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:	Baltinglass Community Hospital
Name of provider:	Health Service Executive
Address of centre:	Newtownsaunders, Baltinglass, Wicklow
Type of inspection:	Unannounced
Date of inspection:	27 July 2022
Centre ID:	OSV-0000485
Fieldwork ID:	MON-0037029

About the designated centre

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

The centre caters for a maximum of 60 residents and provides care to both male and female residents over 65 years of age. The centre provides 54 residential beds; 12 of these beds (including one respite bed) are specifically dedicated to dementia care and will accept residents under 65 years of age with a diagnosis of dementia. There are six respite beds in total in the centre. Managers and staff aim to provide high quality individualised care to residents and to support their families and friends. The centre's philosophy is to meet the social, psychological, physical and spiritual needs of residents in a manner that reflects their right to respect, dignity, privacy and independence. Accommodation is divided into three units. Ceidin unit accommodates 28 residents in twin and single bedrooms providing a mix of en suite and communal wheelchair accessible toilet, shower and bathing facilities. There is a large communal lounge and dining room and two smaller seating areas. Primrose unit is a specialist 12 bed unit which provides accommodation for residents with a diagnosis of dementia. The unit comprises seven bedrooms providing single and twin bedroom accommodation, one with en suite and communal toilet and bathroom facilities. There is a communal lounge/dining room which leads out to the enclosed dementia friendly garden area and an additional smaller communal room. Willow unit accommodates 20 residents in single and twin bedrooms with a mix of en suite and communal wheelchair accessible bathrooms and toilets. There is a large communal lounge/dining room a small chapel and smaller seating areas leading out to the garden and gazebo. The centre has recently extended the entrance area to provide a pleasant cafe and meeting area which welcomes residents and their visitors.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	45

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 27 July 2022	09:30hrs to 16:30hrs	Bairbre Moynihan	Lead
Thursday 28 July 2022	09:20hrs to 16:00hrs	Bairbre Moynihan	Lead

What residents told us and what inspectors observed

Residents were positive in their experience of living in Baltinglass Community Hospital and praised staff for the care they received. An inspector greeted and chatted with a number of residents and spoke in depth with six residents and a small number of visitors. Both residents and visitors were highly complimentary about the care and attention their loved ones received. One resident stated that she "loves it here" and the "food is excellent".

On arrival at the centre, the inspector was greeted by the person in charge and the assistant director of nursing. The centre's entrance was renovated five years ago and was bright and welcoming. Tea and coffee making facilities were available for residents and their families who chose to meet there. The entrance contained a "Tree of Life" where residents who were deceased within the previous year were remembered containing their name and date of death on the tree. Following a brief meeting, the person in charge guided the inspector on a tour of the centre.

The centre was registered for 60 beds, however, the inspector was informed that the maximum number of residents that lived in the centre at any one time was 54. This was to comply with Health Act 2007, (Care and Welfare of Residents in Designated Centres for Older People) (Amendment) Regulations 2016, Statutory Instrument 293. The centre had three units; Primrose, a dementia specific unit, containing 12 beds but with 10 residents on the day of inspection. Ceidin Unit, 28 bedded unit with 21 residents on the day of inspection and Willow Unit, 18 beds with 14 residents on the day. All three units had a mixture of double rooms and one to two single en-suite rooms. Showers, baths and toilets were shared. Residents rooms were decorated with photographs, pictures and personal belongings for example; blankets. The majority of residents rooms contained two sinks, a clinical handwash sink and a resident's sink. These were clearly identified. The majority of clinical handwash sinks were compliant with the required specifications. Each unit contained a open plan sitting room and dining room. All three units had their own entrance for visitors. Primrose had a dedicated activities room and a sensory room. Old pictures of the locality were on display in corridors.

Resident's activities were observed to be taking place on all three units on the day of inspection. An activities board identified activities for that day. This was updated daily. Residents were observed to be reading newspapers. The centre did not have WIFI but the inspector was informed that WIFI was being activated on the Monday following the inspection. A number of residents stated how they loved the bingo. A singalong was observed in Ceidin. Residents in Primrose were sitting out in the sunshine in the enclosed garden, listening to music, with some residents knitting. Following a fundraising initiative and subsequent consultation with residents in Primrose a fish tank was purchased. Photographs were on display in Ceidin of a lamb and residents were bottle feeding the lamb. A resident informed an inspector about a concert he had recently attended with an activities co-ordinator. A quarterly newsletter was available for both residents and relatives. Resident's meetings took

place in April, May and June of 2022. Meetings were chaired by a resident with assistance from an activities co-ordinator. Minutes reviewed identified that the residents were informed that the hospital was 100 years old in 2022 and centenary celebrations had been planned for September 2022 with all residents attending. In addition, residents discussed the plans for a polytunnel in the garden. The inspector was informed that this was planned to be installed in the next two months. The polytunnel will be wheelchair accessible so all residents can avail of it. A resident's satisfaction survey was completed in January 2022. Responses included that residents personal storage was "fair", however, no action plan accompanied the survey so it is unclear if this was addressed.

An inspector observed the dining experience. This was observed to be a very positive and social occasion with the majority of residents attending the dining room. All staff were assisting at lunchtime. The menu was displayed in the dining area. Mass was celebrated once weekly on a Tuesday. In addition, a Church of Ireland representative attended once weekly on a Tuesday or a Friday.

The next two sections of the report present the findings of this inspection in relation to governance and management arrangements in place in the centre and how these arrangements impacted the quality and safety of the service being delivered.

Capacity and capability

This was a well-managed centre with effective leadership and management in place which ensured the residents received high quality, person-centred care and support to meet their assessed needs. The management team were proactive in response to issues as they arose. Staff were knowledgeable regarding residents needs and provided care in a dignified and respectful manner. However, improvements were required under training and staff development and governance and management.

Baltinglass Community hospital is a residential care setting operated by the Health Service Executive (HSE). There was a clearly defined management structure with identified lines of accountability and responsibility for the service. The person in charge reported to a general manager for older person services who reported to the head of social care. The head of social care was present onsite for the second day of the inspection to address any queries from the inspector during the inspection. The person in charge was supported on-site by an assistant director of nursing, three clinical nurse managers 2 (CNM), one for each unit, a CNM dedicated to infection prevention and control, nurses, care staff, administration staff and activities co-ordinators. Overall, on the day of inspection, the centre had an adequate number of staff, however, deficits were identified in the number of activities co-ordinators. This will be further discussed under the domain of quality and safety.

The centre had a training matrix in place. Staff had an personal education passport which provided staff with ownership of their training and when it was due. This was overseen by the local clinical nurse manager. Staff had access to mandatory training

and had a number of trainers onsite including trainers for behaviours that challenge, basic life support, and infection prevention and control. In addition, the centre had five hand hygiene trainers. Training attended by staff included hand hygiene training, clinical waste, manual handling, basic life support and fire training. Safeguarding training was provided via HSEland with the majority of staff having completed it at the time of inspection. Improvements were required around fire training and managing behaviours that challenge which will be discussed under the relevant regulation. Staff confirmed their attendance at the various training. Observations of the inspector was that training was effective, for example; staff were able to describe the face to face training received on infection prevention and control.

An audit schedule was in place for infection prevention and control. In addition, medication management audits were taking place. However, while action plans were devised there was no date for completion of the actions or if the actions had progressed. Furthermore, no tracking and trending of incidents were taking place. However, management stated that there was a plan in place to introduce nursing metrics in conjunction with CHO 7. For example; metrics on falls risk and prevention and person experience. The centre had number of systems of communication including meetings with the general manager for older person services fortnightly, ward meetings, clinical nurse manager meetings and a recently established a quality and patient safety committee meeting which took place monthly. This was established in January 2022 and was evolving at the time of the inspection. These will be further discussed under Regulation 23: Governance and Management.

A sample of contracts for provision of services were reviewed. While the contracts do not individually outline the additional charges such as hairdressing the inspector was informed that this was handed to the resident at the time of signing the contract and a sample of this was in the contract folder.

Information leaflets outlining the complaints process were on display throughout the centre. A review of the complaints log showed that a small number of written complaints were received and these were responded to promptly. A comments and suggestion box was observed outside Ceidin. All incidents were notified to the Chief Inspector in line with Regulation 31: Notification of incidents.

Four staff records reviewed identified that Garda (Police) vetting was in place and contained the up-to-date professional registration certificates for nursing staff.

Regulation 15: Staffing

On the day of inspection, nursing and healthcare assistant staffing in the centre was adequate for the needs of the residents, and the size and layout of the centre. However, deficits were identified in activities co-ordinators. This will be discussed under Regulation 9: Residents' rights.

Judgment: Compliant

Regulation 16: Training and staff development

The training matrix was requested on the day of inspection and while the majority of training records were provided, no training records were provided on managing behaviours that challenge. The inspector was informed that while there were staff onsite who could provide this training, a number of staff had yet to complete it.

Furthermore, the training matrix provided identified that 32 members of staff fire training was out of date. However, fire training had been completed on the day prior to inspection and records were in the process of being updated. Plans were in place to complete fire training monthly until all staff had completed it. The inspector was advised at the feedback meeting that there was two months where there was no training due to a change in contracts which accounted for this deficit

Judgment: Substantially compliant

Regulation 21: Records

Records were stored securely and were readily accessible. A review of a sample of four records found the requirements of schedule 2 were met.

Judgment: Compliant

Regulation 23: Governance and management

Improvements were required in the oversight and monitoring of the service to ensure the quality and safety of residents living in the designated centre. For example;

- While auditing was taking place a time-bound action plan was not always devised to address issues identified and recommendations made.
- Residents meeting took place in April, May and June 2022. While meeting minutes were comprehensive, no action plan was devised; for example it was identified that the bell at the visitors entrance to Ceidin was not working. Management stated that the bell was fixed, however, the time bound action plan to support this was not available.
- The inspector requested tracking and trending of incidents. These were not provided. In addition, ward meeting minutes reviewed identified that there was no feedback or learning from incidents discussed at these meetings.

- Meeting minutes reviewed of ward meetings and quality and safety committee meetings identified that no timebound action plans were devised.

Judgment: Substantially compliant

Regulation 24: Contract for the provision of services

A sample of contracts were reviewed. The registered provider had agreed in writing with each resident, on the admission of that resident to the designated centre concerned, the terms on which that resident shall reside in that centre.

Judgment: Compliant

Regulation 31: Notification of incidents

All incidents were notified to the Chief Inspector in line with the regulatory requirements.

Judgment: Compliant

Regulation 34: Complaints procedure

A review of the complaints log showed that a small number of written complaints were received and these were responded to within the timelines. Verbal complaints were logged with the outcome and whether the resident and or complainant was satisfied. One complaint stated that there was no activities co-ordinator for four days. The outcome of this complaint was not clear. This will be further discussed under Regulation 9; Resident's Rights. Residents informed the inspector that they would know who to make a complaint to.

Judgment: Compliant

Quality and safety

The inspector found that residents had a good quality of life in Baltinglass Community Hospital and where possible, were encouraged to live their lives in an unrestricted manner, according to their own capabilities. The healthcare needs of

residents were met through good access to medical, nursing and other healthcare services if required. While the centre was working to sustain a good level of person-centred care, improvements were required around a number of regulations; Regulation 11: Visits, Regulation 17: Premises, Regulation 27: Infection Control and Regulation 9: Residents' Rights.

Baltinglass Community Hospital was celebrating its' centenary this year and the hospital was planning celebrations with residents and the local community in September. The premises has been updated over the years with the foyer updated five years ago and the three units updated eight years ago. Notwithstanding this general wear and tear was noted throughout the centre. There were a small number of single rooms with en-suite facilities and all residents in twin rooms were required to share shower, bath and toilet facilities.

The centre had an up-to-date risk management policy in place which outlined the assessment and control of risk and the recording, investigation and learning from incidents and detailed the five specified risks required by Regulation 26: Risk management.

Visits were observed to be facilitated on the day of inspection. Visitors could have their nominated person visit at any time and for any number of times, however, notwithstanding this visiting was observed to be overly restrictive. This will be discussed under Regulation 11: Visits.

The centre had being proactive in its approach to infection prevention and control (IPC). A clinical nurse manager with a qualification in infection prevention and control was dedicated to this area. In addition, the centre had infection prevention and control link nurses in each of the three units. IPC link practitioners met once monthly. An infection prevention and control audit schedule was in place and a number of audits had taken place to date for example; environmental audits, audits of the waste, sharps and mattresses. Audits were comprehensive and identified the issues, action plans were devised but there was no date or follow-up on the actions. On the last Friday of every month the centre had an antimicrobial stewardship audit. The laundry of residents clothes was carried out onsite. The laundry had a clean to dirty flow with signage in place to indicate this. Management informed the inspector that cleaning staff had induction training on site with their own supervisor on the principles and practices of cleaning with certificates of attendance. Findings requiring improvement will be discussed under Regulation 27; Infection control.

Good practices were identified under Regulation 28: Fire precautions and Regulation 29: Medicines and pharmaceutical services. These will be discussed under the specific regulation.

Regulation 11: Visits

The inspector observed that visiting in the designated centre was not in line with the current public health guidance. For example; three visiting slots were available per

day with visitors required to book in advance. The inspector was informed that aside from the nominated visitor, residents could have visitors three times weekly. Temperature checks and risk assessment forms were required for each visitor. The inspector was informed that the centre was taking a cautious approach to visiting at the centre as a COVID-19 outbreak was declared over by public health on 19 July 2022. In addition the centre's standard operating procedure on visiting referenced guidance from July 2021.

Judgment: Substantially compliant

Regulation 17: Premises

General wear and tear was observed throughout the premises for example; damaged walls, scuffed paint and chipped skirting and doors. These issues had been identified in environmental audits and will be discussed further under Regulation 23; Governance and management. The inspector was informed that there was a plan to repaint the open plan dining and sitting room areas, however, there was no date for this at the time of inspection.

In addition, a small number of clinical handwash sinks some were not compliant with the required specifications.

Judgment: Substantially compliant

Regulation 26: Risk management

The centre had an up-to-date risk management policy in place. The policy outlined the five specified risks required by the regulations with reference to associated policies for each risk. In addition, the policy contained the arrangements for the identification, recording, investigation and learning from serious incidents involving residents.

Judgment: Compliant

Regulation 27: Infection control

While the centre was clean, areas for improvement were identified in order to ensure the centre was compliant with procedures consistent with the National Standards for Infection prevention and control in community services (2018). For example;

- The medication trolley in Primrose was in a state of disrepair and as such did not facilitate effective cleaning.
- The clinical handwash sink was inaccessible in the laundry due to a trolley blocking it. This was brought to management's attention on the day and rectified immediately.
- The housekeeping room in Ceidin did not contain soap or handtowels.
- A COVID-19 outbreak summary report was completed following the outbreak in 2021 and the most recent outbreak in June and July 2022. The summary reports were not comprehensive did not detail the learning from the outbreak.
- While the centre had an up-to-date COVID-19 preparedness plan in place, it referenced interim guidelines and a circular from 2020.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Systems were in place for monitoring fire safety. Fire extinguishers, the fire alarm and emergency lighting had preventive maintenance conducted at recommended intervals. Weekly and monthly checks to ensure that fire safety equipment was functioning appropriately and that emergency exits were free from obstruction were carried out. Each resident had a completed emergency evacuation plan in place which was reviewed four monthly to guide staff containing a lanyard for each resident with their personal details, photograph, means of evacuation and their medical history. The fire alarm system met the L1 standard which is in line with the current guidance for existing designated centres. Fire drills were completed monthly during fire training, outside of this, two fire evacuation drills had taken place this year. From the documentation reviewed both residents and staff were involved in the night-time scenario evacuation drill.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

The centre had systems in place for the management of medications. A pharmacist from an acute hospital attended once weekly. Medications were stored securely including medications requiring strict control measures (MDAs). Medication incidents/errors were classed using the "National Coordinating Council for Medication Error Reporting and Prevention" (NCCMERP).

Judgment: Compliant

Regulation 6: Health care

Residents had access to two local general practitioners (GPs). After hours the centre contacted the out of hours on-call service. The inspector was informed that the centre had good access to health and social care professionals including speech and language therapist and dietitian with no waiting time for review from once a resident was referred. A physiotherapist was onsite two days per week (0.5 whole time equivalent). In addition an optometrist attended onsite yearly to review residents ocular health. Residents had access to a Consultant Geriatrician at a local acute hospital. Regular multidisciplinary team meetings were held with attendance by the GPs and health and social care providers.

Judgment: Compliant

Regulation 9: Residents' rights

The inspector was not assured that residents had opportunities to participate in activities in accordance with their interests and capacities, seven days a week. For example:

- Each unit had an activities co-ordinator, however, documentation reviewed including a complaint and an issue raised at a residents' meeting indicated that some days no activities were available to residents. Management stated that activities were provided five days per week by the activities co-ordinators and two days by healthcare assistants some of whom were training to be activities co-ordinators. The inspector was informed by management at the feedback meeting at the end of the inspection that due to staffing deficits it was not always possible to provide cover for activities.

Judgment: Substantially 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	Substantially compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Substantially compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Baltinglass Community Hospital OSV-0000485

Inspection ID: MON-0037029

Date of inspection: 28/07/2022

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: 1. Staff training planned to enhance the understanding and management of actual or potential aggression (MAPA) with a particular focus on staff that had yet to complete this training or require further updates. Training scheduled to be delivered to staff through two onsite MAPA trainers - 6th September 2022 / 4th October 2022 /8th Nov 2022 and 6th Dec 2022 .	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: 1. The facility plans to rollout of QCM to all our units through the office of the NMPDU/ONMSD in October 2022. A key focus is to further enhance the service's ability to track and trend incidents through the existing assurance system (NIMS incident reporting tracker system)- target for completion 31/10/22. 2. Tracking and Trending practices are established on site through the reviewing on a quarterly basis incidents captured on the NIMS incident reporting tracker system. The outcome of this analytics are discussed at the local nurse managers meetings /QPS /Health & Safety meetings as per schedule 2022 with outcomes and learnings shared with all staff- implemented. 3. Auditing of Medication Management / Falls / Restrictive practice incident reports and	

monthly IPC audit reports 2022 are given to all nurse managers to discuss with their staff and formulate an action plan to improve practice if required. This is also tracked through the DSKWW-CH IPC team with trend analysis for all HSE- led Community units- implemented

4. Ward meetings and Quality Patient Safety meetings have specific owner actions and completion dates for meetings held during 2022, which will continue to have a standard template with owner actions identified - implemented.

5. Plan to establish a Falls & Incident Management Committee and a Medication Management committee in October 2022, in conjunction with the QCM introduction to the facility and governance oversight obtained through the commencement of the new Assistant Director of Nursing to the service – 31/10/22.

6. Residents meetings have specific owner actions and completion dates for meetings as a standard template .

Regulation 11: Visits	Substantially Compliant

Outline how you are going to come into compliance with Regulation 11: Visits:
1. The service operates a visiting access policy based on an updated risk assessment to reflect HPSC Guidelines 1.7 and more recently V1.1 getting back towards normal life in nursing homes guidelines.

2. Visiting access to the service is unlimited with no restrictions to the number of different people who can visit the unit. No more than two visitors at a time facilitated to avoid an overcrowding risk and in the instance of a group visit, visitors encouraged to consider a "taking turns" process.
3. Current visit practices to the service is has no time limit unless a risk of over-crowding occurs. Only one designated visiting/family-room exists on each unit as identified on the day of the HIQA inspection with no restricted access to residents.
4. Visits to residents supported in all areas of the service with the front reception a popular area for such practices. Residents, families and/or carers are provided with a copy of the leaflet getting back towards normal life in nursing homes v1.1 08/08/22 for their perusal.
5. The visiting risk assessments used by the service as a SOP (standard operating procedure) for all staff and not the SOP detailing HPSC July 2021, which was obsolete. Visiting risk assessments are stored at ward level and utilized by nursing administration for ease of access for visiting references.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
1. General wear and tear areas identified are part of a painting refurbishment scheduled of works targeted for completed in Q4 2022.
2. Two hand wash sink replacement in compliance with HBN0010Standard scheduled for Q4 2022
Both of these schedules of works are part of the implementation of the serivce's 2022 IPC Quality improvement plan.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
1. A schedule of repairs rectified the absence of the hand wash dispenser and hand towels in the house keeping room. This works as mentioned in the feedback was part of a 2022 IPC planned schedule of works - completed.
2. The outbreak Form (formulated by the CHO7 IPC team) utilised by the service includes a section on how the Facility can document learnings that may have occurred. The completed template and resident /staff feedback analysis are reviewed post an outbreak at local nurse management team meetings/QPS meetings with the key outcomes/learnings disseminated to all staff- completed.
3. The Covid / influenza / extended respiratory illness preparedness plan is up dated on a quarterly basis or more frequently if guidelines change. Staff are given this local document and HPSC newest published guidelines by the local IPC CNM2 as they evolve- completed.
4. Drug trolley replaced on Primrose unit - September 2022

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
1. The service has 3 WTE activities team to cover the Ceidin/ Willow/ Primrose units with the support of 2 further staff to cover short term absence such as sick leave or holiday leave – implemented.

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 11(2)(a)(i)	The person in charge shall ensure that in so far as is reasonably practicable, visits to a resident are not restricted, unless such a visit would, in the opinion of the person in charge, pose a risk to the resident concerned or to another resident.	Substantially Compliant	Yellow	31/08/2022
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	08/08/2022
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	31/12/2022

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	08/08/2022
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 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Substantially Compliant	Yellow	20/08/2022