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:	Maryville Services
Name of provider:	Health Service Executive
Address of centre:	Sligo
Type of inspection:	Unannounced
Date of inspection:	07 September 2022
Centre ID:	OSV-0005520
Fieldwork ID:	MON-0036170

About the designated centre

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

This is a residential service managed by the Health Service Executive (HSE) and is located on the outskirts of a town in Co. Sligo. This centre comprises of a two-storey house and can accommodate up to four female residents with low to moderate intellectual disability from 18 years of age to end of life. The centre comprises of a hallway, four residents' bedrooms, one staff room, a kitchen and dining area, a utility room, a shared bathroom, a shared toilet and two sitting rooms. Residents also have access to well-maintained gardens to the front and rear of the centre. During the day, residents are supported by a team of staff consisting of nursing support and healthcare assistants. At night, residents are supported by a waking night staff, to ensure their health and safety needs are met.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

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
Wednesday 7 September 2022	10:00hrs to 16:25hrs	Alanna Ní Mhíocháin	Lead

What residents told us and what inspectors observed

This was an unannounced inspection to review the infection prevention and control measures that had been put in place by the provider, in line with the relevant *National Standards on infection prevention and control in community settings*. Inspectors met and spoke with residents and staff throughout the inspection. In addition, the inspectors observed the lived experience of residents by observing daily interactions and practices in the centre.

The centre consisted of a large two-storey house on the edge of a town. Each resident had their own bedroom. One bedroom had an en-suite bathroom. This bathroom had a step-in shower. There was also a shared bathroom upstairs with a step-in shower and large bath. Staff reported that the bath was not used and it was noted that the hot tap on the bath was missing. An additional bathroom was located downstairs, next to the utility room. This bathroom had a level access shower. The other shared rooms of the house consisted of two sitting rooms, a kitchen-dining room, and a utility room. An open sharps bin was located in the utility room. The bin was labelled and stored off the ground in line with the provider's guidelines. There was also a staff office upstairs that contained a hand hygiene sink. Cupboards located at the rear of the house contained stocks of personal protective equipment (PPE). Outside, the grounds were well maintained. There were large bins for the disposal of general waste and for waste that could be recycled. There was no outdoor shed or storage facilities in the centre for clinical waste. This will be discussed later in the report.

The house was clean and large surfaces were clear of dust. This included harder to reach areas in the home. The furniture in the house was clean and in a good state of repair. However, the inspector noted a number of areas in the house that required refurbishment. There was discolouration noted on the ceiling of the kitchen above the cooker. There was also discolouration on the ceiling in the downstairs bathroom. Staff reported that this was due to leaks from the showers upstairs. It was also noted that there was black discolouration on the grouting in the showers upstairs in the centre.

Hand hygiene facilitates were located at appropriate points around the house. Hand sanitiser and a pedal bin were located at the entrance to the house. In most cases, sinks were equipped with hand soap, paper hand towels and a pedal bin. However, there was no pedal bin at the hand hygiene sink in the utility room. Also, there was no paper hand towel dispenser at the sink in the kitchen. Instead, hand towels were stacked on the window sill. This was not in keeping with best practice in relation to hand hygiene. Colour-coded mops were used in the centre and staff reported that the centre was in the process of moving to a flat mop system.

There were signs at the front door of the centre in relation to COVID-19. The signs advised visitors not to enter the centre if they were showing symptoms of COVID-19. There was also a sign encouraging visitors to the centre to wear face masks.

One resident received visitors on the day of inspection and it was observed that their visitors wore masks while in the centre chatting with residents and staff. Further signs regarding COVID-19 and the wearing of PPE was located in the kitchen. Some of this information was dated 2020 and was no longer in line with current public health guidelines.

The inspector had the opportunity to meet with three of the four residents in the centre. The fourth resident was away for the day. Residents reported that they were happy in the centre. They said that they were happy with staff. One resident said that the staff were 'fantastic'. They said that they were happy that their home was kept clean and that staff helped them to keep their bedroom clean and tidy. One resident said that they would like a new bathroom in the house. Residents were knowledgeable on steps that they could take to protect themselves from infection. They spoke about wearing face masks and using hand gel to clean their hands. They told the inspector that they could go to their general practitioner (GP) if they were not feeling well. They said that staff would support them if they were unwell. They talked about the need to isolate if they had COVID-19. Residents also chatted about some of the activities that they enjoyed in the house and in the community. There were no restrictions in relation to visitors coming to the centre. Residents said that they liked going out for meals and meeting friends.

Staff were observed interacting with residents in a friendly and respectful manner. Staff respected the residents' privacy and dignity. They were observed knocking before entering bedrooms and sitting rooms. Staff respected the residents' choices. Staff routinely offered choices to the residents in relation to their food and activities. There was a very pleasant atmosphere in the house. Residents and staff were observed chatting comfortably with each other. Staff were knowledgeable on the needs of residents and the supports that they required. Staff were noted completing household tasks throughout the day. This included meal preparation and cleaning tasks.

Overall, the provider had taken steps to protect residents from the risk of infection. Residents were provided with information in relation to the risk of infection and how to protect themselves from infection. Staff were knowledgeable on the needs of residents and the supports that they required. The centre itself was largely clean and tidy. However, some refurbishments were required to address leaks from showers, to locate appropriate hand hygiene facilities throughout the house and to ensure that clinical waste was stored and disposed of appropriately. The next two sections of the report will outline the governance and oversight arrangements in the centre regarding infection prevention and control and how this impacted on the quality of the service delivered to residents.

Capacity and capability

The provider had developed policies, protocols and guidance documents for staff in

relation to infection prevention and control. There were defined lines of accountability and escalation in relation to infection management. However, improvement was required in relation to the oversight and audit of infection prevention and control practices. Improvement was also needed in relation to the information provided to staff regarding clinical waste management and the recording of staff training.

There were clear governance arrangements in the centre with specified lines of management and accountability. The names of senior managers and their role within the organization were available on noticeboards in the centre. There was a rota of on-call senior managers available to provide support to staff out of hours. There was a local infection prevention and control team with named individuals who could be contacted for advice and support as required. The person in charge had responsibility for management of infection control within the centre. However, some tasks had been delegated to other named members of staff. For example, one staff member acted as the COVID-19 Lead Worker Representative (LWR) and a staff nurse completed environmental audits. Incidents that occurred in the centre were reported and escalated to senior management. There were specific incident reporting forms established for confirmed cases of COVID-19 among residents and staff.

There were a number of policy and guidance documents available to staff in the centre. These documents gave guidance on best practice in relation to hand hygiene, standard precautions, transmission based precautions and sharps management. There was guidance available on precautions that should be taken if residents presented with specific infections. Guidelines for cleaning the general environment and resident specific equipment was available from the provider. There were copies of recent publications and updated guidelines from public health available to guide staff in the centre. There was additional documentation that guided staff on local infection prevention and control policies. For example, the centre's COVID-19 plan gave contact details of the local clinical nurse specialist in infection prevention and control. However, improvement was needed in the information that was given to staff in relation to the management of clinical waste. National documents referred staff to local guidelines in relation to the storage and disposal of clinical waste. However, this information was not available for staff. When consulted, staff were unsure of the steps that should be taken in relation to clinical waste management. This had been noted most recently during an outbreak of COVID-19 in the centre. Staff reported that they were unsure of how to dispose of used PPE during the outbreak period. This was not reflected in the centre's outbreak review record. This will be discussed later in the report.

Staff were also guided by risk assessments in the centre. The person in charge maintained a risk register for the centre that identified risks to residents, staff, visitors and the service as a whole. The risks assessments were regularly reviewed and updated. A number of the assessments related to the risk of infection and identified control measures to reduce the risk. Some risk assessments, for example the risk assessment relating to use of sharps, identified that clinical waste guidelines should be implemented as control measures to reduce the risk of infection. However, as outlined above, clinical waste guidelines were not clearly documented

in the centre.

The centre had a specific plan in place to guide staff on how to respond to a suspected or confirmed case of COVID-19. The plan was last reviewed on 16 June 2022. The plan identified a named clinical nurse specialist on the local infection prevention and control team who should be contacted in the event of a confirmed case. The plan contained guidance for staff on how to self-isolate if they became symptomatic. It also gave guidance on how each resident should isolate if they tested positive for COVID-19. There were also named senior managers who could be contacted in the event of staff shortages and the staffing contingency plan that was in place should this occur. Specific tasks relating to the prevention of COVID-19 in the centre were also allocated to named individuals. One task that was identified in the plan was the completion of a safety pause checklist at the beginning of each shift. This checklist asked staff to confirm that they were free from symptoms of COVID-19 and hand hygiene ready. However, it was noted that this checklist had not been completed by staff in the centre in the last number of months.

The provider maintained oversight of the measures taken to prevent the spread of infection through a number of audits. The COVID-19 LWR completed monthly audits that specifically looked at measures that were taken to prevent the spread of COVID-19. The COVID-19 LWR met with the person in charge within a week of completing the audit to highlight any issues that were identified. A separate environmental audit looked at specific rooms within the centre regarding their level of cleanliness and state of repair. It was noted on the audit schedule that the environmental audits were due to be completed on a quarterly basis. On the day of inspection, there was no record of an environmental audit completed in the previous three months as the staff member responsible was on leave. However, these were emailed to the inspector after the inspection. The audits relating to infection control were limited in their scope and mainly focussed on cleaning and refurbishment. They had not identified some of the issues noted on inspection. For example, the audits had not identified that cleaning checklists and staff safety pause checklists were not completed in line with the provider's guidelines. In addition, audits were not always completed in line with the provider's policies. For example, the provider's policy on hand hygiene stated that regular audits of hand hygiene should occur. However, no specific audits of hand hygiene had occurred in the centre. On the day of inspection, it was noted that not all staff adhered to the guidelines on being hand hygiene ready with some staff wearing wrist watches and false nails.

Issues relating to infection prevention and control were identified in the centre's annual review into the quality and safety of care and support. This was completed in November 2021. This report identified that the bathrooms in the centre required refurbishment and that the centre needed to be repainted. These actions were given a target completion date of 30 March 2022 but had not occurred on the day of inspection. This was also noted in the centre's quality improvement plan. This plan detailed service improvement actions that had been identified in the centre on audit and through other service reviews. Each action had a target date for completion. In addition to the previously mentioned refurbishment works, the target dates that the provider had set for the removal of damp and the replacement of taps had elapsed.

The staffing arrangements in the centre were reviewed. The person in charge maintained a planned and actual staff roster. A review of this roster found that the number and skill-mix of staff on duty was adequate to meet the assessed needs of residents and to complete the cleaning duties required in the centre. Staff reported that staff decided amongst themselves what cleaning duties they would complete on their shift. They were knowledgeable on the location of guidance documents and policies in the centre relating to infection prevention and control. They knew the steps and precautions that should be taken when dealing with certain tasks that carried a high level of risk of infection.

A review of the staff training matrix found that staff were offered training specific to infection prevention and control. This included training in relation to hand hygiene, primary food hygiene, standard precautions and COVID-19 specific training. Records indicated that all staff were up to date in training relating to hand hygiene and standard precautions. However, a review of the recording of information on the training matrix found that, overall, it was inadequate to keep track of the number of staff who had completed training and those who required refresher courses. The matrix was not up to date and staff training that had been completed was not recorded on the matrix. This meant that assurances regarding staff training could not be provided.

Quality and safety

Residents were supported to protect themselves from infection. There was good record keeping relating to residents' medical care needs. However, improvement was required in relation to the refurbishment of the centre to ensure that residents were safe from infection. Plans relating to the management of COVID-19 in the centre also needed to be updated following a recent outbreak of the virus.

Residents were knowledgeable on the steps they should take to protect themselves from the risk of infection. They understood the reasons that staff wore masks. A review of residents' meeting minutes showed that residents had been given information and debriefed following an outbreak of COVID-19 in the centre. Residents were supported to complete routine cleaning and household tasks in the centre, if they wished. Easy-to-read and picture-based information was made available for one resident who had recently undergone medical treatment.

A sample of residents' care plans were reviewed during the inspection. Detailed medical histories were kept for each resident. Records of medical examinations and tests were maintained. Residents had access to a wide variety of health professionals and records of their appointments and reports were recorded. Residents' care plans recorded their colonisation status, if known. Information relating to residents' vaccinations was also recorded. Residents had hospital passports that gave relevant information to hospital staff should they be admitted to hospital. Staff reported that the hospital passport would be used to alert hospital

staff if any resident had a known infection or colonisation. However, it was noted that hospital passports were not kept fully up to date. One passport that was seen by the inspector was due for review on 16 March 2022 but this had not occurred. Overall, care plans were routinely updated. Some plans related specifically to care that carried an increased risk of infection, for example, intimate care and skin breakdown. These plans advised staff to ensure that they followed good practice in relation to hand hygiene.

As outlined previously, there were parts of the centre that required refurbishment. Of significant concern, there was a leak from an upstairs bathroom into the kitchen above a food preparation area. This had been identified by the provider but the target dates set for addressing these issues had elapsed. There were no definite dates planned to address these issues. Overall, there was a good level of cleanliness in the centre. However, routine cleaning checklists did not provide assurances that cleaning tasks had been completed in line with the provider's guidelines. The checklists did not identify the frequency that certain tasks should be completed and checklists were not always completed in line with the provider's guidelines. The inspector also noted that there were significant gaps in the completion of some checklists indicating that some tasks had not been completed at all. In addition, the checklists were not specific to cleaning and included other everyday tasks like making lunches and grocery shopping. As mentioned previously, COVID-19 safety pause checklists were also not completed in the centre.

There was a separate cleaning checklist for residents' personal medical equipment. This clearly identified when this equipment was cleaned and by whom. The cleaning of this was completed in line with the provider's guidelines. There were arrangements for residents' laundry to be washed on site. All residents' laundry was washed separately and dissolvable laundry bags were available if required. There were adequate waste collection services in the centre for household waste and recycling. However, as discussed, the arrangements for the management of clinical waste in the centre was unclear.

The inspector reviewed the records of the measures that had been taken during a recent outbreak of COVID-19 in the centre. There was evidence of correspondence between the person in charge, members of senior management and the local infection prevention and control team. Minutes from outbreak meetings showed that specialist guidance was provided to the person in charge in relation to the management of the outbreak. The layout of the centre meant that residents who were positive for COVID-19 had to pass through communal areas on occasion to access shared bathrooms. There were checklists in place that showed that enhanced cleaning had occurred whenever residents had entered these spaces to reduce the spread of infection to other residents. Following the closure of the outbreak by the infection prevention and control team, the person in charge had completed a review. This documented the actions that had been taken during the outbreak. However, the review had failed to identify the lack of clarity in relation to clinical waste management and the centre's COVID-19 plan had not been updated following the outbreak to reflect any learning that may have occurred during the event.

Overall, there were good practices in the centre in relation to infection prevention

and control. The centre was kept clean and tidy. Residents were kept informed of the steps that they should take to protect themselves. Records relating to the residents' medical needs were well-documented. However, improvement was needed in relation to the repair of leaks in the centre and the review of plans following an outbreak in the centre.

Regulation 27: Protection against infection

There were defined lines of accountability in the centre and within the service. There were clear lines of escalation in relation to the management of infection prevention and control. There were named members of staff who had taken on certain duties in relation to infection control audits. There was evidence that the outcomes from these audits were escalated to the person in charge and onward to more senior management as appropriate. There was a local infection prevention and control team who could be contacted when needed.

The provider had policies, guidelines and protocols in place that gave information to staff in relation to best practice regarding infection prevention and control. This included information regarding hand hygiene, standard precautions, cleaning of the environment and equipment, laundry management, and sharps management. However, information relating to local guidelines on the storage and disposal of clinical waste was not available to staff. This impacted on the risk assessments in the centre as effective management of clinical waste was identified as an important control measure in a number of risk assessments.

The provider maintained oversight of the effectiveness of infection prevention and control through a number of audits. While these audits were completed routinely and information shared with the person in charge, the audits were not adequate to identify some of the service improvement issues noted on inspection. Hand hygiene audits were not completed in the centre despite this being identified in the provider's guidelines. On the day of inspection, it was noted that not all staff adhered to best practice in relation to hand hygiene readiness. In addition, the cleaning checklists used in the centre did not provide adequate guidance to staff regarding the frequency that certain parts of the centre should be cleaned. The checklists also did not provide assurances that the tasks listed had been completed in line with the provider's guidelines. Checklists that were due to be completed regarding symptom checks for COVID-19 had not been completed in a number of weeks.

The centre's COVID-19 contingency plan gave good information to staff on how to self-isolate if they became symptomatic, how to support residents to isolate if presenting with COVID-19, and the arrangements in place for addressing staff shortages. However, the plan had not been updated following a recent outbreak of the virus to reflect any learning from the event.

Residents were supported to protect themselves from infection. They were provided with information in an accessible manner. Their healthcare needs were well-

managed and they had access to relevant healthcare professionals.

The centre itself was kept clean and tidy. Hand hygiene facilities were available in the house and were largely adequate. However, a paper hand towel dispenser was not available in the kitchen and one sink did not have a pedal bin for the disposal of paper towels. Also, there were areas of the house that required repair. Of particular concern was a leak from a bathroom over a food preparation area in the kitchen. The provider had identified the need to complete these refurbishments but the target date for the completion of these works had passed. The provider did not have a definite timeline for when these works would be completed.

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 Maryville Services OSV-0005520

Inspection ID: MON-0036170

Date of inspection: 07/09/2022

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 compliance with Regulation 27 the following actions have been undertaken :

• The position statement guides the management and disposal of waste within Maryville from the HSE Community Service Infection Prevention & Control Nursing Team. This clearly outlines the procedure of the disposal and management of healthcare risk and non-risk waste generated in the home setting. All staff have been made aware of this document and procedure and have signed off at the staff meeting to say they have understood it. This will be a standing item on staff meeting agenda.
· The contingency and response plan for the center has been updated to reflect these procedures.
· The site-specific safety statement also has been updated and outline waste management procedures.
· Furthermore audits are been completed monthly in the center under the MEG auditing tool for healthcare waste management. Any actions arising from these will be added onto centers QIP.
· The CHO1 IPC team and the clinical waste technician is available for advice and support in relation to waste management as required. Their contact details are available in each centre.

• Maintenance works required for completion include

· Main bathroom and ensuite bathroom will have a total refurbishment This will include all new sanitary wear hygienic boarding to the walls and safety floor covering installed. Both leaks have been addressed and the discoloration noted on the kitchen ceiling and in the downstairs bathroom ceiling has been removed. These works have commenced and will be completed by 25/11/2022
· The centre is due to be painted. This will be complete by 23-11-22

• All residents within Maryville have hospital passport in place that outline relevant information required in the event of the resident being transferred to the acute settings. These have been updated and reviewed and going forward will be reviewed annually or if change of need occurs.

• All training will be inputted in accordance with the HSE policy 'Guideline to support the governance and compliance with statutory occupational safety and health training. The PIC will ensure oversight of the matrix by carrying out monthly review of the matrix and in addition, the Quality Improvement Team will carry out a quarterly review and will furnish the PIC with a report on same. This will further enhance governance and compliance and ensure that all training to be completed with be captured including refreshers. All outstanding training will be completed in line with the matrix.

• Sharps in the center are managed in line with HSE policy. This ensure that sharp bins are stored with the temporary closure mechanism in place. All staff are made aware of this through staff meetings. Sharps bins will be also monitored through the MEG auditing system. Risk assessment in relation to the use of sharps bins has been updated

• The center contingency plan has been updated, following the outbreak of COVID 19 in the center and the key learning aspects from the latest outbreak has been included.

• Specific infection prevention procedures that have been completed in line with guidance documents.

· There has been a pedal bin placed in utility room hand washing sink
· Hand towel dispenser has been placed in the kitchen area
· All signage has been replaced with most up to date current public health guidelines
· Cleaning checklists have been updated and are now specific to the center and will identify the frequency that these tasks will be completed in line with the guidance document.
· Cleaning checklists will be completed daily by all staff in the Centre
· Staff safety pause is now completed daily in line with the center contingency plan. This will be monitored by the PIC on a daily basis and will communicated to all staff through staff weekly meetings.
· Education and awareness sessions have taken place with staff highlighting the importance of been hand hygiene ready
· The PIC will conduct spot checks on staff to ensure they are hand hygiene ready
· Risk assessments have been reviewed and updated to ensure all control measures in place.

All of these actions will be monitored through visual daily checks and through the completion of weekly checklist and these actions will be communicated to all staff through weekly staff meetings. Date Completed -15-9-22

• The auditing of REG 27 infection prevention and control practice will be monitored

through the MEG auditing system. The areas audited include

- Environmental cleaning of each room
- Equipment Cleaning and Maintenance
- Training
- Sharps management
- Healthcare Waste Management
- Hand hygiene facilities and compliance
- PPE
- Linen Management
- COVID 19 IPC compliance

These audits will be completed monthly initially and then proceed to quarterly. All actions identified will be closely monitored through the centers QIP and will be completed in a timely manner.

The CHO1 audit schedule has been updated to specify that MEG audits can be accessed via an app on the center's computer

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	25/11/2022