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:	Sacred Heart Residence
Name of provider:	Little Sisters of the Poor
Address of centre:	Little Sisters of the Poor, Sybil Hill Road, Raheny, Dublin 5
Type of inspection:	Short Notice Announced
Date of inspection:	26 November 2020
Centre ID:	OSV-0000157
Fieldwork ID:	MON-0031158

About the designated centre

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

Sacred Heart Residence is owned and operated by the Little Sisters of the Poor, and is located near St. Anne's Park in Killester on the northside of Dublin. The centre can accommodate 86 residents, both male and female over the age of 65, with low to maximum dependency levels. Residents are accommodated in 84 single bedrooms and 1 double bedroom, all with en suite facilities. Other facilities available to residents include sitting rooms, a shop, tea bar and a chapel.
The person in charge is supported by the registered provider representative, a chief nursing office, a clinical nurse manager. There is team of registered nurses and healthcare assistants who provide care to the residents in the centre. Allied health professionals are contracted to provide specialist services to the residents in accordance with their wishes and needs.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	78

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 26 November 2020	09:30hrs to 18:30hrs	Siobhan Nunn	Lead
Thursday 26 November 2020	09:30hrs to 18:30hrs	Michael Dunne	Support

What residents told us and what inspectors observed

The design and layout of the building was spacious and ensured the comfort, privacy and wellbeing of the residents. There was a calm peaceful, atmosphere in the centre. Residents had single ensuite spacious bedrooms which were personalised with their choice of furniture pictures and paintings. Residents commented that they liked their bedrooms and mentioned that staff assist in keeping their personal space clean and tidy.

Inspectors observed staff speaking with respect and kindness to residents, while demonstrating their knowledge of residents' needs and preferences.

The majority of residents seen on the day were in their own rooms or were seen in the centres dining rooms. Inspectors were informed that residents could have their breakfast in their room should they wish while those who wished to attend the dining room to have their meal could do so.

Residents who spoke with inspectors said that they were very well cared for and were happy living in the centre. They said that they enjoyed the food and were happy with the current laundry arrangements. One residents said that they understood the restrictions, but kept in contact with family members on the phone.

There was a Chapel located inside the main entrance of the designated centre. This was closed in accordance with infection prevention and control guidance. Residents were facilitated to pray quietly in their rooms, or to listen to religious services on the television. Inspectors observed residents enjoying a service on television while remaining socially distanced in an upstairs living room. Inspectors observed residents using the designated visiting room to meet their families in a safe, comfortable environment in line with the guidance at the time of the inspection.

Although residents were content with the service they received, inspectors found that there were gaps in oversight arrangements in a number of areas in the centre These included, staff training, COVID -19 contingency planning and risk management. The next two sections of the report will outline the gaps that were identified.

Capacity and capability

This was a short notice risk inspection which was announced on the 25th November 2020. This was done in order to ensure that inspectors were aware of the current infection prevention and control measures that were in place in the designated

centre and that key staff were available to speak to inspectors.

Sacred Heart Residence is registered by the Little Sisters of the Poor. The centre has an established management team with the person in charge being supported by a clinical nurse manager and a chief nursing officer. The registered provider representative had changed in July 2020.

On the 9th April 2020 the Chief Inspector was informed of an outbreak of COVID-19 in the designated centre. 71 staff and 37 residents contracted the virus and sadly 7 residents passed away. Public Health personnel confirmed the end of the outbreak on 5th June 2020.

During the outbreak the management team received support and advice from the local public health team. Inspectors maintained phone contact with the centre and were aware of the advice they received.

To assess assurance arrangements in place on the day of inspection the management team was asked for a number of documents including the review of the COVID-19 outbreak in the centre, a contingency plan in the event of a outbreak of COVID-19, risk assessments, audits and records of staff training. Inspectors found that a comprehensive review of the COVID-19 outbreak had not taken place and a limited contingency plan had been developed that did not provide sufficient guidance to staff.

Inspectors found that a schedule of auditing was not used to guide managers, resulting in some audits being infrequent and others not containing time bound action plans to ensure that necessary improvements were completed.

Following discussion with managers and a review of the centre's floor plans inspectors found that the proposed cohort area identified for residents in the event of a COVID-19 outbreak was not appropriate.

The registered provider was unable to provide thorough records of staff training and when inspectors reviewed fire training records in detail they found that under one half of staff had been trained in 2019 and 2020.

The centre had sufficient staff to meet the daily assessed needs of residents. Key clinical performance indicators were reviewed on a monthly basis to ensure a high standard of clinical care.

The designated centre had a complaints policy which was accessible to residents and their families, however the recording of complaints was incomplete and the policy required updating.

Regulation 15: Staffing

The designated centre had a sufficient number and skill mix of staff to meet the

assessed needs of residents. Clear rotas were in place detailing the numbers and assignments of staff on duty. There was evidence in staff rosters that nursing staff were on duty at all times.

Inspectors viewed staff records which showed that employment references and Garda checks were in place for staff prior to being employed.

Judgment: Compliant

Regulation 16: Training and staff development

While staff had received training in a number of areas including, infection prevention and control, safeguarding and fire safety, the registered provider was unable to provide details of the number of staff who had attended training or those who were due to attend. Following a review of fire training records inspectors found that 39% of staff received training in 2019 and 38% in 2020. Managers were unable to tell which staff had been trained and therefore staff may not have been aware of key fire procedures or fire safety measures which should be adhered to within in the designated centre. At the time of the inspection evidence of regular training was not available.

An induction programme had recently started for new staff who commenced working in the designated centre.

Judgment: Not compliant

Regulation 23: Governance and management

Inspectors found that there was a defined management structure in place which was documented in a Governance and Management Framework. However the responsibility for monitoring certain areas of the service was not clear. For example, staff received training but the registered provider did not have an oversight system in place to ensure that staff received the required training on a consistent basis.

A comprehensive review of the COVID-19 outbreak had not taken place. As a result a limited contingency plan was developed which did not provide sufficient guidance for staff in the event of a second outbreak of COVID-19.

When discussing planned cohorting arrangements with managers for residents in the event of a COVID-19 outbreak the area of the building identified for cohorting was not part of the designated centre. Managers agreed to submit alternative

arrangements to the Chief Inspector within 3 days.

Inspectors viewed a sample of audits which had been completed by the management team. A number of gaps were identified including the absence of a regular timetable for auditing and long intervals between audits. For example hand hygiene audits were completed once in 2019 and 3 times in 2020. this resulted in the limited monitoring of the service being delivered.

Medication management audits did not contain action plans to implement required improvements which had been identified during the audit. Following a review of the audit documentation and discussion with the management team inspectors were not assured that there was sufficient oversight of auditing arrangements. Inspectors found that action was required to ensure that there was sufficient management resource to develop and maintain proper oversight and monitoring arrangements in the centre.

Records of monthly clinical key performance indicators were viewed by inspectors. These included information on falls, use of bedrails, skin integrity, and the use of certain medications. This information was monitored at monthly management meetings and used to improve patient care.

Inspectors reviewed the minutes of quarterly health and safety meetings in which areas requiring improvement were identified and action plans were put in place to complete the required work.An annual review of the service had been completed for 2019, and the views of residents were included in the report.

The governance and management arrangements in the centre were found to require a review of the number and skill mix of senior staff to ensure that the centre was able to meet the requirements of the regulations. Inspectors were not assured that there was sufficient management resources in place to carry out all of the management functions for all areas of care

Judgment: Not compliant

Regulation 34: Complaints procedure

There was a complaints policy and procedure in place to assist residents and families register a complaint about the service. Inspectors reviewed complaint records available for 2019 and 2020 and found that there were low levels of complaints received. Only two complaints were on file for 2019 and one for 2020. There were no open complaints for review at the time of the inspection.

Improvements were required regarding the recording and administration of complaints. Not all complaints seen were recorded on the centres complaint form, while others required data such as dates and signatures.

The centres complaints policy was advertised in a prominent position near to the

centres reception area and contained information on how a complainant would register a complaint. The policy also contained information about appeals should the complainant be unhappy with how the complaint was dealt with. The policy required updating to reflect the current designated complaints officer in order to allow complainants to contact the appropriate personnel.

Judgment: Substantially compliant

Quality and safety

The registered provider had worked hard to ensure that safe visiting arrangements were in place to allow residents to maintain contact with their families, while at the same time complying with up to date infection prevention and control guidelines.

Residents had comprehensive assessments prior to their admission, which identified their identified needs. This ensured the ability of the centre to cater for their care, medical and social requirements in advance of their transfer to live in the designated centre. Following the review of residents' care plans inspectors noted that some plans were not reviewed within the regulatory requirement of four months. Activity care plans were absent from the records of a number of residents, thus not assuring inspectors that staff had guidance on how to meet some residents' social needs.

Inspectors found that residents health care needs were met through the availability of GP services, access to allied health professionals and gerentology support from Beaumont Hospital. Residents records and care plans showed evidence that clinical recommendations made by medical professionals who attended residents were recorded, thus ensuring that staff had up to date medical information for each resident.

There was evidence that residents' rights were respected within the centre, as adjustments had been made as a result of COVID-19, to facilitate communication with families, to provide safe activities and to ensure residents' voices were heard through residents' surveys.

On reviewing the risk policy and register inspectors found that the documents did not provide details of the hazards related to COVID-19. The risk policy and register did not identify and mitigate the risks listed in the regulation.

Although inspectors found areas of good practice related to infection prevention and control including arrangements for cleaning linen, the storage of equipment, cohorting arrangements for staff and residents had not been established and staff changing, dining and rest areas were not arranged to ensure social distancing. The "Interim Public Health, Infection Prevention and Control Guidelines on the Prevention and Management of COVID-19 cases and Outbreaks in Residential Care facilities" had not been integrated into the infection control policy, risk policy or audit system. As a result evidence of management oversight of infection prevention

and control was limited.

Regulation 11: Visits

There were arrangements in place for residents to receive their visitors in a visiting room located on the ground floor of the designated centre. The layout of the visitor's room complied with guidance issued from the Health Protection Surveillance Centre "Interim Public Health, Infection Prevention and Control Guidelines on the Prevention and Management of COVID-19 cases and Outbreaks in Residential Care facilities".

Inspectors reviewed information which confirmed that the provider had liaised with families during the pandemic to keep them informed and updated with regard to restrictions around visiting as and when the guidance changed.

All visits were pre-arranged 24hrs in advance of the visit with only one visitor allowed at any one time. Visitors were asked to complete a COVID-19 questionnaire and had their temperature taken upon arrival. Visitors were also required to comply with the centres infection, prevention and control policy with regard to mask wearing, social distancing and respiratory etiquette.

Inspectors noted that the visitor's room was sufficient in size to allow for social distancing with plastic screens in place to provide additional protection.

Judgment: Compliant

Regulation 26: Risk management

Inspectors reviewed a risk management policy and an environmental risk register which was updated in February 2020. Many of the items listed were not linked to a person who had responsibility for the risk. There was no evidence to show that the risks identified were linked to audits or quality improvement action plans.

Hazard identification and assessment of risks was not in place throughout the designated centre. For example the policy and register did not contain measures and actions to control risks related to an outbreak of Covid-19. Risks listed in regulation 26 were not included in the documentation viewed. These included abuse and the unexplained absence of a resident.

Following discussion with managers inspectors found that they were not assured that adequate management systems were in place to mitigate all risks within the designated centre.

Judgment: Not compliant

Regulation 27: Infection control

Inspectors viewed the infection prevention and control policy which had been reviewed by the registered provider on the 3.09.2020. The policy was not comprehensive and did not follow the "Interim Public Health, Infection Prevention & Control Guidelines on the Prevention and Management of COVID-19 Cases and Outbreaks in Residential Care Residential Care Facilities and Similar Units guidelines.

On the day of inspection inspectors observed that four staff were not wearing masks, in accordance with guidance. Managers rectified this immediately. Hand sanitizers were available throughout the designated centre and inspectors observed staff using these appropriately. Staff temperatures were monitored in the morning and evening.

The registered provider had sufficient supplies of personal protective equipment (PPE) stored in an accessible location within the centre. All wheelchair, hoist and linen stores viewed by inspectors were clean and tidy with equipment stored according to standards.

Arrangements had been put in place to ensure the safe management of laundry. Inspectors observed that separate areas were designated for the segregation of clean and used laundry in line with national standards. Staff wore PPE when handling laundry and were observed to change PPE and use the hand washing sinks provided when delivering laundry and leaving the laundry area.

Inspectors found that cleaning trollies were well organised and separate storage rooms for cleaning equipment in the units where residents lived were clean and tidy. However the janitorial room close to the kitchen had a bad odour and floor cleaning equipment was not stored or cleaned in accordance with expected standards.

Residents dining room areas were organised to facilitate social distancing. However in some living room areas chairs had not been removed and as a result there was a risk of transmission of infection from residents sitting close together.

The registered provider had not organised staff to work in separate groupings, in order to prevent the transmission of COVID-19 in the event of an outbreak. Inspectors observed that staff changing rooms were not allocated to designated groups of staff, and signage was not in place to indicate the maximum number of staff allowed in these areas. Staff dining and rest areas were not laid out in a manner to facilitate social distancing.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

A review of care records held in the centre indicated that residents had a comprehensive assessment of their needs prior to their admission to the centre. This assisted in ensuring that the centre would be able to meet the needs of the resident before moving in. There was evidence which showed the centre liaising with residents and where appropriate the resident's families when constructing care plans to meet their identified needs. A review of daily care notes indicated they described the daily interventions made by staff to meet residents care needs as described in resident care plans.

The majority of resident care plans provided detail setting out how to meet residents social and nursing care support needs. A small number of residents did not have an activities care plan in place which would direct staff on how to support residents with their social care needs and interests.

A care plan audit carried out by management in July 2020 to measure compliance levels indicated that a number of care plans required improvement and highlighted areas to focus on such as care plan reviews and resident social care plans. Inspectors were not assured that the findings from this audit were implemented in full due to a number of care plans which were outside of the required review period.

Judgment: Substantially compliant

Regulation 6: Health care

Inspectors found that there were arrangements in place which ensured that residents had access to appropriate medical and allied healthcare support. There was access to a GP who visited the centre every Tuesday. Residents who required input from an occupational therapist tissue viability nursing (TVN), dietitian or speech and language therapy were referred to the community for support. The centre had access to a physiotherapist who attended the centre on a Tuesdays and Thursday afternoon.

There was additional input from psychiatry of later life and gerontology support based at Beaumont hospital. The provider ensured continuity of healthcare support during an outbreak of COVID-19 in the centre and had arrangements in place for anticipatory prescribing.

The effectiveness of health care support was measured through a system of healthcare audits with current practice supported by a range of policies and procedures. A review of resident care records indicated that where medical updates and guidance was received then relevant care records such as care plans or risk assessments were updated with the required clinical information.

Inspectors reviewed a number of care plans with regard to wound care and found detailed notes from a tissue viability nurse and dietitican recorded in residents care records and incorporated into the residents care plans.

Judgment: Compliant

Regulation 8: Protection

The registered provider had up to date policies on safeguarding and the management of residents accounts and property including pensions. Records showed that a recent safeguarding incident had been responded to appropriately.

Judgment: Compliant

Regulation 9: Residents' rights

All residents who spoke with inspectors on the day said that they felt safe in the centre and that they held the staff in high regard. The ambiance in the home was calm and relaxed. Interactions between staff and residents were positive with each interaction seen based on respect for the individual. Where residents needed time to communicate their needs staff were seen to engage in active listening and were mindful of residents communication needs.

The activity coordinator had departed the centre during the summer with activities currently provided by care staff and a unit sister based on each of the centres five units. Group activities had been curtailed due to COVID-19 however residents were supported with a range of one to one activities according to resident's individual requirements. Inspectors were informed that each floor had access to a tablet to assist residents communicate with their friends and families. Those residents spoken with acknowledged that restrictions on visiting were difficult to deal with but were understanding of why they were in place. Residents were happy to see that visits although controlled were happening again.

Inspectors observed residents congregating in a temporary communal room on the third floor which was set aside for residents who wanted to participate in religious observance. There were also facilities in place which allowed religious services to be programmed to residents' TVs in their bedrooms.

Resident committee meetings had restarted after been postponed during the pandemic and this afforded residents the opportunity to voice their opinions about the home and the services provided. Inspectors noted that there was an annual review of quality and safety for 2019 which included resident views accessed from a resident satisfaction questionnaire.

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	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 26: Risk management	Not compliant
Regulation 27: Infection control	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Sacred Heart Residence OSV-0000157

Inspection ID: MON-0031158

Date of inspection: 26/11/2020

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
ACTIONS TAKEN:

• The responsibility of monitoring, recording and arranging of mandatory training has been delegated to the Personnel office from December 2020.

• The personnel office are recording training using a matrix. This system has in-built alert for training that is due which allows for better coordination and planning.

• The Personnel office schedules training sessions with internal trainers, notifies staff of training and provides attendance sheets for staff to sign at end of each session.

• Attendance sheets are returned to the personnel office on day of training and the training matrix is updated within 3 working days. All signed record sheets are being stored for verification purposes.

• Non-attendance is being actively managed by the personnel office by recalling such staff to next available trainings session. Recurrent non-attendance will be managed through the Home's performance management/disciplinary procedures.

• The personnel office coordinates with external training providers also.

• Fire training has been provided to 86 staff since inspection date in November. Training sessions will continue twice weekly basis until full compliance is achieved.

• Infection prevention and control training has continued. There are 12 members of staff yet to attend training, to be completed for the 10th March 2021.

• Safeguarding Vulnerable Adults training will be provided on a weekly basis pro tem.

Next date of training is the 17th February.

• Dr. Toney Thomas (IPC-Beaumont Hospital) has provided an education and training talk on COVID-19, which addressed hand hygiene, case identification and management, safe use of PPE, etc. A booklet on hand hygiene has been distributed throughout the home

• Scheduling of training from external provider for Manual Handling and people moving is underway. (When level 5 restrictions are lifted)

• The RPR will liaise with the personnel office on a monthly basis to monitor the training programme schedule and to provide support as required. The RPR will ensure the registered provider and the management team is kept informed of this information.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

• Infection prevention and control training oversight is addressed in above response to regulation 16: Training and staff development.

• Detailed contingency plans for the prevention and management of COVID-19 have been prepared, actioned and reviewed. These address the establishment of isolation unit, case management of residents with suspected and confirmed COVID-19 infection, staffing, training, record keeping communication etc. Copies of these have been submitted to the Authority previously.

• In December 2020 a more detailed contingency plan has been drawn up, and distributed with in the home, in collaboration with Nursing Matters.

• Immediately after the inspection in November, the Home has formally established an Infection Prevention and Control team comprising of the RPR, PIC, CNO and CNM. This team aims to meets twice weekly and is attended by other members of staff as required. This meeting is chaired by Sr. Jacinta, RPR.

• Cohorting arrangements were achieved and information given to HIQA during a zoom call on the 2nd December 2020

• A schedule of audits has been created for the calendar year 2021. The PIC, CNO and CNM are responsible for adhering to this schedule. This includes increased frequency of infection control-related audits.

• A revised sign off sheet has been added to all audits. This includes place to record

completion of all steps of the auditing process to include completion, circulation of results are subsequent review. It also includes a place to record review by PIC.

• At weekends, a staff nurse will be highlighted on the rota as nurse in charge. This staff nurse will act as a resource for other nursing staff in managing care and associated issues. He/She will be responsible for reporting to/ contacting senior management as required.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:

• All complaints will be recorded using the Home's complaints form.

• The complaints procedure notification at reception has been updated to include the name of current complaints officer.

• In future, signature(s) to record that the complaint has been resolved / closed.

• We are adding a complaints management checklist with each new complaint to record completion of complaints process. This will include a section for the PIC to record that she has read the complaint and that it has been processed and managed to her satisfaction.

Regulation 26: Risk management	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management:

• Since October 2020, a programme of work has been underway to establish and maintain more robust processes to meet the Risk Management needs of the home.

This programme includes:

• A site visit from a Health and Safety Officer in October 2020

• Preparation of a Health and Safety Handbook which will be circulated to all staff by 31st March 2021. Staff will be expected to record that they have read and understood the contents of this. (Copy attached)

• Risk management/ health and safety training for the Home's maintenance staff

(attended via Zoom on the 9th February)

• A facilities company (Globoserv) with expertise in this area is engaged to attend to the following responsibilities:
· Lead out on the risk management and health and safety for the Home;
· Weekly contact (via Zoom at present) with the maintenance team;
· Scheduling of planned preventative maintenance and mandatory testing (Legionella etc.);
· Attending quarterly health and safety meetings-meeting scheduled for the 5th March 2021 (via Zoom)
· Recording of health and safety activities and meetings held with maintenance staff in the Home.
· All non-clinical risks within the centre will be managed and audited by the person nominated by the external company, in liaison with the homes Health and Safety Team.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
• Since inspection, the Home has formally established an Infection Prevention and Control team. This team meets twice weekly and is attended by others as required. This meeting is chaired by Sr. Jacinta, RPR.

• The infection prevention and control policy has been updated to make distinct reference to of COVID-19 and the associated national guidance in relation to its management. This policy will be reviewed as required to reflect changes in national guidance and best practice in the management of infections to include COVID-19.

• Copies of the revised infection prevention and control policy, visiting and admissions policies are now available in hard copy on each unit.

• The Home has established an isolation unit to provide care for residents who have a COVID-19 diagnosis. This unit is self-contained and has and will be staffed appropriately to reflect the needs of such residents. There is capacity for 8 residents to be cared for on this unit.

• Further training in infection prevention and control has been and will continue to be provided to staff. This training is recorded on the Home's training matrix.

• Additional changing rooms have been established so that there is a changing room for staff from each distinct unit in the home. These are spacious and signs are in place that state the maximum number of staff permitted in the room at any one time.

• In addition, signs are in place to remind staff of social distancing, hand hygiene etc.

• Surplus seating has been removed from the staff dining room. Extra notices are in place to remind staff of maintain social distancing when using the dining room.

• Notices have been placed on some of the seating in the staff sitting room to advise staff not use those particular chairs so that social distancing can be observed in that room.

• Surplus seating has been removed from the main dining room to assist residents in observing social distancing guidelines also. The remaining seating is arranged in a manner to facilitate social distancing.

• COVID-19-specific noticeboards have been put in place on all units. These are populated with current pertinent information and instruction for staff, to include hand hygiene posters and COVID-19 response guidance.

• A COVID 19 folder can be found on each unit, this folder contains: contingency plan/action plan, visitor's policy, admissions policy, highlighting COVID 19 practices throughout the home.

• Surplus seating has been removed from resident sitting rooms to assist residents in observing social distancing.

• We have established a central location on each unit for cleaning schedules and daily cleaning completion records. The cleaning schedule documentation has been revised to include a place for supervisors to record that they have signed off on work done. Unit sisters have received instruction on signing off on the completion of cleaning on a daily basis.

• We have recently put in place a monitoring record for the PIC/CNO/CNM to record compliance of individual units in relation to: PPE use and availability, Hand gel availability; cleanliness of cleaning (janitorial) rooms; the completion of cleaning records and the preparation and set up of isolation rooms, this will be done on a weekly basis.

• Environmental hygiene audits are ongoing.

• Housekeeping staff have had training updates in use correct use of hygiene products, the colour-coding of cleaning equipment and in cleaning and storage of cleaning equipment when not in use.

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:
• All residents now have an activities care plan to direct staff on how to support their social care needs/interests.

• The evaluation and of the activity care plan will be monitored as part of the assessment and care plan auditing.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	31/03/2021
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	21/03/2021
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Not Compliant	Orange	19/02/2021

Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	05/02/2021
Regulation 26(1)(a)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.	Not Compliant	Orange	12/03/2021
Regulation 26(1)(b)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the risks identified.	Not Compliant	Orange	12/03/2021
Regulation 26(1)(c)(i)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control abuse.	Not Compliant	Orange	12/03/2021
Regulation 26(1)(c)(ii)	The registered provider shall ensure that the risk management	Not Compliant	Orange	12/03/2021

	policy set out in Schedule 5 includes the measures and actions in place to control the unexplained absence of any resident.			
Regulation 26(1)(c)(iii)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control accidental injury to residents, visitors or staff.	Not Compliant	Orange	12/03/2021
Regulation 26(1)(c)(iv)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control aggression and violence.	Not Compliant	Orange	12/03/2021
Regulation 26(1)(c)(v)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control self-harm.	Not Compliant	Orange	12/03/2021
Regulation 26(1)(d)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes	Not Compliant	Orange	12/03/2021

	arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents.			
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.	Not Compliant	Orange	15/03/2021
Regulation 34(1)(f)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.	Substantially Compliant	Yellow	31/01/2021
Regulation 34(3)(b)	The registered provider shall nominate a person, other than	Substantially Compliant	Yellow	31/01/2021

	the person nominated in paragraph (1)(c), to be available in a designated centre to ensure that the person nominated under paragraph (1)(c) maintains the records specified under in paragraph (1)(f).			
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	05/03/2021