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:	Birr Community Nursing Unit
Name of provider:	Health Service Executive
Address of centre:	Sandymount, Birr, Offaly
Type of inspection:	Unannounced
Date of inspection:	31 August 2022
Centre ID:	OSV-0000522
Fieldwork ID:	MON-0037435

About the designated centre

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

Birr community Nursing Unit is a single-storey facility located in a quiet residential area, within walking distance of Birr town centre. The centre can accommodate 74 residents over the age of 18 years, both male and female for long term and respite care. Two beds are also dedicated to rehabilitation care. Accommodation is set out in three suites, Laurel, Sandymount and Camcor with communal dining and sitting rooms in each suite. Bedroom accommodation for residents is provided in 15 bedrooms with three beds, eight twin bedrooms and 13 single bedrooms. Twenty six bedrooms have en suite toilet, wash basin and shower facilities and 10 bedrooms have toilet and wash basin facilities only. A palliative care suite is available in the centre. Services provided include 24 hour nursing care of residents with the following needs; general care, mental health, palliative care and dementia. A medical officer and health and social care professionals are provided as part of the service to residents.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	60

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 31 August 2022	09:00hrs to 18:00hrs	Sean Ryan	Lead

What residents told us and what inspectors observed

Residents living in Birr Community Nursing Unit complimented the service, staff and quality of care they received. Residents told the inspector that they felt at home living in the centre and that staff provided them with the necessary care and supports to enjoy a satisfactory quality of life.

On arrival at the centre, the inspector was met by the clinical nurse manager who provided information with regard to the current residents living in the centre. The inspector walked through each of the three units with the clinical nurse manager. Following an opening meeting with the person in charge, the inspector met with residents in their bedrooms and communal dayrooms.

The inspector observed a calm, relaxed and friendly atmosphere in the centre. Residents were observed freely walking around the centre, sitting outside in the gardens and relaxing in their bedroom. Residents told the inspector that they were happy with the care they received and that staff were kind, caring, polite and attentive to their needs. The inspector observed multiple staff and resident engagements that were as the residents described.

Birr Community Nursing Unit is comprised of three distinct units, the Camcor, the Sandymount and the Laurel unit. The centre is registered to provide accommodation to 74 residents in 15 bedrooms with three beds, eight twin bedrooms and 13 single bedrooms. The centre is a single storey premises.

The inspector noted that the provider had made some improvements to the premises which addressed some of the issues identified on the previous inspection. A number of corridors had been repainted and there was decorative adhesive wall signage in place to support residents to navigate their environment. Some bedroom furnishings had been replaced and new curtains and privacy screens had been installed. The inspector observed that the secure gardens were accessible to all residents and appropriately maintained. Residents complimented the addition of outdoor furnishings that had been provided for them to enjoy the warm weather during the Summer. A new sensory garden was under construction outside the main dining room to the front of the building. Residents were hopeful that they would be able to enjoy this outdoor space once completed. The inspector observed that residents' communal space, previously used by staff had reverted to resident's use. This included the parlour room and quiet rooms on each of the three units. However, the inspectors observed that some areas of the premises were not maintained in a satisfactory state of repair such as floor coverings that were torn and impacted on effective cleaning.

Throughout the inspection, the inspector observed a number of residents who spent a significant amount of time in their bedrooms throughout the day. Those residents told the inspector that they would go outside for a walk when the weather was warm but as the winter months approached, they would spend the majority of the

time in their room or they might attend activities in the small communal rooms 'if is was not too busy'.

Residents' bedrooms were clean, brightly decorated and appropriately furnished. Residents were satisfied with their bedroom accommodation and the storage facilities they had to display personal possessions, such as photographs and ornaments. Multi-occupancy bedrooms had been reconfigured to provide additional space for residents, made available by the reduction in the number of beds in the room. Additional storage, seating and televisions had been provided for residents to use. Call bells were available in all resident bedrooms and communal areas. The management team confirmed that call bells were being installed in two external areas used by residents. Residents expressed their satisfaction with the time taken for staff to respond to their call bells.

The dining experience was observed to be a social, pleasant and unhurried experience for some residents on each of the three units. The inspector observed a number of residents who had their meals in their room while a small number of residents who required minimal assistance were observed to attend the larger dining room at the front of the building. Residents told the inspector that they could attend the dining room if they wished. Residents complimented the quality and quantity of food they received. Staff provided discreet assistance and support to residents during meal times.

Throughout the day, the inspector observed that residents were actively engaged in meaningful activities. There was a weekly activities schedule developed in consultation with the residents. This included card games, sensory activities, table quizzes and gardening. Some residents had participated in baking activities while others had the choice of board games or going for a walk outside. The inspector observed one-to-one activities with residents such as hand massage and nail painting. Residents told the inspector that they were provided with frequent opportunities to engage with the management with regard to the quality of the service and were kept informed about changes in the service. Residents told the inspector that they felt their feedback was valued by the management and staff. Residents participated in discussions regarding the redecoration of some communal areas and an action plan was in place to implement residents' suggestions. Residents had access to religious services in the centre on a weekly basis.

Residents were satisfied with the arrangements in place to receive their visitors. Residents could meet with their friends and family in either their bedroom or in the visitors rooms. The inspector spoke with some visitors who expressed their satisfaction with the quality of care provided to their relative and confirmed they could visit residents without any restriction.

The following sections of this report detail the findings with regard to the capacity and management of the centre and how this supports the quality and safety of the service provided to residents.

Capacity and capability

This was an unannounced risk inspection by an inspector of social services to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. The inspector reviewed the actions taken by the provider following the findings of the last inspection in October 2021. The findings of this inspection were that the provider, the Health Service Executive, had taken action to comply with regulations in respect of the provision of activities for residents, maintaining consistent staffing levels, the premises and the management of restrictive practices. While the provider had taken some action to comply with regulations in respect of the provision of training for staff, infection prevention and control and fire safety, the actions taken were not sufficient to bring the centre into full compliance with those regulations.

The centre was found to have an effective governance and management structure overseeing the quality and safety of the service provided to residents. The person in charge reported to a general manager who provided governance oversight and support. The person in charge was supported by an assistant director of nursing who had responsibility for clinical and administrative duties. The provider was actively recruiting for an additional assistant director of nursing to further enhance the management capacity and oversight in the centre.

There were established management systems in place to monitor the quality and safety of the service. A schedule of clinical and environmental audits evaluated the quality of the environment, medication management and clinical documentation. The quality of care was monitored weekly through key clinical indicators such as the incidence of pressure wounds, residents at risk of malnutrition, restrictive practice and monitoring the use of antibiotics. Analysis of the information gathered through the aforementioned management systems was used to inform the development of improvement actions plans that were reviewed by the management team. However, the inspector found that some improvement actions plans were not subject to review or updating to accurately identify actions completed or actions outstanding. Staff were informed about improvements in their areas of responsibility and ensured that improvement action plans were implemented.

The application of the risk management systems, as detailed in the risk management policy, was effective in identifying risks that may impact on the safety and welfare of residents living in the centre. However, action was required to ensure risk assessments were appropriately risk rated and categorised according to their risk as required by the centre's risk management policy. The inspector found that the risk register contained risk assessments with regard to the impaired integrity of fire doors, however the assessment did not indicate the significance of the risk or a time frame for this risk to be addressed.

The provider had taken action to ensure there was sufficient and safe staffing levels on each unit to meet the assessed health and social care needs of the residents and to support residents to access all communal areas in the centre, if they wished. Each

unit was staffed with nursing, healthcare and activities staff who were supervised by clinical nurse managers. Each unit was supported by housekeeping, catering and maintenance staff. There were systems in place to ensure clear and effective communication between the management and staff.

A review of the staff training records found that not all staff had completed training appropriate to their role. This included infection prevention and control, medication management, and managing behaviour that is challenging. A small number of staff had expired training in fire safety. However, the inspector found that staff demonstrated appropriate knowledge, commensurate to their role. Arrangements were in place to ensure staff were supervised and supported in their role.

Systems were in place to ensure there were appropriate record-keeping and file management systems in operation. Information requested in respect of Schedule 2, 3 and 4 of the regulations were made available for review. A sample of staff personal files reviewed by the inspector indicated that they were maintained in compliance with regulatory requirements.

A review of complaints records found that resident's complaints and concerns were responded to promptly and managed in line with the requirements of Regulation 34. Residents were aware of the process of making a complaint and were encouraged to express dissatisfaction with regard to any aspect of the service provided.

Regulation 15: Staffing

On the day of inspection, the staffing numbers and skill mix were appropriate to meet the needs of the current residents taking into consideration the size and layout of the centre.

Since the previous inspection, the provider had capped admissions at 60 residents while recruitment was ongoing to ensure safe staffing levels.

Judgment: Compliant

Regulation 16: Training and staff development

The inspector reviewed staff training records and found that there were gaps in attendance by staff in managing behaviour that is challenging, infection prevention and control and medication management while a number of staff were overdue training in fire safety.

Judgment: Substantially compliant

Regulation 21: Records

Records were securely stored, easily retrieved and made available for the inspector to review.

A sample of staff personnel files were reviewed by inspectors. There was evidence that each staff member had a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 on file prior to commencing employment as required by Schedule 2 of the regulations.

Residents records evidenced daily nursing notes with regard to the health and condition of the residents and treatment provided.

Records in respect of Schedule 2 and 3 were maintained in the designated centre.

Judgment: Compliant

Regulation 23: Governance and management

Governance and management systems were not effectively implemented or monitored. For example,

- The risk management system was not implemented. Risks were not effectively rated, or prioritised, and the effectiveness of controls in place to mitigate risks were not reviewed by the management team.
- There was poor oversight of quality improvement plans arising from audits. For example, the action plan developed following a fire door audit in August 2021 did not evidence the actions completed or the actions outstanding. Consequently, the management team could not assess the risk associated with specific, impaired, fire doors or provide a timeline for completion.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Incidents reviewed were managed effectively and were notified to the Chief Inspector as required under Regulation 31.

Judgment: Compliant

Regulation 34: Complaints procedure

The complaints management system met the requirements of the regulations. A complaints procedure was displayed in an accessible format for residents, visitors and staff. Residents were aware of the procedure to make a complaint and the personnel involved in the management of complaints.

Judgment: Compliant

Quality and safety

Overall, the inspector found that residents felt safe living in the centre and were encouraged to have a good quality of life. Residents reported that they received good quality care and support from staff and that their health and social care needs were met. While the provider had taken action to comply with the regulation in respect of supporting residents who experience responsive behaviours, residents rights and ensuring the premises met the needs of the residents, the actions taken to comply with infection prevention and control and fire precautions were not sufficient to bring the centre into full compliance with those regulations. Action was also required with regard to the management of risk and the associated policy.

Residents care plans and daily nursing notes were recorded through a paper based system. The comprehensive assessment of resident's care needs, through validated assessment tools, ensured that resident's individual support needs were identified on admission to the centre. Potential risks to residents such as the risk of falls, impaired skin integrity and risk of malnutrition were identified and a corresponding care plan was developed in collaboration with the residents and, where appropriate, their relative. The resident's assessments and care plans reviewed by the inspector evidenced that reviews were carried out at intervals not exceeding four months or when there was a change in the residents assessed care and support needs.

Arrangements were in place for the service to provide compassionate end-of-life care to residents in accordance with resident's preferences. Staff had access to specialist palliative care services for additional support and guidance to ensure residents end-of-life care needs could be met.

Residents had good access to general practitioner (GP) services as required or requested by the resident. There were systems in place to ensure the timely referral and access to allied health and social care professionals and evidence that recommendations made by professionals was implemented and reviewed to ensure best outcomes for residents.

The risk management policy set out the systems to be implemented to identify, record, investigate and mitigate risks with the potential to impact on the safety and

welfare of the residents. However, the policy did not contain the risks as required by the regulations or the controls in place to mitigate those risks to residents.

Action had been taken with regard to the maintenance of the premises since the previous inspection. Corridors had been re-painted and additional signage was put in place to support residents in navigating the environment. The reconfiguration and decoration of some multi-occupancy bedrooms supported the privacy and dignity needs of the residents. The provider had submitted a compliance plan that detailed quality improvement actions to enhance the living environment for residents. This included making the larger dining room at the front of the building accessible to all residents for dining, recreation and leisure activities while awaiting a decision on a permanent solution in the form of a capital build that would also address the issue of inadequate communal space for residents on each of the three units. On the day of inspection, residents were observed enjoying this space. The management team confirmed that the plan regarding a capital build, which would include enhancing the communal space on each unit, was still under review.

The provider had a number of assurance processes in place to monitor infection prevention and control systems in the centre. This included access to an infection prevention and control nurse specialist who provided oversight support. The provider had taken some action following the previous inspection that included the installation of an additional wash hand basin on the Camcor unit, cleaning trolleys with secure storage to lock away cleaning agents and sluice rooms were decluttered of inappropriate storage of items. The monitoring and oversight of the cleaning procedure was the responsibility of the housekeeping supervisor. Comprehensive records of cleaning were maintained. The centre had appropriate arrangements in place to monitor and respond to the risk of COVID-19. A contingency plan detailed the actions to be instigated in the event of an outbreak. The plan had been reviewed following outbreaks in the centre and improvement actions plans were developed to prevent and prepare for future outbreaks. However, there were areas of the centre that were not amenable to effective cleaning as a result of damaged floor coverings and poor management of storage areas. Further findings are detailed under Regulation 27, Infection control.

Arrangements were in place to ensure residents were protected from the risk of fire. This included ensuring that the relevant daily and weekly checks were carried out on the fire alarm system, emergency lighting and fire-fighting equipment. Means of escape were observed to be unobstructed. Staff demonstrated an awareness of the fire evacuation procedures and the purpose of residents personal emergency evacuation plans (PEEP) to support the safe and timely evacuation of residents in the event of a fire emergency. However, the inspector found that timely action had not been taken with regard to the integrity of fire doors. While minor maintenance had been completed on doors where intumescent strips were missing, a number of fire doors required replacement and there was no timeline for those works to be completed. Further findings are discussed under Regulation 28, Fire precautions.

Residents were provided with opportunities to express their views about the quality and safety of the service. There was evidence that actions plans were developed following scheduled resident forum meetings and the progress of the actions were

reviewed with residents at subsequent meetings. A daily activities plan detailed a variety of meaningful activities available for residents to attend in accordance with their interests and capacities. Records were maintained with regard to residents participation and engagement in activities. Residents were provided with access to local and national newspapers, telephone, radio and television.

Visiting was facilitated in the centre and residents could receive visitors in both their private accommodation or in designated visiting areas.

Regulation 11: Visits

Residents were supported to maintain personal relationships with family and friends. The registered provider had arrangements in place to facilitate residents to receive visitors in either a dedicated visitor area or in the privacy of their bedroom. Visiting was observed not to be restricted.

Judgment: Compliant

Regulation 13: End of life

Arrangements were in place to provide residents with appropriate care, and comfort, during their end-of-life. Staff consulted residents and, where appropriate, their relatives to gather information with regard to residents needs and wishes to support the provision of person-centred, compassionate, end of life care.

Suitable facilities were provided to to allow residents be with their family in privacy.

Judgment: Compliant

Regulation 17: Premises

Action had been taken to ensure the premises met the individual and collective needs of the residents and was maintained in a satisfactory state of repair. There was adequate sitting, recreational and dining space made available for residents to use.

The external grounds were well maintained and accessible to residents. Additional garden furniture had been installed for residents to use.

The centre was found to be well-lit, warm and comfortably furnished for residents.

Judgment: Compliant

Regulation 18: Food and nutrition

Residents were provided with a choice of meals that were safely prepared, wholesome and nutritious and individualised to each residents nutritional preference and requirement. Residents received support and assistance of staff, when needed, to ensure their nutritional and hydration needs were met in a caring and discreet manner.

Arrangements were in place for monitoring of residents nutritional and weight status and referral pathways were clearly identified to ensure residents had access to dietetic and speech and language services for nutritional and swallow assessments if required.

Judgment: Compliant

Regulation 26: Risk management

The risk management policy did not contain the risks, and controls to mitigate those risks, as required by 26(1)(c) of Regulation 26. This included the risk of;

- abuse,
- the unexplained absence of any resident,
- accidental injury to residents, visitors or staff,
- aggression and violence, and,
- self-harm

The recording and review of identified risks was not in line with the centres risk management policy. This is actioned under Regulation 23, Governance and management.

Judgment: Substantially compliant

Regulation 27: Infection control

The provider had not taken action to ensure that infection prevention and control procedures were consistent with the national standards for infection prevention and control in community services published by the Authority. This was evidenced by;

- There was inappropriate storage of cleaning equipment in the sluice rooms

and used linen was stored in bags on the floor in sluice rooms. This increased the risk of cross contamination.
- Some equipment, such as grab rails in communal toilets, had chipped paint, were rusted and were not clean on inspection.
- There was inappropriate storage of equipment and personal belongings in treatment rooms such as furniture items and staff personal items.
- Floor coverings in some areas of the centre were damaged or torn and covered with adhesive tape. This impacted on effective cleaning of the area.
- Some staff did not display an appropriate knowledge with regard to the storage of sterile products and the management of single use items such as dressings.
- Poor practice was observed with regard to the use of personal protective equipment (PPE) such as face masks.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Action was required by the registered provider to comply with fire precautions in the centre. This was evidenced by;

- Poor practice was observed where fire doors were held open by means other than an appropriate hold open devices connected to the fire alarm system. For example, the treatment room doors were held open by a chain.
- Some fire doors had damaged essential smoke seals and were misaligned resulting in a gap when doors were closed. This compromised the function of the fire doors to contain smoke in the event of a fire emergency.
- The registered provider had not ensured that adequate arrangements were in place to review fire precautions. For example, the action plan developed in response to a fire door audit completed in August 2021 did not detail the remedial or replacement works completed, or outstanding, with regard to fire doors. This is actioned under Regulation 23, Governance and management.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

A comprehensive assessment of the residents needs was completed prior to admission to the centre to ensure the service could meet the needs of the residents.

Care plans were developed to guide the care to be provided to residents and were underpinned by validated assessment tools to identify potential risks such as the risk of falls, impaired skin integrity, malnutrition and to establish the residents

dependency care needs.

There was evidence that residents and, where appropriate, their relatives were involved in the development and quarterly review of assessment findings and care plan updates.

Judgment: Compliant

Regulation 6: Health care

Residents had timely assess to medical assessment and treatment by the general practitioner (GP). Systems were in place for residents to access the expertise of allied health and social care professionals through a system of referral.

There was evidence that the advice of allied health and social care professionals was incorporated into the resident's care plan and reviewed for effectiveness in supporting the residents needs.

Judgment: Compliant

Regulation 9: Residents' rights

There was evidence of residents' rights and choices being upheld and respected. Residents reported that staff made them feel at home in the centre and that they were treated with dignity and respect. Residents felt supported and could exercise choice in how they spend their day. Advocacy services were available as required.

Residents expressed their satisfaction with the activities programme and could choose from a variety of activities in line with their own interests.

The facilities had improved in the centre which provided residents with adequate space to undertake personal activities in private or spend time in communal day rooms if they wished.

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	Substantially compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 13: End of life	Compliant
Regulation 17: Premises	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management	Substantially compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Birr Community Nursing Unit OSV-0000522

Inspection ID: MON-0037435

Date of inspection: 31/08/2022

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: Responsive Behaviour Since the inspection, 43 additional staff have been trained in managing behavior that challenges, training facilitated by 2 onsite instructors. Training dates planned to train outstanding 38 staff. Fire Safety 19 additional staff have attended fire training since the HIQA inspection. The outstanding 15 will be facilitated at onsite training planned for 8th November 2022. Medication Training Matrix updated with majority of nurses having now submitted certs for medication management-4 outstanding. Infection Prevention and Control All Staff are currently completing Refresher Training in Infection Control available on HSE Land. IPC Link Nurse is facilitating Hand Hygiene Training Onsite for All Staff. Training Matrix has been updated in relation to IPC training. IPC CNM has agreed to facilitate onsite training on Standard and Transmission Based Precautions for all staff. Dates planned for November 2022. All Staff are currently completing Refresher Training in Infection Control available on HSE Land. IPC Link Nurse is facilitating Hand Hygiene Training Onsite for All Staff. Training Matrix has been updated in relation to IPC training. IPC CNM has agreed to facilitate onsite training on Standard and Transmission Based Precautions for all staff. Dates planned for November 2022.	

All training will be up to date by 31/12/22 and will be reflected on the training matrix.

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The HSE's Quality and Patient Safety Risk Adviser has agreed to facilitate Risk Assessment training in the centre for all nurses.
Training was facilitated with nursing staff on 11.10.22 and on the 17.10.22.
Nurse managers are currently completing refresher Risk Management Training on HSE Land.
The HSE risk rating matrix has been included on each risk assessment and a Risk Rating has been documented for all risk assessments on the Risk Register.

An action plan with a schedule of priorities and timeframes is in place to address the fire safety issues identified following a report issued by a contracted fire safety consultant. Nine actions have been completed and an additional seven actions in the fire risk assessment will be completed by the 11th Nov 2022 with a further plan to address remaining deficits.
All audits have an action plan and these are reviewed by the PIC to monitor progress.

Regulation 26: Risk management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management:
The Risk Management Policy and associated Risk Assessments in line with 26(1)(c) of Regulation 26 have been updated and are now included on the center's Risk Register.

The HSE's Quality and Patient Safety Risk Adviser has agreed to facilitate Risk Assessment training for all nurses in the centre.
Training was facilitated with nursing staff on 11.10.22 and on the 17.10.22.
Nurse managers are currently completing refresher Risk Management Training on HSE Land.
The HSE risk rating matrix has been included on each risk assessment and a Risk Rating has been documented for all risk assessments on Risk Register.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:

Staff education has been facilitated on IPC best practice to mitigate the risk of cross contamination.
An audit to monitor storage practices in the sluice area has been developed. Signage in the sluice has been updated.
Staff Education on IPC practices is ongoing and is supported locally by IPC link nurse and externally by Infection Control Team, led by ADON in IPC.

Alternative system is being implemented in all sluice rooms to ensure best practice in infection control precautions in relation to the handling and storage of used linen.
The frequency of collection of used linen has been increased to mitigate risk of cross contamination.

The Domestic Supervisor and Nurse Managers are completing regular checks of the grab rails and cleaning schedules relating to same to ensure that IPC standards are being met in relation to cleaning. Grab Rail Audit completed since HIQA inspection with action plan implemented to address remedial works required.
There is an ongoing schedule being followed in relation to floor repairs and replacements in the centre.
Since the inspection the floor covering in 1 single room, 4 multi-bedded rooms and 3 office spaces has been replaced. There are current works being completed to replace outstanding flooring in bedrooms and areas on corridors.
Storage of sterile products and Single Use Items addressed with CNMs at planned meeting on 30.09.22. Ongoing Staff education on IPC includes the correct storage of sterile products and procedure to be followed regarding single use items is as per manufactures guidelines.
Weekly staff meetings being facilitated in all areas, with daily safety pauses.
Signage updated in Treatment Rooms regarding the Storage of Sterile Products and Single Use Items.

Ongoing Support from Tissue Viability Nurse (TVN) on Best Practice on Wound Management. TVN onsite weekly to support the nursing team.

Environmental Audit completed in September 2022 by the IPC Team with action plan being implemented.

Ongoing training with staff to ensure the appropriate use of PPE-Face Masks
Observations to ensure compliance and adherence with current HPSC guidelines, completed with actions implemented, to include ongoing supervision.

Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: All inappropriate devices, eg chain have been removed. Staff education completed regarding risk of using inappropriate devices to hold open fire doors, even on temporary basis to move out trollies. Fire doors identified for magnetic devices compatible with the fire system to be fitted as a matter of urgency, this includes the drug rooms and service areas. Fire doors have been reviewed by the maintenance team and smoke seals will be replaced where identified as defective and fire doors adjusted to ensure closure fitting is in accordance with fire safety standards. Fire Risk remains standing item at weekly risk meetings in BCNU.	

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.	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	14/10/2022
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.	Substantially Compliant	Yellow	14/10/2022
Regulation 26(1)(c)(ii)	The registered provider shall ensure that the risk management	Substantially Compliant	Yellow	14/10/2022

	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.	Substantially Compliant	Yellow	14/10/2022
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.	Substantially Compliant	Yellow	14/10/2022
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.	Substantially Compliant	Yellow	14/10/2022
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and	Substantially Compliant	Yellow	31/12/2022

	control of healthcare associated infections published by the Authority are implemented by staff.			
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	15/02/2023
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	15/02/2023