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

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| Name of designated centre: | Castleross |
| Name of provider: | Castleross Nursing Home Ltd |
| Address of centre: | Carrickmacross, Monaghan |
| Type of inspection: | Unannounced |
| Date of inspection: | 11 February 2025 |
| Centre ID: | OSV-0000124 |
| Fieldwork ID: | MON-0046265 |

## About the designated centre

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

Castleross nursing home is a purpose-built premises which can accommodate up to 125 residents. The centre has 91 single and 17 twin bedrooms some of which have ensuite bathrooms. Residents are accommodated in four individual houses (Lisdoonan, Broomfield, Creevy and Killanny). In addition, there are two civic centres; the village centre and Kavanagh community centre for communal activities. The philosophy of the designated centre is to preserve the dignity, individuality and privacy of the residents who live in Castleross in a manner that is sensitive to their ever changing needs. To this end management have adopted the 'household model' of care which primarily is based on the principles of home life. Each household is individually staffed and includes a homemaker whose responsibility is to create a homely environment through normal daily kitchen activities and provide a warm welcome to all who pass through.

**The following information outlines some additional data on this centre.**

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| Number of residents on the date of inspection: | 116 |

## 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 11 February 2025 | 08:45hrs to 16:45hrs | Sheila McKevitt | Lead |

## What residents told us and what inspectors observed

The inspector spent time throughout the day speaking with residents, staff and relatives as they went about their daily lives. Residents said they felt safe living in the centre however, some spoken with stated that the standard of care could be improved.

Three residents expressed dissatisfaction with the standard of care. Residents told the inspector that they were not being offered or being provided with a shower as frequently as they used to be. The inspector reviewed a sample of these residents care plans and found that they did not have their hygiene care preferences clearly outlined in their care plan. The daily records reviewed for a sample of residents did not reflect if they had been offered a shower, bath or wash or if they had accepted and been assisted with a shower, bath or wash. In addition, residents in the same unit told the inspector that at times there was no running hot water in their bathroom and that staff had to go to the kitchen to fill a basin with hot water, so they could have a wash in the mornings.

The inspector followed up on this issue with a member of the management and maintenance team and found that a number of residents living in bedrooms on one side of one unit did not have access to running hot water in their ensuites. This resulted in an urgent compliance plan being issued to the provider requiring a five day response time.

Residents said there were enough staff on duty to meet their needs and they said their call-bell was answered by staff in a timely manner. Those residents residing in their bedroom had access to their call-bell. The inspector observed that staff interactions with residents was kind, caring, and patient. Residents with communication needs were facilitated to communicate with additional communication aids.

The inspector observed a number of visitors entering and leaving the centre, and spoke with some of them. The relatives told the inspector there were no restrictions on visiting and they enjoyed taking their loved one to the coffee dock. They also told the inspector that residents were always well presented, and their clothes were well maintained.

Staff did not always have access to appropriate equipment to ensure they could meet the needs of maximum dependent residents. The inspector observed that this group of residents were not being offered a shower or bath due to no shower trolley being available within the centre.

Residents were complimentary of the choice, quantity and quality of food available to them. The inspector observed that the dining room tables were set with cutlery and condiments and staff were available to ensure that residents were supported to

eat and enjoy their meals. Staff were observed to assist residents discreetly and respectfully.

The premises were clean and overall well-maintained and the inspector observed improvements since the last inspection, including the installation of clinical hand wash sinks in clinical rooms and the commencement of refurbishment of two of the four units.

Residents and their relatives expressed satisfaction with the wide variety of scheduled activities which included quizzes, exercise classes and live music which was a firm favourite for many residents.

The governance of the centre will be discussed under the following two sections, capacity and capability of the service and quality and safety of the care and services provided for the residents. The areas identified as requiring improvement are discussed in the report under the relevant regulations.

## Capacity and capability

The level of compliance in this centre had deteriorated since the last regulatory inspection despite the governance and management arrangements in the centre remaining stable. The inspector found that strengthening of the management and oversight of the following areas was required; premises, assessment and care planning and the oversight of all areas of practice that were found to be not fully compliant with the regulations referred to in this report.

This was an unannounced risk inspection carried out to monitor the provider's compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older people) Regulations 2013. The inspector found that some improvements had been made and that all of the compliance plans from the previous regulatory inspection had been addressed.

There was a good open channel of communication between the provider and the person-in-charge. The person-in-charge gathered key performance indicators (KPI) each week and maintained an audit process for overseeing the standard and quality of care being provided. However, the audit process was not effective in ensuring regulatory compliance in some areas of practice, such as, premises and assessment and care planning.

The centre was in general well-resourced and the staffing levels on duty were adequate to ensure the needs of residents were being met in a timely manner within the limitations outlined in the first section of this report. The training needs of staff were being met in a timely however, the supervision of staff was not adequate and this resulted in residents not receiving care in accordance with their wishes.

Records reviewed, such as, the certificate of insurance, contracts of care, the residents guide and staff files were fully compliant with the legislative requirements, however, the directory of residents required review to ensure it contained all the required data.

## Regulation 15: Staffing

There were adequate numbers of staff on duty with appropriate skill-mix to meet the needs of the residents, taking into account the size and layout of the designated centre.

Judgment: Compliant

## Regulation 16: Training and staff development

Staff were not appropriately supervised to ensure they were delivering a high standard of care to residents. For example, the supervision of the delivery of morning care particularly hygiene care require strengthening.

Judgment: Substantially compliant

## Regulation 19: Directory of residents

The directory of residents did not include all the information specified in paragraph 3 of Schedule 3. For example, the address for a number of residents' next-of-kin were not reflected in the directory of residents.

Judgment: Substantially compliant

## Regulation 21: Records

The records requested for review under Schedule 2, 3 and 4 were made available to the inspector. Those reviewed were compliant with the relevant legislative requirements.

Judgment: Compliant

## Regulation 22: Insurance

A contract of insurance was available for review. The certificate included cover against injury to residents and other risks, including damage of residents' property.

Judgment: Compliant

## Regulation 23: Governance and management

The management systems in place were not sufficient to ensure the following areas of practice had appropriate oversight and required strengthening to ensure these areas of practice are brought into compliance with the legislative requirements:

- the auditing process in place for the new directory of residents had failed to identify the gaps observed during this inspection, and as evidenced under Regulation 19: Directory of residents, it did not contain all the required data.
- the processes in place to ensure that the centre was adequately resourced and staff had access to the required equipment for care delivery required review, as the absence of a shower trolley was having a negative impact on residents. This had not been identified by provider's own internal management systems.
- the processes in place to ensure residents had access to running hot water required review as the absence of running hot water was having a negative impact on a number of residents.
- person-centred care was not provided to all residents on the day of inspection; many residents did not receive care as per their preference as further outlined under Regulation 5.

Judgment: Substantially compliant

## Regulation 24: Contract for the provision of services

A sample of contracts of care were reviewed. Each were signed by the resident, their next-of-kin or power of attorney. The weekly fees charged to the resident were clear and any possible additional charges were outlined. The room occupied by the resident and how many other occupants, if any, were reflected in those contracts reviewed.

Judgment: Compliant

## Quality and safety

The inspector was assured that residents felt safe and secure in the centre, however there was evidence that residents were negatively impacted by the non-compliances identified under Regulation 17: Premises and Regulation 5: Individual assessment and care plan outlined in this report.

Comprehensive assessments and corresponding care plans were available for each resident. From a review of records, residents' and relatives' feedback as well as direct observation, the inspector was not assured that all residents' hygiene needs were being met to a high standard. Following conversations with some residents, relatives and staff it was determined that some residents in one unit were not receiving care in accordance to a person-centred care plan. This had a negative impact on these residents, as they were not having their hygiene needs met in accordance to their preference.

A refurbishment programme was in progress in the centre. The inspector saw that work had commenced in two of the four units. This work included the replacement of the kitchen in each unit, the upgrading of furniture in both communal rooms and bedrooms together with the re-painting of the walls, skirting boards and door-frames in the corridors. Notwithstanding these improvements, an urgent compliance request was issued to the provider in respect of ensuring all residents had access to hot running water and satisfactory assurances were received following the inspection.

Fire doors and corridors were free from obstruction, hand rails were available on both sides of the corridors and these facilitated residents to mobilise independently. Staff had access to clinical wash hand sinks some of which had been replaced since the last regulatory inspection to ensure they met the required standard. Staff were observed using these throughout the day of inspection and overall infection control practices were good.

Medication management had improved since the last inspection. A review of medication storage, dispensing, prescribing, administrating, and return of unused medication showed good levels of compliance and that practices in the centre were safe.

There was a clear policy in place in relation to the detection of abuse and safeguarding the residents. All staff had received training in how to identify and report a concern in relation to abuse. Staff who spoke with the inspector were very clear about their responsibility to keep the residents safe and confirmed their knowledge of safeguarding.

## Regulation 10: Communication difficulties

Residents with communication difficulties were supported to communicate freely and staff were aware of their needs. The inspector found that each resident's communication needs were regularly assessed and a person-centred care plan was developed for those residents who needed support with communications.

Judgment: Compliant

## Regulation 17: Premises

Under this regulation the provider was required to submit an urgent compliance plan to address an urgent risk.

- some of the bedrooms on one of the four units did not have access to a supply of hot water at all times.

The provider's response provided assurance that the risk was adequately addressed. within the required timeframe.

In addition, staff did not have access to the equipment required to ensure they could meet the needs of maximum dependent residents, for example:

- staff did not have access to a shower trolley which would enable them to assist maximum dependent residents to have a shower.
- manual handling equipment was inappropriately stored in one communal bathroom; this impeded residents' access to the facilities in this room as well as posing a cross-contamination risk.

Judgment: Not compliant

## Regulation 20: Information for residents

A residents guide was available and included a summary of services available, terms and conditions, the complaints procedure and visiting arrangements.

Judgment: Compliant

## Regulation 27: Infection control

There were processes in place to mitigate the risks associated with the spread of infection and to limit the impact of potential infectious outbreaks on the delivery of care. Clinical wash hand sinks that met the required standards had been installed in the clinical rooms. Clinical wash hand sinks were accessible to staff on corridors and the inspector observed some examples of good hand hygiene practices. Appropriate systems were in place to ensure the regular cleaning and/or decontamination of communal equipment between each use.

Judgment: Compliant

## Regulation 29: Medicines and pharmaceutical services

The medication administration was in line with current best practice. The inspector was assured that measures were in place to ensure residents were protected by safe medicine management procedures and practices. Medication was stored and dispensed in line with the regulations.

Judgment: Compliant

## Regulation 5: Individual assessment and care plan

A sample of comprehensive care plans were reviewed. The hygiene section of these care plans were not person-centred in respect of the residents in one of the four units. For example:

- the care plans reviewed did not reflect the resident's wishes in relation to their hygiene needs. This had a negative impact on the quality of care they received as staff spoken with were not aware of the residents wishes in relation to their personal hygiene needs.
- the daily care records of these residents were of poor quality, they did not reflect if and when the residents were offered a shower or bath. The records reviewed indicated that some residents had not been offered or had a bath or shower for two or more weeks.
- the records reviewed reflected institutional practices, that is, staff were using a 'shower list' to record when a resident had a shower. This was ineffective as it was not person-centred and was not completed accurately by staff. Some staff were using the computerised system to record hygiene care provided and some were using the 'shower list'.
- some residents assessed as maximum dependent were not being facilitated to have a shower as staff did not have access to the equipment required.

Judgment: Not compliant

## Regulation 8: Protection

The safeguarding policy had been reviewed within a three year time frame. Staff had received refresher training in safeguarding vulnerable adults.

Evidence that residents' pensions were being paid into a residents account was available on request. As a result the inspector was assured that monies collected on behalf of residents were being lodged into a residents' account, in line with the Social Protection Department guidance.

Judgment: Compliant

## Appendix 1 - Full list of regulations considered under each dimension

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

| Regulation Title | Judgment |
|---|---|
| **Capacity and capability** | |
| Regulation 15: Staffing | Compliant |
| Regulation 16: Training and staff development | Substantially compliant |
| Regulation 19: Directory of residents | Substantially compliant |
| Regulation 21: Records | Compliant |
| Regulation 22: Insurance | Compliant |
| Regulation 23: Governance and management | Substantially compliant |
| Regulation 24: Contract for the provision of services | Compliant |
| **Quality and safety** | |
| Regulation 10: Communication difficulties | Compliant |
| Regulation 17: Premises | Not compliant |
| Regulation 20: Information for residents | Compliant |
| Regulation 27: Infection control | Compliant |
| Regulation 29: Medicines and pharmaceutical services | Compliant |
| Regulation 5: Individual assessment and care plan | Not compliant |
| Regulation 8: Protection | Compliant |

# Compliance Plan for Castleross OSV-0000124

## Inspection ID: MON-0046265

## Date of inspection: 11/02/2025

**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:<br>Supervision is in place day to day from the management team (Clinical Coordinator or nurse in charge and Household Co-Ordinator) of each house. This is also supported by the Senior Management team comprising of 2 Care Managers and PIC.<br>There is a robust auditing program in place in the Centre and while quarterly reviews of personal hygiene were completed, this has subsequently been increased too weekly. This is then reviewed and overseen by the Person in Charge. This was commenced immediately after the inspection, on 12th of February 2025. | |
| Regulation 19: Directory of residents | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 19: Directory of residents:<br>While NOK details were recorded on Epiccare for each resident the first contact was not selected appropriately to carry these details through to the directory of resident's report. This has since been updated and staff notified of the correct format to document these details going forward. In addition, A review of the directory of residents has now been added to monthly audit schedule to ensure ongoing compliance. | |

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| Regulation 23: Governance and management | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Castleross/Grace Healthcare have a comprehensive audit schedule in place which included weekly/monthly and quarterly audits to ensure quality of care in the home. These are conducted through a digital auditing system which allows for timely review and oversight by the PIC on a monthly basis. This has been augmented by adding an audit on the directory of residents and enhanced auditing on showers and baths to ensure ongoing oversight. This was completed on 12th February 2025.

A shower trolley has been purchased and is now availalbe to the residents who may require it in Castleross. This was received on March 11th 2025. All Staff have been informed that they have access to a shower trolley for any resident that wish to use it An audit was completed for any resident that may require this equipment and each of these residents have been informed that this is available to them. All care plans outlining resident preferences for personal hygiene and which equipment should be utilised have been reviewed and updated. This was completed by February 28th 2025.

Castleross has a program of testing water temperature checks monthly, following the issue with hot water on the day of inspection, this was increased to daily for these rooms until all works were completed and, in the weeks, after to ensure that correct temperatures were maintained. These monthly checks are completed by the maintenance team in the centre with oversight by the PIC upon completion.
Furthermore the PIC recieves notification of all logged mainteance issues in the centre to ensure oversight and promt response.
To ensure ongoing oversight facilities has been added as an agenda item to all local management meetings to support the escalation of any areas of concern in a timely manner. All staff have been reminded of the appropriate escalation pathways if there are any issues.

As outlined above a number of actions have been taken to ensure that resident's rights are upheld in the centre with significant efforts taken to enhance oversight of all personal hygiene delivery. The 7 bedrooms that had hot water impacted have since been resolved.

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| Regulation 17: Premises | Not Compliant |

Outline how you are going to come into compliance with Regulation 17: Premises:
The issue with hot water in bedrooms was reviewed by a plumber and necessary works completed to restore hot water by 13th February 2025.
Castleross has a program of testing water temperature checks monthly, this was increased daily for these rooms until works completed and, in the weeks, after to ensure that correct temperatures were maintained.

Staff now have access to a shower trolley to assist maximum dependent residents to have a shower. Residents have been informed that this option is available to them in line with their personal hygiene preferences.

Castleross has designiated areas for storage of all manual handling equipment . The items incorrectly stored on the day of inspection were immediately removed from the communal bathroom to their correct location . Staff have been reminded of appropriate storage of equipment and observational audits are completed by the management team to ensure adherence.

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| Regulation 5: Individual assessment and care plan | Not Compliant |

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
Castleross utilize a holistic care plan to outline the needs and preferences of all residents. It is acknowledged that additional information on personal hygiene needs and preferences were required. All care plans have been reviewed and updated to ensure that these are accurately documented and that all staff have access to these care plans. Monthly audits are completed by the Senior Management team to ensure ongoing ahderence.

A weekly audit is now carried out to ensure residents are being offered a shower as per their preferences. This was introduced on 12th February 2025 and is ongoing.

Any shower list in use in the centre was used to oversee showers completed not schedule them, however this practice has ceased in the centre and all personal hygeine is documented on Castleross computerised system only. To ensure that this practice is consistent through all units weekly review is completed by the Household Coordinator/ Clinical Coordinator of each unit with additional oversight by PIC/Care Managers. This was completed by February 12th 2025.

A shower trolley has been purchased and is now availalbe to the residents who may require it in Castleross . All Staff have been informed that they have access to a shower trolley for any resident that wish to use it An audit was completed for any resident that may require this equipment and each of these residents have been informed that this is available to them. All care plans outlining resident prefences for personal hygiene and which equipment should be utilised have been reviewed and updated. This was completed by February 28th 2025.

## 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 16(1)(b) | The person in charge shall ensure that staff are appropriately supervised. | Substantially Compliant | Yellow | 12/02/2025 |
| Regulation 17(2) | The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6. | Not Compliant | Red | 12/02/2025 |
| Regulation 19(3) | The directory shall include the information specified in paragraph (3) of Schedule 3. | Substantially Compliant | Yellow | 25/03/2025 |
| Regulation 23(a) | The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery | Substantially Compliant | Yellow | 11/03/2025 |

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| | of care in accordance with the statement of purpose. | | | |
| 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. | Substantially Compliant | Yellow | 12/02/2025 |
| Regulation 5(1) | The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2). | Not Compliant | Orange | 11/03/2025 |
| Regulation 5(3) | The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned. | Not Compliant | Orange | 28/02/2025 |