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:	Orwell Private
Name of provider:	MCGA Limited
Address of centre:	112 Orwell Road, Rathgar, Dublin 6
Type of inspection:	Unannounced
Date of inspection:	13 January 2022
Centre ID:	OSV-0000078
Fieldwork ID:	MON-0035397

About the designated centre

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

Orwell Private is located in south Dublin close to local amenities such as bus routes, restaurants, and convenience stores. The centre can accommodate 170 residents, both male and female over the age of 18 years. They provide long term care, short term care, brain injury care, convalescence care, respite and also care for people with dementia.
The centre is made up of a period premises that has been adapted and extended to provide nursing care and support through a number of units. The units provide bedroom accommodation alongside communal areas including sitting and dining areas and a kitchenette that are homely in design. Bedroom accommodation is a mix of single and double rooms, in the new areas of the centre the bedrooms are en-suite. Additionally on the premises there is a full time hair dressers, cafe, gym, library and training rooms.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	145

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 13 January 2022	09:00hrs to 17:50hrs	Michael Dunne	Lead
Friday 14 January 2022	09:00hrs to 16:35hrs	Michael Dunne	Lead
Thursday 13 January 2022	09:00hrs to 17:50hrs	Deirdre O'Hara	Support
Friday 14 January 2022	09:00hrs to 16:35hrs	Deirdre O'Hara	Support

What residents told us and what inspectors observed

Residents living in this centre were supported and empowered to live a meaningful life where their choices and views were respected. Inspectors observed residents receiving support in an unhurried manner which was provided in a manner taking into account the preferences of the individual resident. Residents expressed their satisfaction living in this centre and mentioned that staff were available to support them when needed.

Residents who spoke with inspectors said that staff are quite nice, "brilliant and work very hard" and that they come and take care of them when they ring the call bell. They said that they are seen by the GP when they are sick or when they want to speak with them. While there were positive health and social care outcomes for the residents living in the centre there were a number of gaps identified in the monitoring and oversight of regulations. Actions were required to ensure compliance with the regulations and are discussed under each individual regulation and under the sections called quality and safety and capacity and capability.

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

Orwell Private nursing home provides accommodation to residents in three separate buildings namely, Orwell, Raglan and Elgin which are linked internally. At the time of this inspection there was a COVID-19 outbreak on one of the units in the Elgin building.. This outbreak was managed in line with the registered provider's preparedness plans with the provider maintaining close links with the public health team for support and guidance.

The lived environment was clean and warm and inspectors noted that there were maintenance systems in place to ensure that the fabric of the building including fixtures and fittings were maintained to a high standard. There were a number of communal areas available for residents to meet their family and friends however due to the outbreak access to these areas was curtailed during the outbreak. Residents rooms were spacious and included sufficient storage space for residents to store and retrieve their personal items.

There was a café, which was normally open for residents and visitors to use but this had been closed due to the outbreak in the centre. Safe visiting was arranged through a booking system. Residents were also assisted to stay in touch with their family or friends using phones or IT platforms. There were visiting care plans for each resident to provide guidance for safe visiting.

Residents' views on the quality of the service was sought in a number of ways both formally and informally. There was a system in place to capture residents' views at

resident meetings or through resident satisfaction surveys. There was access to independent advocacy which was advertised in the residents guide and at locations throughout the designated centre. Residents also told inspectors that they could talk to staff on a daily basis should they have a problem or concern.

Residents who spoke with inspectors said they liked the food. They had plenty of choice with regard to what they would like to eat. Menus seen, showed there were three choices at meal times and should resident like something else, they could request it. While residents were supported with their meals in an unobtrusive manner, in one unit the tea cups were set out upturned on tables at the start of lunch which could be seen as institutional type practice. A dishwasher was operating loudly in this unit while residents were having their lunch.

Overall, the residents met during the inspection said that they felt safe in the home and that they liked living there. The next two sections of the report will present findings of this two day inspection in relation to the governance and management arrangements in place, and how these arrangements impact on the quality and safety of the service provided.

Capacity and capability

The management arrangements in the designated centre were well defined with clear lines of accountability and authority. There was a strong commitment evident among staff and managers to provide a quality service to residents and to maintain their safety and welfare. However despite this commitment, inspectors identified areas of oversight that required strengthening to ensure that a quality service was maintained and provided across all areas of the service. Actions were required to ensure full compliance with the regulations with regard to fire, behaviours that challenge,the safe storage of medicines, infection prevention and control and management oversight systems.

This was an unannounced risk inspection to monitor the registered provider's compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and to assess the registered provider's preparedness plan to manage the current COVID -19 outbreak. In addition this inspection also focused on measures the registered provider undertook to ensure that internal communication systems were sufficiently robust to ensure that staffing resources were allocated should a COVID-19 outbreak occur in the designated centre.

MCGA limited is the registered provider for Orwell Private of which there are four directors, one of which was on site during this inspection and was available for feedback following the inspection. There was a person in charge of the designated centre and inspectors were informed that two assistant directors of nursing had been promoted to directors of nursing and provided support to the person in charge. A team of nursing, care and household staff also contributed to the care provided to

the residents.

Inspectors found that a six monthly multi-disciplinary team review of restrictive practices had not taken place since January 2021, as directed by the centres own policy. This meant that the registered provider was not assured that if restrictive practices were used that they may not be used in a manner that is least restrictive. A director representing the registered provider informed inspectors that this was due to difficulties in recruiting an occupational therapist. A new occupational therapist had commenced employment in the centre the day before this inspection.

Of a sample of complaints reviewed, records indicated that each complaint was investigated and the outcome of the complaint process was recorded. While the complaints process was displayed in the reception area of each building there was a need to ensure that the process was on display in each unit so that resident could access this information easily.

This inspection found that management systems regarding the transfer of handover information from night to day staff had been strengthened with management audits in place to ensure that communication between night and day staff was regularly monitored. The provider had also reinforced their on call systems to ensure that communication between the centre and members of the management team was in place. A nursing handover audit tool had been developed to monitor the transfer of information between teams and was seen to be effective.

Other management systems in place included a suite of audits, quality improvement initiatives and reviews of clinical indicators. While there was regular management oversight of these systems,it did not identify that a review of restrictive practice was required. This oversight is required to ensure that when a restrictive practice is used that it is reviewed to ascertain if it is still required and that it is the least restrictive option in use. Inspectors were informed that the vacant position for an occupational therapist had been filled and that the six monthly review of the use of restrictive practices in the designated centre would recommence.Similarly audits which were in place to monitor daily adherence to effective infection prevention and control protocols were not identifying areas of poor practice in respect of hand hygiene and the oversight of some cleaning practices.

There was a COVID-19 outbreak in the centre at the time of this inspection and the registered provider had a preparedness plan in place which set out the measures to be taken to manage this outbreak effectively. Staff were aware of their role in minimising the spread of infection to other areas of the centre. The registered provider had taken measures to ensure that residents and staff in the affected area were cohorted to their individual unit. The current preparedness plan had been reviewed and included lessons learnt from previous outbreaks. The registered provider was in consultation with public health and was also following their advice in managing the outbreak.

While there were a number of measures in place to promote fire safety in the designated centre , inspectors observed the storage of items on stairwells and furniture beside exit routes. This had the potential to impact of the safe evacuation

of residents in the event of a fire emergency. The registered provider was aware that a number of fire door seals required replacing to ensure that they provided the necessary protection. A significant number of fire drills had been carried out in the centre however some of these drills did not identify accurately the location or the compartment being evacuated or the specific role played by those staff in attendance. This information would provide the registered provider with assurances that these drills were effective and fit for purpose.

There were arrangements in place to ensure that staffing numbers were as described in the designated centre's statement of purpose. All staff were supported in their role by means of an induction, supervision and appraisal programme. Staff had the required skills, competencies and experience to fulfil their roles. Staffing and skill mix were appropriate to meet the needs of the residents on the day of the inspection. Staff had access to education and training appropriate to their role. Staff who spoke with inspectors were knowledgeable of residents and their individual needs.

There was an annual review of quality and safety available for 2020 and the registered provider was progressing with the publishing of the annual report for 2021. Inspectors noted that the report for 2020 contained contributions from residents and their families in relation to the quality of the service provided

Regulation 15: Staffing

The registered provider ensured that the number and skill mix among the staff team was sufficient to meet the assessed needs of the residents and the layout of the designated centre. There was a recruitment programme in place with a number of nursing staff due to commence employment in February 2022. Arrangements for staff cover was done by using existing staffing resources, where this could not be achieved staff agencies were used to provide cover.

There was evidence of good communication between staff members at handovers and at the changing of the day and nightshift. This was supported by policies and procedures implemented by the management team to ensure that communication, resources and oversight of the teams were in place.

Judgment: Compliant

Regulation 16: Training and staff development

Staff were supported and facilitated to attend training. A review of training records indicated that all staff had completed up to date mandatory training such as challenging behaviour, manual and people handling, fire safety and safeguarding

residents from abuse.

Judgment: Compliant

Regulation 19: Directory of residents

The directory of residents was up-to-date and contained the required information with regard to Schedule 3 of the regulations: Records to be kept in a designated centre in respect of each resident.

Judgment: Compliant

Regulation 22: Insurance

The registered provider had a contract of insurance in place which was in date and met the requirements of the regulations

Judgment: Compliant

Regulation 23: Governance and management

Inspectors found that a number of management systems needed review to ensure that the service provided was safe and monitored in a manner that was able to identify specific areas for improvement. For example:

- On the floor supervision to ensure that all staff adhered to infection prevention and control protocols with regard to effective hand hygiene.
- The maintenance and oversight of cleaning records to ensure best practice with regard to infection prevention and control.
- A review of the systems to monitor the integrity of fire doors in the centre to ensure that they provided the required levels of protection.
- A review of information collected in fire evacuation reports to ensure that this information was reflective of what was found during the evacuations and informed practice going forward.
- The safety and security of medication trollies when in the residents environment and when stored in the clinical area.
- The maintenance of risk assessments and consent forms to underpin the use of a restrictive practice to ensure residents were not subject to unnecessary restrictions and the reintroduction of multidisciplinary oversight to monitor

the use of restrictive practice in the designated centre.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The provider had a complaints policy in place, and the complaints procedure was prominently displayed at the entrance to each unit and contained all information required by the regulations.

The complaints logged showed that complaints had been investigated, with the outcome and the complainants' satisfaction recorded for all closed complaints.

Judgment: Compliant

Regulation 4: Written policies and procedures

There was a set of policies and procedures in place which met the requirements of schedule 5 of the regulations.

Judgment: Compliant

Quality and safety

Inspectors found that the residential centre was providing a high standard of care, support and quality of life for residents. The design and layout of the premises ensured that the registered provider was able to support residents with their assessed needs. However, there were aspects of medication safety, infection control, care plans and managing behaviour that is challenging that required review.

Residents had good access to medical care and records indicated that residents were reviewed regularly. Residents also had good access to allied health and social care specialist services such as speech and language therapy, dietetics, physiotherapy and tissue viability. Medical records reviewed included detailed notes of residents' care. Palliative care support was provided by a nearby hospice when it was needed.

Pre-admission assessments were conducted by directors of nursing or nurse

managers in order to ensure that the provider could meet the needs and choices of residents before admission to the centre. Residents were assessed using validated tools and care plans were mostly developed within 48 hours of admission to the centre, in line with regulatory requirement. Care plans were personalized to resident's individual needs. There was evidence of discussion with residents and/or their family members. However, a number of residents care plans had not been reviewed within a four month time frame.

The centre had residents who had responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) due to their medical condition. A positive approach was taken to support these residents' care needs. Each resident had a detailed, person-centred behaviour support care plan in place. However risk assessments were not always used when updating restrictive practice care plans. In addition, historical care plans with regard to the use of chemical restraints were maintained on current care plans. This could result in the inappropriate use of restrictive practice within the centre. While there was a register of restraints maintained in the centre, the use of a lap belt for one residents was not included and there was no consent for the use of a bedrail for another resident. Nevertheless, compassionate, sensitive and supportive care from staff positively impacted on resident's well-being and quality of life in the centre.

Visiting was unrestricted in Raglan and Orwell building where visits were arranged through an online booking system or made through a call with reception. Visiting was restricted in Elgin unit due to the outbreak. Visiting took place in resident's bedrooms. If residents had a preference for receiving visitors away from their bedroom, there were visiting pods outside. Window visits were facilitated for residents on the ground floor of Orwell and Elgin only, due to the layout of the building. Visits were facilitated on compassionate and clinical grounds when they were needed.

Overall, the residents were happy with the quality and choice of food available to them. The inspector observed residents dining experience and found that the food served appeared to be wholesome, nutritious and appropriate to residents' dietary needs. Snacks and refreshments were provided outside of mealtimes and inspectors saw that adequate staff were available to assist residents with refreshments and at mealtimes.

The inspector reviewed a sample of residents' prescription charts and saw that they contained all the required information about the resident and medications. A sample of prescriptions reviewed, indicated compliance with administration practice. However gaps were identified with regard to the safe storage of medication and in documentation for medications that were out of date or that had been returned to the pharmacist.

Inspectors saw a number of changes following the last inspection such as the installation of wipeable surfaces in the laundry room and staff knowledge on the safe use and storage of cleaning chemicals and equipment. There was a new cleaners store in Orwell Orange unit. The centre was generally well maintained and

was visibly clean throughout. Residents confirmed that their bedrooms are cleaned daily.

However improvements were required with regard to good hand hygiene practice, and appropriate use of PPE. Hand hygiene facilities required upgrading to comply with national standards. The storage of clinical waste awaiting collection and records for the completion of cleaning also needed to be improved.

Regulation 11: Visits

Visiting was facilitated in many areas in the centre and was well managed in line with Public health advice and the Health Prevention Surveillance Centre guidelines.

Judgment: Compliant

Regulation 18: Food and nutrition

Inspectors saw that residents' nutritional needs were assessed by a dietitian and specialist advice was communicated effectively to the chef and catering staff. Residents who had special dietary requirements were provided with meals suited to their needs.

Judgment: Compliant

Regulation 20: Information for residents

All residents living in the designated centre were issued with a residents guide upon admission, this guide included relevant information about the designated centre and the services available for residents. Residents were also informed about how to register a complaint should they be unhappy with any aspect of the service. Information about developments and important events in the centre were contained in a residents newsletter which was published on a regular basis. Newsletter's also contributed contributions from residents living in the centre.

Judgment: Compliant

Regulation 26: Risk management

The risk management policy contained all of the requirements set out under Regulation 26(1). The local risk register was kept under review and was comprehensive and detailed. The risk register identified risks and included additional control measures in place to minimise the risk.

Judgment: Compliant

Regulation 27: Infection control

There were issues important to good infection prevention and control practices which required review. For example:

- Staff hand hygiene practices required review as a sample of staff were seen to wear nail varnish, stoned rings and watches. This meant that they could not effectively clean their hands.
- Refresher training was required with regard to performing hand hygiene during a drug round observed by inspectors.
- There were gaps in practice for one staff member who was seen to wear gloves when handling dirty bedlinen and did not remove their gloves when accessing the clean linen cupboard. This practice could lead to cross infection.
- The paintwork behind the hand hygiene sink in Elgin Convalescent unit was peeling away and could not be cleaned effectively.
- Hand hygiene facilities were not provided in line with best practice and national guidelines. The available hand hygiene sinks did not comply with current recommended specifications for clinical hand hygiene sinks.
  The external yard which contained clinical waste awaiting collection, was open to access and five clinical skips were not securely locked.
- All cleaning records to ensure that rooms had been cleaned were not available to inspectors.
- Records seen for the completion of deep cleaning did not show which room was cleaned or that the supervisor had signed it off as being completed.
- There was no cleaning schedules for soft furnishings such as curtains.
- There was no cleaning procedure available to staff in the cleaners rooms to guide them with regard to cleaning processes.
- The covering on the bedpan rack in Elgin Blue was damaged which would not facilitate effective cleaning.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Staff were knowledgeable of their role in maintaining fire safety in the designated centre and had received appropriate training to support them in this task, however

- Inspectors found inappropriate storage of items in stairwells.
- A number of fire doors were observed to require fire seal replacement
- A hoist and a sofa were observed to prevent access to escape routes.
- More detailed information was required to be included in fire evacuation drill reports, to identify where improvements were needed and the subsequent action taken to remedy the shortfall

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

The person in charge had not ensured that all medicinal products dispensed or supplied to residents were stored securely in the centre. For example:

- Keys were left in two drug trollies while they were unattended.
- All but two drug trollies seen were not secured when in the clinical storage area.
- There were gaps in signature records for medication returned to the pharmacy. For example two signatures are required to verify that medication is returned. Inspectors found that one signature on a number of records.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

For one resident two of their care plans had not been developed within 48 hours of admission. Seven resident care plans had not been reviewed within the required four month time frame as required by the regulation and therefore inspectors were not assured that current care plan interventions were appropriate to meet the needs of the residents.

Judgment: Substantially compliant

Regulation 6: Health care

Suitable arrangements were in place to ensure each resident's health, well-being and welfare was maintained by a high standard of nursing, medical and social care provision.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

The person in charge had not ensured that the least restrictive practice was used in the following areas:

- The most up-to-date information with regard to the use of prn (as required) psychotropic medication was not clearly identified in two care plans seen.
- Risk assessments were not always used when updating care plans for restraints such as bed rails or lap belts.
- Consent records were not available for the use of bedrails for one resident and therefore the person in charge was not assured that the resident or their family members consented to their introduction and use.

Judgment: Substantially compliant

Regulation 8: Protection

The registered provider had systems in place to ensure that residents were protected from abuse. This included safeguarding polices which were based on the prevention, detection and response to abuse. Staff were facilitated to attend safeguarding training and those spoken with were able to inform inspectors how they would use these procedures to protect residents living in the designated centre from abuse. In instances where potential abuse had been identified the registered provider investigated these concerns in an effective manner in accordance with legislative requirements.

Judgment: Compliant

Regulation 9: Residents' rights

Throughout the day inspectors observed residents being consulted and offered choice regarding their personal care support, attendance at activities or finding out

their food preference on the menu. Staff were aware of residents needs and were responsive to residents who required immediate support. Residents told inspectors that staff were kind and caring and were doing a great job. There was information on display in each unit to guide residents as to the activity schedule on that day. Residents were supported to give their opinions on the quality of the service through resident satisfaction surveys which the provider arranged to occur twice per year. The annual report for quality and safety for 2020 was completed and incorporated the views of residents and of their families. At the time of this inspection the residents satisfaction survey carried out in December 2021 was being analysed and processed to be included in the annual quality and safety report for 2021.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 11: Visits	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	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Orwell Private OSV-0000078

Inspection ID: MON-0035397

Date of inspection: 14/01/2022

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 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:
On the floor supervision to ensure that all staff adhered to infection prevention and control protocols with regard to effective hand hygiene.
This has been discussed with the IPC nurse and the clinical management team. Daily checks on adherance to infection prevention and control prcatices are carried out by the clinical team,immediate feedback given to the staff on observing any non-conformances. Any recurrent non-adherance to IPC practices will be raised as an incident which will be addressed under the disciplinary procedues.

The maintenance and oversight of cleaning records to ensure best practice with regard to infection prevention and control.
We are in the process of reviewing all forms,documents,checklist which are used by the Accomodation staff inorder to simplify the process of recording.Accomodation manager or her delegate will be responsible to check the cleaning records weekly and to report the compliance monthy at the departments meeting.
Completion date for review all form and checklist: 30th April 2022

A review of the systems to monitor the integrity of fire doors in the centre to ensure that they provided the required levels of protection.
The door check records which are in place will be undertaken more frequently as discussed with the inspectors on the day. In February a full audit was completed and documented to establish a baseline. From March, a minimum of two floors in each building will be checked each month.

A review of information collected in fire evacuation reports to ensure that this information was reflective of what was found during the evacuations and informed practice going forward.

The format and structure of simulated fire drills have been reviewed following the inspection ,a person will be appointed to document the drill while the Fire safety officer actively participates in the simulated scenario. DOC or her delegate will be responsible to carry out monthly audit to ensure that the drills carried out captures all the information as per the requirements.
This is being implemented in March and will be audited and reported monthly at the monthly management meetings.

The safety and security of medication trollies when in the resident's environment and when stored in the clinical area.
All medication trollies are always locked and secured to the wall. Regular observational audits will be carried out by the CNM's to ensure compliance to this practice.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
e paintwork behind the hand hygiene sink in Elgin Convalescent unit was peeling away and could not be cleaned effectively.
Repair and repaint were completed on 7th March .These checks are included in the planned preventive maintenance for the second quarter.

Hand hygiene facilities were not provided in line with best practice and national guidelines. The available hand hygiene sinks did not comply with current recommended specifications for clinical hand hygiene sinks.
We plan to replace the current hand washing sinks to clinical handwashing sinks by the end of 2022.

The external yard which contained clinical waste awaiting collection, was open to access and five clinical skips were not securely locked.
A lock to the bin enclosure was put in place immediately to restrict access. All clinical bins have locks in place. Further solutions including replacement of any bin that cannot be closed correctly being replaced by the clinical waste company are being discussed for implementation by start of Q2.

All cleaning records to ensure that rooms had been cleaned were not available to inspectors.
We have reviewed this following the inspection.The cleaning records from each units are collected by the accomodation supervisors and are filed in the folder the Accomodation's office.This is then audited by the Accomodation manager and the compliance will be reported at the monthly deprtament meetings and at Quarterly governance meetings.

Records seen for the completion of deep cleaning did not show which room was cleaned or that the supervisor had signed it off as being completed.

We have discussed this with the Accommodation team and will be audited by the accommodation manager going forward and compliance will be reported at monthly department meetings.

There were no cleaning schedules for soft furnishings such as curtains.
A new cleaning schedule is being developed which will be completed by 31st March

There was no cleaning procedure available to staff in the cleaners' rooms to guide them with regard to cleaning processes.
Environmental Cleaning policy will be printed, bound and will be placed into each cleaners' stores.
Completion date : 31st of March

The covering on the bedpan rack in Elgin Blue was damaged which would not facilitate effective cleaning.

This is on the maintenance list for replacement, this has been ordered and upon receipt it will be installed
Completion date: 30th April 2022

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Inspectors found inappropriate storage of items in stairwells
This was actioned on the day of the inspection. This will be discussed at the weekly fire drills with the staff and will be covered in the daily walk arounds carried out by the Facilities supervisor.

A number of fire doors were observed to require fire seal replacement
These were actioned immediately. It is planned to increase the frequency of the door checks to ensure that areas are covered regularly. Each door shall be checked every month and will be documented in the Fire register maintenance plan in care monitor.

A hoist and a sofa were observed to prevent access to escape routes.
Actioned on the day of the inspection. The critical need to keep escape routes clear were discussed with staff and forms part of the fire marshal daily checks, it will be emphasized at all training, effective immediately.

More detailed information was required to be included in fire evacuation drill reports, to identify where improvements were needed and the subsequent action taken to remedy the shortfall

The format and structure of simulated fire drills have been reviewed following the inspection, a person will be appointed to document the drill while the Fire safety officer

actively participates in the simulated scenario. The DOC or her delegate will be responsible to carry out a monthly audit to ensure that the drills carried out, captures all information required.
We will continue to undertake fire drills to check staff response and to educate staff, creating a baseline to be used for improvement if necessary.
This is being implemented in March and will be audited and reported at the monthly management meetings

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
Keys were left in two drug trollies while they were unattended.
Discussion at daily huddles, ongoing supervision, and immediate action on observing such practices

All but two drug trollies seen were not secured when in the clinical storage area.
Discussion at huddles, ongoing supervision, and immediate action on observing such practices.

There were gaps in signature records for medication returned to the pharmacy. For example two signatures are required to verify that medication is returned. Inspectors found that one signature on a number of records.
This has been discussed with the nurses. The nurse managers carry out checks on medication returns records every weekend and will report the compliance monthly at the management meetings.

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
For one resident two of their care plans had not been developed within 48 hours of admission
Actioned and will be audited as part of the ongoing audit plan for new admissions to the facility
Seven resident care plans had not been reviewed within the required four-month time frame as required by the regulation and therefore inspectors were not assured that

current care plan interventions were appropriate to meet the needs of the residents.
A system of weekly care plan checks have been implemented following the inspection .The list of overdue assessments and care plans are printed off by the nurse manager on duty on each Monday and Friday and are assigned to named nurses to review and to update within 24 hours. This is then checked by the nurse managers working at the weekend to ensure completion.

Regulation 7: Managing behaviour that is challenging	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
The most up-to-date information with regard to the use of prn (as required) psychotropic medication was not clearly identified in two care plans seen
Re-educate the nurses on "SOP on the use of PRN medications", audit compliance in adherence to the SOP monthly, by the night managers which will be reported on and discussed at the quarterly governance meetings . One to one education is being provided to nurses which will be completed by 10th April.

Risk assessments were not always used when updating care plans for restraints such as bed rails or lap belts.
Re-educate nurses on the care plan review process, audit adherence to the process when doing care plan audits and report at the quarterly audit governance meetings.

Consent records were not available for the use of bedrails for one resident and therefore the person in charge was not assured that the resident or their family members consented to their introduction and use
Audit consent forms against the use of bedrails in use at the time of the audit, take action if required and report compliance/ non-compliance at the audit governance meetings. The audit was carried out post inspection, this is now at 100% compliance.
An MDT review on the use of restraints is scheduled to be carried out on 24th of March . A further review is scheduled to be carried out in September.

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 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	30/04/2022
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	31/12/2022
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all	Substantially Compliant	Yellow	30/04/2022

	fire equipment, means of escape, building fabric and building services.			
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	30/04/2022
Regulation 29(4)	The person in charge shall ensure that all medicinal products dispensed or supplied to a resident are stored securely at the centre.	Not Compliant	Orange	22/03/2022
Regulation 29(6)	The person in charge shall ensure that a medicinal product which is out of date or has been dispensed to a resident but is no longer required by that resident shall be stored in a secure manner, segregated from other medicinal products and disposed of in accordance with national legislation or guidance in a manner that will not cause danger to public health or risk to the environment and will ensure that the product concerned can no longer be used as a medicinal product.	Substantially Compliant	Yellow	30/04/2022
Regulation 5(3)	The person in	Substantially	Yellow	30/04/2022

	charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Compliant		
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Substantially Compliant	Yellow	30/04/2022
Regulation 7(2)	Where a resident behaves in a manner that is challenging or poses a risk to the resident concerned or to other persons, the person in charge shall manage and respond to that behaviour, in so far as possible, in a manner that is not restrictive.	Substantially Compliant	Yellow	30/04/2022
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated	Substantially Compliant	Yellow	30/04/2022

	centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.			