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:	Caiseal Geal Teach Altranais
Name of provider:	Caiseal Gael Teoranta
Address of centre:	School Road, Castlegar, Galway
Type of inspection:	Unannounced
Date of inspection:	27 May 2020
Centre ID:	OSV-0005491
Fieldwork ID:	MON-0029514

About the designated centre

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

Caiseal Geal Teach Altranais is a purpose built facility located in Castlegar, Co Galway. The centre admits and provides care for residents of varying degrees of dependency from low to maximum. The nursing home is constructed on three levels. There are two floors designated for residents, each having communal areas, dining room and sitting room in addition to residents' bedrooms. The first floor has a spacious sun terrace accessed from the day room and leading to an enclosed courtyard and gardens. Both floors have lift access to and from residents' own areas. Resident bedrooms and living accommodation is on the second and third level. There are 34 single bedrooms and four double bedrooms. The ground floor includes the laundry, storage area as well as the kitchen.
The provider employs a staff team consisting of registered nurses, care assistants, housekeeping and catering staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	32

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 May 2020	09:00hrs to 16:30hrs	Una Fitzgerald	Lead
Wednesday 27 May 2020	09:00hrs to 16:30hrs	Brid McGoldrick	Support

What residents told us and what inspectors observed

Inspectors spent time observing resident and staff engagement. A small number of residents spoke with inspectors while outside enjoying the gardens. Feedback was mostly positive and residents told inspectors that they felt supported by staff. Concern was voiced at how isolating the pandemic has been for residents and the negative impact it is having on their daily lives. Residents spoken with wished for family visits to resume. Residents also wished to have the code to be able to enter and leave the garden area independently and a quiet space to pray and reflect.

Inspectors observed that some residents walked with staff along the corridors for exercise. Inspectors also observed residents in the communal sitting room. There was an activities staff member on duty who told inspectors about group activities that are currently held while also complying with the Health Protection Surveillance Centre (HPSC) two metre physical distancing guidance. In the afternoon inspectors observed an exercise class that residents took part in. Inspectors observed that the staff facilitating the class ensured that all residents were included in the programme.

Inspectors had concerns about the lack of importance that was attributed to resident's personal belongings. For example, a resident who was relocated to a new bedroom did not have access to their personal belongings. This resident was in isolation and lack of access to their personal items increased their sense of isolation.

The care of resident's clothing and bed linen required significant improvement. Inspectors saw multiple examples of clean laundry that was heavily wrinkled. In addition, clean laundry that was stored in the trolleys and ready for use by residents were heavily wrinkled. Staff informed inspectors that there was no iron in the centre. In addition, the laundry room had a large box of laundry that was unlabelled and staff did not know which resident owned the items in the box.

Inspectors observed positive staff interactions with residents in the communal room during dining and activity sessions.

Capacity and capability

Inspectors found that the management of the centre required significant review to ensure that the service provided was safe, appropriate, consistent and effectively monitored. Clinical oversight and supervision of the delivery of resident care required improvement.

This was an unannounced risk-based inspection. The impact of the poor governance and management had on the care of residents is discussed throughout the report.

Caiseal Geal Teach Altranais was first registered in November 2016 with Caiseal Geal Teoranta, a limited company which has three directors, as the registered provider. Inspections of this centre, carried out in in December 2018 and June 2019, found non-compliance under Regulation 23: Governance and Management and Regulation 15: Staffing. The company is now required to review these issues and to display ability and a commitment to make the required improvements that will ensure that regulatory compliance is achieved.

Following notification of an outbreak of COVID-19 on 13 April 2020, HIQA received information which raised concerns about the care of residents during the outbreak. The provider was not present in the center for substantial periods during the COVID-19 outbreak but was available by phone.

At the end of April, concern about the care of residents resulted in the Health Services Executive (HSE) crisis management team taking an active role in the operational management of the centre. A manager from the HSE commenced duty in the centre to ensure that residents were receiving appropriate care and the HSE provided specialist infection prevention and control advice support. The upskilling of practices on infection and prevention control practices was provided to staff including hand hygiene and the appropriate application of personal protective equipment (PPE). This training was required to ensure that staff were following correct procedures to protect residents and to minimise the spread of the infection. In addition to infection control practices, the HSE team took other immediate action to ensure that the service received by residents was appropriate and safe. For example:

- The number of registered nurses and healthcare assistants on duty was increased to meet resident care needs. The HSE team on site had found that there were insufficient numbers and skill-mix of staff to safely care for residents. For example; there was one nurse rostered on night duty to attend to the care needs of upto 42 residents across two floors.
- Immediate action was taken to relocate residents within the centre and ensure that the COVID-19 positive residents were isolated to a designated zone in the centre in line with the national guidance. This was required to ensure that the risk of the spread of COVID-19 was minimised.
- A deep cleaning of the centre premises was required which was completed by an external company.
- The provider was required to purchase additional supplies of linen and cleaning products.

The Office of the Chief Inspector continued to receive unsolicited information that raised concerns about the management structure in place, staffing levels and infection control practices within the centre. This information was substantiated during this inspection. On the day of the inspection, neither the person in charge nor their deputy were available. A clinical nurse manager, who was the most senior person in charge during the inspection, had not received an induction to the role.

This meant that there was no one in the centre who could locate a number of the documents and records that were requested by the inspectors. The staff on duty on the day were professional in their responses but were unable to present a number of key documents such as the current complaints log, current training records and the risk register.

Findings from this inspection resulted in the issuing of an urgent action plan under Regulation 23: Governance and Management and Regulation 27: Infection. The systems and resources in place that required immediate review and action included:

- Governance and Management - while the provider had developed a series of policies and procedures in the centre, the failure to adequately implement and monitor adherence to these policies meant that care practice delivery was inconsistent and posed a risk to the quality of life and safety of residents living in this service.
- Staffing - Prior to the inspection, information was received that there was an inadequate number of staff on duty to care for the residents needs. Following the involvement of the HSE crisis management team, the nursing and healthcare staffing numbers on duty increased. Notwithstanding the outbreak, the overall staffing in the centre requires a full review. The provider has committed to maintaining the increased staffing levels in the centre and not to review this without communication with inspectors of social services.
- Staff supervision - The oversight of staff practices in the centre was inadequate. This was evidenced by the inspectors observation of infection control practices, the cleanliness of resident equipment, the overall cleanliness of the premises and unsafe medication management practices.
- Care plans were not always completed in accordance with Regulation 5 requirements. For example, a resident on pain medication had their medication changed without any documented rationale. Some pain assessments were not completed prior to and post any pain medication administration, therefore, staff did not know if the medication had relieved the resident's pain. In addition, inspectors found evidence that residents who had experienced unintentional weight loss and were assessed as being at risk of further weight loss did not have appropriate arrangements in place to alert catering staff to the need for an increased protein diet and the fortification of food. This meant that the residents did not always receive the appropriate diet.
- Inspectors found significant gaps in the auditing of clinical care and were not satisfied that the service was effectively monitored. For example, inspectors were informed that a medication management audit was completed in February 2020; however, the audit was not available for review and so inspectors could not ascertain if management were aware of the gaps identified during this inspection.
- There was no evidence available that the management team had any awareness of the risks identified during this inspection or that any actions had been taken to reduce or address these risks. The clinical nurse manager on duty had yet to receive training or guidance on risk management within this centre.
- Staff knowledge of medication management and infection prevention and

control required improvement.
- Oversight of maintenance systems was required to ensure that refrigerators were working properly and that the bedpan washing machine was regularly serviced (last serviced in 2016).

Inspectors acknowledged how challenging a time it had been for residents and for staff who had worked additional hours in responding to residents' increased clinical needs. Inspectors acknowledged that staff working in the centre have been through a challenging time. However, significant improvement and focus is now required under management systems to ensure that the quality and safety of care delivered to residents achieves regulatory compliance.

Regulation 15: Staffing

As previously stated, the number of staff and skill-mix required review to ensure that residents' needs could be met. Prior to the involvement of the HSE, there had been insufficient staff numbers rostered on night duty, and for the cleaning of the premises. The nursing and healthcare staffing on duty was increased following the HSE crisis management team involvement. The provider has committed to maintaining the current staffing levels. Any reduction in the numbers or skill-mix of staff on duty will be discussed with inspectors of social services prior to implementation.

On the day of the inspection, two members of staff rostered for duty were unable to attend the centre and no replacements were provided. The clinical nurse manager who was rostered to deliver care to residents had to also fill the role of the nurse manager on duty. As a consequence, inspectors found that the oversight of staff practice was inadequate. For example, staff temperatures were not recorded at the start of every shift to ensure that they are not developing symptoms of COVID-19. This was also confirmed by staff that spoke with inspectors.

The centre currently relies on the use of agency staff to ensure that there are sufficient staffing numbers. There were two agency nurses working a mix of day and night duty and a total of ten agency healthcare assistants required to cover 14 night and ten day shifts. An undue reliance on agency staff has consequences for resident care:

- Staff may not know what constitutes a resident's baseline condition and may fail to recognise and respond to early signs of any deterioration from the baseline, a key early sign of a COVID-19 infection.
- Agency staff do not always know the resident's specific care needs. Lack of resident knowledge can impact on the delivery of person-centred care.

On the day of the inspection, staff moved between COVID-19 suspected and COVID-19 free zones in the centre. There was one working roster. On the day of inspection, the management confirmed that they were not tracking what area staff

worked in from day to day. This created an increased risk of spreading COVID-19 among residents and staff. Registered nurses confirmed that in the past when there was only one nurse on duty there was no option but for the nurse to move between floors and zones as only a registered nurse is authorised to administer medications.

Further action is now required so that the centre employs sufficient staff in all departments to ensure that a safe service is provided by staff who are familiar with residents and the systems in place in the centre.

Judgment: Not compliant

Regulation 16: Training and staff development

Inspectors found that training received was not always implemented. During the inspection, three staff members told inspectors that they had not had a practical demonstration on the correct use of PPE. During observations, inspectors observed a staff member escorting a resident who was suspected to have COVID-19 back to her bedroom and providing assistance for her to return to bed. The staff member did not perform hand hygiene after the interaction and before leaving this resident's room.

Inspectors observed a staff member transport a trolley with clean linen and a trolley carrying laundry for washing. On exit from the elevator, the staff member went into the laundry to deposit the laundry for washing and exited without performing hand hygiene. Taking account of observations of staff practice, and findings on environmental hygiene and equipment, inspectors concluded that further training and development was required for all staff in keeping with their roles and responsibilities on infection prevention and control. In addition, supervision and support is required to guide and direct staff on implementation of any training provided.

Other areas of training and supervision required related to:

- medication management,
- care planning and record keeping,
- and safeguarding training.

Inspectors acknowledge that some staff had been recently recruited and that some training has been provided.
The centre currently has agency staff providing cover. Inspectors were informed that not all agency nurses with responsibility for the direct provision of care had access to the electronic care planning system. This meant that information was being entered by a third party and this is a risk as to the accuracy of the recordings.

Judgment: Substantially compliant

Regulation 21: Records

Confidential resident files were not always securely stored. For example, inspectors found a folder of confidential resident records in the equipment store room in the basement. Such poor information governance risks confidential resident information becoming public knowledge. On the day of inspection, inspectors found that many other examples of poor record keeping including:

- Gaps in records required to ensure that residents who needed two hourly turning were completed. This meant that staff were not aware of when a resident last had their care needs attended to. The risk to residents is that they are lying in the same spot for an extended period of time which can be uncomfortable but also increases the risk of developing a pressure sore.
- Gaps in medication administration records meant that is was not possible to verify if residents had received their medications as prescribed.
- The training records displayed on the training records notice board in the person in charge's office were records from 2018 and 2019 and did not evidence that all staff had recently received updated training on infection prevention and control, hand hygiene and putting on and off personal protective equipment (PPE).

Judgment: Substantially compliant

Regulation 23: Governance and management

Prior to the on-site inspection the office of the chief inspector had had extensive engagement with the centre management team in relation to the providers ensuring there were sufficient resources available in the centre to deliver a safe and quality service. In particular, the provision of sufficient staff, cleaning products and the provision of clean linen. As a result of this engagement the registered provider increased the staffing, purchased linen and engaged with an external company to ensure the building was cleaned to an appropriate standard.

The management systems in place did not ensure that the service was safe, appropriate, consistent and effectively monitored. As previously stated, the Chief Inspector had requested information from Caiseal Gael Teoranta in relation to the governance and management, staffing and supplies. The responses received did not provide assurances that the provider was providing a safe service. On the day of inspection, inspectors found:

- A lack of leadership and management in the centre. Inspectors were

informed that the provider was not present in the centre for substantial periods during the COVID-19 outbreak but was available by phone.
- Poor infection prevention and control practices on the day of inspection.
- Inadequate oversight and staff supervision of practices.
- No evidence that a review had been completed and that lessons had been learnt from the recent outbreak of COVID-19 would be used to inform future practice.
- Failure of the provider to ensure that there were sufficient staff with the appropriate skill-mix in place to deliver direct care.
- Inspectors requested to review the audits that monitor the service. Inspectors were informed that audits had been completed, however, they were not made available on the day of inspection. The last audit that was provided was dated December 2018. When more up to date audits were requested they could not be provided.

The governance systems in place to manage risk and to ensure that the service provided was safe, consistent and effectively monitored required review. While there was a risk management scoring matrix, there was no evidence that the management team had identified or had a process in place to manage the risks found during this inspection. Risks identified on this inspection that require assessment and action include:

- The risk of a second COVID-19 outbreak.
- The risk associated with the absence of the person in charge owing to unplanned sick leave.
- The risk associated with the use of agency staff who are not familiar with the residents or the nursing home.
- The risks associated with failing to follow the HPSC guidelines. For example, staff temperatures were not checked and recorded at the beginning of each shift.
- The risk associated with inadequate systems of infection prevention and control.
- Lack of access to a sluice in the area of the centre that was zoned as COVID-19 positive.
- The risk associated with the zoning of residents who are suspected of having COVID-19 and residents who had recovered form COVID-19 along the same corridor.

Inspectors found that five of the nine regulations assessed were found to be not compliant and four regulations were substantially compliant. Futhermore, findings from this inspection substantiate the unsolicited information received by the Chief Inspector.

Judgment: Not compliant

Regulation 4: Written policies and procedures

All of the policies and procedures required by the regulations were available within the centre. Inspectors were given a copy of the COVID-19 policy that was in the person in charge's office. Inspectors reviewed the Infection control policy. The clinical nurse manager (CNM) on duty confirmed that individual policies were not updated to reflect new guidance as per the HPSC guidance. For example, the infection control policy dated March 2019 did not contain any guidance for staff on the management of COVID-19

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The person in charge or deputy had not submitted notifications relating to the death of a resident within the three days notification period as set out in the regulations.

Judgment: Substantially compliant

Quality and safety

Poor governance and management arrangements impacted on the quality and safety of care delivered to residents as evidenced in nursing documentation to guide the care, medicines management, risk management and infection control practices. The systems in place to evaluate and monitor the quality and safety of care required review to ensure that improvements are brought about in work practices to achieve optimal outcomes for residents.

As previously stated, the centre submitted a notification to the Chief Inspector detailing the number of residents and staff that were effected by the COVID-19 outbreak. At the time of this inspection, there have been 15 residents with a confirmed COVID-19 result. On the day of inspection, 12 of these residents had made a full recovery. At the time of the outbreak, under public health guidance, the centre had been divided into zones to ensure that affected residents could be grouped together as per the HPSC guidelines on the prevention and management of COVID-19 cases and outbreaks in residential care facilities and similar units (HPSC guidelines). This step was taken to minimise the spread of infection. Inspectors were concerned that staff in the centre did not understand the rationale behind zoning of parts of the centre. This was evidenced by:

- Residents who had recovered remained in the same zone as residents that were either suspected of having COVID-19 and residents that were in isolation as a result of a direct contact.

- Residents who were relocated to the zoned area as a result of a direct contact had been sharing a room with another resident. The other resident in the room was not relocated. In addition, no deep cleaning of the room had occurred.
- Staff were allocated to their area of work at the beginning of each shift. There was no clear system in place to track staffing on a day to day basis to ensure that staff were not working in both areas. For example, staff confirmed that over a period of days they had worked in all areas of the centre.

Systems in place for the oversight and review of medicines management required improvement. During the inspection, a number of areas were identified as requiring improvement to comply with legislation and professional guidelines. These are discussed under Regulation 29: Medicines and pharmaceutical services.

Significant improvements were required to residents' rights,these are detailed under regulation 9.

Regulation 27: Infection control

On the day of inspection there were plentiful supplies of PPE available. Signage was erected regarding COVID-19 and the storage area for clinical waste was secure.

However, the registered provider failed to ensure that procedures consistent with good infection prevention and control were implemented by staff. For example:

- The overall standard of cleaning in the premises was poor. Staff were not appropriately supervised. A full review and monitoring of the cleaning practices within the centre was required to ensure that residents were living in a clean and safe environment.
- The HPSC guidelines was not fully implemented. For example, the grouping together of residents with possible or confirmed COVID-19 required review.The deployment of staff also required review as staff had worked in both COVID-19 and non-COVID-19 zones.
- Poor adherence to hand hygiene practices by staff and an insufficient supply of hand towels at hand wash stations.

Other practices in respect of infection prevention and control that required review included:

- There was no area to prepare and draw up medication for administration. Medication trolleys were not in a hygienic state. Staff did attend to this before the end of the inspection. There was no alcohol gel available on each trolley to facilitate hand hygiene while administering medication. Equipment for use by residents was not a in clean state; for example, hoists stored along corridors were visibly dirty and a chair weighing scales was dirty.

- The laundry room did not have a defined clean or dirty zone which presents a risk of cross-contamination.
- Environmental hygiene required supervision; there were multiple gaps in cleaning schedules and some glass on doors and windows required cleaning. In addition, the centre required decluttering, for example, the assisted bathroom had a broken wheelchair and brown cardboard box which needed to be removed. There were two broken chairs in the garden area that required removal and disposal.
- The sluice room was unclean and the sluice bedpan washer had not been serviced since 2016. Staff did not know how to action a warning on the machine and there was no manual available to assist them.
- There were no procedures to ensure that all reusable equipment is appropriately cleaned.
- The management of sharps required improvement. Inspectors requested that two sharps containers which were full should be locked and removed, and requested that staff replace these containers with new empty ones.
- The uniform policy was not implemented; for example, a small number of staff were wearing jewellery.
- There was unlabelled products in use such as body lotion and nail clippers in one of the bathrooms increasing to risk of communal use and the spread of infection through the use of such products.

As a direct result of the findings on the days of inspection, the provider was issued with an urgent compliance plan in this regard.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Systems in place for the oversight of medicines management required immediate review and significant improvement to ensure that the residents were protected by safe medicines management. This was evidenced by:

- several examples where medication had been signed as having been administered but the medication was still in the resident's blister pack indicating that it was not administered.
- gaps were noted in the medicines administration records, for example, a resident on a prescribed medication for the treatment of a fungal infection had not received the appropriate dose for seven nights in a row.
- a code system in place to identify why a resident did not receive a medication was not always adhered to.
- there was large amounts of medication stock that were not identified for individual resident use.
- PRN (when required) doses of medication did not outline the maximum dose prescribed that can be safely administered over a 24-hour period.

Inspectors observed that the clinical room which stored medication on the first floor required attention. The room to the medication room was jammed open by a chair allowing anybody to enter the room and access medications which were not all stored securely. In addition, the medication fridge in this room was not in working order.

Judgment: Not compliant

Regulation 9: Residents' rights

There was one activity staff member on duty five days a week; on the day of the inspection, the activities staff member was observed to be engaging with residents in the downstairs communal living area. There was no evidence that activities were scheduled for weekends and the roster did not have an allocated staff member responsible for activities at weekends.

The level of activity available to residents was minimal and required review, particularly in light of the HPSC guidance and the aligned reality that now residents continued to spend significant time in their bedrooms.

On the day of inspection the sun was shining. Inspectors asked why only two residents had been seen to be facilitated to use the enclosed manicured garden area and large balcony with panoramic view of the city. Staff could not give a rationale but cited staff availability to supervise as a challenge. This meant that residents were not afforded the choice and opportunity to sit outside and enjoy the fresh air.

The overall culture on privacy and dignity required improvement as evidenced by:

- The management of personal possessions required review. For example, there was a large cardboard box in the laundry room with unlabelled items of personal clothing belonging to residents. In addition, the labelling system was not effective. Multiple items of clothing had either a tag placed on the item or the number of the room the resident had been written in marker. This system did not factor in the significant room changes that have occurred due to COVID-19 and the relocation of residents to new bedrooms.
- A resident was returned to bed, however their special mattress to ensure they did not have a skin breakdown was not plugged in.
- A resident was relocated to an isolation room as a result of being a contact person. The resident was in isolation and did not have all of their personal belongings transferred with them.
- Some resident clothing was wrinkled and there was no iron available in the centre.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and 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	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 4: Written policies and procedures	Substantially compliant
Regulation 31: Notification of incidents	Substantially compliant
Quality and safety	
Regulation 27: Infection control	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Caiseal Geal Teach Altranais OSV-0005491

Inspection ID: MON-0029514

Date of inspection: 27/05/2020

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 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Deputising arrangements are in place for a CNM to deputise, should the PIC and ADON be unable to work. The RPR works full-time within the centre and this is noted on the roster. Staffing is being audited using a recognised staffing tool which takes account of resident dependency levels. Staffing is maintained at two nurses, six HCAs and a dining room attendant, in the morning and early afternoon; two nurses and five HCAs in the afternoon; and two nurses and two care assistants at night. Where a rostered staff member becomes unavailable for work, they are replaced on the rota. Weekly monitoring and ongoing auditing of staffing levels has been initiated with an aim of significantly exceeding the staffing tool recommendations. To date staffing levels have exceeded the staffing tool recommendations by at least 50% each week. An additional cleaner has been appointed. There are now two cleaners on duty every day. Staff temperatures are monitored and recorded each day. Staff are tracked using an allocation sheet. All staff work solely in the centre ensuring continuity of care.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Infection Control became the focal point of training for staff in all departments with particular emphasis being applied to hand hygiene PPE donning and doffing. These programmes of training have been repeated at regular intervals during the Covid period and have taken precedence over our annual training schedule. Ongoing Training and Development have been undertaken in house in strictly Nursing	

related matters by the Person in Charge, and by the Senior Care Manager for Care Staff. Consistent training for Cleaners is provided by the Maintenance Manger. This is further supported by ongoing monitoring and Record keeping. The central role for Electronic Record Keeping requires ongoing supervision and training which is being provided by the Deputy Director of Nursing. Specialised Training by external Consultants in areas such as Fire Prevention and Control which had already been planned by the Person in Charge, came to a halt everywhere from the beginning of the Covid 19 pandemic in March. Some training by external Consultants has been rescheduled e.g Safeguarding at the end of August.

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
All Resident Records are appropriately stored in secure filing, including archived records of former residents in a locked basement store. Turning records have been updated, and Medication Management Records are under continuous review and Kardexes audited. All staff have received updated training in Infection Prevention Control, Hand Hygiene and Personal Protective Equipment. All Records for Equipment, Plant and Machinery, Electricity and Water Supplies and related Certification have been updated.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
A strengthened management structure is now in place with clear lines of authority and accountability. Clearly defined deputising arrangements are in place for the PIC and the RPR. The RPR works full-time in the centre and is on the roster. A suite of audits are being used to monitor the quality of care in order to achieve continuous improvement. Cleanliniess is monitored and audited on an ongoing basis by an external specialist. All staff have received additional training in hand hygiene and infection control. A new cleaner has been appointed so there is now two cleaners working every day. At least two nurses are rostered for hands on care for day and night shifts.
A review into the outbreak of COVID-19 has been completed by the PIC, including lessons learnt to inform future practice. Staffing and skill mix is monitored and audited using a recognised staffing tool which takes account of resident dependency levels to ensure person-centred care. Since the return of the PIC there is an enhanced emphasis on staff supervision. Enhanced auditing of the centre's service provision ensures that residents receive the highest standards of care and support at all times.

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
The Person in Charge is currently reviewing all Policies and Procedures updating them where necessary and also updating records of staff having read them. Infection Control Policy in particular reflects the challenges posed by Covid 19.
31/08/20

Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
The NF01 referred to was submitted one working day late. It is acknowledged that such Notifications are required to be submitted within the regulatory time frame and further Notifications will be submitted in time.

23/04/20

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
The external cleaning company are no long engaged but replaced by CGTAs own staff one of whom is recently recruited. These are trained and closely supervised by the Maintenance Manager who has provided schedules and record keeping protocols. This Manager has also repaired cleaning machinery, and bought any new equipment required on an ongoing basis. The bedpan washer which was working on the day of inspection has been serviced and is in daily use for its purpose. It is confirmed that there is a sufficient supply of hot water throughout the centre, thermally controlled for various uses in different locations and monitored continuously. An external mechanical engineer has provided a written statement of the performance and consistency of all the heating plant

in the building. All other Infection Prevention Control cleaning and environmental issues were resolved by 4th June 2020 and continue to be under close scrutiny.

04/06/20

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
Since May Medication Management audits show that Medication Records continue to be reviewed and updated, Medication stock is monitored in close cooperation with the Pharmacy. Medication storage checked with ongoing supervision of security of nurses' stations and medicine trolleys. Particular attention has been and is being given to GP involvement e.g signing off Kardexes.

04/06/20

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
Improved practices in the laundry introduced and supervised by the Senior Care Manager. Ongoing training and supervision has raised awareness of appropriate temperatures and cycles of washing and drying equipment.
Newly recruited laundry staff has also resulted in more comprehensive treatment of all items of clothing and linen. Additional laundry equipment has been purchased. New automated mattresses have been provided together with training in their use. Activities are provided daily according to a varied schedule. Care Staff regularly engage in informal interaction with Residents. There is easy access to the enclosed garden and front balcony and during fine weather the exit door to it is generally left open. Residents do come and go at will.
Management and the Activities Coordinator have reviewed the social events weekly calendar and have adapted it to fit Covid times.

04/06/20

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 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	06/07/2020
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	30/09/2020
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	30/09/2020
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre	Substantially Compliant	Yellow	04/06/2020

	and are available for inspection by the Chief Inspector.			
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Substantially Compliant	Yellow	04/06/2020
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	Red	04/06/2020
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	04/06/2020
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	Red	04/06/2020
Regulation 27	The registered	Not Compliant	Red	04/06/2020

	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.			
Regulation 29(4)	The person in charge shall ensure that all medicinal products dispensed or supplied to a resident are stored securely at the centre.	Not Compliant	Orange	04/06/2020
Regulation 29(5)	The person in charge shall ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.	Not Compliant	Orange	04/06/2020
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in charge shall give the Chief Inspector	Substantially Compliant	Yellow	23/04/2020

	notice in writing of the incident within 3 working days of its occurrence.			
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Substantially Compliant	Yellow	31/08/2020
Regulation 9(1)	The registered provider shall carry on the business of the designated centre concerned so as to have regard for the sex, religious persuasion, racial origin, cultural and linguistic background and ability of each resident.	Not Compliant	Orange	04/06/2020
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Not Compliant	Orange	04/06/2020
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and	Not Compliant	Orange	04/06/2020

	capacities.			