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

Issued by the Chief Inspector

Name of designated centre:	Middletown House Nursing Home
Name of provider:	Joriding Limited
Address of centre:	Ardamine, Gorey, Wexford
Type of inspection:	Unannounced
Date of inspection:	15 June 2022
Centre ID:	OSV-0000251
Fieldwork ID:	MON-0036381

About the designated centre

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

This centre was opened in 1984 and has undergone a series of major extension and improvement works since then. The premises consist of two floors with passenger lifts provided. It is located in a rural setting in north county Wexford close to Courtown. The centre is near to a range of local amenities including Courtown community and leisure centre, with a large swimming pool and a gym offering keep-fit and aerobics for the over-65s. Resident accommodation consists of 31 single bedrooms with en-suite facilities, ten twin bedrooms with en-suite facilities, a sitting room, an oratory, three lounges, a sunroom, a reception lobby and a visitors' tea room. The centre is registered to accommodate 51 residents and provides care and support for both female and male adult residents aged over 18 years. The centre provides for a wide range of care needs including general care, respite care and convalescent care. The centre caters for residents of all dependencies, low, medium high and maximum and provides 24 hour nursing care. The centre currently employs approximately 65 staff and there is 24-hour care and support provided by registered nursing and health care staff with the support of housekeeping, catering, and maintenance staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	51

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 15 June 2022	09:40hrs to 19:30hrs	Bairbre Moynihan	Lead
Wednesday 15 June 2022	09:40hrs to 19:30hrs	Catherine Furey	Support

What residents told us and what inspectors observed

Inspectors arrived to the centre in the morning to conduct an unannounced inspection to monitor ongoing compliance with the regulations and national standards. From the inspector's observations and from speaking to residents, it was clear that the residents received a good standard of care. However, recent changes to the governance structure, and a number of staff vacancies, meant that the management and staff were challenged to maintain a satisfactory service. Overall, residents expressed that they were generally very happy living in the centre.

On arrival, inspectors were met by the person in charge and a temperature check was performed prior to accessing the centre and touring the premises. The centre is registered to accommodate 51 residents and was at full capacity on the day of inspection. Inspectors chatted with a number of residents and spoke in more detail with six residents to gain their feedback on their lives in Middletown House nursing home. The centre is laid out over two floors, accessible by lifts and stairs. The centre was generally clean throughout and there were two cleaning staff on duty, which was appropriate given the size of the centre. Residents rooms were personalised with photographs and the majority of rooms had a door leading out to either the garden, a balcony area or the grounds. Not all beds had a curtain encirciling them, which impacted on the privacy and dignity of residents.There was a range of comfortable and varied seating and relaxation areas in the centre, including a bright sunroom, and a number of tastefully decorated and furnished sitting rooms. There was a small relaxation room upstairs, which was used for small groups, however most of the residents on the first floor preferred to go to the living areas downstairs, with access to the dining room and external gardens. The main garden area was nicely laid out with tables and chairs. Shade was provided from the direct sun and it was a beautiful and relaxing area to sit and enjoy the fresh air. It was a sunny day, and many residents were seen sitting outside at various times during the day. Visitors were observed to be enjoying this area with their loved ones.

The centre had one full-time activities co-ordinator with an additional activities co-ordinator during the summer months. Inspectors were informed that activities were not always available on Fridays and no activities co-ordinator was rostered on a Sunday. Resident meeting minutes reviewed and observations on the day confirmed that activities staff had been assigned another role of ensuring that symptom checks for COVID-19 were completed on arrival to the centre. This removed the activities co-ordinators from their role of spending valuable time with the residents. Residents were observed to be watching mass in the morning and the rosary was held in the evening time which the majority of residents participated in. Inspectors were informed that sonas was taking place on the day of inspection. The activities schedule required review to ensure that activities offered were available to residents in accordance with their interests and capabilities. A resident told an inspector that the bingo and other activities were not of interest. Another resident informed inspectors that they were bored sometimes.

Residents were observed to be well-dressed with individual styles evident. While a hairdressing salon was available for residents, the salon was cluttered with inappropriate storage of wheelchairs, a hoist and hoist batteries with trailing leads. This posed an infection control risk but in addition it did not ensure that the resident had a relaxing hairdressing experience.

An inspector observed the dining experience. This was observed to be a very positive and social occasion with the majority of residents attending the dining room. All staff were assisting at lunchtime to serve a restaurant style service. There was a good choice of food on the menu, all tables were pre-set and there was soft music playing in the background. However, the medications were being administered during the lunch which took away from the ambiance of the dining experience. Management were in attendance during the lunch and a resident informed an inspector that management attended the dining room at lunchtime every day.

Visitors were observed to be attending the centre throughout the day. Symptom checks for COVID-19 were completed on arrival at the centre. Inspectors were informed that there was open visiting Monday to Saturday but visiting was by appointment on Sundays to manage footfall through the centre. A small number of visitors were observed to be wearing a gown and respirator mask during the inspection. This will be further discussed under Regulation 11: Visits.

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

Capacity and capability

This was a risk based unannounced inspection to monitor compliance with the regulations and national standards. Additionally, inspectors assessed the overall governance of the centre and establish if the actions outlined in the centre's compliance plan following the inspection in June 2021 had been implemented. Overall, inspectors found that improvements were required in the governance and management of the centre, particularly in relation to oversight of the quality and safety of care delivered to residents.

Middletown House Nursing Home is a privately owned nursing home. The registered provider was Joriding Limited. The centre was acquired by a new provider in early 2022 who owns and runs a number of centres throughout the country. Reporting relationships were outlined to inspectors. The person in charge reported to the regional director who in turn reported to the chief executive officer. A newly appointed assistant director of nursing was employed to support the person in charge for 12 hours per week. However, the person in charge had been alone in a

managerial capacity since the resignation of two clinical nurse managers in January 2022 with no plan at present to replace them. The centre were recruiting for registered nurses and healthcare assistants at the time of inspection. In addition inspectors were informed that five new members of staff had commenced the week of the inspection. In the interim of the recruitment of new staff the provider was very reliant on current staff covering the shifts or agency staff. This will be further discussed under Regulation 15; Staffing.

Inspectors found that while some of the previous issues identified in the inspection in June 2021 were addressed, for example; the medication management policy was updated in line with the most up-to-date guidance, a number of issues outlined in the compliance plan had yet to be addressed. In addition, inspectors identified that significant improvements were required around the governance and management in order to sustain a safe, effective and quality service for residents for example; risks identified on inspection were not risk assessed and or recorded on the centre's risk register. These will be further discussed further under Regulation 23: Governance and Management.

Staff had access to a range of mandatory online courses including fire safety, managing behaviours that challenge, manual handling, restraint, infection prevention and control, responsive behaviours and medication management. Fire training had been cancelled due to a COVID-19 outbreak and a date was planned for the end of June 2022 with 35 staff booked on the training. A number of staff had undertaken fire safety training in March 2022 and the previous training was in February 2021. Significant gaps were identified in medication management training and a small number of staff had to complete safeguarding which is a required under the regulations.

Incidents were reported, however follow-up on incidents was not evident. Tracking, trending and analysing of incidents was not carried out and there no evidence of any learning. Incidents had been notified to the Chief Inspector as required by the regulations. In addition policies and procedures required review to ensure they were up-to-date with the most recent evidenced based guidance.

There was evidence that the centre had a good system in place for the management of complaints. An up-to-date complaints policy was available had there was a record of both written and verbal complaints.

Regulation 15: Staffing

Further oversight of the staffing resources and requirements of the centre was required to ensure staffing resources were sufficient to deliver person-centred, effective and safe care to all residents. On the day of inspection there was vacant posts, for example, three staff nurses and three carers. Inspectors were informed that the provider was currently recruiting for additional nursing staff and carers. In the interim staffing gaps were covered by staff doing extra shifts and agency staff. As a result staff were required to work extra shifts to cover vacancies. For example,

over a two week period one registered nurse worked approximately 101 hours and a second registered nurse worked 97 hours. This is not sustainable.

The registered provider needs to ensure that the registered nurse staffing levels at night are sufficient to meet the assessed needs of all residents and undertake a risk assessment of same. For example; one registered nurse on duty from 2200hrs - 0700hrs was responsible for the care of 51 residents, who were assessed as following:

- Nine residents were assessed as maximum dependency
- 12 residents were assessed as high dependency
- 24 residents assessed as medium dependency
- six residents assessed as low dependency.

In addition,

- Meeting minutes reviewed identified that staff were being refused annual leave due to staff shortages.
- The centre's staffing was not in line with the statement of purpose, for example; inspectors were informed that seven registered nurses were currently employed but nine whole time equivalents (WTE) nursing staff were on the statement of purpose. In addition, the statement of purpose indicated there were two clinical nurse managers but none were were employed at the time of inspection.
- An assistant director of nursing post was rostered for 12 supernumerary hours and the remainder as nursing hours. Inspectors were informed that this was a temporary measure. This will be further discussed under Regulation 23: Governance and management.
- Activities co-ordinators were not always rostered on a Friday and no activities co-ordinator was rostered on a Sunday.

Judgment: Not compliant

Regulation 16: Training and staff development

Inspectors reviewed the staff training records. A number of gaps in staff training were identified. For example;

- A small number of staff members who commenced in October 2021 had not yet completed fire safety, infection prevention and control training, responsive behaviours and medication management.
- 12 staff had not completed training on responsive behaviours.
- Fire safety training was overdue for a number of staff, however, the provider had training planned.
- Only two staff had undertaken medication management training.

Judgment: Substantially compliant

Regulation 23: Governance and management

Monitoring systems in place were not robust enough to identify the issues that were identified by inspectors on inspection. Examples include;

- Risks identified on the day of inspection, were not risk assessed and or documented on the centre's risk register, for example, the inspectors identified that the smoking area was located on the corridor adjacent to a cleaners storeroom containing chemicals and a lift and was a thoroughfare to the garden.
- Systems of communication were not robust. While meeting minutes with staff outlined issues, no time-bound action plan was devised to address actions.
- While incidents were reported in the centre with the majority being falls related, it was not clear from incidents reported the outcome following the incident. For example; falls reviewed did not indicate if the resident was reviewed following the fall and the outcome for the resident. In addition, tracking and trending of incidents was not taking place. This is a missed opportunity to share learning from incidents and implement quality improvement plans to address any findings from the tracking and trending.
- The annual review of the quality and safety of care, while completed for 2021, was not sufficiently comprehensive, and did not adequately incorporate an assessment of quality and safety of care against relevant standards.
- An audit completed by the provider in quarter one 2022, against the National Standards for Residential Care settings 2016, identified that there were no issues or areas for improvement. However, this was not the finding on the day of inspection as:
  - the privacy and dignity of each resident was not respected in that a small number of curtains did not fully encircle residents' beds. This was also a finding in a previous HIQA inspection June 2021.
- The audit provided to inspectors was not comprehensive enough to identify issues observed on the day of inspection.
- The governance structure was not in line with the statement of purpose for example; there were two vacant clinical nurse manager posts on the day of inspection.

In addition, not all of the changes outlined in the previous compliance plan had been sustained or implemented particularly around governance and oversight at the centre. For example; the compliance plan received from the provider in 2021 stated that:

- The clinical nurse manager would be allocated 36hrs per week to assist the director of nursing with management duties. This was not the finding on inspection. The assistant director of nursing was allocated 12 hours. While inspectors were informed on this inspection that this was a temporary measure, it was not clear when these hours would be increased.

- Audits outlined in the compliance plan in 2021 requested by inspectors were not available for example a monthly audit on commodes and mattresses.
- Gaps remained in staff training.
- The sample of resident's contracts of care reviewed did not specify the charges for services offered.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

Four contracts were reviewed for the provision of services. In line with the finding from the inspection in June 2021, the contracts did not outline the fees for services provided. Inspectors were informed that new contracts contained the fees but these were not provided to inspectors.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Incidents were notified to the Chief Inspector in line with the requirement under the regulations and within the time period.

Judgment: Compliant

Regulation 34: Complaints procedure

The complaints log was reviewed by an inspector. There was evidence that both written and verbal complaints were recorded, investigated and the outcome of the complaint was clear. The complaints procedure was displayed in the centre.

Judgment: Compliant

Regulation 4: Written policies and procedures

Schedule 5 policies were reviewed. Not all policies were available to inspectors. In addition, the date of the most recent review was handwritten. Furthermore, inspectors identified that not all policies were in line with up-to-date guidance. For

example; "Meeting the Hydration needs of the residents" did not contain the most up-to-date guidance.

Judgment: Substantially compliant

Quality and safety

Overall, while the centre was working to sustain a good level of person-centred care provision, deficits in the governance and management of the centre were impacting on key areas such as risk management, infection control, care planning, management of behaviours that challenge and residents' rights. Improved oversight of these areas is required to ensure a consistent safe service which supports best outcomes for residents.

Inspectors found that the healthcare needs of the residents were met through good access to medical and other healthcare services if required. The centre was generally well maintained with brightly lit corridors and assistive handrails throughout. Inspectors found that the premises were in line with the requirements under Schedule 6 of the regulations. In addition, inspectors identified good processes around medication management and fire safety with up-to-date records and Personal Emergency Evacuation Plans (PEEP's) in place.

Resident activities required review to ensure that residents were consistently facilitated with opportunities for activities according to their preferences. In addition, while residents were consulted on occasion through residents' meetings, these meetings required strengthening to ensure the voice of all residents were included. This will be further discussed under Regulation 9: Residents' Rights.

Overall, the centre was clean on the day of inspection, however, areas for improvement were identified in relation to infection control to ensure the centre was compliant with the *National Standards for infection prevention and control in community services* (2018) including sharps management and sluice rooms. These will be further discussed under Regulation 27: Infection Control.

Visitors were observed throughout the day on inspection with a high but safe level of visitor activity but inspectors observed that visiting was not in line with Health Protection Surveillance Centre's (HPSC) guidance or the centre's own visiting policy.

Individual care plans and assessments were carried out prior to residents being admitted to the centre, these were found to be generally very detailed, but the paper-based system was difficult to navigate, with some care plans being lengthy and replicated, making it difficult to easily identify the plan and goal of care. The person in charge outlined that the centre were moving towards a more streamlined electronic care planning system in the coming months.

Regulation 11: Visits

Visitors who had recently been abroad were required to wear gown and respirator masks when visiting the centre. This is not in line with current guidance. In addition, it is not in line with the centre's own visiting policy. This practice was overly restrictive and any decisions to place a restriction on visiting should be underpinned by an up-to-date risk assessment.

Judgment: Substantially compliant

Regulation 17: Premises

The overall premises met the requirements of Schedule 6 of the regulations.

Judgment: Compliant

Regulation 26: Risk management

The centre had an up-to-date risk management policy in place. However, the policy only covered four of the five specified risks outlined in the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Judgment: Substantially compliant

Regulation 27: Infection control

The registered provider did not ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority were implemented by staff, as follows:

- A sluice room had no suitable racking for the storage of cleaned equipment. This was seen to be inappropriately stored on top of the bedpan washer. Additionally, the internal surround of the door to the sluice room had exposed wood which had not been painted or sealed and therefore could not be effectively cleaned.
- A second sluice room contained an array of items stored within, including vases, buckets and commodes which were clean and should not be stored in a sluice of "dirty utility" room.
- Inappropriate storage of wheelchairs, hoists and hoist batteries with trailing

leads were observed in the hairdressing salon. In addition, towels used for residents' hair were openly stored in the room beside a coat stand containing a coat. Meeting minutes identified that this was highlighted at a health and safety meeting in January 2022 and as such had not been actioned.

- Linen store rooms contained a mixture of linen, personal care items, personal protective equipment (PPE) and resident assistive equipment, with no system for ensuring items were cleaned before storage.
- Sharps bins were not stored in line with best practice guidance, and the temporary closure mechanism was not engaged on any of the sharps bins seen by inspectors.
- Open, but unused portions of wound dressings were stored together, and not dedicated for individual resident use. Re-use of open wound dressing is not recommended due to risk of contamination.
- There was a limited number of clinical handwash sinks in the centre, including no hand wash sink in either of the domestic store rooms or the nurses' treatment room. The handwash sinks that were present, did not comply with current recommended specifications.
- The domestic store rooms did not contain a janitorial sink for disposal of used mop water, instead, water was disposed of down a drain outside.
- There were some examples of worn, scuffed and peeling surfaces including handrails, bed tables and walls, which hindered effective decontamination and cleaning.
- Unlabelled bottles of cleaning products were observed unsupervised on a corridor.

Judgment: Not compliant

Regulation 28: Fire precautions

Up-to-date service records were in place for the maintenance of the fire equipment detection, fire alarm system and emergency lighting. Residents all had PEEP's in place and these were updated regularly. This identified the different evacuation methods applicable to individual residents for day and night evacuations. Regular fire drills were undertaken, however the most recent drill was not timed and did not describe the full evacuation scenario in the methods of evacuation. A full compartment evacuation was conducted and submitted to inspectors following the inspection which provided assurances regarding suitable evacuation times.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

Overall medication management procedures in the centre were good. Medications

which were dispensed from the pharmacy were appropriately stored in the centre. Medications that required administrating in an altered format such as crushing were all individually prescribed by the GP and maximum doses were prescribed for as required (PRN) medications. Out of date medicines and medicines which were no longer is use were returned to pharmacy. Controlled drugs were carefully managed in accordance with professional guidance for nurses. All staff signed when medicines had been administered and medicines which had been discontinued were signed as such by the GP.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Inspectors reviewed a sample of residents' individual assessments and care plans and found that not all had been updated at a minimum of four monthly, as required by the regulations. For example, one high-risk resident with multiple presenting issues had no clinical assessments carried out over a six-month period.

Judgment: Substantially compliant

Regulation 6: Health care

Residents were provided with good access to a high level of medical and nursing care, appropriate to their individually assessed needs. There was a good GP service in the centre, and evidence of regular medical reviews. Appropriate referrals were made to health and social care professionals when additional expertise was required.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

The indication for pro-re-nata (PRN) or "as-required" psychotropic and sedative medications was not documented on the residents' medication chart. There was no procedure in place to ensure that medications were given as a last resort to manage behaviours, as outlined in the national policy on restraint published by the Department of Health. Inspectors saw that alternative de-escalation techniques to manage the behaviour were not documented or trialled.

As outlined under Regulation 16: Training and staff development, not all staff had completed training in the management of behaviours that challenge.

Judgment: Substantially compliant

Regulation 9: Residents' rights

A review of residents' meeting records identified that residents were not consistently consulted about the organisation of the centre. For example, residents' meetings took place infrequently, and there was a very low attendance. There was no mechanism of feedback for residents with a cognitive impairment, such as surveys of residents' representatives.

While residents were observed to be taking part in activities during the day, inspectors found that activities were not sufficiently tailored, varied and person centred to meet the needs of the residents. The activities schedule in the centre required review, as it was scheduled over five days of the week only. The recent residents meeting identified that activities staff were also responsible for assisting with visiting, which took valuable time away from the activities schedule.

Similarly to the previous inspection, the privacy and dignity of residents in twin bedrooms required review. Efforts had been made to amend the privacy curtains in some of these rooms, however the curtain only encircled one of the beds and did not afford the same privacy to both residents.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 11: Visits	Substantially compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management	Substantially compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Middletown House Nursing Home OSV-0000251

Inspection ID: MON-0036381

Date of inspection: 15/06/2022

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 15: Staffing	Not Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
We are in the process of recruiting 2 overseas RGN and 3 HCA at present. Our plan is to continue our recruitment drive to ensure that we will have a contingency level of staff to ensure ample cover for staff annual leave and sick leave as it may arise.

Our DPIC is covering clinical hours at present, however we do anticipate that this level of "floor cover" will reduce once our RGN are fully onboarded.

We regularly assess our staffing needs and compare with the dependency needs of our Residents.

During times of sick leave – we do offer to our own staff the opportunity to take up extra shifts if they wish – this is not enforced. We have regular agency staff in Middletown House which is to benefit both the Residents and staff on duty.

We will adjust our statement of purpose the reflect some recent staff movements.

The minutes of the meeting referred to in the inspection report were unclear. It was brought up at a staff meeting that staff felt that they couldn't take holidays due to "staff shortages". We have in recent months employed additional agency staff to ensure our staff do avail of their due time off. To fully manage a working roster within the home, we have an allowance of staff part time and full time that are able to take holidays at the same time. This is a prudent approach to allow for safe staffing.

We will survey our Residents to ensure that our current activity plan and schedule is appealing and open to all Residents. Once completed, we will adjust our activity hours as wished/ required as specified by our Residents.

Regulation 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
All staff have completed their fire safety training since the inspection. Since the date of inspection all RGN have updated their medication management training on HSELand
We will ensure that are brought up to date with the mandatory topics by the end of September 2022.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
A review of our audit suit and process will take place to ensure that identified changes are put into action. This will be a cyclical process and where further training is required this will be provided.

We will review our risk register to ensure that all areas of the home are identified and assessed correctly and that staff are made aware of this risk assessments and the controls therein.

We will make the necessary changes to the arrangements for the curtains within the double rooms identified and will review all other shared rooms to ensure the curtain arrangements there also comply.

We will adjust our statement of purposed to ensure that it reflects all recent staff movements. We do have 2 senior nurses in position along with a deputy person in charge. The management hours for all of these positions will increase as staffing levels return to normal and as referred to in Reg 15 – our new staff are fully onboarded, circa end of August 2022.

As mentioned with Reg 16: we have a training matrix in place and have planned the rest of year to incorporate both the outstanding topics and staff who have yet to complete their requirements for this year yet.

We have newer contracts of care that specify the various different charges that apply for different services. We communicate with our Residents at the start of each year and inform them of the current charges or any changes/proposed changes to charges that are in place within Middletown House.

We will review all of our topics in our audit schedule to ensure that all aspects of daily care and protocols are covered comprehensively.
We have added as suggested an audit on commodes and mattresses since the inspection.

Regulation 24: Contract for the provision of services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 24: Contract for the provision of services:
As per Reg 23, we do communicate with our Residents at the start of each year and inform them of the current charges that are in place in Middletown House. All of our new contracts of care have these charges specified within them.

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
We will review our current policies and update all which need to be updated to ensure that we are in line with up to date guidance.

Regulation 11: Visits	Substantially Compliant

Outline how you are going to come into compliance with Regulation 11: Visits:
We are continually reviewing both our own visiting policy, the guidance from the HPSC and the prevalence of Covid not only in our community area but overseas also. With these measures in mind, visits and visitors are assessed to determine the level of risk to all of our Residents and staff in Middletown House.
We will ensure that we are following the most up to date advice from the HPSC.

Regulation 26: Risk management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management:
Our risk management policy will be updated to cover all aspects of risk.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
Following the inspection a review of our sluice rooms was carried out. All items that were "clean" have been removed and only items for sluicing will be stored in the sluice rooms.
We have reviewed our hairdressing salon and have planned for press for Residents hair towels, more storage for items for general activities and have planned for a number of designated bays to be put in place so that hoists and wheelchairs can be stored safely without impinging of Residents space.
Linen store rooms have been inspected and all non appropriate items have been removed. We have kept an emergency supply of PPEs in store rooms as a precaution and to avoid staff cross over to different corridors.
All open dressing materials have been removed and all nurses have been informed to label the dressings for individual residents and ensure that they are kept separately from other dressings. There is a sink in treatment room.
Whilst there is no hand wash sink in domestic store room, we do have hand sanitizing stations available throughout the Centre. We have risk assessed this and have clear instructions to staff on where their nearest hand sanitizing station is. Our household staff use a flat mop cleaning system, which means that there is no mop water to be disposed of.
We will ensure that there are no unlabelled cleaning products throughout the home and that all cleaning products are stored securely as per our policy and have clear labels to instruct staff as to the contents and correct usage of each container.

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
All Resident care plans and assessments will be brought up to date and a schedule will

be drawn up to ensure that they are kept up to date as per the guidance. We do anticipate within the next 2-3 months to implement a nursing software system which will streamline this process.

Regulation 7: Managing behaviour that is challenging	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
We will review our medication Kardex to ensure that the indications for any prn medications are clearly documented. Hand in hand with this, we will ensure that each Resident who is prescribed prn psychotropic/sedative medication has a careplan to support this. We will also ensure that an ABC chart is kept for each Resident -which will show what de-escalation techniques were trialed prior to the administration of the prn medication.
As mentioned in Reg 16: we have a training matrix in place and will review same to ensure that all staff complete the relevant training each year.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
Whilst we do hold Resident meetings, we will ensure that any concerns/suggestions etc that are raised at these meeting are addressed and responded to within a set time frame. All minutes and subsequent actions and follow up plans will be documented.

We will survey our Residents to determine the level of activities that they would prefer along with the type of activities. We do recognize the difference in Residents activity level in winter and summer and already adapt our planner to suit.

As mentioned in Reg 23, we will review our curtains in our double rooms to ensure that each Resident is afforded their own privacy and dignity.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 11(2)(a)(i)	The person in charge shall ensure that in so far as is reasonably practicable, visits to a resident are not restricted, unless such a visit would, in the opinion of the person in charge, pose a risk to the resident concerned or to another resident.	Substantially Compliant	Yellow	31/07/2022
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	30/09/2022
Regulation 16(1)(a)	The person in charge shall ensure that staff	Substantially Compliant	Yellow	31/10/2022

	have access to appropriate training.			
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Substantially Compliant	Yellow	30/09/2022
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	30/09/2022
Regulation 23(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.	Substantially Compliant	Yellow	30/09/2022
Regulation 24(2)(b)	The agreement referred to in	Substantially Compliant	Yellow	30/09/2022

	paragraph (1) shall relate to the care and welfare of the resident in the designated centre concerned and include details of the fees, if any, to be charged for such services.			
Regulation 26(1)(c)(i)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control abuse.	Substantially Compliant	Yellow	30/09/2022
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	31/10/2022
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.	Substantially Compliant	Yellow	30/11/2022
Regulation 04(2)	The registered provider shall make the written policies and procedures referred to in	Substantially Compliant	Yellow	30/11/2022

	paragraph (1) available to staff.			
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Substantially Compliant	Yellow	31/10/2022
Regulation 7(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.	Substantially Compliant	Yellow	31/10/2022
Regulation 7(2)	Where a resident behaves in a manner that is challenging or poses a risk to the resident concerned or to other persons, the person in charge shall manage and respond to that behaviour, in so far as possible, in a manner that is not restrictive.	Substantially Compliant	Yellow	31/10/2022
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated	Substantially Compliant	Yellow	31/10/2022

	centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.			
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Substantially Compliant	Yellow	30/09/2022
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Substantially Compliant	Yellow	31/10/2022
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned.	Substantially Compliant	Yellow	30/09/2022