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:	Arus Breffni
Name of provider:	Health Service Executive
Address of centre:	Manorhamilton, Leitrim
Type of inspection:	Unannounced
Date of inspection:	04 March 2020
Centre ID:	OSV-0000659
Fieldwork ID:	MON-0027875

About the designated centre

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

Arus Breffni Community Nursing Unit is a bungalow style unit which provides residential care for 25 residents. It is situated in the picturesque market town of Manorhamilton in County Leitrim. There is an enclosed courtyard which provides space for residents and their families. The centre is a community based residential service accommodating the care needs of the elderly population in North Leitrim. The centre provides care to male and female residents over the age of 18. Most of the residents in the service are aged over 65 years. The centre is staffed with 24 hour nursing care supported by Health care assistants and multi-task attendants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	25

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 4 March 2020	09:30hrs to 13:00hrs	Catherine Sweeney	Lead
Wednesday 4 March 2020	09:30hrs to 13:00hrs	Brid McGoldrick	Support

What residents told us and what inspectors observed

Due to a suspected outbreak of Norovirus in the centre on the day of inspection, the inspectors had minimal interaction with residents and their families. Residents were observed to be relaxed and comfortable in the company of staff.

One resident spoken to and who was an avid reader, was unable to reach his light due to the position of his bed. Inspectors observed that some residents could not reach their bed side light or had access to a glass of water, if required.

Inspectors heard the telephone ringing unanswered. Staff advised that the procedure in the centre was that the nurse-in-charge managed all in-coming telephone calls. Inspectors concluded that this system required immediate review to enable staff to administer medication uninterrupted, and to ensure that family members calling the centre to inquire about their loved ones well-being would get a prompt response.

Capacity and capability

This was a monitoring inspection for the Office of the Chief Inspector. The inspection followed up on actions from the last inspection on the 29 and 30 November 2017. Some actions had been completed, for example, the detail of resident's care plan had improved. However, actions in relation to staff training, communication and complaints had not been addressed. Due to the suspected outbreak of infection, Inspectors were unable to review the provision of appropriate activities to the residents on this inspection.

The Chief Inspector had received

- Four notifications of 'any outbreak of any notifiable disease' since the last inspection, the most recent was received on 02 January 2020. The centre was closed to visitors from 02 Jan -15 Jan 2020. Three further outbreaks of infectious disease were notified to the Office of the Chief inspector on 21 June 2019, 20 December 2018 and 11 January 2018
- A notification had also been submitted in relation to an incident of a potential fire in the centre.

Information had been received by the Chief inspector in relation to visiting, infection control, promotion of residents rights and governance and management. The information was substantiated by inspectors of the day of inspection.

The inspectors found that significant improvements were required in relation to the governance and management of the designated centre in order to bring the service into regulatory compliance. This centre is managed by the Health Service Executive (HSE).The management systems that were in place did not ensure that the service was safe and that the service was delivered in line with the statement of purpose. An immediate action plan was required to ensure the safety of residents in the centre.

Inspectors were informed that staffing levels were low on the day of inspection and that nursing staff had been called in to cover for a health care assistant who was on leave. The nurse-on-duty was in charge of the unit on the day of inspection. A review of the rosters and the fire drill records found that staffing levels were not adequate to ensure the residents safe evacuation from the unit in the event of a fire.

A review of the staff training matrix found gaps in the mandatory training of the centre.

Two hours after entering the centre Inspectors were informed by a non-nursing member of staff that a number of residents were unwell due to a suspected virus. No restrictions were in place and no sample's had been obtained by the nursing staff.

The centre did not have systems in place to communicate with residents' and families when there was a suspected outbreak in the centre. The impact for residents on the restrictions imposed had not been risk assessed and no measures were in place to prevent social isolation.

Following a walk around of the centre and a document review, inspectors found that the governance and management systems, infection control procedures and fire safety required immediate action. An urgent compliance plan was issued the day following the inspection.

Regulation 15: Staffing

Inspectors reviewed the staff rosters and found that the care hours provided were not in accordance with the statement of purpose. The statement of purpose identifies a full time staff member dedicated to the laundry. There is no laundry facility in the centre and there was no staff member allocated to the laundry on the roster. According to the statement of purpose, there were five multi-task attendants (MTA) working in the centre. The roster identifies 12 MTA's on the roster. From a review of the roster, it is not clear what role the MTA's are allocated in the centre.

Inspectors found there was insufficient cleaning staff on duty to ensure appropriate hygiene standards throughout the building.

A review of the provision of clerical support was required to assist unit management.

Inspectors observed that the nurse-in-charge was tasked with responding to telephone calls which took away from her other duties. There was evidence of a backlog of documentation for filing.

In addition, as described under Regulation 28, the responses from staff in relation to fire safety procedures did not provide the necessary assurances that residents would be safely evacuated at night time.

Judgment: Not compliant

Regulation 16: Training and staff development

A review of the staff training record found gaps in mandatory training and in the training record of newly recruited staff in the centre. This was evidenced by

- a newly recruited member of staff had not received any fire safety training or safeguarding training.
- Staff did not receive updated infection control training, including hand hygiene following four outbreaks of notifiable disease in the centre over two years.
- Some care staff had no training in managing residents who exhibited challenging behaviour or manual handling training completed. This is a restated action from the last inspection.

Judgment: Not compliant

Regulation 23: Governance and management

Inspectors were not assured that the centre had sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.The management systems that were in place did not ensure that the service was safe, appropriate, consistent and effectively monitored. This was evidenced by the failure to

- provide sufficient staffing levels
- ensure safe fire safety management systems
- ensure that all staff were aware of the fire safety procedures
- implement infection control procedures including responses to a suspected viral outbreak on the day of inspection
- ensure that equipment required for use by residents is in good order for example soiled supportive equipment such as wheelchairs, crash mats and pressure relieving cushions were heavily soiled.

- provide a safe environment for residents. The care environment was cluttered and disorganised.
- put robust communication systems in place when visiting restrictions are employed.
- learn from a review of previous suspected outbreaks. No training in infection control and prevention for staff following four outbreaks of a notifiable disease over two years was provided, for example, training on hand hygiene.
- ensure that the laundry system was safe and was of an acceptable standard.
- investigate and learn from complaints received.
- review the adequacy of hot meal provision. No provision of hot food for residents was provided outside of scheduled mealtimes.
- submit a notification for an alleged incident of abuse

The provider was issued with an immediate action plan on the day after the inspection. A satisfactory urgent compliance plan response was received from the provider on the 12 March 2020 which addressed the non-compliant issues.

Judgment: Not compliant

Regulation 34: Complaints procedure

The centres complaints policy identified the procedures to make a complaint. There were two complaints logged since Jan 2020. The complaints log was reviewed and a number of matters were highlighted for immediate attention. The complaints related to management of personal laundry, interruption to sleep patterns for residents accommodated in a twin room, poor staff attitude and a range of matters relating to a lack of communication to residents and families, when there was a suspected outbreak of infection. One of the complaints viewed related to an alleged incident of verbal abuse, this was not notified to the Office of the Chief inspector, as required by the regulations. There was no evidence that this alleged incident was investigated as required by Regulation 8(3).

The Office of Chief Inspector had also received information which related to the lack of promotion and protection of the rights of residents and a failure to communicate effectively with residents and family members.

The concerns raised were substantiated as evidenced throughout this report. Inspectors concluded that training and supervision was required to ensure that residents were safeguarded.

Judgment: Not compliant

Quality and safety

Inspectors found significant non-compliance in the area of Fire precautions and infection control. The provider was issued with an immediate action plan following the day of inspection. The response received from the provider on the 12 March 2020 was reviewed by the inspector of fire and estates and gave assurance that the actions would bring the centre into compliance.

A review of the visiting policy was required to ensure clear and appropriate communication for residents and their families particularly during times when visiting was required to be restricted.

The premises was in a poor state of repair, the outdoor areas available to residents was limited to an internal courtyard. The surrounding gardens were in a poor state of repair with discarded equipment and multiple trip hazards. The centre was cluttered and not visibly clean. Resident access to toilets and showers was limited.

While there was a kitchen on the premises, there was no facility to serve the residents hot food outside of scheduled mealtimes. There was no working laundry facility on-site.

Inspectors observed poor practice in relation to the procedures to be followed during a suspected outbreak of an infectious disease. The infection control policy for the centre was requested on the day of the inspection but only received on the day following the inspection. The policy was generic and was not centre-specific. Furthermore, the actions of staff on the day did not reflect the guidance outlined in the policy.

There were a number of issues related to fire safety that required immediate action. These included staff knowledge of fire procedures, poor fire safety documentation, and doors observed to be propped open with chairs and wooden wedges. A full review of fire safety precautions was required.

Regulation 11: Visits

Visiting restrictions had been put in place following an outbreak of Norovirus in January 2020. The staff on duty confirmed that visitors were restricted from the centre as part of the centres infection control policy. Inspectors reviewed the process and arrangements in place for residents to contact and communicate with families and found that this was poor.

Judgment: Not compliant

Regulation 17: Premises

Residents have limited access to outdoor space. There is a large internal paved garden in the centre of the centre. The grounds of the centre are not well maintained. Ramps on the driveway are not identified. There are no parking spaces for disabled residents or visitors. Inspectors observed a discarded profiling bed on the grounds of the centre. The paving area around the centre was uneven and could pose a tripping hazard to residents, staff and visitors. Multiple cigarette butts had been discarded on the path around the designated centre. No ash tray was available in that area. There were no seating areas external to the building for residents to rest if out walking. The decor throughout the building was tired and uninviting, with many areas requiring painting and refurbishment. The following was found:

- The layout of some of the rooms was poor. No sink was available in the en-suite toilet in Room 15 and 16. Residents need to return to their room to use sink after using the toilet. Access to en-suite toilet in these room is difficult as door opens from left to right requiring the door to be fully open to access toilet.
- Residents beds were position in such a way that they could not access their reading lights to turn on
- There was no facility in the centre to prepare hot food. Meals aware delivered into the centre from the hospital kitchen.
- There was no laundry facility in the centre due to a machine malfunction. Sheets, blankets and towels were outsourced for cleaning. Personal clothes are delivered to the local laundrette for cleaning or given to family member to clean. The linen provided was of poor quality and required replacement.
- The centre was not clean.

Four en-suite toilets were shared between eight residents. There were three communal shower/ bath rooms in the centre. There were two further toilets available for resident use.

Judgment: Not compliant

Regulation 27: Infection control

Inspectors were not assured that procedures and practices consistent with good practice standards for the prevention and control of health care-associated infections were implemented by staff. The inspectors found the management of infection control poor. An infection control policy was requested on the day of inspection. This was not received. An infection control and outbreak policy covering the Community Health care organisation was forwarded to inspectors 06 March 2020. This policy was not site-specific. Infection control practice observed from staff did not reflect the centre's policy. For example,

- Personal protective equipment (PPE), including gloves, were worn by staff around the centre. This was not in line with centres infection control policy which states that PPE should be removed before leaving a residents room.

- There was evidence of an inappropriate response to a suspected outbreak- no stool samples were collected to test for potential outbreak.
- The centre has no facility in place for clinical specimen collection
- No updated infection control or hand hygiene training was delivered to staff.
- Environmental hygiene and cleaning of equipment used by residents was inadequate, for example, a number of comfort chairs, wheelchairs, bedpans and support cushions were observed to be heavily soiled.
- There was no dedicated cleaning team. Cleaning duties were fragmented and carried out by catering and care staff. Some toilets and bathrooms viewed were not in a clean state.
- A number of electric mattresses were stored in the centre but there was no evidence of a decontamination process.
- Some laundry viewed, in what was described as a clean store, was of poor quality, for example, some of the towels viewed were stained. The sheets viewed were very thin and see-through and required replacement.
- Water outlets in showers needed more effective cleaning
- There were black bags with residents clothing, it was unclear if this clothing was waiting for laundry collection or for return to residents family.
- Some skirting boards were chipped and painting was required in number of areas.
- Equipment was stored inappropriately.

Parts of the centre were very cluttered and visibly unclean on the day of inspection. The centre did not provide a suitably clean environment to make it easier for staff to adhere to infection prevention and control best practices. Staff were not competent in applying transmission-based precautions appropriate to their role. The inspectors requested an audit be carried out to examine both clinical and environmental practices in the centre.

Judgment: Not compliant

Regulation 28: Fire precautions

The registered provider (HSE) had not taken adequate precautions to ensure that residents were protected from the risk of fire or to ensure that safe systems were in place for the safe and effective evacuation of residents in the case of an emergency. Immediate action was required to ensure the safety of residents, visitors and staff in the centre. The centre did not meet the requirements of the regulations in the following areas:

The registered provider did not take adequate precautions against the risk of fire.

- Risk assessments were not being used to identify and respond to fire risks throughout the centre. There was an non -fire protected hatch and doors were held open with wedges.

Staff spoken with did not demonstrate an understanding of the procedures to be followed in the event of a fire.

- Some staff members had not received suitable training in fire prevention and emergency procedures.
- Fire doors where available were propped open with bin and door wedges
- Staff were unfamiliar with resident's personal emergency evacuation plans

Adequate arrangements had not been made for the detecting and containing fires

- An assessment of the likely performance of doors throughout the premises was required as door to bedrooms were not fire doors and has no door closure devices. Doors on corridors were found to have visible gaps and some had glass which was not fire rated.
- Fire maps were not consistent. The rooms numbers and room function differed considerable throughout the centre. For example, one map numbered the double rooms as room 10 and 11, while an up-to-date map identified the rooms as room 17 and 18. This could cause confusion in the event of a fire or an emergency. Some maps did not identify the location of the fire-fighting equipment or the emergency exits.

Inspectors were not assured that the larger compartments can be evacuated in a timely manner with the staff and equipment resources available.
Inspectors identified one compartment which could accommodate 10 residents. A full review of residents dependency needs and evacuation needs was required to ensure that residents could be evacuated safely. There were no recommendations for future learning or training recorded on fire drill reports to assist in reviewing precautions.

The provider submitted an immediate action plan which was reviewed and accepted. Inspectors acknowledge that the provider has committed to bring the centre into compliance.

Judgment: Not compliant

Regulation 8: Protection

Not all aspects of this regulation was reviewed. Inspectors viewed a complaint which indicated an alleged incident of abuse. This was not identified as a safeguarding issue and was not investigated as per the centres own policy. No notification was submitted as is required by the regulations.

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	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 11: Visits	Not compliant
Regulation 17: Premises	Not compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Arus Breffni OSV-0000659

Inspection ID: MON-0027875

Date of inspection: 04/03/2020

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:
1. A full review of the Statement of Purpose has been completed to include:
• The care hours currently in place for all grades of staff are in accordance with the Statement of Purpose (Regulation 15) (Schedule 2)
• As laundry services are not carried out within the centre this has been removed from the Statement of Purpose
• A review of Multi Task Attendant's (MTA) working within the centre has taken place and these have been assigned a discipline ie. Health Care Assistants (HCA) /catering/household. The Statement of Purpose has been amended to reflect the above changes. The duty roster has been amended to identify each employee's role and area of responsibility week commencing 12th April 2020.

2.
The center has been de-cluttered and an external cleaning company with experience of deep cleaning in health care facilities has carried out a 3 day deep clean of the center on the 13th, 14th and 15th March 2020.

An environmental audit and review of the cleaning requirements has been carried out by an experienced Community Hospital Domestic Supervisor 10th March 2020 and 1.69 Whole time equivalence (WTE) been assigned to household duties. This includes 8.5 hours of cleaning on six days and 15 hours cleaning on one day per week.
Daily cleaning schedules used effectively in other Health Service Executive (HSE) Residential centres have been
introduced from the week of 16th March 2020 to the unit and these are signed daily by the household staff and countersigned by the Person in charge (PIC) /senior nurse on duty. A deep cleaning schedule has also been implemented which includes the tasks to be completed and the scheduling of deep cleans.

Ongoing support from an off-site Domestic Supervisor has been sourced to provide assistance to the household staff to include audit, face to face training, ongoing risk

assessments in relation to chemicals, chemical storage and safety data sheets.
Both Household staff are completing on line training in general cleaning, deep cleaning and chemical usage.

The Provider Representative has requested a review of all tasks carried out by Administration Support and has provided a list of all duties carried out by an Assistant Staff Officer in a similar sized HSE Unit. PIC and Assistant Staff Officer are working with the job specification of the assistant staff officer and key tasks have been identified as part of the review process.

3. As part of the review the assistant staff officer is responsible for answering of all calls to the centre with immediate effect ensuring the nursing staff are free to carry out administration of medication without interruption. A review of the filing on the unit has taken place and this is being addressed as an urgent requirement with the Assistant Staff Officer now being responsible for filing.

4. As per Regulation 28 and Regulation 15- all staff have now received Fire Training (09/03/2020, 11/03/2020, 16/03/2020) and are aware of fire procedures in place in the response to the activation of the Fire Alarm.

To ensure that residents can be safely evacuated at night a review of residents dependencies per zones has taken place and actioned as appropriate. Residents Personal Emergency Evacuation Plans (PEEPs) have been updated and these are stored at the residents bedside and also a master copy in the nursing office.

The Centre is registered for 25 residents however based on dependency and Fire Safety Issues the Registered Provider Representative having risk assessed has reduced the beds temporarily to 23 beds. Zone four has been reduced from 10 to 8 beds to assist in mitigating risk should there be a fire in the zone.

Twenty five ski pads have been ordered for use when evacuating the building. Staff are currently being trained in the use of ski pad to assist with timely safe evacuation of residents.

The Provider Representative has directed that twice weekly simulated Fire Evacuations are carried out until all fire issues have been closed out. These will include rotating zones and times of day to include opportunity for those on night duty to take part to ensure all staff are aware of the procedure and are efficient in carrying out an evacuation.

A review of the staffing levels has taken place with the HSE's Provider Representative and the current 1 WTE nursing vacancy is being recruited via the Human Resources (HR) department. Daily review of staffing levels takes place and risks identified in relation to staffing are escalated to the Service Manager and actioned as required. The PIC has access to Agency to backfill the nurse vacancy until recruitment is complete.

A Person in Charge post has been approved and the recruitment process is underway. The PIC will be supported by a Clinical Nurse Manager (CNM) 2 in line with the management structure in the other smaller units in Sligo / Leitrim.

PIC/Nurse In Charge to review dependency levels daily, to ensure staffing levels are maintained at a safe level.

The Catering allocation has been reviewed and there is now a dedicated 1.9 WTE catering staff to serve food delivered from the adjacent hospital kitchen. A HSE catering manager has been contacted to review the kitchen to determine if an oven and hob can be installed in line with Environmental Health Organisation (EHO) regulations to provide for access to hot food and snacks in the evening and outside of planned meal times. This facility will also be used to support residents with baking activities.

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
1. A Practice Development Co-Ordinator is currently being recruited whose role 0.5 WTE monitoring HIQA compliance within the 5 residential units and 0.5 WTE education and practice development. The Practice Development Co-Ordinator will be based initially in Arus Breffni on 3 days per week to support PIC and staff with education / training and practice development.
2. All staff to include newly recruited staff have completed mandatory training to include manual handling, safe guarding, hand hygiene, fire training.
3. Training in Behavioral Support Planning has been sourced and a training plan has been developed. (This has been delayed at present due to the Covid 19 crisis). Once the training restrictions have been lifted training will take place for all staff.
4. A newly developed training log has been implemented for staff and this will be used to record all staff training and this will alert the PIC to staff who require refresher training and will ensure compliance with mandatory training requirements.
5. A training needs analysis of staff has been carried out which includes mandatory training and a training schedule has been developed to ensure that all staff receive training in line with their roles and responsibilities.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
1. A full review of the staffing levels has taken place in the unit to ensure safe staffing levels. The staff nurse vacancy has been prioritised by HR. In the interim an agency

staff nurse has been sourced to fill this vacancy. A CNM2 with previous experience of the PIC role has been assigned to the center to support the PIC in the management of the center.

2. A review of the rosters has taken place and employees have been assigned to key areas etc. household, catering, HCA. The roster on the unit clearly identifies where staff are assigned to and what task's per week/day.

3. A review of staffing levels now takes place daily and any risks identified in relation to staffing impacting on the safety of residents/management of the center will be identified through a risk assessment forwarded to the HSE Provider Representative and mitigated as required.

4. The Provider has commissioned a Fire Safety consultant to carry out a full review of the fire safety management systems and an action plan has been submitted to HIQA Fire Safety office. There is ongoing discussion between the HSE Fire Safety Office and HIQA.

5. All staff within the center have received fire training on the 09/03/2020, 11/03/2020, 16/03/2020 and all staff have partaken in simulated fire drill which are carried out twice weekly, this ensures that staff are aware of the fire safety precautions within the centre. All residents PEEPs have been updated and these are discussed at the daily safety pause which informs all staff to resident's dependencies and modes of evacuation in the event of a fire.

6. Twice weekly simulated fire drills have commenced in the unit to ensure that all staff are aware of fire safety evacuation plans. A Fire Drill evaluation is carried out and a quality improvement plan is developed following these drills, which identifies any areas of concern raised by staff and an action plan is developed to address these concerns. Simulated Fire Drill documentation is stored within the centers Fire Register.

7. All staff within the center have had training and education regarding the management of an expected or confirmed outbreak. The centers Infection Prevention and Control Policy has been read by and discussed with all staff.

8. A flow/ prompt chart has been developed for staff as a prompt regarding the procedures to carry out in relation to a suspected or confirmed outbreak

9. The center has reviewed its communication system and a robust communication system has been put in place when visiting restrictions are implemented. The PIC has spoken with residents in the center in relation to visiting restrictions and the PIC has also sent a letter and an update of the policy on visiting restrictions in the center to inform all family members of the procedures that will occur in the event of an outbreak and visiting is restricted. A leaflet has been developed to provide easily accessible information for residents and their families in the event of an outbreak. This communication system has been discussed with all staff who have signed this policy to state that they understand the communication system in place.

10. The PIC has obtained the last four management reports from the Infection Prevention and Control Nurse Manager and these reports have been discussed with staff

in a reflective session to determine key mitigating factors that may have resulted in the outbreak commencing. Following any further outbreaks within the center the PIC will obtain the management report from the Infection Prevention and Control Nurse Manager and a review of areas of good practice and poor practice will be discussed with staff to mitigate the risk of reoccurrence. A quality improvement plan will be developed following same and actions identified.

11. Key issues have been identified and risk assessed to ensure that the measures have been implemented to reduce the risk occurring going forward

12. All staff have up to date training in hand hygiene and also in standard precautions.

13. The laundry service within the center for resident's personal clothing has ceased. Resident's personal soiled laundry is now sent to a local launderette on a daily basis and clean laundry returned daily. A center specific policy on laundry has been developed within the center and this has been approved by the Infection Prevention and Control Nurse Manager. Hospital laundry ie. Bed linen etc goes to a central laundry in Sligo, this laundry is stored in laundry bags in a soiled laundry storage room awaiting collection. Infection Prevention and Control measures are in place to ensure the safe transportation of laundry. This is also documented in the units laundry policy.

14. The complaints procedure has been reviewed within the center to ensure that staff reflect and learn from all complaints. Following receipt of a complaint the PIC will discuss the complaint in detail with staff using a reflective practice model to identify areas of good practice and areas of poor practice. A quality improvement plan will be developed based on each complaint and shared with staff in the center.

15. The PIC has completed an NFO6 late notification for an alleged verbal abuse, same to be submitted 17/04/2020 via the centres portal.

16. PIC to review and ensure that the current cleaning system is effective and records are maintained for all equipment cleaned daily.

17. PIC to inform all staff daily at the safety pause to ensure that all equipment used in the unit is cleaned after every use and returned to the correct storage area. PIC to review implementation during safety walk rounds.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
1. The PIC discussed complaints process with residents and family on admission to unit.
2. All complaints within the center will be investigated as required to comply with Regulation 8(3) and also as per Regulation 34.

3. A review of complaints in the center within 2020 has commenced and areas of concern have been identified. Key learning from review of complaints has been identified and action plans developed to mitigate the likelihood of similar complaints occurring again within the center.
4. All staff are involved in the review process of complaints.
5. A review of the Complaints Policy has taken place and all staff within the center are aware of the process following a complaint being received.
6. All staff within the center have up to date safeguarding training and are aware of the requirements to safeguard all residents within the center from any form of abuse.
7. The monthly complaints log is sent to the Consumer Services Officer for review and to ensure compliance with the HSE's Policy, "Your Service your Say".
8. The Number of complaints are reported to the HSE Provider Representative via the monthly dashboard and discussed at the Older Persons Governance Meetings held monthly.
9. The PIC will discuss with residents at the next resident's forum the complaints process and all residents are aware of their right to complain about areas of concern.
10. All families are informed of the HSE's "Your Service Your Say" complaints process via an information leaflet in the residents pack on admission and also via the Statement of Purpose. Additional posters have been placed within the center informing residents and family members of the procedure to follow when making a complaint.
11. Consumer Affairs Officer has been requested to provide training on complaints to include open disclosure training to be scheduled when COVID 19 Public Health Emergency has ended.

Regulation 11: Visits	Not Compliant

Outline how you are going to come into compliance with Regulation 11: Visits:
1. To ensure compliance with Regulation 11 a review of visiting procedures has taken place within the center. This includes open visiting for family members till 21.00 hrs.

2. In the event of an outbreak visiting restrictions will be put in place following discussions with public health and the Infection Prevention and Control Nurse Manager.

3. Residents care plan's will be updated to reflect individual contact with Family members and detail resident's communication preferences.

4. In the event of visiting restrictions the PIC or designate will inform all residents of the visiting restrictions and also all Next of kin (NOK) will be contacted in relation to visiting restrictions. In the event that restrictions are in place the quality of life of residents in relation to mental health and welfare will be reviewed and a visiting plan will be put in place as required.

5. To increase resident's social contacts with family members during times of visiting restrictions a smart phone has been purchased for the unit which allows for video calls.

Residents are also encouraged to contact their family members via phone as much as possible and family members will be encouraged to ring the unit to speak with their family member.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
1. A gardening contract is currently being established with a local gardener who provides maintenance to other local HSE centers. This contract will ensure that the grounds and the internal courtyard of the center will be maintained to include Window boxes and hanging baskets.

2. The PIC has spoken to maintenance and has requested that there is a designated parking space provided for disabled residents or visitors. Funding has been approved for completion of this work.

3. The Maintenance Manager will carry out a risk assessment on 23rd April 2020 of the surrounding paving area of the center and that any hazards identified will be actioned to ensure that residents can mobilise around the center free from any hazards. Following completion of the risk assessment and when any risks have been mitigated outdoor seating will be purchased and placed at various areas around the center to allow residents to rest while out walking.

4. Wall mounted ash trays have been purchased and residents and staff are requested to use same if smoking outside. Staff have been advised that they must not smoke within the blue line.

5. Maintenance have been requested to ensure that the ramp on entrance to the center is marked to alert visitors and staff to the presence of the ramp. This will be reviewed as part of the Risk Assessment to be carried out on 23rd April 2020.

6. A review of the décor of the unit has commenced and the unit will undergo a painting programme. Replacement blinds and curtains will also be purchased for resident's bedrooms and for communal areas. Residents will be involved in the choosing of colours for the center. Replacement flooring in the entrance, dining room, sitting room, corridors and removal of skirting in these areas will be undertaken. Building work to support the re-location of the Assistant Staff Officer to the entrance of the building and the opening up of the Nursing Office with window between Nursing Office and the Day room will be installed to ensure visual contact with residents at all times. The Person In Charge Office will be re-located to the front of the building and a window between the Person In Charge office and the dining room will be installed to ensure visual contact with residents.

7. The PIC has spoken to maintenance and has requested a sink to be fitted in bedroom

15 and 16. A review of the door opening has also been requested to determine if the door could be moved to the right allowing more space for residents to enter and exit the en-suite toilet.

8. A review of all resident's bed positions has taken place. All residents can now access their reading light. Purchasing of bed side lamps has commenced.

9. HSE catering manager catering manager has been contacted to review the kitchen to determine if an oven and hob can be installed in line with EHO regulations to provide for access to hot food and snacks in the evening and outside of planned meal times. This facility will also be used to support residents with baking activities.

10. A review of the laundry facilities within the center has taken place. Resident's personnel laundry is laundered in a local launderette. The local launderette collects residents clothing daily and clothing is returned within 24 hours. Bedding sheets and towel laundry is collected three times weekly and taken to the central laundry services in Sligo. A review of soiled laundry provisions has taken place in conjunction with Infection Prevention and Control and designated laundry storage and pick up point has been identified to ensure compliance with Infection Prevention and Control standards. The unit has developed a site specific Laundry Policy for the center which has been approved by the Infection Prevention and Control Clinical Nurse Manager.
A replacement program for the purchase of linen has commenced in the center. The PIC is sourcing individual resident's fire resistant duvets for residents. Residents are involved in selecting their individual bed linen ie. colours etc.

11. De-cluttering of the center was carried out followed by a three day deep clean by an external cleaning company experienced in cleaning health care facilities. Designated staff have been assigned to household duties and these staff will be supported by a Community Hospital domestic supervisor. Daily cleaning schedules have been introduced that have to be signed by the household staff and countersigned by the PIC/senior nurse on duty. A schedule for deep cleans for the center has been developed and this will be reviewed by the PIC to ensure compliance. External environmental audits will be completed by the domestic supervisor and quality improvement plans will be developed post same and actions corrected as appropriate.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
1. All staff within the center have completed the module on wearing Personal Protective Equipment (PPE) in Community Settings as per HSE Land. This informs staff to the correct use of PPE equipment.
2. All staff are now aware of the procedures to follow in the event of a suspected or confirmed infection outbreak. A flash card has been developed for staff to outline the

procedures to follow in the event of an outbreak. All staff have also read the centers policy on Responding to a suspected or Confirmed Outbreak of Infection.
3. Specimens are collected daily by the portering service at Our Lady's hospital and specimens are transported via this service to Sligo University Hospital. The center has a site specific policy on The Transportation of Specimens.
4. All staff within the center has up to date Hand Hygiene Training. Hand Hygiene audits will be completed quarterly within the center to determine compliance with good hand hygiene practices.
5. A review of the roster has now taken place and 1.69 WTE staff have been assigned household duties. Daily and weekly cleaning schedules have been introduced for household staff and for health care staff for the cleaning and maintenance of resident's equipment. The household staff will be supported by an off-site domestic supervisor. External Clinical audits by the Infection Control Nurse Manager and Environmental Audits by the External Domestic Supervisor will be completed to ensure compliance with Infection Prevention and Control standards.
6. The center has a rental program in place for the use of electrical mattresses within the center. Any fault noted in relation to mattresses are returned to the company for fixing or decontamination. The rental company has requested that any mattresses that are to be returned for replacement/decontamination are placed in a sealed plastic bag (which is supplied to the company) and these are collected each Wednesday or sooner if requested.
7. A review of all linen has commenced within the center. The PIC is sourcing duvet covers for each resident's bedroom. New towels have been ordered awaiting delivery of same. Additional bed linen has been ordered. Any bed linen which is noted to be discolored or not fit for purpose has been removed from the centers supply.
8. The cleaning of outlets in the shower area is addressed on the weekly cleaning schedules this will ensure with effective Infection and Control Procedures.
9. Funding has been approved for a painting program of the center and will commence when COVID 19 Public Health Emergency is over.
10. A review of equipment has taken place within the center. Any equipment that was not in use has been removed off site. A de-cluttering of the center has also taken place and key areas for the storage of equipment has been identified. This will ensure the safe and correct storage of equipment.
11. An external clinical and environmental audit has been completed within the center by the Infection Prevention and Control Nurse Manager. A quality improvement plan has been developed and areas identified are being addressed.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
1. Door wedges have been removed from the center and all staff have been made aware that it is essential that fire doors are kept closed. Signage has been put in place requesting fire doors remain closed at all times.

2. The Provider has commissioned a Fire Safety consultant to carry out a full review of the fire safety management systems and an action plan has been submitted to HIQA Fire Safety office. There is ongoing discussion between the HSE Fire Safety Office and HIQA.

3. All staff within the center have received fire training on the 09/03/2020, 11/03/2020, 16/03/2020 and all staff have partaken in simulated fire drill which are carried out twice weekly, this ensures that staff are aware of the fire safety precautions within the centre. All residents PEEPs have been updated and these are discussed at the daily safety pause which informs all staff to resident's dependencies and modes of evacuation in the event of a fire.

4. Twice weekly simulated fire drills have commenced in the unit to ensure that all staff are aware of fire safety evacuation plans. A Fire Drill evaluation is carried and a quality improvement plan is developed following these drills, which identifies any areas of concern raised by staff and an action plan is developed to address these concerns. Simulated Fire Drill documentation is stored within the centers Fire Register.

5. Twenty Five fire ski pads have been ordered for the unit. Staff are currently being trained in the use of fire ski pads that has been delivered to the unit.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
1. All allegations in relation to abuse will be investigated in line with the HSE's Safeguarding and Protections of Vulnerable Policy and a Safeguarding plan will be developed. All allegations of abuse will be notified to the Chief Officer via the NF06.

2. All staff within the centre have up to date Safeguarding Training and aware of the Units Policy in relation to the reporting of allegations of abuse.

3. The centre has three designated officers as per the Safeguarding and Protection of Vulnerable Policy.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 11(1)	The registered provider shall make arrangements for a resident to receive visitors.	Not Compliant	Orange	16/04/2020
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	03/04/2020
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	16/04/2020
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular	Not Compliant	Orange	31/08/2020

	designated centre, provide premises which conform to the matters set out in Schedule 6.			
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	10/03/2020
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	19/03/2020
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Not Compliant	Orange	03/04/2020
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of	Not Compliant	Red	19/03/2020

	fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.			
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Red	10/03/2020
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.	Not Compliant	Red	13/03/2020
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons	Not Compliant	Red	10/03/2020

	working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.			
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	16/03/2020
Regulation 28(2)(ii)	The registered provider shall make adequate arrangements for giving warning of fires.	Not Compliant	Orange	16/03/2020
Regulation 28(3)	The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place in the designated centre.	Not Compliant	Red	10/03/2020
Regulation 8(2)	The measures referred to in paragraph (1) shall include staff training in relation to the detection and prevention of and responses to abuse.	Not Compliant	Orange	03/04/2020