with a range of easy-to-read documents, posters and information supplied to them in a suitable format regarding COVID-19 information such as, travel restrictions and social distancing. There were weekly resident meetings with discussions around hand hygiene, COVID-19 guidance and vaccines.

Where appropriate residents were supported to receive the COVID-19 vaccine by way of a de-sensitisation programme.

Overall, while there were some good IPC practices and arrangements in place, significant improvements were required in relation to staff training and further improvements were required with regard to hand hygiene arrangements, cleaning of residents' equipment, staff use of PPE, IPC oversight arrangements, and with regard to each of the premises. These identified issues will be discussed further in the report.

The following sections of the report will present the findings of the inspection with regard to the capacity and capability of the provider and the quality and safety of the service.

Capacity and capability

The inspectors found the governance and management arrangements were ineffective in assessing, monitoring and responding to infection control risks and hadn't adequately monitored all care practices in the centre. The provider did not demonstrate that there were adequate arrangements in place to determine and oversee performance in this area.

There were policies in place at an organisational level regarding a range of infection prevention and control risks. It was clear that these were informed by best practice however, practice on the ground within the centre did not always follow the guidance. There were a number of potential people to seek support information from however, there was no clear organisational structure to demonstrate this.

Inspectors found that while there was an IPC lead within the organisation and there was monitoring at a high level overview, this resource was under-utilised. It would be difficult for the centre to oversee areas for improvement in the absence of an IPC specialist’s input and consequently due to audits not been carried out by an IPC

specialist some quality improvement opportunities had not been identified by the provider.

The person in charge had recently completed a self-assessment against the centre's current infection prevention and control practices. There was good use of tools and checklists available however, these would benefit by being supplemented by an IPC audit by an appropriately trained person to ensure risks were picked up in a timely manner. For example, a periodic review of facilities would have picked up the IPC risks identified by the inspectors in this centre.

Staff had received training in IPC to support them in their role such as, donning and doffing PPE, hand hygiene, and introduction to infection prevention and control trainings. It was evident that this training had contributed to an understanding of COVID-19 and transmission. However, hand hygiene training had been provided online with no assessment of visual competency and there were some gaps in food safety training identified by the provider as outstanding for staff.

It was not evident that IPC risks and care practices were considered with regard to staffing and planning. The inspectors were not satisfied that the skill mix and the specialist advice at the time of inspection was sufficient. Significant improvement was required to ensure that workforce planning considered the infection control risks in the centre and that all staff had training appropriate to their role and responsibilities. In the case of house three, staff had either not received specific training or refresher training that was required to support an individual resident. Staff had not received training in aseptic techniques which was required in the same house due to the nature of the care and support staff provided to one resident. This was required in order for staff not to inadvertently cause an infection control risk to the resident through supports they provided.

Staff members were able to explain to inspectors the signs and symptoms of COVID-19 and were aware of the procedures to follow and who to contact in the event of an outbreak.

There were monthly team meetings occurring and some meetings included discussion regarding COVID-19 and cleaning equipment for the centre.

Overall it was found that the governance and management arrangements had failed to ensure that IPC risks were identified and managed in a prompt manner. There were significant concerns raised with regard to staff training with respect to infection control and assurance sought from the provider in relation to staff training.

Subsequent to the inspection the provider gave assurances that all staff would receive training in the identified areas with regard to aseptic techniques and the training required to support the healthcare needs of a particular resident and more robust oversight, and on-going assessments would be implemented.

Quality and safety

There were some good practices observed in relation to the delivery of person centred care and in some of the local implementation of infection prevention and control procedures. However, it was found that improvement was required to ensure residents received safe care and also in the cleanliness and safety of the physical environment in order to minimise the risk of acquiring a healthcare-associated infection.

Inspectors found that residents were provided with appropriate information and were involved in decisions about their care to prevent, control, and manage healthcare-associated infections.

There were systems in place to promote and facilitate hand hygiene, such as antibacterial gel available in several locations in each house and hand hygiene guidance was available for staff. The arrangements in place required improvement to ensure that there were adequate materials and facilities to ensure hand hygiene could be carried out appropriately. For example, some hand washing sinks in resident's bedrooms did not have soap or drying facilities available and the hand drying facilities at the sink in the utility room in house one was empty.

The provider had sufficient stock of PPE. While staff were observed to wear PPE for the most part in line with their training and best practice, some improper use of gloves was observed. Review was required in the provider's assurance of staff's adherence to PPE being used appropriately for the task required and doffed safely.

Inspectors found good evidence that staff were routinely self-monitoring and recording for symptoms and temperatures which may help to identify early symptoms of infectious illnesses. There were procedures in place for staff to record their own and residents' temperatures twice per day. There were also procedures for recording visitors' temperatures. Inspectors reviewed the temperature logs for the month of January 2022 in house one and found that temperatures were not always recorded for residents as outlined in the provider's guidance documents with some minor gaps identified. In addition, while staff and the person in charge were aware of the procedure to be taken in the event of a high temperature, they were not clear on what constituted a 'high' temperature as per the organisation's guidance, as the guidance had changed on a few occasions as to the organisation's definition of a high temperature.

Laundry was completed on-site using a domestic washing machine and the person in charge and a staff member informed the inspectors the centre had water-soluble laundry bags for the laundering of contaminated garments on site.

The inspectors completed a walk-through of each house that made up the centre. Each of the three premises were found to be generally clean and tidy with clear recording of cleaning conducted. However, some areas of the centre required significant improvement to ensure a safe environment. For example, mould was found in two out of the three kitchens, there was thick mould in an area of the utility room in house two and mildew found in a number of other areas in the houses. This was self-identified by the person in charge but yet to be dealt with by

the provider.

More attention was required in areas that were cleaned more infrequently as per the cleaning schedule. For example, the skirting boards in the kitchen of house one was notably dirty.

The inspectors found that some areas in the houses were not conducive to cleaning. For example, the taps in some resident bedrooms and bathrooms had limescale build up around the base of the taps which would prevent thorough cleaning of the area.

Some facilities required to be replaced or repaired in order to ensure effective cleaning of surfaces. These included, damaged wood surfaces in shared areas, kitchen chairs in house one, one bathroom tap was no longer fixed in place leaving a gap between the tap and the sink and the flooring between the kitchen and utility room of house two was taped together with duct tape.

In the main bathroom of house two, inspectors observed there to be an exposed pipe that that previously been used to plumb a bath. This pipe was blocked with material but had not been properly sealed or capped.

While there were some checklists in place for specific cleaning of certain items that used to support residents best possible health it was not evident that the checklists were followed accurately. With regard to a nebuliser used for one resident the nebuliser parts were observed to not have been cleaned properly as per the checklist and were seen to be visibly dirty. Staff spoken with were aware of aspects of the cleaning schedule but not each step. Some nebuliser parts were seen to be cracked and it was not evident how often parts were to be replaced.

Some single use items that were used to dispense resident medications were seen to be cleaned and reused.

There was no designated clinical area to store and prepare sterile supplies for aseptic procedures and no evidence that sterile supplies were used during these aseptic procedures.

There were arrangements in place to manage general waste. However, improvements were required to the waste management arrangements for the disposal of non-clinical waste in the centre as the majority of foot-pedal-operated bins had no bin liners but yet some contained used PPE and feminine products. There was no guidance in place for how to clean the bin receptacle in the event that no bin liners or bags were used. The person in charge spoke of the arrangements in place with regard to waste management and removal of clinical waste if required and this was in line with the organisation's guidance.

More consideration was required to storage of items in the centre. Some PPE was being stored on the ground in an outside shed and in house two a cover for the vehicle’s boot along with some boxes that contained new handrails to be installed were being stored on the ground in a bathroom. This could promote cross

contamination onto those stored items.

It was evident that staff were knowledgeable with regard to COVID-19 risk management as inspectors observed some good hand hygiene techniques and waste management. However, inspectors observed some improper use of PPE in relation to the use of gloves when supporting a resident with some personal care, as the gloves were used while completing other tasks prior to the personal care.

There was a colour-coded system in place for cleaning the centre, to minimise cross contamination and guidance was prominently displayed for staff in some of the houses but not others. This was required to ensure staff were using correct items in accordance with the colour-coded system.

Improvements were required in relation to the storage of and to ensure there were adequate amounts of mops and buckets for each house. The inspector found that there were inadequate amounts of buckets used for the cleaning of each house. Mops and mop heads were not stored or cleaned in a manner that minimised infection risk, with mops sitting in or on top of the buckets. The storage and cleaning arrangements had not ensured mop buckets were kept clean or that mop heads were safely dried prior to use.

There were clear outbreak management plans at an organisational level for a variety of infections. From talking to staff and the person in charge there was an awareness of reporting and were to seek advice. There were clear outbreak plans in place regarding COVID-19 for the centre and individuals had an individual COVID-19 isolation plan in the event that they were required to isolate or restrict their movements. The plans were very personalised and provided clear guidance on the supports that residents would require if they were to isolate. However, it would be beneficial to have input from an infection prevention and control specialist in the devising of any outbreak management plans to ensure all areas of the plan would work in practice. For example, when considering where staff should enter and exit from in the event of an outbreak and what areas should be made "clean rooms".

Regulation 27: Protection against infection

Systems in place for the oversight and review of infection prevention and control practices were not effective. While there were some arrangements in place to manage infection control risks and some good practices identified, improvement was required in a number of key areas where adherence to national guidance and standards required improvement.

Areas requiring improvement in order to comply with the standards include:

- staff required training in aseptic techniques, in a specific healthcare technique used to support an individual and refresher training in food safety as identified by the provider
- improvements were required with regard to hand hygiene competency

assessments, in the assessment of competency of the specific healthcare technique used to support an individual and in on-going spot checks of this competency
- review was required of the arrangements for the use of sterile equipment and a clinical area to store and prepare sterile supplies for aseptic procedures
- residents' healthcare equipment cleaning and frequency of replacement of equipment required review
- more consideration was required to storage of items in the centre
- arrangements for hand hygiene in the centre required review to ensure hand hygiene supplies were readily available
- while the house was generally clean and tidy some areas required a more thorough or deep clean
- damaged surfaces required repair or replacement
- adequate quantities of mops and buckets were required for each house
- storage of buckets and mops and laundering of mop heads required review to ensure that it was undertaken in a hygienic manner
- guidance was required for the use of the colour-coded system in place for cleaning the centre in house two
- improvement was required in terms of waste management as the majority of bins had no bin liners and no guidance was available for cleaning the bin receptacle if no liner was used
- review was required in the provider's assurance of staff's adherence to PPE to ensure PPE was worn in accordance with best practice
- an exposed pipe in a bathroom required to be capped or sealed properly
- not all infection control risks in the centre had been appropriately assessed, with some risks not identified
- not all identified infection control risks were dealt with in a timely manner
- the centre would benefit from specialist IPC oversight and audits in order to identify centre risks in a timely manner.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

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

Compliance Plan for Delvin Centre 1 OSV-0003955

Inspection ID: MON-0035631

Date of inspection: 31/01/2022

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

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 27: Protection against infection	Not Compliant
Outline how you are going to come into compliance with Regulation 27: Protection against infection: • To ensure effective governance and oversight a full review of the Designated Centre's Covid-19 contingency plans has taken place. IPC Contingency Plans will merge Covid-19 and other infectious diseases contingency measures. Plan will include guidance on location and specified use of 'clean rooms'. Further guidance will be sought from organisation's IPC's lead and Public Health Teams as required. • Infection Prevention and Control is now a standing agenda item on all designated centre team meetings, on monthly local area management team meetings and senior management team meetings within the region. • At local, area and regional meetings updated IPC guidelines, advice and policy will be advised and discussed. • Residents are advised in relation to any updated IPC guidelines, advice and policy and issues that will affect them or the running of the designated centre through Resident's Meetings and Easy Read Documentation • Families are advised of any IPC contingency plan implementation within the designated centre that will directly affect their family member or them e.g. visiting restrictions/limitations. • The organization has established an IPC Control Committee for this region, chaired by the Regional Director (Registered Provider) with all Area Directors (PPIM) as members. The IPC Control Committee meets every fortnight. • Muiriosa Foundation Training Department is currently developing IPC Training modules (QQI Level 5) which will be delivered to all Persons in Charge. This training is planned to be completed by 30/06/2022. • There will be a nominated IPC Lead (with qualification) in each designated centre. • Staff Training- full review of staff training requirements conducted on 21/02/2022 · All outstanding training in Aseptic Techniques (specific healthcare procedures) have been completed and a refresher training schedule created. · All staff have updated the following training on IPC through HSElanD:	

• Putting on taking of PPE in community healthcare setting
• Hand Hygiene for HSE Non Clinical Staff
• Breaking the Chain of Infection
· A trainer in Hand Hygiene has been identified and will complete in person competency assessments with all staff by 07/04/2022
· Food Safety training and refresher training to be completed by all staff by 07/04/2022
· Staff Training Requirements is a standing agenda item at monthly Area Team meetings with all PICs.
• In Quarter 1 2022, the Area Director and nominated PIC will conduct a thorough IPC audit and develop action plan for designated centre. The PIC will update the HIQA IPC Self-Assessment Tool and submit IPC Quality Improvement Plan to Area Director for review. This auditing and planning will be completed by 31/03/2022.
• The Area Director will support PIC to conduct additional thorough IPC audits on quarterly basis.
• Monthly maintenance request log is maintained by Area Director – all structural/building/fittings deficits that raise an IPC risk are added to Location Risk Register. Area Director will prioritise these deficits for action with Operations Manager at monthly review meeting. Area Director and PIC monitor these risks and implement control measures as appropriate.
• Individuals Risk Management Plans- full review of individual risk management plans re: IPC undertaken on 07/03/2022. Individual Risk Management Plans addressing potential social isolation of residents due to restrictions incurred with infectious disease outbreak are currently in development – to be completed with all residents by 18/03/2022

The registered provider shall ensure that:

Aseptic techniques:
• Local Procedure (developed by Registered Nurse) and associated risk management plan implemented. To be reviewed quarterly or sooner if identified or needs change.
• Dressing trolley in place to prepare sterile supplies for procedures
• All staff (including relief panel) have completed Aseptic technique training on HSElanD and are required to renew every two years.
• All Staff (including relief panel) have completed on-site training on resident's specific healthcare procedure supports by a registered nurse. All Staff have completed competency assessments and there will be continuous nursing oversight to complete spot checks and observations throughout the year with all trained staff. All staff are required to complete refresher training every two years or sooner if identified.

Hand Hygiene Observations:
• All Staff have been scheduled to complete AMRIC hand Hygiene training - to be refreshed every two years.
• A trainer in Hand Hygiene has been identified and will complete in person competency assessments with all staff by 07/04/2022
• Audit conducted on 25/02/2022 in designated centre to ensure full supply of hand hygiene equipment available to residents and staff in all identified handwashing areas.

Care and Maintenance of Nebulisers:
• Procedure (step by step visual) implemented to support all staff in appropriate technique of cleaning all parts of the nebuliser and when to change tubes and mask as

per Organisation's Cleaning & Infection Policy. All single use nebulisers are identified easily with symbol- all staff supporting residents who use nebulisers have been informed of same by PIC
• Local Procedure on the Care and Maintenance of nebulisers implemented in designated centre.
• Local procedures on local team meeting agenda to be demonstrated and review quarterly.

Medication Pots:
• Single use medication pots and disposal of same and reusable medicine pots and cleaning of same (as per organisation's Cleaning & Disinfection Policy) reviewed and discussed at February 2022 staff team meetings in designated centre.

Storage:
• Full review of storage across the designated centre conducted by PIC and items inappropriately stored on day of inspection have been removed.

PPE Storage:
PPE to be centrally stored. Local Procedure in place for the distribution of same. PPE that is stored in the designated centre is stored appropriately as per manufacturer's instruction.

Cleaning & Disinfection Guidance:
• Guidance on use of colour coded system as per policy updated and provided to all staff in the designated centre
• PIC has reviewed mopping systems and storage across the designated centre. Order placed for adequate supply of mops and buckets for the designated centre
• Protocol for laundering of mop heads implemented.
• Plan for hygienic storage of mop buckets implemented.
• Cleaning Schedule and adherence to same- standing agenda item on location team meetings going forward.

IPC Training:
• Muiriosa Foundation Training Department is currently developing IPC Training modules (QQI Level 5) which will be delivered to all Persons in Charge and Area Directors (PPIM). This training is planned to be completed by 30/06/2022.

Food safety training:
• All staff requiring food safety training or refresher training have been identified and training schedule now in place.

PPE Use:
• All staff in centre have completed training in Donning & Doffing of PPE in a Community setting. PIC has reviewed adherence to appropriate use of PPE in accordance with best practice with all staff at March 2022 team meetings.

Mould:
• Identified areas on the day have been cleaned and re painted.
• Local Procedure implemented on how to safely remove/ wash any area that have mould on them and on how to escalate same to PIC.

IPC
• Deep Clean (Professional Contractors) scheduled in QTR 1 2022 of designated centre.
• PIC has implemented quarterly IPC audit to ensure all areas are maintained as per cleaning schedule and IPC risks are escalated to Area Director and maintenance team- advice sought from organisational IPC Lead as required.
• Continue to audit with HIQA IPC Self-assessment tool and develop Quality Improvement Plan quarterly
• Monthly IPC audit conducted in each location
• All guidance, policies, audits and QIPs stored centrally in IPC folder in each location.
• Advice and guidance on IPC risks and identifying same sought from Organisational Lead in IPC as required.

Maintenance:
• Exposed pipe in bathroom has been sealed.

Waste Management
• Local Guidance Protocol implemented in designated centre on cleaning of bins.

Risk Register:

• All identified IPC risks in the designated centre are assessed and added to Location Risk Register and control measures implemented to reduce risk.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Not Compliant	Orange	30/06/2022