Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

<table>
<thead>
<tr>
<th>Name of designated centre:</th>
<th>Gormanston Wood Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of provider:</td>
<td>Costern Unlimited Company</td>
</tr>
<tr>
<td>Address of centre:</td>
<td>Gormanston, Meath</td>
</tr>
<tr>
<td>Type of inspection:</td>
<td>Unannounced</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>10 November 2020</td>
</tr>
<tr>
<td>Centre ID:</td>
<td>OSV-0000131</td>
</tr>
<tr>
<td>Fieldwork ID:</td>
<td>MON-0031019</td>
</tr>
</tbody>
</table>
About the designated centre

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

Gormanston Wood Nursing Home is situated across the road from Gormanston beach in Co Meath. It is registered to care for 89 residents both male and female over the age of 18. The centre provides individualised care to residents who require long term residential, convalescent and respite care. The philosophy is to embrace positive aging and place the resident at the centre of all decisions in relation to provision of their care.

The centre is made up of four separate units, Laurel, Cedar, Elm and Beech a dementia specific unit these units are spread over two floors. The centre has 73 single and seven twin bedrooms, all of which have an ensuite bathroom. Residents have access to mature and colourful gardens from each of the four units.

The following information outlines some additional data on this centre.

| Number of residents on the date of inspection: | 82 |
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:

<table>
<thead>
<tr>
<th>Date</th>
<th>Times of Inspection</th>
<th>Inspector</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tuesday 10 November 2020</td>
<td>09:30hrs to 16:30hrs</td>
<td>Sheila McKevitt</td>
<td>Lead</td>
</tr>
<tr>
<td>Tuesday 10 November 2020</td>
<td>09:30hrs to 16:30hrs</td>
<td>Noreen Flannelly-Kinsella</td>
<td>Support</td>
</tr>
</tbody>
</table>
Residents described the centre as their home and said that it was a comfortable place to live. One resident told inspectors that they had great peace of mind since they moved into the centre and that they had improved a lot since their admission.

The centre appeared calm, quiet, warm and homely. Although some residents remained in their room others were observed using the sitting rooms while maintaining social distancing. Staff supervised residents in these rooms and were conducting activities with residents.

Residents said staff were kind and caring and took time to explain things to them. One resident described how staff sat and went through the choices on the daily food menu and this was important as the resident enjoyed the food served. Inspectors observed residents relaxing in their bedroom, with their nurse call bell by their side. Those residents who spoke with the inspectors confirmed that there was absolutely no delay in staff coming to their aid when they called for assistance.

Inspectors observed that a number of residents had their own mobile phone and residents said they were using them to communicate with family together with the computer which they used for on line calls and face to face time. Residents said they had enough to do during the day with one resident saying he often went outside to the grounds of the nursing home just to get some fresh air. Residents told inspectors that they were seen by their general practitioner (GP) on a regular basis.

Residents spoken with who had not contracted the coronavirus said they were grateful and praised staff who had worked hard to protect them from contracting the virus.

At the time of the inspection an outbreak of COVID-19 infection had occurred in the centre. 26 residents and 13 staff had tested positive to the virus, sadly an additional three residents who had tested positive to the virus had died.

The Department of Public Health was liaising with the person in charge in relation to the outbreak on a daily basis. The centre had four units. Residents who were COVID-19 detected were being cared for on two units. Residents who had tested negative to COVID-19 were being cared for on two different units. Inspectors focused their inspection in these two units.
The Person in Charge and senior management team were managing the outbreak in-line with advice from the local Public Health team with whom they were in contact on a daily basis. Overall, the outbreak was being managed well with evidence of outbreak management meetings taking place.

The care and welfare of the residents was closely monitored. Inspectors saw an audit schedule for 2020 and reviewed a sample of audits that had taken place. These audits included action plans and evidence that these had been addressed in a timely manner. However some areas of the premises were not well maintained or equipped and did not meet the required standards. As a result further resources were required in these areas to ensure the risk of the spread of infection within the centre was minimised. In addition e training and staff development processes required review to ensure staff were clear about the exact training they were required to complete to enable them to meet the required infection prevention and control standards.

Documents such as the statement of purpose and some policies required review to ensure that they were compliant with the legislation.

Registration Regulation 4: Application for registration or renewal of registration

An application by the registered provider to re-register the centre in accordance with the requirements set out in the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 had been made. All the required supplementary documents were also submitted however some of these documents required further review to ensure they clearly reflected the facilities and services available to residents. These included the statement of purpose and the floor plans.

Judgment: Compliant

Regulation 15: Staffing

There were sufficient numbers of nursing and care staff with the appropriate knowledge and skills to meet the needs of the residents during the day. This included a minimum of one staff nurse on each of the four units together with the management team. Residents who had contracted COVID-19 were being nursed on two of the four units. During the day staff were segregated to work in one unit, however at night nursing staff decreased to two nurses on duty. This meant that there was one staff nurse working across the two units with COVID-19 positive residents which increased the potential risk of the spread of infection.

At the end of the inspection this was discussed with the senior management team and assurance was given to inspectors that another staff nurse would be rostered on night duty to ensure there was a staff nurse on each of the two COVID-19
positive units. A copy of the planned roster was submitted to reflect this change. Inspectors were assured by the person in charge that this would remain in place until the COVID-19 outbreak was over.

Judgment: Substantially compliant

**Regulation 16: Training and staff development**

Records showed that staff had completed the required mandatory training in fire, manual handling and safeguarding the vulnerable adult.

Staff had completed training in infection control practices and inspectors were informed that external training was due to commence on-site within the coming days. Inspectors found it was not clear if all staff had received the appropriate education as outlined in the current guidance (Interm Public Health, Infection Prevention & Control Guidelines on the Prevention and Management of COVID-19 Cases and Outbreaks in Residential Care Facilities' V6.1 03/11/2020, 4.2.1.). The training matrix given to inspectors did not clearly reflect this information and a review of a sample of staff files did contain a copy of certificates to reflect that each staff member had completed all of the recommended COVID-19 enhanced training.

Judgment: Substantially compliant

**Regulation 23: Governance and management**

The governance and management of the centre was good. The Chief Inspector had been informed of a change in the Person-in-Charge (PIC). This change was not due to occur until the end of November 2020. The incoming PIC was in the centre attending induction and was introduced to the inspectors.

Members of the governance team including the provider representative, operations manager and person-in-charge were in the centre throughout this unannounced inspection. They all attended the feedback meeting at the end of the inspection and demonstrated a commitment to address the non-compliances found on the inspection.

Inspectors found that the oversight of care delivered and of the services and facilities provided were closely monitored. However a number of the improvements that were found on this inspection had not been identified through the centre's own oversight processes.

An annual review had been completed for 2019, it included residents feedback and a
quality improvement plan for 2020, some of which had been implemented. Improved oversight of staff training, infection control practices and the premises was required as outlined under regulation 16, 26 and 27.

**Judgment:** Substantially compliant

**Regulation 3: Statement of purpose**

The statement of purpose submitted with the application to renew was reviewed by the inspectors. Some areas did not accurately reflect the care and services provided for the residents in the centre. For example, the facilities available to residents and the whole time equivalent of staff working in the centre. An email containing this feedback was sent to the provider post this inspection.

A copy of the statement of purpose was available to residents living in the centre.

**Judgment:** Substantially compliant

**Regulation 4: Written policies and procedures**

The schedule 5 policies were available for review. Inspectors found that all the Schedule 5 policies had been updated to include the guidance from the Health Protection Surveillance Centre (HSPC) (Interim Public Health, Infection Prevention and Control Guidelines on the Prevention and Management of COVID-19 Cases and Outbreaks in Residential Care Facilities). All policies had been updated in the past three years in line with the regulation; however, the admission, transfer and discharge policy required more detail to provide clarity on the process to follow when a resident was transferred out to another service.

**Judgment:** Substantially compliant

**Quality and safety**

Residents received a good standard of care that was being continuously monitored. However, inspectors noted that some areas of the premises did not comply with the standards and therefore increased the risk of the spread of infection within the centre. In addition, a number of infection control practices required improvement.

Facilities had been put in place to enable residents to communicate with their
families and those residents who spoke with the inspectors said this was working well for them. They were aware of the reasons why visiting had been suspended during the current outbreak.

Overall the premises was clean and tidy, however some non resident areas were not well maintained and were difficult to keep clean. Residents' bedrooms were personalised and appeared homely. The corridors were clutter free and hand rails on either side facilitated residents to mobilise independently. The equipment in some non resident areas such as sluice and housekeeping rooms, was not inline with that outlined in the standards and as a result these areas were not meeting the required infection and prevention and control standards to ensure the safety of the residents.

Inspectors found that overall infection control practices in the centre required improvement. A detailed infection control audit was recommended to enable all risks to be identified and appropriate control measures put into place to decrease the level of risk these practices posed. Those identified on this inspection are clearly outlined under Regulation 27. Inspectors outlined the key areas during the feedback meeting at the end of the inspection and the provider agreed to address the findings without delay.

Following the inspection inspectors were informed that the centre had had an infection control audit completed by an external person and a report would be submitted when it was available.

**Regulation 11: Visits**

Measures were taken in line with the Health Protection and Surveillance Centre (HPSC) guidance to protect residents and staff regarding visitors during the outbreak. While visiting by families had been suspended virtual visiting by telephone or video-link and essential visiting on compassionate grounds was facilitated. The person in charge communicated with families and relatives on a daily basis and kept them informed during the outbreak. Window visits had been put on hold following advice by public health.

A member of staff had responsibility for ensuring infection prevention and control precautions were in place should a visitor or an essential service provider enter the building. These included a COVID-related questionnaire to be completed along with a temperature check, hand hygiene, mask-wearing, and social distancing. Information pertaining to COVID-19 precautions, personal protective equipment (PPE) and hand hygiene was displayed at the entrance to and throughout the centre.

**Judgment: Compliant**
**Regulation 17: Premises**

The centre was made up of four units, two of which were reviewed on this inspection. These units appeared clean and tidy and residents enjoyed their personal en-suite bedroom space. The corridors were wide and fitted on either side with hand-rails.

Some areas of the premises did not meet the required standard and this had a negative impact on infection control practices as described under regulation 27. It also posed a potential risk to residents.

For example:

The sluice and cleaning rooms in the two units inspected did not contain all the required equipment as outlined in the standards. Inspectors advised that the provider ensured that the sluice and cleaning rooms in all four units be brought up to the required standard.

The staff changing room required review to ensure all areas could be accessed and cleaned thoroughly. For example, exposed chip board under the wash hand basin appeared wet and chipped and therefore could not be cleaned properly.

The treatment/clinical store room and pharmacy room required review to ensure the design and facilities were appropriate and facilitated good infection prevention and control practices.

Judgment: Substantially compliant

**Regulation 25: Temporary absence or discharge of residents**

A sample of the files of residents who had been recently transferred to hospital were reviewed. Inspectors found that all relevant information about a resident had been provided to the receiving hospital/care facility transfer. However, the policy in relation to this area of care required review as discussed under Regulation 4.

Judgment: Compliant

**Regulation 26: Risk management**

There was a risk management policy in place which reflected the requirements of the regulations. For example specific risks as outlined in the regulation such as aggression and abuse, and associated measures and actions to control these risks.
were included. The risk policy also outlined procedures for the management and reporting of non-serious and serious incidents at the centre.

The provider maintained a risk register for the centre and a COVID-19 specific risk register. The centre’s risk register included risks such as unexplained absence of residents, self-harm and accidental injury. The COVID-19 risk register included risks such as outbreak of infection, communication and infection prevention and control. This risk register had been recently updated in light of the current outbreak.

The inspectors found that both risk registers included a number of risks which were risk rated with existing and additional controls, responsible persons and time-bound review dates identified. However inspectors found that although a number of controls were identified in order to mitigate the risk, not all had been implemented. For example although twice daily active monitoring of residents for signs and symptoms of respiratory illness which included recording vital signs was documented, vital signs were only recorded on a daily basis. Furthermore some additional risks identified on this inspection for example in relation to lack of clinical hand wash sinks had not been identified as a risk on the risk register.

Inspectors found that management meetings provided oversight of risks and incidents at the centre. The registered provider had arrangements put in place for the identification, recording and learning from serious incidents or adverse events involving residents and staff. Incidents were recorded electronically, risk rated, recommendations made and learning shared. The centre maintained an incident log and an audit of incidents was undertaken on a monthly basis.

Judgment: Substantially compliant

Regulation 27: Infection control

At the time of inspection an outbreak of COVID-19 infection had been declared and a high number of residents and staff had been affected by the virus. The department of public health was providing leadership and liaising with the person in charge in relation to outbreak management on a daily basis. The management team had held three outbreak control meetings at the centre during the outbreak. The provider had prepared a comprehensive preparedness and contingency plan for COVID-19. The management team and staff kept residents informed about public health measures required to minimize risks associated with COVID-19. The person in charge had actively engaged with the inspectorate during the outbreak.

The centre had formalized support arrangements and access to designated specialist staff with expertise in infection prevention and control however there had been no on-site presence at the centre at the time of this inspection. An action plan had been put in place whereby two units affected by the COVID-19 virus were operating as discreet zones. A traffic-light system was used in relation to the stages of the virus to classify residents with possible or confirmed COVID-19 on each unit. The
residents were isolated in their own single en-suite room and designated staff was
assigned to each unit. The person in charge told inspectors that dedicated single
resident use equipment such as blood-pressure cuffs and hoist slings were assigned
to residents affected by the virus.

The inspectors found that there was an established governance and management
team in place for infection prevention and control. The person in charge was the
lead and was supported in her role by the clinical operations officer, an assistant
director of nursing and clinical nurse managers. The minutes from management
meetings reviewed by inspectors showed that relevant issues in respect of infection
prevention and control were featured.

The hygiene supervisor had undertaken a two-day training course in relation to
cleaning. The supervisor reported that new staff received training in relation to
cleaning by the supervisor at induction which was followed by peer-to-peer training
overseen by the supervisor.

The centre had an up to date policy to support staff in relation to COVID-19 and
infection prevention and control with signposts to the latest HPSC guidance in
relation to COVID-19. Inspectors were told that staff uptake of the influenza virus
was well below recommended national targets for 2019-2020 season therefore
further action was required to ensure staff were fully informed about the flu vaccine.

In light of the outbreak the inspectors limited their movement within the centre. The
inspectors observed that face protection masks were worn by healthcare workers
and staff adherence to ‘Bare below Elbow’ initiatives, hand hygiene techniques and
social distancing was evident in areas inspected. Although wall-mounted alcohol
hand rub was available it was not readily accessible at point of care in all areas.
Based on observation the inspectors were not assured that there were a sufficient
number of easily accessible and conveniently located dedicated clinical hand wash
sinks for staff to use where soap and water was required. Therefore an assessment
of hand hygiene facilities was recommended.

Furthermore the hand wash sinks in place were not compliant with recommended
best practice standards for clinical hand wash sinks. The staff on the dementia unit
had personal wearable alcohol gel dispensers so as to minimize the risk of accidental
use by residents.

The management team had a quality assurance programme in place to monitor and
support improvements in relation to infection prevention and control however
oversight and assurance arrangements required to be further strengthened. The
centre had a planned auditing schedule in relation to infection prevention and
control in place which included hand hygiene facilities, clinical practice and isolation
facilities, and environmental and room checklist audits. Overall audit results showed
good compliance was achieved however this inspection identified that further
improvement was required. The inspectors also found that audit results were not
tracked and trended making it difficult to identify trends and ensure corrective
action to address adverse trends was taken promptly. Although inspectors were told
by staff that reusable equipment was cleaned after use a review of periodic cleaning
schedules is required as cleaning checklists reviewed did not identify all the elements of reusable equipment which required cleaning. The inspectors found that an independent audit and a more comprehensive audit tool as used by the infection prevention and control team in public health was required.

The centre had arrangements in place for scheduled testing, and servicing of bedpan washer disinfectors and laundry equipment. The management team reported that preventative control measures in relation to water-borne infection, including regular flushing of water outlets and water testing had been implemented. Going forward, it is recommended that a Legionella risk assessment review is performed within the timeframes recommended in line with current relevant national guidance.

In light of the outbreak of infection the resident’s rooms were not visited however those viewed from the corridor appeared clean, tidy and well maintained. Daily cleaning checklists for residents’ rooms and twice daily enhanced cleaning for frequently touched surfaces during the outbreak were in place. A staff member demonstrated a good knowledge of cleaning processes, color-coded cleaning cloths and a flat mop system and there was appropriate separation of clean and unclean items evident on the cleaning trolley. However one unit inspected did not have an appropriately equipped room for the storage and management of cleaning equipment. For example there was no janitorial sink, hand washing facility and space for all cleaning equipment such as hoovers. A janitorial sink and chemical cleaning product was therefore inappropriately located in a sluice facility.

The laundry facility was visited and the facility was observed to be clean, well ventilated with appropriate facilities such as an equipment and hand wash sink and PPE. The staff maintained a unidirectional work flow from dirty to clean functions within the confines of the facility however clean linen was not stored separate to the area where used/infectious linen was processed. A laundry transport trolley for distribution of clean linen protected linen from inadvertent contamination. Colour-coded linen skips and alginate (dissolvable) bags were available at the centre.

However opportunities for improvement were identified in relation to segregation of healthcare risk and non-risk waste such as:

The management (signage and temporary closure mechanism) and storage of sharps containers in a pharmacy room in Beech Unit
The location of healthcare risk waste bins and labelling of non-risk waste bins
The management of external storage containers for healthcare risk waste as one was overfilled and unsecured; an urgent action plan was issued.

The inspection identified additional opportunities for improvement in relation to the following:

management and reprocessing of spoons used for dispensing medication to residents
management and reprocessing of reusable spray bottles for cleaning products
management and storage of equipment in storage facilities
inappropriate storage in ancillary facilities such as treatment room, sluice room and
store room in one unit
damaged surfaces and finishes in some ancillary facilities did not facilitate cleaning.

Judgment: Not compliant

**Regulation 28: Fire precautions**

The fire procedures and evacuation plans were prominently displayed. Fire escape signage to guide residents, staff and visitors to the assembly area in the event of emergency was evident. The external fire exit doors were clearly displayed, free from obstruction and tested on a weekly basis. Records showed that fire-fighting equipment had been serviced within the required time-frame. A staff member confirmed that mandatory fire training had been undertaken on an annual basis and training records reviewed confirmed this.

Judgment: Compliant

**Regulation 6: Health care**

Residents had good access to medical and allied health care services. Two general practitioner (GP’s) visited the centre each week to review residents and prescribe treatment if required. The GP’s also undertook a full review of residents under their care on a three to four monthly basis. An out of hour on-call GP service was available from 18.00hrs to 08.00hrs. During changeover periods between 17.00-18.00hrs and 08.00-09.00hrs the nursing staff would either contact the residents’ GP by phone or transfer the resident by ambulance to the nearest acute hospital facility in the event of a resident becoming acutely unwell.

The residents had access to physiotherapists, occupational therapist, dietician, and speech and language therapist via a referral process. Where required, residents had access to palliative care and psychiatry services for older age. However some improvements were required in relation to timely follow-up assessments by specialist healthcare professionals for residents on prescribed eating and drinking plans. For example, in one record reviewed there was no evidence that a follow-up assessment of a resident on an eating and drinking plan for swallowing difficulties had taken place. This would help to ensure that the prescribed plan remained appropriate to meet the needs of the resident.

At the time of inspection the public health team and an infection prevention and control nursing expert was providing advice and guidance in relation to the outbreak management at the centre.
Judgment: Substantially compliant

<table>
<thead>
<tr>
<th>Regulation 8: Protection</th>
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<tbody>
<tr>
<td>Inspectors found that all reasonable measures were taken to protect residents from abuse. There was a policy in place which covered all types of abuse and inspectors saw that all staff had received mandatory training in relation to detection, prevention and responses to abuse.</td>
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<tr>
<td>A sample of staff files reviewed showed that all staff had appropriate Garda vetting completed prior to commencing employment in the centre.</td>
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<tr>
<td>The process in place for managing residents' pensions was safe. All monies collected on behalf of residents were being lodged into a residents account, in line with the Social Protection Department guidance.</td>
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Judgment: Compliant
Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended) and the regulations considered on this inspection were:

<table>
<thead>
<tr>
<th>Regulation Title</th>
<th>Judgment</th>
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<tbody>
<tr>
<td><strong>Capacity and capability</strong></td>
<td></td>
</tr>
<tr>
<td>Registration Regulation 4: Application for registration or renewal of registration</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 15: Staffing</td>
<td>Substantially compliant</td>
</tr>
<tr>
<td>Regulation 16: Training and staff development</td>
<td>Substantially compliant</td>
</tr>
<tr>
<td>Regulation 23: Governance and management</td>
<td>Substantially compliant</td>
</tr>
<tr>
<td>Regulation 3: Statement of purpose</td>
<td>Substantially compliant</td>
</tr>
<tr>
<td>Regulation 4: Written policies and procedures</td>
<td>Substantially compliant</td>
</tr>
<tr>
<td><strong>Quality and safety</strong></td>
<td></td>
</tr>
<tr>
<td>Regulation 11: Visits</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 17: Premises</td>
<td>Substantially compliant</td>
</tr>
<tr>
<td>Regulation 25: Temporary absence or discharge of residents</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 26: Risk management</td>
<td>Substantially compliant</td>
</tr>
<tr>
<td>Regulation 27: Infection control</td>
<td>Not compliant</td>
</tr>
<tr>
<td>Regulation 28: Fire precautions</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 6: Health care</td>
<td>Substantially compliant</td>
</tr>
<tr>
<td>Regulation 8: Protection</td>
<td>Compliant</td>
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**Compliance Plan for Gormanston Wood Nursing Home OSV-0000131**

**Inspection ID: MON-0031019**

**Date of inspection: 10/11/2020**

**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. **Specific** to that regulation, **Measurable** so that they can monitor progress, **Achievable** and **Realistic**, and **Time** 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:**

<table>
<thead>
<tr>
<th>Regulation Heading</th>
<th>Judgment</th>
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<tbody>
<tr>
<td>Regulation 15: Staffing</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outline how you are going to come into compliance with Regulation 15: Staffing: This action was addressed at the feedback on the day of the inspection and a copy of the planned Rota was submitted to the inspector the following day.</td>
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<table>
<thead>
<tr>
<th>Regulation 16: Training and staff development</th>
<th>Substantially Compliant</th>
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<tbody>
<tr>
<td>Outline how you are going to come into compliance with Regulation 16: Training and staff development: All staff in Gormanston Wood have their mandatory training completed to include fire, manual handling, safeguarding the vulnerable adult and HACCP. They also have additional training completed to suit their role and responsibilities. All staff have completed training in relation to infection control, donning and doffing of PPE, and Hand Hygiene. All staff are appropriately supervised during their shift and are aware of the reporting structure within the Home. The Home maintains an up-to-date training matrix to highlight all training, this was reviewed by the HR Director and the Administration staff on the 11/11/20 and know clearly reflects the infection prevention training completed by all staff as per the latest guidance. A review of all staff files commenced on the week beginning the 14/11/20 and all files now contain a copy of the certificates to reflect training completed.</td>
<td></td>
</tr>
<tr>
<td>Regulation 23: Governance and management</td>
<td>Substantially Compliant</td>
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</table>
| Outline how you are going to come into compliance with Regulation 23: Governance and management:  
The PIC in Gormanston Wood performs their functions as outlined in relevant legislation, regulations, national policies and standards to protect each resident and promote their welfare. The Home has effective leadership, governance and management arrangements in place and clear lines of accountability. There is a detailed organisation chart in place and outlined in the Statement of Purpose. The Home has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose. There are management systems in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored. There is a fortnightly management meeting that takes place with the DON, ADON, COM, HR Director and the CEO, minutes of these meetings are available, there are also monthly Health and Safety, Head of Department meeting, Catering meeting, and Activity meetings. There are staff nurse and HCA at least quarterly. There is an annual review of the quality and safety of care delivered to residents conducted for 2019 in the Home to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act. The DON and ADON are experienced in Auditing with a comprehensive schedule in place. While the quality of care and experience of residents are monitored, reviewed and improved on an ongoing basis the Don and ADON will ensure that all audits conducted will identify areas for improvement, identify actions and ensure that all actions are signed off on going forward. |

<table>
<thead>
<tr>
<th>Regulation 3: Statement of purpose</th>
<th>Substantially Compliant</th>
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</thead>
</table>
| Outline how you are going to come into compliance with Regulation 3: Statement of purpose:  
Gormanston Wood has a Statement of Purpose in place and it is reviewed on at least a yearly basis. It is available to all residents living in the Home. Post inspection the Provider Representative received an email from the inspector containing feedback in relation to gaps in the Statement of Purpose. These gaps were rectified, and the Statement of Purpose was resubmitted to the Inspector on the 08/12/20 |

<table>
<thead>
<tr>
<th>Regulation 4: Written policies and procedures</th>
<th>Substantially Compliant</th>
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</thead>
<tbody>
<tr>
<td>Outline how you are going to come into compliance with Regulation 4: Written policies</td>
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</tbody>
</table>
There are five sets of policies in the Home one in each of the four units and one in the DON's office. All Schedule five and Non schedule policies were up to date, in place and reviewed within the last three years. Relevant policies were updated to include the guidance from the Health Protection Surveillance Centre (HSPC) (Interim Public Health, Infection Prevention and Control Guidelines on the Prevention and Management of COVID-19 Cases and Outbreaks in Residential Care Facilities) On the 25/11/20 TC1 Admission, Transfer and Discharged policy was updated to provide more detail and clarity on the process to be followed when a resident is transferred out to another service or Home. The policy was placed in all folders and a new sign off sheet is in place to ensure that all staff have signed that they have read and understood the policy.

<table>
<thead>
<tr>
<th>Regulation 17: Premises</th>
<th>Substantially Compliant</th>
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</thead>
<tbody>
<tr>
<td>Outline how you are going to come into compliance with Regulation 17: Premises: Gormanston Wood is a well-maintained Home and is made up of four units, the units are maintained and cleaned to a very high standard with cleaning schedules and sign offs in place. Following the inspection, a detail review was carried out by the PIC and the Clinical Operations Manager on the premises paying particular attention to the Non-Residential areas on the 09/12/20. All Sluice rooms, cleaning store and treatment/clinical stores, staff changing rooms as well as pharmacy rooms were reviewed. A plan has been put in place to ensure that all rooms are brought up to the required standard ensuring the design and facilities are appropriate and facilitate good infection prevention and control practices. This will be completed by the 31/03/21</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Regulation 26: Risk management</th>
<th>Substantially Compliant</th>
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</thead>
<tbody>
<tr>
<td>Outline how you are going to come into compliance with Regulation 26: Risk management: There is a risk management policy in place dated Aug 2023 highlighting risks documented as per Reg 26. There is an up to date safety statement in place dated June 2020 with Hazards identifications and risk assessment. There is a current and up to date risk register in place last reviewed October 2020. There is also a COVID 19 risk register in place that is updated according There are good practices of reporting alleged abuse in the Home and the PIC is competent in carrying out investigations. There is a quarterly Absconsion drill carried out quarterly with learning recorded and actions to be completed if required. PEEP and Manual Handling charts are maintained and are easily accessible for staff. There are monthly Health and Safety Risk Management meetings chaired by the</td>
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</tbody>
</table>
PIC with minutes maintained. The Home has an emergency Box and folder in place with contents checked weekly. As per the risk register all residents vital signs were to be monitored twice a day while this was taking place in the hole, there were gaps as reported by the inspector. As of the 11/11/20 all residents vital signs are monitored twice daily and the process regularly reviewed by the DON and ADON. A review of the risk register has been completed to address the potential risk associated with the clinical handwashing sinks.

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<tr>
<th>Regulation 27: Infection control</th>
<th>Not Compliant</th>
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Outline how you are going to come into compliance with Regulation 27: Infection control:

There is a comprehensive Infection Control policy in Gormanston Wood, with the addition of a COVID -19 Policy since the Pandemic in February 2020. All staff are required on induction and on an ongoing basis to review all policies and procedures in relation to Infection Control and to sign that they have read and understood them. Current policies are updated regularly in line with best practice as per HSE and HPSC guidelines. There is a Preparedness plan in place to guide staff and specific COVID 19 policies to manage an outbreak within the home. All staff have been trained in Donning and Doffing PPE, Hand Hygiene, and Infection Control. All equipment is serviced regularly. Signage are available for residents that are in isolation and all staff are aware that this needs to be erected if and when necessary. Clinical waste bins are in place around the home for staff to safely duff their masks.

The Home carry out audits monthly on Infection Prevention and control, these are competed by both the PIC and the Head housekeeper. Following the inspection, the PIC will ensure that the oversight and assurance arrangements are further strengthen. As of the 01/12/20 as well as monthly IPC audit the Home will carry out Biannually a more comprehensive independent IPC audit used by the HSE in their Long-Term Residential Facilities. These audits results will be tracked to address any adverse trends and actioned according

The Home had a reusable equipment cleaning schedule in place, following the inspection the PIC reviewed the schedules and on the 07/12/20 revised the schedules to ensure that all elements of reusable equipment which required cleaning was in place.

An external company carry out the homes legionella risk assessment annually, on the day of the inspection only 2017 was available in the Maintenance folder. On the 11/11/20 the facilities manager contacted the Company and they provided the Home with up-to-date copies of the resent Risk Assessments carried out. These were place in the maintenance folder.

Following the inspection, a detail review was carried out by the PIC and the Clinical Operations Manager on the premises paying particular attention to the Non-Residential
areas on the 09/12/20. Three of the four units has an appropriate equipped room for the storage and management of cleaning equipment. Some minor works were required in relation to open shelving in all three rooms, stainless steel presses have been ordered and will replace the open shelves, this will be completed by the 31/01/21. There was one unit that had a storeroom but not appropriately equipped. This will be fitted out to include janitorial and handwashing sinks and an area for the dispensing of chemicals, removing the dispenser in the sluice room. This will be completed by the 31/03/21. All other non-clinical nor non chemical store rooms were reviewed and the PIC has a plan in place to declutter and reorganize these room, all non-clinical items stored in treatment and pharmacy rooms were removed. There is now an SOP in place for the reprocessing of reusable spray bottles for cleaning products.

The laundry area was reviewed on the 09/12/20 and a plan has been developed to store all the clean linen in a separate area where it is not exposed to used linen. Additional shelving will be required, and this will be in place by 31/03/21.

The management and storage of sharps containers was addressed on the day of inspection and the PIC will ensure that this process continues. All clinical and non-clinical waste bins are labeled according and will continued to be monitored by the PIC. The management of the external storage containers of healthcare waste was addressed on the day of the inspection. The clinical waste company delivered 3 additional bins to bring the total to five and pick up was increase to weekly for the duration of the outbreak.

The management of reprocessing spoons for dispensing of medications was reviewed and all spoons are now plastic single use spoons.

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<tr>
<th>Regulation 6: Health care</th>
<th>Substantially Compliant</th>
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Outline how you are going to come into compliance with Regulation 6: Health care:
The registered provider has, having regard to the care plan prepared under Regulation 5, provided appropriate medical and healthcare, including a high standard of evidence-based nursing care in accordance with professional guidelines issued by An Bord Altranais. All residents have available to them a medical practitioner or have the choice to keep their own if they so wish. The GP visits every Monday and Thursday and is always available to take calls and call to the Home outside of these days if needed. The Home has access to specialist allied healthcare professionals to meet the resident needs if needed. The Home has access to full MDT, Dietitian and speech and language, Physiotherapist and Occupational therapist. Community Palliative care visit if required as can psychiatry of old age. Following the inspection, the DON will ensure that all follow up assessments required by the residents are completed as to inform the care plan.
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).

<table>
<thead>
<tr>
<th>Regulation</th>
<th>Regulatory requirement</th>
<th>Judgment</th>
<th>Risk rating</th>
<th>Date to be complied with</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 15(1)</td>
<td>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.</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>10/11/2020</td>
</tr>
<tr>
<td>Regulation 16(1)(a)</td>
<td>The person in charge shall ensure that staff have access to appropriate training.</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>30/11/2020</td>
</tr>
<tr>
<td>Regulation 17(1)</td>
<td>The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>31/03/2021</td>
</tr>
<tr>
<td>Regulation 23(a)</td>
<td>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.</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>08/12/2020</td>
</tr>
<tr>
<td>Regulation 23(c)</td>
<td>The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>30/11/2020</td>
</tr>
<tr>
<td>Regulation 26(1)(a)</td>
<td>The registered provider shall ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>30/11/2020</td>
</tr>
<tr>
<td>Regulation 27</td>
<td>The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>31/03/2021</td>
</tr>
<tr>
<td>Regulation 03(1)</td>
<td>The registered provider shall prepare in writing a statement of purpose relating to the designated centre concerned and containing the information set out in Schedule 1.</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>08/12/2020</td>
</tr>
<tr>
<td>Regulation 04(3)</td>
<td>The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>25/11/2020</td>
</tr>
<tr>
<td>Regulation 6(1)</td>
<td>The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>30/11/2020</td>
</tr>
</tbody>
</table>
Cnáimhseachais from time to time, for a resident.