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:	Middletown House Nursing Home
Name of provider:	Joriding Limited
Address of centre:	Ardamine, Gorey, Wexford
Type of inspection:	Unannounced
Date of inspection:	17 January 2023
Centre ID:	OSV-0000251
Fieldwork ID:	MON-0038771

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:	50

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
Tuesday 17 January 2023	09:30hrs to 18:30hrs	Bairbre Moynihan	Lead
Tuesday 17 January 2023	09:30hrs to 18:30hrs	Kathryn Hanly	Support

What residents told us and what inspectors observed

Overall, on the day of inspection inspectors observed staff being kind and caring to residents. Inspectors spoke with ten residents to elicit their experiences of living in Middletown House nursing home. Residents informed inspectors they were happy in the centre and felt safe. Residents were complimentary about the care they received and about the level of environmental hygiene. Residents confirmed they got a choice at mealtimes and this was evident from the menu and a choice at the time they went to bed at and got up at with one resident stating that "they get alot of freedom to do what they want".

Inspectors arrived to the centre in the morning for an unannounced inspection to monitor compliance with the regulations and standards with a focus on infection control. Inspectors were greeted at the entrance by the clinical nurse manager. The person in charge and assistant director of nursing were both on leave on the day but attended the centre during the day to meet with inspectors. Inspectors were guided on a tour of the premises by the activities co-ordinator followed by a introductory meeting with the assistant director of nursing.

Middletown House nursing home provided a homely environment for residents. It was registered to accommodate 51 residents with one vacancy on the day of inspection. The premises was laid out over two floors. The majority of rooms on the ground floor had a door leading out to the driveway or to the enclosed garden. A small number of residents had keys to the doors. The centre contained 31 single en-suite rooms and 10 twin en-suite rooms. It was spacious with surfaces, finishes and furnishings that readily facilitated cleaning. Overall the general environment and residents' bedrooms, communal areas and toilets, bathrooms inspected appeared well decorated, clean and contained residents photographs and personal belongings. A revision of the curtain rails had taken place in twin rooms since the last inspection. The ground floor contained three sitting rooms within the same area and a separate open plan sitting area. Residents could only attend the sitting rooms on alternate days. In addition, the centre contained an enclosed garden which was not in use on the day due to the weather conditions.

Ancillary rooms included a clean utility, laundry and sluice rooms. Work was ongoing to fit out and stock a dedicated clean utility room for the storage and preparation of medications, clean and sterile supplies such as needles, syringes and dressings on each unit. The inspectors were informed that plans were in place to install a clinical hand wash sink within this room. The infrastructure of the onsite laundry supported the functional separation of the clean and dirty phases of the laundering process. This area was well-ventilated, clean and tidy. However some shelving and work surfaces were not intact. This impacts effective cleaning.

Conveniently located alcohol hand gel dispensers were available throughout the centre. However barriers to effective hand hygiene practice were observed during the course of this inspection. For example; single use bottles/ pouches of alcohol

hand gel were not used in dispensers. In addition there was a limited numbers of dedicated clinical hand wash sinks available for staff use.

The registered provider had one wholetime equivalent (WTE) activities co-ordinator. This role covered Monday to Thursday. Inspectors were informed that healthcare assistants carried out activities on Friday and Saturdays with no activities taking place on a Sunday. The activities co-ordinator role included answering the door to visitors, ensuring they completed the COVID-19 risk assessment form and answering the mobile phone. Approximately thirteen residents were observed to be taking part in a sensory stimulation activity. One to one activities were also taking place such as hand massage and nail painting. Inspectors were informed that mass was celebrated onsite on occasion and that the centre had a residents' choir who sang during the mass. Residents informed the inspector about live music that was onsite every two weeks and how much they enjoyed it. Residents were observed to be reading newspapers during the day and chatting to each other in the open plan sitting room. The registered provider had converted a visiting area that was created outside for visitors during the height of the COVID-19 pandemic into a small green house for residents.

The lunchtime experience was observed. Residents attended either the dining room or sitting room for lunch. Residents requiring assistance were provided with it in a discreet manner. Music was quietly playing in the background and the lunchtime experience was observed to be relaxed. A resident expressed to an inspector that they could only attend the dining room on alternate days and on the day of inspection the resident was required to eat in the bedroom. Seven residents were observed eating in their room on the first floor. Staff confirmed this practice. This will be further discussed under Regulation 9: Resident's Rights.

Visitors were observed in the centre in a high but safe number. Visitors confirmed that they could visit at anytime and the checks required before visiting. Inspectors spoke to three visitors. All were complimentary about the centre and the care their relative/friend received.

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 unannounced inspection was carried out to assess the overall governance of the centre and to identify if actions in the compliance plan had been completed from the previous inspection in June 2022 and improvements sustained. Overall, inspectors found while some areas in the compliance plan had progressed such as staffing in the centre, improvements were required in the governance and management of the centre with a number of non-compliances identified including; Regulations 34: Complaints, Regulation 23: Governance and management,

Regulation 6: Healthcare and Regulation 9 Residents' Rights. In addition, inspector's 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 governance, antimicrobial stewardship and environment and equipment management. Details of issues identified are set out under each regulation.

Joriding Limited is the registered provider for Middletown House nursing home. There was a change in the operational management of the centre in early 2022 but Joriding Limited remained the registered provider. The centre is now part of a wider group who own and run a number of centres throughout Ireland. The operations manager attended onsite on the day of the inspection and was present at the close out meeting. Reporting relationships were outlined to inspectors. The person in charge reported to the operations manager who in turn reported to the registered provider representative who was also a company director. The person in charge worked full-time and was supported in the role by an assistant director of nursing, clinicial nurse manager 3, a clinical nurse manager 1, staff nurses, healthcare assistants, housekeeping, catering, activities, laundry and maintenance staff. Inspectors observed there were sufficient numbers of housekeeping staff to meet the needs of the centre. Two housekeeping staff were rostered on duty daily and all areas were cleaned each day. Improvements were identified by inspectors since the last inspection. Management stated that the centre had their full complement of staff and that they were currently recruiting for planned leave. The assistant director of nursing and CNM3 worked 18 hours supernumery each per week. In addition, an additional staff nurse was rostered on nights who replaced a healthcare assistant. However, there was no increase in the WTE in nursing staff to cover this additional staff member on nights and the gap was covered by staff doing extra shifts with some staff nurses doing 96 hours in a fortnight.

Staff had access to mandatory training for example; cardio pulmonary resuscitation, fire safety, safeguarding and infection control. Efforts to integrate infection prevention and control guidelines into practice were underpinned by mandatory infection prevention and control education and training. A review of training records indicated that the majority of staff were up to date with mandatory infection prevention and control training. However inspectors identified, through talking with staff, that further training was required to ensure staff are knowledgeable and competent in the management of residents' colonised with multi drug resistant organisms (MDROs) including Carbapenemase-Producing Enterobacterales (CPE). Furthermore, gaps were identified in training in managing behaviours that challenge. Staff training will be further discussed under Regulation 16: Training and staff development and Regulation 27: Infection control.

Overall responsibility for infection prevention and control and antimicrobial stewardship within the centre rested with the Director of Nursing who was also the designated COVID-19 lead. However, the provider had not nominated a staff member with the required training and protected hours allocated, to the role of infection prevention and control link practitioner to support staff to implement effective infection prevention and control and antimicrobial stewardship practices

within the centre.

The registered provider had a directory of residents in place which met the requirements of the regulation.

The provider had reviewed the system of audit since the inspection. Audits completed included a behavioural audit, infection prevention and control and a quarterly accident audit where incidents were reviewed. Infection prevention and control audits covered a range of topics including use of personal protective equipment (PPE) hand hygiene practices, waste management and sharps safety. High levels of compliance were consistently achieved in recent audits. However, audits were not scored, tracked and trended to monitor progress. Inspectors also found that findings of recent audits did not align with the findings on this inspection.

Incidents were reported and a review of these indicated that majority of incidents reported were falls related and a small number of medication incidents. It was unclear from incidents reviewed the outcome from the incident for example: if the resident required review by a general practitioner or attendance at hospital. Communication systems in the centre were through staff meetings and management meetings. No time bound action plan accompanied the meeting minutes reviewed. Inspectors were informed that the annual review of the quality and safety of care for 2022 was being completed at the time of inspection.

The provider had a number of effective assurance processes in place in relation to the standard of environmental hygiene. These included cleaning specifications and checklists and disposable cloths to reduce the chance of cross infection. However there were no housekeeping rooms available for the storage and preparation of cleaning trolleys and equipment.

The volume of antibiotic use was monitored each month but the overall antimicrobial stewardship programme, to improve the quality of antibiotic use, needed to be further developed, strengthened and supported in order to progress. In addition, surveillance of healthcare associated infection (HCAI) and multi drug resistant bacteria colonisation was recorded. However, the information recorded was inaccurate. Findings in relation to these issues are presented under Regulation 27; Infection control.

A sample of contracts of care were reviewed. The contracts included a list of services that required additional payments for example hairdressing and activities however, in two of the records reviewed the weekly fee had not been updated. In addition, the number of residents in a room was not outlined in the contracts. These will be further discussed under Regulation 24: Contracts for the provision of services.

The person in charge was the nominated person to deal with complaints. A small number of complaints were received since the last inspection. The majority were managed in line with the regulations however, a complaint reviewed had not been fully investigated. This complaint required notification to the Office of the Chief Inspector.

Written policies procedures and guidelines were being reviewed at the time of inspection. Schedule 5 policies were generally in one folder with three policies not available on the day. A number of policies had not been fully updated since 2016. A date was written on the policies that they were reviewed however, the original date of writing the policy was in some instances 2016. This was highlighted on the inspection in June 2022 with a commitment from the provider that policies requiring updating would be completed by November 2022.

Regulation 15: Staffing

The centre had sufficient staffing taking into account the assessed needs of the residents and the size and layout of the designated centre. For example; on the day of inspection the centre had a CNM3, two staff nurses and 8 healthcare assistants, six of whom worked until 2000hrs. Two staff nurses and two healthcare assistants covered the night shift.

Judgment: Compliant

Regulation 16: Training and staff development

Gaps in training and staff development were identified including:

- 15 staff had not completed training in managing behaviours that challenge. This was also a finding on the inspection in June 2022.
- Three staff had not completed fire training within the last year.
- Two staff had not completed safeguarding training within the last three years. Following the inspection, the inspector was advised that face to face training was arranged for 26 January 2023.

Judgment: Substantially compliant

Regulation 19: Directory of residents

The registered provider had established a directory of residents following the registration of the centre. This directory was maintained, available for review and contained all of the information specified in Schedule 3 of the regulations.

Judgment: Compliant

Regulation 23: Governance and management

Improvements were observed in the assurance systems in place, however, further actions were required in order to strengthen the governance and management at the centre. For example:

- A number of areas requiring action identified in the inspection in June 2022 had been addressed but not sustained or had not been addressed to date.
- Enhanced oversight of residents' rights was required by management to ensure that the residents' voice was heard and issues addressed and that all residents had opportunities to take part in activities.
- Improvements were observed in audits completed however, audits were not comprehensive enough to identify the issues. For example: There were disparities between the findings of local infection prevention and control audits and the observations on the day of the inspection which indicated that there were insufficient assurance mechanisms in place to ensure compliance with the National Standards for infection prevention and control in community services.
- The outcome for residents following an incident was not documented. This was also a finding on the inspection in June 2022.
- Only one staff meeting had taken place since the last inspection. An action plan accompanied the minutes but it was not time bound with no person identified for responsibility for the actions. Furthermore, documentation indicated that a weekly key performance management meeting was scheduled, however, the last meeting minutes available were from October 2022 and June 2022 with no accompanying time bound action plan.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

A sample of contracts of care were reviewed. Contracts reviewed did not set out the number occupants in a room for example a single or twin room. In addition, of the four files reviewed two of the residents were initially admitted on transitional funding but were now long term residents. These contracts had not been reviewed to set out the weekly fee payable by residents.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

All incidents reviewed were notified to the Office of the Chief Inspector in line with

regulatory requirements. However, a complaint reviewed by an inspector met the criteria for notification to the office of the chief inspector. This will be discussed under Regulation 34: Complaints.

Judgment: Compliant

Regulation 34: Complaints procedure

An inspector reviewed the complaints log. The registered provider had received a small number of complaints since the last inspection. A complaint reviewed was not investigated by management. This complaint met the criteria for notification to the Office of the Chief Inspector.

Judgment: Not compliant

Regulation 4: Written policies and procedures

Schedule 5 policies were reviewed. While improvements were observed, three out of the 20 policies were not available for review by inspectors on the day and were not accessible to staff. Furthermore, similar to finding in the last inspection, a number of policies contained a hand written date that the policy was reviewed. A number of policies had been devised in approximately 2016. The policy on "meeting the nutrition and hydration needs of residents" did not contain the most up to date guidance and remained unchanged since the last inspection, however, management stated that it was in the process of being reviewed. The most up-to-date guidelines were contained in a separate folder.

Judgment: Substantially compliant

Quality and safety

Overall, the inspector found that since the previous inspection, there had been incremental improvements in the quality and safety of care being delivered to residents. Despite these efforts, the quality and safety of resident care on the day of inspection was compromised by non compliances in Regulations 27; Infection control, 6 Healthcare and 9 Residents' Rights.

Improvements were identified in visiting since the last inspection. Visiting restrictions had been removed and public health guidelines on visiting were generally being followed. Residents said they were glad that visiting had resumed.

Resident outings and visits to homes of families and friends were also being facilitated. Visitors were required to book a visiting slot on Sundays to manage footfall in the centre. Risk assessments were undertaken prior to each visit. However the risk assessments required review to ensure they aligned with public health guidelines.

The centres' risk management policy had been reviewed to include the five specified risks outlined in the regulations. However, two versions of the policy were found in folders provided to inspectors.

Inspectors identified some examples of good practice in the prevention and control of infection. 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. Ample supplies of personal protective equipment (PPE) were available. Appropriate use of PPE was observed during the course of the inspection with few exceptions. For example; two staff members were observed on a corridor wearing gloves and aprons. However, inspectors also observed inconsistent application of standard and infection prevention and control precautions. For example; inspectors observed inappropriate disposal of general waste in clinical waste bins throughout the centre. A chlorine disinfectant was used as part of routine cleaning when there was no indication for it's use. The trolley containing stocks of various wound dressing was brought into a resident's bedroom. This could lead to contamination of clean and sterile dressings. Safety engineered needles were not available. The inspectors also saw evidence that needles were recapped after use on residents. This practice increased the risk of needle stick injury.

The centre's outbreak management plan was available in the COVID-19 resource folder. This plan was regularly reviewed and defined the arrangements to be instigated in the event of an outbreak of COVID-19 infection. There were no residents with confirmed or suspected respiratory infections in the centre on the day of the inspection. The centre had managed a small number of outbreaks and isolated cases of COVID-19. While it may be impossible to prevent all outbreaks, a review of notifications submitted to HIQA found that management had contained the outbreaks and limited the spread of infection among residents. A formal review of the management of the December 2022 outbreak of COVID-19 was pending. Excessive COVID-19 signage was on display throughout the centre.

The location of the staff changing room and toilet was not ideal from an infection prevention and control perspective. This room opened directly into an area with open access to the main kitchen. Failure to appropriately segregate functional areas posed a risk of cross contamination.

The centre had good access to a general practitioner (GP). The GP attended onsite when required and was available by phone for any queries or concerns. An out of hours service was used outside working hours. A private company provided dietetic, speech and language therapy and tissue viability advice and support. Physiotherapy and occupational therapy was provided to residents if required for a fee, payable by the resident. However, improvements were required in the management of

resident's incontinence which is detailed under Regulation 6; Healthcare.

The provider was in the process of transferring to an information technology system. The centre's pre admission assessment included a comprehensive healthcare infection and MDRO colonisation assessment. However, this detail was not included in the admission assessment template. Some residents care plans and assessments tools remained on a paper based system. Validated risk assessment tools were completed every four months or more frequently if required. A review of care plans found that they were generally person centred but further work was required to ensure that all resident files contained resident's current health-care associated infection status and history. Furthermore, not all care plans were updated at four monthly intervals in line with regulations. Details of issues identified in care plans and transfer documentation are set out under Regulations 5; Individual assessment and care planning and 27; Infection control.

Improvements were identified in residents with behaviours that challenge. The provider had introduced behavioural charts and these were observed to have been completed in residents who displayed behaviours that challenge. Inspectors were informed that there was a low use of PRN (as required) medications in the centre and resident's records reviewed indicated that these were not administered following recent episodes of behaviours that challenge. Instead alternative de-escalation techniques were utilised.

Residents could generally undertake activities in the privacy of their rooms. A sensory activity was observed to be taking place in the afternoon on the day of inspection. However, only about a quarter of residents took part in this. Other residents were observed in the open plan sitting area watching TV. In addition, a review of residents' records indicated that a room visit to the resident's room was documented as an activity. Residents were consulted about the running of the centre through resident meetings. Only three residents meetings had taken place in the last 18 months. Issues raised at meetings had not been addressed. For example; in May 2022, residents stated that they would like more activities for example arts and crafts. An explanation was given as to why it could not be provided rather than exploring the possibility. This was also raised by a resident on inspection. Some infection-control measures focused on minimizing COVID-19 exposure risk by restricting residents' contact with other residents were not aligned to HPSC guidance and were disproportionate to what is considered necessary to address the actual level of risk. Findings are further discussed under Regulation 09; Residents' Rights.

Regulation 11: Visits

Visitors were observed in the centre during the inspection. However, visitors were required to take a temperature check, complete a risk assessment and carry out an antigen test twice weekly prior to visiting the resident. These overly restrictive practices required review and were and not in line with public health guidance.

Judgment: Substantially compliant

Regulation 26: Risk management

The centre had an up to date risk management policy in place. The policy identified the measures and actions for the five specified risks outlined in the regulations. In addition, the policy also outlined the procedure for managing serious incidents in the centre.

Judgment: Compliant

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;

- The provider had not nominated an infection prevention and control link practitioner to increase awareness of infection prevention and control issues locally whilst also motivating their colleagues to improve infection prevention and control practices.
- There was no evidence of targeted antimicrobial stewardship quality improvement initiatives, training or guidelines.
- Staff and management were unaware of which residents were colonised with Multi-drug resistant organisms (MDROs). This meant that appropriate precautions may not have been in place when caring for these residents.
- Additional education was required to ensure staff are knowledgeable and competent in the management of residents colonised with MDROs including Carbapenemase-Producing Enterobacterales (CPE).
- The most recent Health Protection and Surveillance (HPSC) COVID -19 guidance was available to staff working in the centre. However guidelines on the care of residents colonised with MDRO's including including Carbapenemase-Producing Enterobacterales (CPE) were not available.

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

- In the absence of housekeeping rooms, trolleys were stored in rooms containing clean supplies. The inspector was informed that buckets were prepared within sluice rooms. This practice significantly increases the risk of environmental contamination and cross infection.
- The covers of several mattresses were worn or torn. These items could not effectively be decontaminated between use, which presented an infection

risk.
- Wall-mounted alcohol hand gel dispensers throughout the centre were refilled from a bulk container. This practice posed a risk of cross-contamination.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Areas for action were identified including:

- Care plans were transitioning from written to an electronic system. Care plans viewed by the inspectors were generally personalised, and sufficiently detailed to direct care with some exceptions. For example infection prevention and control care plans were generic and did not effectively guide and direct the care residents colonised with MDROs.
- A sample of care plans reviewed identified that not all care plans were reviewed at four monthly intervals in line with regulations.
- The centres admission assessment did not include a comprehensive healthcare infection and MDRO colonisation assessment.

Judgment: Substantially compliant

Regulation 6: Health care

A number of residents' beds observed contained plastic sheeting with a draw sheet over it. This practice is not evidence based, could potentially increase the risk of a resident acquiring a pressure ulcer and is undignified for the resident.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

Some residents had responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). The centre had improved their approach to managing these behaviours. Behavioural assessments were completed and informed the care of the resident. Comprehensive behavioural support care plans guided staff to provide care. However, gaps were identified in training for staff in managing behaviours that challenge. This was discussed under Regulation 16: Training and

staff development.

The use of bed rails was low and all physical restrictions were risk assessed in line with the national policy on restraint.

Judgment: Compliant

Regulation 9: Residents' rights

Action was required by the registered provider to ensure that residents' rights were respected and their social care needs were met. Areas to be addressed included:

- All new admissions and transfers were routinely required to remain in their bedroom for five days following admission. These residents were tested for COVID-19 infection pre admission and on day five post admission. This practice was contrary to national guidelines which advise that isolation and testing of asymptomatic residents on transfer or admission is generally not required.
- In addition social activity in "pods" continued. Residents were divided into two groups. Each group remained in their bedrooms on alternate days. The burden of prolonged isolation on residents is considerable. There was no evidence that the infection prevention measures that restricted the liberty of residents had been balanced against a robust ethical justification.
- Similar to findings from the inspection in June 2022 activity provision required review to ensure that all residents had opportunities to participate in activities in accordance with their interests and capacities. Furthermore, activities staff continued to assist with visiting and answering the phone which took time away from the residents and the activities schedule.
- There was no evidence that issues raised at residents' meetings were addressed either through the complaints process or any other avenue.
- The provider gave a commitment in the compliance plan from the inspection in June 2022 that a survey would be completed on the level and type of activities that residents would like. This survey was requested on the day and not received.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	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	Not compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 11: Visits	Substantially compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Middletown House Nursing Home OSV-0000251

Inspection ID: MON-0038771

Date of inspection: 17/01/2023

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: We are reviewing the training needs for the staff for 2023 and will ensure that staff receive training in managing behaviour that is challenging. A training plan for the year is updated to ensure all the staff is provided with mandatory trainings. Any gaps identified in mandatory training at the time of the inspection will be closed off by the end of March 2023. Training matrix held on drive & each staff member training to be entered onto epic to enable ease of reporting.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: A schedule will be drawn up for Resident and departmental meetings for the year. The agenda will be set, and time given for those who wish to, to add to the agenda. All meetings will be conducted as per policy, therefore an agenda, minutes, action plan and timeline for actions will be set after each meeting and reviewed again prior to the next or at the stated time. All incidents and accidents will be recorded on our nursing software, and this will enable ease of oversight and auditing of same. The learned outcomes will be discussed with	

staff during daily meetings.

Residents/family satisfaction survey is being sent out and will be completed in 2 weeks.

Audit system will be further reviewed by PIC in consultation with the managers. Annual audit schedule will be strengthened, and results of the audits will be discussed with DPIC and CNMs. An action plan will be developed from the audit results and will be implemented, monitored, and reviewed. IPC audit tool will be reviewed in line with AMS audit tool.

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:
An audit will be done on our contract of care and will update the contracts as required. Checklist will be prepped for each file – will indicate timeline of events with new residents or residents who are changing from one contract to another. All will be scanned to the drive to allow for greater oversight.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
All complaints will be investigated and actioned as per our policy. This will be audited quarterly as per policy to ensure procedure is being followed.
Any complaint that is required to be notified to the chief inspector will be.

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
All Schedule 5 policies to be reviewed and all will be held in one folder at the nurse's

station for ease of use.

Regulation 11: Visits	Substantially Compliant

Outline how you are going to come into compliance with Regulation 11: Visits: We have reviewed our visiting protocols and are fully compliant with the guidance issued from the HPSC.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control: We have appointed an IPC link person in the home to liaise with the IPC lead within the company. Link person has the responsibility to maintain the antimicrobial register, auditing, action plan and review. Training is completed in IPC for the link person. We have updated and all staff, are both aware of the infection status within the home and the whereabouts of the register. We have ensured that we have the relevant guidelines on MDRO available to staff. We will conduct in house training for all staff on MDRO and our staff nurses will complete the hseland training on same with a view to improve our own approach to same. We are reviewing our housekeeping storage areas to identify a single use room. A full mattress audit has been conducted and we have a traffic light system in place for mattresses and other items to be reviewed/replaced in the home. Our wall mounted hand gel dispensers will be replaced entirely within the next few months on an ongoing basis as more stock is available.

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:
As mentioned by the inspectors we are in the process of transitioning from a paper-based system to an electronic system. This will enable oversight and will provide staff with reminders regarding care plans/assessments as they fall due in a 4 monthly interval if not updated already.
We will ensure that our admission assessment does include an assessment on healthcare infection and MDRO colonization.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
All draw sheets have been removed.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
As mentioned previously in this response, we have reviewed the national guidelines and are following this guidance.

We have also reviewed our Residential groupings within the home and can confirm that all Residents are able to move around the home as they wish. We do have to ensure a staggered approach to mealtimes as a result to ensure that all Residents if they wish can access the dining areas, we will review this again in 3 months.

Since the inspection we have completed our administration desk downstairs so our administrators will be assisting with visiting and phones etc. which will free our activity staff to concentrate solely on the Resident activities.

As before, all meetings will have an agenda, minutes, and action plan to follow up on – these will be held on the drive.

The inspectors noted during the inspection that we were in the process of compiling our annual report. The Resident's survey is part of this report so the responses from the survey will be reflected in the report.

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	22/02/2023
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	30/03/2023
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	Not Compliant	Orange	30/04/2023

	monitored.			
Regulation 24(1)	The registered provider shall agree in writing with each resident, on the admission of that resident to the designated centre concerned, the terms, including terms relating to the bedroom to be provided to the resident and the number of other occupants (if any) of that bedroom, on which that resident shall reside in that centre.	Substantially Compliant	Yellow	30/05/2023
Regulation 24(2)(b)	The agreement referred to in 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.	Substantially Compliant	Yellow	30/05/2023
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	30/05/2023

Regulation 34(1)(d)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall investigate all complaints promptly.	Not Compliant	Orange	30/03/2023
Regulation 04(2)	The registered provider shall make the written policies and procedures referred to in paragraph (1) available to staff.	Substantially Compliant	Yellow	30/04/2023
Regulation 04(3)	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.	Substantially Compliant	Yellow	30/04/2023
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who	Substantially Compliant	Yellow	30/03/2023

	intends to be a resident immediately before or on the person's admission to a designated centre.			
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	28/02/2023
Regulation 6(1)	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 Cnáimhseachais from time to time, for a resident.	Substantially Compliant	Yellow	28/02/2023
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to	Substantially Compliant	Yellow	30/03/2023

	participate in activities in accordance with their interests and capacities.			
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Not Compliant	Orange	22/02/2023
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	30/03/2023