Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Abbeylands Nursing Home
Name of provider:	Abbeylands Nursing Home & Alzheimer Unit Limited
Address of centre:	Carhoo, Kildorrery, Cork
Type of inspection:	Unannounced
Date of inspection:	03 August 2022
Centre ID:	OSV-0000187
Fieldwork ID:	MON-0037534

About the designated centre

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

Abbeylands Nursing Home is a purpose-built, single storey residential centre with accommodation for 50 residents. The centre is located in a rural area of Co. Cork, close to the village of Kildorrery, on large, well maintained grounds with ample parking facilities. The centre is divided into three suites, Funchion suite accommodates 13 residents, Blackwater suite accommodates 24 residents and the designated dementia unit, Lee suite accommodates 13 residents. Bedroom accommodation comprises 16 single bedrooms and 17 twin bedrooms, all except one of which are en suite with toilet, shower and was hand basin. The centre provides respite, convalescent, palliative and extended care for both male and female residents over the age of 18 but predominantly over the age of 65. Medical care is provided by the residents own general practitioner (GP) or the resident may choose to use the services of one of the other GPs that attend the centre.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	44

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 3 August 2022	08:45hrs to 16:00hrs	Kathryn Hanly	Lead

What residents told us and what inspectors observed

The inspector spoke with four residents living in the centre. All were very complimentary in their feedback and expressed satisfaction about the standard of care provided. Residents spoken with were also happy with the standard of environmental hygiene. Staff were seen to be responsive and attentive without any delays with attending to residents' requests and needs. The inspector saw that staff were respectful and courteous towards residents.

The inspector was informed that the main entrance had remained locked since the onset of the pandemic. There was no bell or signage to direct visitors. Scheduled visitors entered via the chapel where visits were facilitated.

The centre was purpose built and it provided suitable accommodation for residents. Overall the general environment and residents' bedrooms, communal areas and toilets, bathrooms inspected appeared visibly clean. There was a sufficient number of toilets, and of wash-basins, and baths and showers available for resident use.

However the décor in resident's rooms and en-suite bathrooms and corridors was showing signs of wear and tear. Floors in two bedrooms were carpeted. Carpets are difficult to clean during outbreaks when vacuuming should not be done.

The laundry facility had been reconfigured to support the separation of clean and dirty activities. A hand wash sink had been installed for staff use.

Alcohol hand gel dispensers were readily available along corridors for staff use. However barriers to effective hand hygiene practice were observed during the course of this inspection. For example, there were only two hand wash sinks (in the sluice room and treatment room) dedicated for staff use. These sinks did not comply with the recommended specifications for clinical hand wash basins. Findings in this regard are presented under regulation 27.

Ample supplies of personal protective equipment (PPE) were available. Staff continued to wear respirator masks when providing care to residents. These masks provided a higher degree of protection than surgical masks. However a small number of staff were observed to be wearing gloves and aprons in communal areas when there was no indication for their use.

The inspector observed that urinals and commodes were not emptied and decontaminated immediately after use. For example, a used commode remained (unemptied) in a resident's room over the course of the inspection.

Excessive infection prevention and control signage was on display in some areas of the centre. For example social distancing floor stickers were still in place in day rooms and COVID PPE signage was displayed along corridors and on some doors.

The next two sections of the report present the findings of this inspection in relation to the governance and management of infection prevention and control in the centre, and how these arrangements impacted the quality and safety of the service being delivered.

Capacity and capability

The inspector found that the provider did not comply with Regulation 27 and the National Standards for infection prevention and control in community services (2018). Weaknesses were identified in infection prevention and control monitoring and oversight, assessment and care planning in addition to environment and equipment management. Details of issues identified are set out under Regulation 27.

The centre was owned and operated by Abbeylands Nursing Home and Alzheimer Unit Limited who is the registered provider. The company had a board of directors, one of whom was the person representing the provider and was actively involved in the operational management of the centre. The person in charge was an experienced nurse and was supported in her role by an assistant general manager, a clinical nurse manager, nursing staff, healthcare assistants, administrator, catering and household staff.

The inspector found that that there were clear lines of accountability and responsibility in relation to governance and management for the prevention and control of healthcare-associated infection. The provider had nominated the director of nursing to the role of infection prevention and control lead and link practitioner.

Antimicrobial consumption was monitored. However surveillance of multi-drug resistant organisms (MDRO's) was not undertaken. As a result effective antimicrobial stewardship measures were not in place for residents colonised with MDRO's. Details of issues identified are set out under Regulation 27.

Weekly environmental audits were carried out however audit tools were not comprehensive and results were not tracked and trended to monitor progress. There were no records of actions or improvements that had been implemented as a result of recent audits undertaken. This was a lost opportunity for learning. Details of issues identified are set out under Regulation 27.

The inspector observed there were sufficient numbers of clinical and housekeeping staff to meet the needs of the centre. Two housekeeping staff were rostered on duty each day and all residents rooms were cleaned daily. A new flat mop system had recently been introduced and a new colour coded mop was used within each bedroom. However tissue paper was routinely used to clean other surfaces including, sinks, furniture and frequently touched surfaces. Using tissue routinely as a replacement for durable cleaning cloths used in the mechanical cleaning process

may impact the effectiveness of cleaning.

The centre had a comprehensive infection prevention and control guideline which covered aspects of standard and transmission based precautions. All staff had received education and training in infection prevention and control practice that was appropriate to their specific roles and responsibilities. However further training and oversight was required on standard infection control precautions including cleaning practices and processes, glove use, sharps safety and equipment management. Findings in this regard are presented under regulation 27.

Quality and safety

Overall, the inspector was assured that residents living in the centre enjoyed a good quality of life. Staff spoken with were knowledgeable of the signs and symptoms of COVID-19 and knew how and when to report any concerns regarding a resident. Staff and residents were monitored for signs and symptoms of infection twice a day to facilitate prevention, early detection and control the spread of infection.

Visits were facilitated every day. However some visiting restrictions remained in place. Details of issues identified are set out under Regulation 27.

The centres outbreak management plan was regularly reviewed and defined the arrangements to be instigated in the event of an outbreak of COVID-19 infection. An outbreak of COVID-19 was declared in the centre in January 2021, during the third national surge of COVID-19 in Ireland. This was only significant outbreak of COVID-19 experienced by the centre to date. The early identification and management of the 2022 outbreak had limited the spread of infection to 13 residents and two staff members. All residents that had tested positive had since fully recovered.

The national transfer document was available for use within the centre. This document contained details of health-care associated infections to support sharing of and access to information within and between services. However this document was not consistently used. Other versions of transfer documentation in use did not include comprehensive healthcare associated infection and colonisation information. This meant that appropriate precautions may not have been in place when the residents were admitted to the acute hospital setting.

Regulation 27: Infection control

The registered provider had not ensured effective governance arrangements were in place to ensure the sustainable delivery of safe and effective infection prevention and control and antimicrobial stewardship. For example;

- Disparities between the consistently high levels of compliance achieved in local infection control audits and the observations on the day of the inspection indicated that there were insufficient assurance mechanisms in place to ensure compliance with the National Standards for infection prevention and control in community services.
- Surveillance of MDRO colonisation was not routinely undertaken and recorded as recommended in the National Standards. There was some ambiguity among staff and management regarding which residents were colonised with MDROs.
- A small number of residents had been identified as being colonised with various MDROs while in hospital. This information was not documented in their assessments or care plans on return/ admission to the centre. This meant that appropriate precautions may not have been in place when caring for these residents.
- The overall antimicrobial stewardship programme needed to be further developed, strengthened and supported in order to progress. For example there were no antimicrobial stewardship audits, guidelines or training records available. There was no evidence that culture and susceptibility results (lab reports) were used to guide treatment options for residents colonised with MDROs.
- Some visiting restrictions remained in place. Visits continued to be scheduled in advance with the facility. The inspector was informed that visits were limited to one hour and a maximum of two visitors at once. Plans were not in place to progress toward full normal access. Visiting risk assessments viewed did not to align with the latest public health guidelines.

The environment was not managed in a way that minimised the risk of transmitting a healthcare-associated infection. This was evidenced by;

- Some surfaces and flooring was worn and poorly maintained within a small number of rooms and as such did not facilitate effective cleaning.
- The procedure for environmental cleaning and decontamination was not in line with best practice guidance. Durable cleaning cloths were not used for routine environmental hygiene. This may impact the effectiveness of cleaning.
- There were a limited number of clinical hand was sinks available for staff use. Sinks within residents rooms were dual purpose used by both residents and staff. Inspectors were informed that used wash-water was emptied down residents sinks. This practice increased the risk of cross infection.
- Sinks in resident's ensuite bathrooms were not kept clear of extraneous items including toothbrushes, washbasins and personal hygiene products. This increased the risk of cross contamination.
- The sluice room did not support effective infection prevention and control. For example, there was no racking for storage bedpans and urinals. Inappropriate storage of equipment including a rollator, an armchair, a bed table and pressure relieving cushions was observed within the sluice room.
- Clinical waste was disposed of within the treatment room. This increased the risk of cross infection. Clinical waste bins were not enclosed. There was no

clinical waste bin available in the sluice room.

Equipment was not not consistently decontaminated and maintained to minimise the risk of transmitting a healthcare-associated infection. For example;

- Bottles of alcohol gel were topped up and refilled. One alcohol gel dispenser had been refilled with soap. Soap dispensers within residents rooms were also being refilled and topped up. Topping up dispensers increased the risk of contamination. Several soap dispensers were empty on the day of the inspection.
- Safety engineered needles were not available. The inspector observed that two needles in a sharps bin had been recapped before disposal. This practice increased the risk of a needle stick injury.
- Some items of equipment including a commode, standing hoist, three wheelchairs and a raised toilet seat were visibly unclean. Ineffective decontamination increased the risk of cross infection.
- The covers of three sofas in communal areas were worn or torn which meant that they could not be effectively be decontaminated.
- Clean and used linen was transported on the same trolley. This increased the risk of cross contamination.
- Shower seats in resident's bathrooms were rusted and could not be effectively cleaned.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Quality and safety	
Regulation 27: Infection control	Not compliant

Compliance Plan for Abbeylands Nursing Home OSV-0000187

Inspection ID: MON-0037534

Date of inspection: 03/08/2022

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 27: Infection control	Not Compliant

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

We have directed and assisted our staff in online training through the HSeLanD Land e-learning tool on MDRO colonization, this combined with the training our staff have undergone to date on Infection Prevention and Control will enhance our knowledge and ensure compliance with the National Standards for Infection Prevention and Control. We expect all our staff to complete the aforementioned training before the end of September 2022.

MDRO colonized residents returning from Hospital will have line listing recorded and the individual care plan in such cases will be updated to reflect the status, this is now in place and ongoing.

We have a new audit tool in progress and we will roll this out to our team by September end, this will address the deficit in our antimicrobial stewardship programme.

We have procured and are now using safety engineered needles, we have ordered clinical waste bins with a covers as directed and are now using new lined trollies with capacity for separates within each of the three colour coded compartments therein, we have six of these now in operation.

Your observation of single use tissue for cleaning has been noted and we are now using colour ceded cleaning cloths.

We have now opened up the visiting protocols to make it a freer environment, we have written to all families letting them know that access their next of kin is now not restricted to set times or visiting hours, access is via the front entrance and visits can be held in the Residents room if preferred.

Furthermore, we have removed some of the social distancing signage throughout the Home to bring some normality back to our residents as much as possible.

We have identified 4 new locations within the home for staff clinical handwash sinks to be installed, these sinks will conform to HBN 00-10-Part C as required.

We are replacing our refillable hand sanitizing gel dispensers with gel packs and dispensers which will improve our infection control protocols as per the recommendation of your report.

We are in the process of a further painting programme which will take in a further six bedrooms for redecoration, we have ordered new flooring to the two rooms which still have carpeting and have sourced and will shortly repair the defective flooring section to the Lee Suite lounge area.

We are replacing any defective shower seats which we will install as soon as we take delivery of same.

We will put back the racking to the sluice room previously removed under the advice of the Infection Prevention Team at the time of our Covid 19 outbreak.

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 procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Not Compliant	Orange	30/09/2022