Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Adults).

Issued by the Chief Inspector

Name of designated centre:	Galtee View House
Name of provider:	St Joseph's Foundation
Address of centre:	Limerick
Type of inspection:	Unannounced
Date of inspection:	27 October 2021 and 28 October 2021
Centre ID:	OSV-0001826
Fieldwork ID:	MON-0034546

About the designated centre

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

St Joseph's Foundation provides a range of day, residential and respite services in North Cork and Limerick. The centre provides a home to 10 residents and is based in a community setting in county Limerick. The centre mainly provides care and support to residents who have high support needs, while some residents also had changing complex health care needs. The centre is a purpose-built bungalow with a variety of communal day spaces including a large sitting room, visitor's sitting room and beauty room. There was separate large open plan kitchen and dining room. All rooms were bright, spacious and comfortably furnished. Many of the bedrooms and bathrooms had assistive devices to support residents to transfer more easily. The centre is in a tranquil setting with large garden spaces.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	10

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 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 October 2021	12:20hrs to 16:15hrs	Christopher Regan-Rushe	Lead
Thursday 28 October 2021	10:00hrs to 14:50hrs	Christopher Regan-Rushe	Lead

What residents told us and what inspectors observed

This inspection was an unannounced inspection to monitor and inspect the arrangements the provider had put in place in relation to infection prevention and control. The inspection was completed over two days and on both days of the inspection, the inspector met and spoke with residents and staff throughout the course of the inspection. In addition to speaking with staff and residents, the inspector observed the daily interactions and lived experience of residents in the centre.

On arrival at the centre, the inspector was met by one of the residents who introduced themselves. The inspector was introduced to the remainder of the residents who were in the communal areas of the centre, such as the sitting room and the kitchen area. Staff were engaged in a variety of activities in preparation for the main lunchtime meal and residents were being supported to move towards the dining area. The inspector noted that the hot meal being prepared and served on the day of inspection was home-made on site by staff who worked and supported the residents throughout the day. Some residents were seated in the dining area and able to feed themselves without support. Where residents required support with eating, the inspector observed that this was unhurried and that the meal-time was a social and enjoyable activity for the residents. Residents living in the centre, were part of a habitation pod and as such were not wearing masks while in their home, while staff who were supporting residents in close proximity were. The inspector noted the interactions between residents and staff and could see that both residents and staff were familiar with each other and were relaxed in each others company. Some residents required assistance with personal care tasks.

On both days of the inspection residents were primarily engaged in activities based within the centre. Some residents were able to move independently about the centre either on foot or by using electric wheel chairs. Other residents relied on staff to mobilise to different areas of the designated centre, for example from their bedrooms to the shower facilities. The inspector noted that there was a daily schedule of staff duties that was contained within the operational guidance folder for the centre. This broke down per staff member on duty, the tasks that they were to be allocated on a daily basis. The inspector noted that for the majority of time, staff were allocated to functional care giving tasks in the centre, such as waking, bathing, supporting personal care or preparing meals for residents. However, on each day there was allocated activity time of one hour per day in the afternoon, set aside in which to support all of the ten residents. However, due to the length of time allocated and the number of staff on duty this meant that each resident could only be allocated a maximum of approximately 20 minutes of one-to-one time during this period. Following discussion with staff it was established that this time was intended for a group activity within the home to be completed. On the second day of the inspection the inspector saw a beauty therapy session was being held, for both the men and women living in the centre in the main communal room. The residents participating in this event appeared to be enjoying it and happy to participate in the

session.

The inspector reviewed notes of resident meetings and saw that there were a number of occasions that residents had expressed a desire over the recent weeks to become more engaged or involved in activities in the local community such as going to spend time in the community, visit church or meet with family members. The inspector reviewed the records and provider's processes for following up on these requests, to see how the provider had positively responded to the relaxation of public health restrictions. The inspector also spoke to staff members on duty about how residents were supported to achieve these short term goals.

Staff told the inspector that they had recently been supplied with a new vehicle, that could accommodate two residents in their wheelchairs. However, the vehicle was an automatic, and some staff were not confident in driving this. In addition, the staff who met with the inspector explained how sometimes it was not always possible to support residents go out in the community, due to the increased levels of support some residents now have since the beginning of the pandemic. The inspector followed up two examples of where residents had made requests at the most recent resident meetings for an activity in the community. The provider's process for following up on these actions was clearly described on the outside of the meeting record book, and gave guidance to staff on how they should both document the request and record how this was met.

However, it was clear from the records available in the centre, which included the daily activities log and the residents personal planning documentation, that this process was not being followed. In addition, and while there were daily activity logs maintained of activities the resident completed each day, such as collect the post from the front gate or to go and get the paper. these lacked any detail about the outcome for the resident and often were a single word entry such as 'post' or 'papers'. This gave the appearance to the inspector that they were were not meaningful goals but were functional / habitual daily tasks that were being completed every day by the residents. Upon further review the inspector found that there was no evidence that the activities being requested by the residents on a weekly basis were translated into meaningful goals and were being actively followed up. In addition, where community engagement goals had been identified in the residents' personal planning documentation, there was no evidence that these were being actively developed and delivered. This was supported by observations made by the inspector of residents spending the large proportion of their day within the designated centre. The inspector found that as a result, the provider could not demonstrate how they were supporting each resident's rights and freedoms to participate in activities of their choosing in their local community, following the easing of public health restrictions. This was bought to the attention of the provider on the second day of the inspection

As part of the inspection, the inspector completed a walk around with the nurse in charge of all communal areas of the designated centre, the inspector also saw the new vehicle provided to the centre. The inspector observed that some residents bedroom doors were left open. The inspector was able to see that these rooms had been personalised and were fitted with personal support equipment as required,

such as hoists. In the centre, there were a number of hand washing facilities where both soap and/or hand sanitiser were located. Staff were observed to be washing or sanitising their hands in accordance with public health guidance. For example, before preparing a meal or when beginning and finishing a task or activity with an individual resident.Throughout the course of the inspection, the inspector observed that staff were working in close proximity to residents, as a result staff were noted to be wearing face masks throughout the duration of the inspection, in accordance with prevailing public health guidance.

The remainder of this report will present the findings from the walk-around of the designated centre, discussions with staff and a review of the providers' documentation and policies and procedures in relation to infection prevention and control. The findings of this review will be presented under two headings before a final overall judgment on compliance against regulation 27: Protection Against Infection is provided.

Capacity and capability

The provider had developed procedures for the effective management, control and prevention of infection within the centre, however; the systems to oversee and ensure continued delivery of safe and effective prevention and control measures in the centre required improvement.

The provider has a range of policies and procedures in place to both guide and instruct staff in good infection prevention and control (IPC). For example, the provider had an IPC policy and procedure, hand hygiene procedure, a COVID-19 procedure and outbreak management plan. Each of these has references to national guidance published by the Health Service Executive, the Health Protection and Surveillance Centre and the Health Information and Quality Authority, amongst others. The guidance was reviewed by the inspector and found to be consistent with current recommendations made by the National Public Health Emergency Team in relation to the current global pandemic. In addition to these, the provider has developed a suite of internal controls to support good practice and adherence to these policies and procedures, including requiring staff to complete mandatory training in IPC, an annual environmental audit, and daily and weekly cleaning check lists and planners. However, the inspector found that there were significant gaps in the completion of records that would demonstrate adherence to the providers policies and procedures. In addition, the recent environment audit completed in the centre had not identified some of the issues identified in this inspection report and there was no action plan developed on foot of the audit which would demonstrate how the issues identified in that audit would be addressed.

For example, the inspector noted that there were two sharps boxes located in the centre where used needles could be disposed of safely. There was one box in use and the date this had been opened had been signed and entered on the front label

of the box. Another box had been closed and was awaiting disposal. However, the date of closing and the name of the person who had closed this had not been entered onto the label of the box. The environmental audit completed in July had recorded that there were no such sharps boxes in use in the centre and critically, this had not been picked up by the management team in the designated centre. These findings meant that the audit had not been effective in both identifying the issues, this was compounded by the lack of an action plan arising from this audit to address the deficits identified in the audit

The inspector also reviewed the overall effectiveness of the checklists used to provide assurance that tasks were completed. For example; there were daily cleaning schedules and tasks required by both day and night staff to demonstrate that essential cleaning was completed. The inspector noted there were a large number of gaps in these documents being completed and, upon the walk around of the centre, found that the gaps corresponded to less than sufficient cleaning of the centre. While these issues were highlighted in the July 2021 environment audit, and mentioned as a standing agenda item in the monthly staff meetings, there was no evidence that the gaps in the documentation or standard of cleanliness in the centre were being actively tackled and improved.

The inspector reviewed the providers arrangements for the management of an outbreak in the centre and found that they had developed a COVID-19 contingency plan, that would guide staff on the actions to take to monitor and respond to any suspected or confirmed cases of COVID-19. This plan clearly set out the key people within the organisation who held responsibility for infection prevention and control, including their contact details. Throughout the pandemic the provider has maintained a separate isolation facility, which could be used in the event of a resident requiring to isolate. However, in this centre the provider has put in place arrangements for residents to be able to isolate in their own rooms. These arrangements include portable stations for donning and doffing PPE and sanitising hands which can be placed outside of each room where residents are isolating.

The plan includes information on how to access additional staffing and supplies of PPE in the event of an ongoing outbreak. The provider's policies also included a norovirus management plan and included information on how to manage in the event of an outbreak. However, this document (included in the centre's policy folder), which was due to be reviewed in February 2015, had not been updated. The inspector discussed this with a person participating in management (PPIM) to check whether the norovirus toolkit, referred to in this document continued to be located in the on call office as described in the procedure. The PPIM confirmed that this was not the case and, while many of the items detailed in the toolkit were now available in the centre, acknowledged that this procedure did not reflect the current arrangements.

The provider has developed a number of risk assessments to assess and evaluate the risks associated with infection prevention and control. These were completed for residents and for the centre. The assessments gave an overview of the risks and the associated controls that were in place at the time of the assessment. In addition, these assessment identify any additional controls or gaps in control that need to be

addressed in order to reduce the overall risk rating. The inspector reviewed a good proportion of these risks and found that while the initial risk assessment was informative, and had been subject to ongoing review, the review did not always state when key actions had been completed and as a result when the gap in control had been resolved. In some instances the inspector noted that there was a repetition in the narrative of the review, with no discussion on how the gaps in control were being addressed. For example, in one case a risk assessment identified that wound management training was required in the centre, however; there was no evidence that this had been completed and as a result remained a gap in control.

A review of the provider's training matrix highlighted that staff working in the centre had received training in a number of infection prevention and control measures.The inspector noted that all staff had completed training in breaking the chain of infection. The training programme had been developed and provided by the HSE through their online training portal and provided staff with knowledge and skills in the standard IPC precautions, such as hand hygiene and donning and doffing PPE. Staff had also been trained in transmission based precautions.

Quality and safety

The overall standard of cleanliness and infection control and prevention practice in the centre required improvement. This was bought to the attention of the provider on both days of the inspection.

The inspector found that there was sufficient information in and around the centre to encourage and support good hand hygiene. Staff were observed to be regularly cleaning their hands, and they were wearing masks in accordance with current public health guidance in relation to long-term residential care facilities. There was signage at the front door to remind visitors of the requirements to ensure that they wore masks and would be required to give their temperature and adhere to hand washing / sanitising arrangements. There was a separate entrance used for visitors to sign in and complete these checks. During the inspection staff were observed to be prompting and reminding residents in terms of hand hygiene and social distancing requirements, where necessary. Residents were supported to understand and participate in decisions about their care, particularly in relation to infection prevention and control, and had developed communication plans and hospital passports - which would guide staff in how to effectively support residents to understand any upcoming treatment and interventions. For example, the inspector saw a number of very good social stories which would help the residents understand and prepare for a COVID-19 test or to be informed about their vaccination programme.

As previously mentioned residents living in this centre present with a variety of support needs. This meant some residents required additional medical equipment or devices to support them complete or participate in their activities of daily living.

Throughout the centre the inspector noted that there was a significant amount of equipment, ranging from electrically propelled wheelchairs, electric reclining chars, hoists and other portable equipment such as commodes. Due to the limitations in space in the centre, many of these pieces of equipment, when not in use, are stored in the corridors of the centre, in the bathrooms or in one of the rooms used for beauty therapy, the cloakroom or the prayer room. Equipment such as the residents electric wheelchairs, were included on the daily and weekly cleaning schedules. However, other equipment, which was intended to be used by more that one person, such as the portable hoist or an exercise bike, were not. This meant that there was no evidence that these were routinely maintained and cleaned between each resident's use. In another example, the inspector found that improvements were required to the stock control of single use medical equipment to ensure that out-of-date and expired products were not in circulation. For example, the inspector found some sterile products, used for the purposed of percutaneous endoscopic gastrostomy (PEG) feeding was expired and stored alongside newer in date products. This meant that there was a risk that expired products could be used in routine interventions.

Overall the inspector found that significant improvements were required to the overall standard of cleanliness in the premises and the consistency of the cleaning as previously mentioned. During the initial walk around of the centre on day one of the inspection, the inspector drew the provider's attention to a number of issues with the cleanliness in the centre. For example, in one bathroom there was evidence of faeces on one of the walls and on the hand rails for the assisted toileting facilities, and in another, there was evidence of hair and dirt in the bath tub and surrounding area, including the assisted bath chair. On the second day of the inspection the inspector revisited these areas and found that while an attempt had been made to clean the faeces off of the wall, evidence of this remained; and the bath, the assisted bath chair and the rails in the assisted toilet had not been cleaned. This was again brought to the attention of the PPIM on the second day of the inspection. In addition to the above, the inspector found that many of the areas of the centre required a deep clean, including amongst other things ground in dirt on kitchen cupboards and around the fridge, the extractor fan unit in the kitchen, a shower bath used in one of the bathrooms and the sluice room.

On the first day of inspection, the inspector spoke with staff about the types of cleaning they do and what chemicals and products they use. Staff were clear about how the colour coding system, used for cloths and mops in the centre contributed towards good infection control management. Staff also spoke about how the cloths and mops were cleaned in the centre in accordance with the providers policy and procedures. The inspector observed staff over the course of both days of the inspection and noted that, within the context of the current pandemic, there was no regular cleaning of the high touch areas in the centre during the day, such as door handles. This was discussed with the PPIM and the inspector noted that on the second day of inspection that these touch points were being cleaned.

On the second day of the inspection, the inspector noted that a resident had been supported to have a shower, using the shower bed. The inspector noted that following the shower, the bathroom had been cleaned by the staff on duty. The

inspector reviewed the level of cleanliness in the room and found that the staff had effectively cleaned the shower using appropriate chemicals. However, they observed that had only cleaned the areas that they had used and not the entirely of the bathroom. This was again discussed with the PPIM who confirmed with the staff that they had only cleaned the area of the bathroom that they had used and that were visibly affected by the process of showering and meant other areas of the bathroom were not being subject to regular cleaning following its use.

As previously mentioned the provider had recently conducted an environmental audit, this identified that the sluice room located in the centre was suitable for the decontamination and cleaning of residents personal equipment. The inspector noted during the walk around of the centre that there were commodes in use in the centre and that re-usable inserts were being used rather than disposable inserts. The inspector also noted that there was a reusable urine bottle standing in the sluice sink. The provider's policy and procedures in relation to intimate care products recommends that where possible disposable equipment should be used and that manual sluicing should not be undertaken. The inspector noted that there were no hot water facilities in the sluice room and no automatic pan washer where this equipment could be sterilised. The inspector discussed this arrangement with staff who confirmed that they would manually sluice these products. This practice potentially increased the risk of cross-contamination, due to the lack of suitable sluicing facilities and the risk that these products could not be suitably disinfected between use by more than one person. In addition, on the first day of the inspection the inspector noted that the inserts for the commodes were not being stored correctly and noted that one was stored on top of mop buckets intended for cleaning different areas of the centre. On the second day of the inspection, the sluice room had been reorganised and these products were now being stored correctly and separate from the equipment intended for use in cleaning the centre.

Throughout the course of the pandemic the provider has reported three potential occurrences of COVID-19 to the Chief Inspector. Two of these were confirmed as negative following COVID-19 testing. There was one confirmed occurrence. The provider discussed this with the PPIM who was able to discuss the post occurrence review that occurred between the service and other members of the organisations management team. This review was held as a virtual meeting and explored the learning and outcomes from the event. However, the records of this meeting and any recommendations where not available to the inspector on the day of the inspection.

Regulation 27: Protection against infection

The provider had introduced a number of systems and processes which were intended to support and guide good infection prevention and control practice. Staff had received training and were knowledgeable in relation to infection prevention and control measures and the risks associated with any outbreak in the centre and residents appeared to be well-supported and living in a caring and homely

environment, albeit with limited exposure to the local and wider community. However, throughout this inspection the inspector found a number of areas where adherence to these guidelines required improvement. In addition the inspector found that some of the governance and oversight arrangements, which could be used to self-identify areas for improvement or gaps in assurance were ineffective. These included areas such as:

- The audits and checklists used to provide assurance of adherence to basic infection prevention and control practice, such as routine and daily cleaning of the centre and of personal equipment such as wheelchairs were not being completed consistently.
- There were areas of the centre that were not clean and were not being routinely detected by management in the centre and corrected
- The environmental audit was not accurate and failed to identify that the slice facility was not adequate and that there were sharps boxes in use in the centre.
- There was a failure to respond to the audit by the management of the centre, both to validate the findings but to also put in place a clear action plan, which would resolve the areas identified for improvement. Some of the findings made during the audit in July 2021, relating to the environment and cleaning of the centre continued to be issues identified during this inspection.
- Maintenance requests in the centre did not always follow the providers agreed process, and there was evidence that some requests had been repeated and others had yet to be followed up or submitted.
- Reviews of risk assessments did not always clearly identify when additional mitigating actions had been completed and as a result meant the risk remained unresolved.
- Portable hoists, the centre's vehicle and an exercise bike were not included in the schedule for regular cleaning. There was no checklist in place for then the vehicle had been cleaned down after each use and there was evidence in the vehicle of used wipes left in door pockets and on the floor of the vehicle.
- The agenda for the staff team meetings did not include a discussion on infection prevention and control, while these meetings identified gaps in assurance in the cleaning of the centre, there continued to be gaps in the documentation and cleaning of the centre. For example, there were gaps noted in the overall cleaning of the centre in October and in particular there was evidence that some residents' bedrooms where not being cleaned on a regular basis and in accordance with local cleaning plan.
- The outbreak plan for norovirus was not up-to-date and included references to a toolkit that was no longer accurate
- Some of the surfaces of the soft furnishings had begun to deteriorate, in addition damage was noted on a resident chair on the arm which required repair.
- Stock control for single use medical devices needed improvement
- The arrangements for the use of and disinfection of reusable inserts for commodes and reusable urine bottles requires review to ensure that they are consistent with the provider's own policy and procedures, and that suitable facilities are provided to support staff with this task.

As a result of these gaps, the provider was unable to adequately demonstrate how they were ensuring they had implemented the national standards for infection prevention and control in accordance with regulation 27.
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 Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Quality and safety	
Regulation 27: Protection against infection	Not compliant

Compliance Plan for Galtee View House OSV-0001826

Inspection ID: MON-0034546

Date of inspection: 27/10/2021 and 28/10/2021

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 Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

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 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
To come into compliance with this Regulation the Registered Provider has ensured the length of time allocated to activities contained within the operational guidance folder for the centre was reviewed. On review post inspection it is evident that residents needs have not increased since previous inspection in April 2021 and that the residents are engaging in both community and in house activities on a regular basis, however capturing of same required improvement.
The vehicle is an automatic and was purchased by the designated centre in July 2021. Staff have attended for driving lessons with the driving instructor, all Health Care Assistants had passed this assessment since October 15th 2021. The Person In Charge will liaise with all staff nurses and offer driving lessons by November 30th 2021. All community based activity requests will be facilitated in line with COVID-19 Restrictions and in line with residents short and/or long term goals.
The process for recording resident's activity requests, which are raised at resident's weekly meetings, was reviewed on November 2nd 2021. The activity log format has been updated to capture all activities. An activity planner/community engagement goal tracker to enhance planning of resident requests has been implemented since November 4th 2021 and is to be used during all resident's meetings to evidence the development and delivery of goals. Information on the front of the meeting book has been updated to reflect this. Any goals identified are reviewed to detail the outcome for the resident. Functional / habitual daily tasks that were being completed every day by the residents will continue to be captured. This will also ensure evidence that community engagement goals are being actively developed and delivered and demonstrate how the designated centre is supporting each resident's rights and freedoms to participate in activities of their choosing in their local community. This review has increased activity time set aside in order to allocate more meaningful time for resident's activities and staff involvement in same throughout the day.

The audits and checklists used to provide assurance of adherence to basic infection prevention and control practice, such as routine and daily cleaning of the centre and of personal equipment such as wheelchairs were reviewed on November 2nd 2021. This review ensures each audit has a comprehensive action plan and actions are closed off when completed. More stringent monitoring and walkthroughs of the premises commenced on November 1st 2021 in order to detect any shortcomings in the cleaning being completed daily. Cleaning checklists were reviewed and updated on November 4th and implemented on November 8th 2021. This review will ensure more monitoring on completion of cleaning and documentation relating to same, this includes cleaning of rooms/bedrooms and equipment between residents. Regular cleaning schedule now includes daily checks by senior staff nurse on duty at the end of each shift and spot checks by the Person In Charge weekly. High touch point cleaning schedule implemented on November 4th 2021.
The Hygiene Audit template utilised is under review and the Registered Provider plans to have a replacement identified by November 30th 2021. Person In charge has reviewed cleaning audit and has put audit action plan in place identifying issues that had been resolved and issues that remain to be resolved. Person in charge will ensure regular review of this audit tracker to ensure actions are completed in a timely manner. Deep cleaning of the centre has been carried out by external contractors on November 1st 2021. Following the Hygiene audit the PIC had addressed some areas identified such as kitchen chopping boards and fridge checks. The PIC had completed a building risk assessment on October 14th 2021 and forwarded to Area Manager for forwarding to Interim Maintenance Manager. Maintenance Manager created a deep clean schedule across the service, this schedule commenced on October 11th 2021. This deep clean and building risk assessment identified and addressed issues such as dust, deep clean, descaling, vents cleaning, Sharps box and bedroom sink area.

Closed Sharps box dated and signed by the staff member who closed same, this was disposed of November 8th 2021. Documenting and disposing of Sharps box was discussed with all staff nurses individually and at team meetings on November 4th and 11th 2021.
Infection control will be discussed at all team meetings going forward, this commenced November 4th and 11th 2021. This will include discussions surrounding maintaining of cleaning records and documentation and the importance of maintaing accurate records.

Review of the Infection Control Policy in relation to Norovirus outbreak plan occurred on November 11th 2021. This review ensures information is accurate and up to date. Norovirus toolkit in Designated centre was reviewed on November 4th 2021 to ensure all contents required were contained within.

Reviews of risk assessments completed November 3rd 2021 ensured that the reviews contain more information into the actions that had been taken to minimize risks or reasoning as to why there had been no progress on actions required on the risk assessment. HSEland have a Wound Management course, all staff nurses to complete this by November 30th 2021. Individual Risk Assessment re Continence products has been closed on November 9th 2021.There are 7 COVID-19 Risk Assessments in Galtee View. On review post inspection 2 of these risk assessments were reviewed detailing the easing of COVID-19 restrictions, 5 were not as detailed. Person In Charge had made referral in COVID-19 risk assessments to adhering to National Guidelines. Since

inspection Person In Charge reviewed all risk assessments on November 3rd 2021 and included each specific restriction as it is updated.

Any excess equipment has been removed from the designated centre on November 4th 2021. Portable hoist, the centre's vehicle and the exercise bike have been included in the schedule for regular cleaning since November 4th 2021. The exercise bike has not been in use due to change in resident's needs. Discussion took place with staff members on November 2nd, 3rd and 4th with regards the importance of ensuring the bus is maintained.

Stock control monitoring forms for single use medical devices devised and implemented on November 1st 2021 to ensure thorough monitoring of stock rotation and disposal of expired stock.

Sluice management system devised and implemented on November 2nd 2021. Plumber contacted on November 2nd 2021 with regards hot water tap to be placed in the sluice room. Schedule for the maintenance and cleaning of individual inserts for commodes completed on November 4th and implemented. Disposable urine bottles ordered from pharmacy and will be trialled for a month on receipt of same. If this is successful it will eliminate the need for an automatic pan washer. Hot water tap was installed in sluice room by plumber on November 5th 2021 – Person In Charge has contacted Cleaning Department re consideration of installing an automatic pan washer.

Discussion with regards duplication of maintenance requests took place at team meeting on November 4th and 11th 2021. This will reduce the likelihood that there will be no repeats in maintenance request forms. Person in charge will follow up monthly, or sooner if required, on maintenance requests and will document any follow up information into the maintenance request book.

Request for repair to the residents chair was submitted and discussed with the occupational therapist on November 3rd 2021. Soft furnishings with irrepairable damage were removed as adequate seating is present for all residents on November 4th 2021.

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 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Not Compliant	Red	19/11/2021