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:	Cara Care Centre
Name of provider:	Orbitview Limited
Address of centre:	Northwood Park, Santry, Dublin 9
Type of inspection:	Unannounced
Date of inspection:	01 March 2022
Centre ID:	OSV-0000735
Fieldwork ID:	MON-0036333

About the designated centre

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

Cara Care Centre is a five storey, purpose built nursing home. It is located in Northwood Park in Santry, close to shops and amenities. The registered provider is Orbitview Limited, and the person in charge is supported by the management team and staff such as nurses and healthcare assistants. The centre can accommodate 103 male and female residents, in 61 single en suite bedrooms and 21 double en suite bedrooms. There are facilities in place for social, recreational and religious activities, and there is a pleasant zen garden available for residents to use.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	79

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 1 March 2022	08:05hrs to 18:10hrs	Jennifer Smyth	Lead
Tuesday 1 March 2022	08:05hrs to 18:10hrs	Niamh Moore	Support

What residents told us and what inspectors observed

From what residents told inspectors and from what was observed, it was evident that residents were happy living in Cara Care Centre. Residents who spoke with inspectors said that staff were kind and caring. Visitors were also complimentary of the communication they had received from the registered provider throughout the COVID-19 pandemic.

On arrival to the centre inspectors were met by a member of staff who guided them through an infection prevention and control procedure which included the use of hand sanitising gel, the wearing of a mask and temperature monitoring.

Cara Care Centre is a five storey, purpose built nursing home. Residents' accommodation and living space is laid out over five floors which is served by two lifts and all areas are easily accessible to residents. There are facilities in place for social, recreational and religious activities. There was a pleasant zen garden available for residents to use, however areas needed to be cleared following the winter.

Residents' bedrooms were single or twin occupancy with ensuite facilities. Residents were supported to personalise their bedrooms, with items such as photographs, artwork and personal belongings, to help them feel comfortable in the home. Residents reported to be happy with their rooms.

The inspectors spoke directly with individual residents and also spent time observing staff and resident engagement. Inspectors spoke with eight residents, who all spoke positively about the care they received from staff. They found staff to be "helpful and kind". Three residents also discussed staffing levels with inspectors, two residents said they felt there had been a lot of changes in staff personnel recently and another resident said that at times during morning care responses to their call bell was delayed.

Inspectors saw that there was an activity schedule displayed on each floor. Inspectors saw pancake decorating, to celebrate Pancake Tuesday took place for the residents of two floors. Inspectors saw that these activities took place on different floors and at different times. Residents of the other three floors were not seen to have any access to activities on the day of the inspection. Residents sat in communal areas watching television.

Inspectors observed the lunch time dining experience on three floors. Good interactions were observed between catering staff and residents. For example, a member of the catering staff was seen to effectively de-escalate a situation when one resident had started to display responsive behaviour. On one floor there was intrusive music playing that was not suited to residents' preferences. Whilst there were adequate staff to support and assist residents with their meals and refreshments, staff were observed to stand over residents with little or no

interaction. Staff were observed to order their own lunch from the servery, in between the dinner and dessert being served. This did not lend itself to a sociable and relaxed ambiance for residents. Inspectors also observed that a resident on a specialised diet requested a change of meal and was not provided with this request.

Maintenance work was outstanding within the designated centre; for example, some of the surfaces and finishes including wall paintwork and flooring were worn and as such did not facilitate effective cleaning. Inspectors observed that one residents' bedroom floor despite being told this room had been mopped was sticky. Mugs, dinner plates and cutlery used by staff the day before the inspection were seen in staff areas.

During the course of the day, inspectors observed visitors arriving at the designated centre. Inspectors spoke with visitors, who were all complimentary of the service. They felt there was good communication and were kept up to date at all times. Visitors were facilitated to support residents with meals.

The next two sections of the report present the findings of this inspection in relation to the 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

While sufficient clinical staff were seen, inspectors were not assured there was sufficient staffing to provide residents with recreation. Staff supervision and access to training required further oversight. The governance and management systems failed to have effective oversight of auditing, complaints management, notification of incidents and the statement of purpose.

Orbitview Limited company is the registered provider entity for Cara Care Centre. This company is part of the TLC nursing home group. The person in charge had recently taken on the role in February 2022 and was supported in their role by an assistant director of nursing and four clinical nurse managers (CNMs). Other staff members included nurses, a physiotherapist, healthcare assistants, activity coordinators, domestic, catering and maintenance staff.

An outbreak of COVID-19 had been declared in the designated centre on 4 February 2022. Serial testing was undertaken and the registered provider had been in communication with Public Health to manage the outbreak. The provider had a comprehensive COVID-19 contingency plan in place and provided documents which evidenced simulated actions to prepare for a COVID-19 outbreak.

There was a written statement of purpose which had been reviewed in January 2022 that was made available to the inspectors for review. However this document required further amendments to ensure it accurately described the service that was

provided in the designated centre as per Schedule 1, this is further discussed in regulation 3 statement of purpose.

An annual review report for 2020 was available to inspectors, and included direct consultation with residents. Policies were not updated to reflect the current management personnel, this is further discussed in regulation 4 policies and procedures.

A copy of the current complaints procedure was displayed in a prominent position within the centre, however the complaints policy was not reflective of the procedure. Details of the current complaints officer had not been updated in the policy. A comment box was available to residents in the reception but was obstructed by a screen. While the registered provider had a system to identify complaints, inspectors were told that they were recorded in three locations, including on the residents computerised system and a complaints log. This posed a risk to ensure all complaints were logged and investigated.

Following the last inspection, the provider gave assurances that copies of resident transfer letters to hospital were to be kept within the designated centre. Inspectors noted on two recent discharges to hospital, no transfer letter was available. Staff spoken to were not aware that transfer letters were to be kept on resident files.

Staffing was allocated by floor and inspectors saw that each floor had a nurse assigned at all times day and night. Inspectors found there was a sufficient number and skill-mix of clinical staff, housekeeping, catering and domestic staff. However, inspectors were not assured that there was sufficient staff assigned to ensure residents had sufficient access to activities and meaningful use of time.

Inspectors were provided with a sample of staff supervision records and saw evidence that regular probation and performance reviews were occurring within these files. However inspectors requested evidence of two staff files and saw that these had not been completed.

Documentation on staff training records was not readily available. Despite requesting access to this information at 08:00, for return at 12:00, inspectors were given the documentation after 17:00. A number of gaps were seen in training compliance and there was no planned training schedule in place to respond to these gaps.

The provider failed to notify the Chief Inspector of an incident where a resident had an unexplained absence from the centre. Quarterly notifications submitted did not include all physical restraints, crash mats and low low beds were not reported.

Regulation 15: Staffing

Inspectors found that there was insufficient staff to provide meaningful recreational activities in line with residents assessed needs in the centre. There was one activity

staff member on duty assigned to cover all five floors within the designated centre. The planned roster also showed that cover was not provided for planned leave for an activity staff member. This was not a sufficient allocation of staff providing activities for the size and layout of the centre. Inspectors observed that the planned activity schedule was not followed on the day of the inspection and evidence was noted in activity records where activities were not provided to residents through out the week.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Inspectors found that not all staff had access to appropriate training. For example:

• A number of staff were not up-to-date with mandatory training. Inspectors were told that 29% of staff were overdue training in fire safety, 24% were overdue training in safeguarding.

Inspectors were not assured that staff were appropriately supervised. This was evidenced by:

• Appraisals had not been completed for two staff files reviewed.

• A staff member on induction did not have an induction checklist to guide their induction. They were on their second day working in the designated centre. This staff member was not supernumery and was not with their mentor at all times.

Judgment: Not compliant

Regulation 23: Governance and management

The management systems were found to be insufficient to ensure that the service provided was safe, appropriate, consistent and effectively monitored.

- Systems to review policies failed to identify that they did not all reflect the current management personnel. For example inspectors saw that the following policies were not up to date; the restraint policy, safeguarding policy and the complaints policy.
- Audits failed to address deficiencies in resident nutritional care plans highlighted from the previous inspection. The compliance plan submitted from the last inspection in 2020 gave assurances staff training was to focus on care planning and weight monitoring to address the residents who were identified at risk post COVID. Records and care plans reviewed in relation to nutrition, saw evidence that the recommendations in care plans were not

followed. For example, a monthly weight of a resident was not recorded since November 2021 and a plan to refer to a dietitian in July 2021 had not been progressed.
- No systems were in place to retain a copy of transfer letters, for residents discharged to hospital. This had been previously identified in the last inspection.
- No robust systems were in place to monitor training needs and evaluate training provided.
- The oversight and management of the complaints log was not coherent. There were three systems of recording complaints and not all complaints were recorded in the registered provider's complaints log. Instead some were recorded in a separate electronic folder. Inspectors saw evidence where a complaint received from a resident was not logged in the complaints folder. This was identified in the last inspection.
- The oversight and management of the risk register was insufficient, risks were recorded in two different systems each identifying different risks. Inspectors were told that management had transferred the risk register over to a new electronic system, however, not all risks were recorded in this new system.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose required further amendments to ensure it accurately described the service that was provided in the designated centre as per Schedule 1 of the Act. For example:

- There was no mention of respite residents who occupied 15 beds in the designated centre.
- Seven registration conditions were listed instead of the three that were in accordance with the designated centre’s current registration.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The provider failed to notify the Chief Inspector of an incident where a resident had an unexplained absence from the centre as per Schedule 4.

Quarterly notifications submitted did not include all physical restraints in use within the designated centre. For example, crash mats and low low beds were not reported on.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

Whilst a copy of the current complaints procedure was displayed in a prominent position within the centre, the complaints policy was not reflective of the procedure. The current complaints officer was not updated in the policy.

Complaints were not all contained in the one complaints log. Action was required to ensure that complaints were all logged and recorded in the correct place.

A comment box was in the reception but was obstructed by a screen.

Judgment: Substantially compliant

Quality and safety

Overall residents had good access to healthcare services. There was consultation with residents in the organisation of the designated centre and residents were happy with visiting arrangements. However, action was required by the provider in order to come in to compliance in the areas of care planning, premises, food and nutrition and infection control. Gaps were also seen in the management of restrictive practices, protection, access to activities and fire precautions.

There was evidence that residents' rights were upheld throughout the day of inspection. There was an independent advocacy service available and this information was displayed in the designated centre. There was a residents meeting held in January 2022. Minutes from this meeting recorded positive feedback from residents on suggested improvements. In addition inspectors saw there was a planned consultation to occur relating to menus for the upcoming Spring menu. Residents were kept informed relating to topics such as visiting arrangements, infection control measures, fire safety and activity provisions.

Residents on two floors were seen to enjoy a group activity and there was good interactions observed between the residents and staff. However, inspectors found that the activity schedule had not been followed on the day of the inspection. The activity was delayed by 30 minutes and took place on different floors to the schedule advertised. Inspectors found that staff were not aware of planned activities

due to take place and residents' were unable to plan their day to choose what activities to partake in.

There was a menu available and a choice of food was on offer. However,this choice was limited for a resident on a modified diet on the day of the inspection. Fresh water was not available in all resident rooms. Nutritional care plans for all residents were not followed.

The registered provider ensured that residents had appropriate access to healthcare through regular visits from the General Practitioner who visited twice weekly or as required. A physiotherapist was employed Monday to Friday, access to a speech and language therapist, dietitian, occupational therapist and chiropody was through a referral system. However, there was no record of access to the national screening programmes, for example a resident eligible to attend the national retina screening, had no record of attendance.

Three care plans reviewed in relation to physical restraints had a multi- disciplinary restraint and enabler assessment carried out, however the assessments reviewed did not indicate the type of physical restraint deemed appropriate to the individual resident.

The safeguarding policy had not been updated to reflect the current management personnel in the designated centre. One resident who was involved in a safeguarding incident had no safeguarding care plan to protect the resident from a similar incident reoccurring.

Inspectors were not assured that the observed design and layout of the multi-occupancy bedrooms within the designated centre met the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) (Amendment) Regulations 2016 S.I. 293 which took effect on 1 January 2022. Inspectors observed that action was required by the registered provider to comply with the aforementioned S.I 293.

Improvements to the oversight of the premises was required. Inspectors observed that a number of items were inappropriately stored in the treatment room, sluice rooms, a hydrotherapy bathroom and within store rooms. Repairs to paintwork and flooring was required in a number of areas and the enclosed courtyard seen required maintenance.

There was evidence of the monitoring for signs of infection of residents and staff, being completed. However, further oversight was required in relation to infection control measures within the centre. For example, gaps were seen in staff PPE use and hand hygiene. A number of areas and items within the centre were seen to be unclean, there were also gaps evident in some cleaning schedules. Inspectors observed numerous staff areas were unclean with dinner dishes from the night before and mugs with tea still in them from the day before seen.

Visiting within the centre had been on compassionate grounds during the recent outbreak of COVID-19. However on the day of the inspection, in line with Public

Health advice the centre were allowing scheduled visiting by the nominated support person.

Regulation 11: Visits

Inspectors saw evidence where the visiting policy and risk assessments were reviewed in line with the HPSC guidance on COVID-19: Normalising Visiting in Long Term Residential Care Facilities (LTRCFs). Family communication had been issued to update family members on the visiting arrangements. Inspectors saw many visitors arrive to the designated centre and visiting was seen to take place in residents' bedrooms.

Judgment: Compliant

Regulation 17: Premises

The design and layout of two twin bedrooms were not configured to give residents access their belongings in private. They did not have direct access to their chair or wardrobe, residents had to leave their private floor space to access their personal belongings.

Improvements were required in the oversight of maintenance within the designated centre. Wear and tear was visible on paintwork, lighting and a fan in a sluice room were not working. In addition, inspectors saw a resident's bedroom door was not closing properly, this had not been recorded on the maintenance log.

Judgment: Not compliant

Regulation 18: Food and nutrition

Each resident did not have access to a safe supply of fresh drinking water at all times, inspectors found fresh water was not available in dispensers and jugs in all resident rooms.

A review of menus available to a resident on a modified diet found there was limited choice available at mealtimes.

Inspectors found gaps in two resident nutritional care plans,

• One resident identified at risk of losing weight, had not been weighed monthly as recommended in their care plan. This resident's care plan had an entry on the 2 July

2021 to refer them for a dietetic review, there was no record of any referral being sent.

• Another resident who was on prescribed supplements and was identified at risk of losing weight was last seen by a dietitian on the 9 May 2020. Dietitian review of residents had been raised on the previous inspection.

Judgment: Not compliant

Regulation 27: Infection control

There were insufficient local assurance mechanisms in place to ensure that the environment and equipment was decontaminated and maintained to minimise the risk of transmitting health care-associated infections.

For example:

• The hand wash sink facilities for clinical staff were not appropriate. All sinks appeared to splash and there was mops under them to wipe up the spillage.

• The laundry facilities did not have a sufficient dirty to clean system in place. There was only one door into the laundry which was used as an entrance to bring in dirty items of clothing and to exit with clean items.

• Areas of the building and items of equipment were unclean, such as clinical items and the floor in a treatment room. There was also gaps in cleaning schedules of these areas.

Standard precautions and transmission-based precautions were not effectively and consistently implemented. This was evidenced by:

• Insufficient oversight in relation to infection control measures within the centre. Hygiene audits failed to identify inappropriate use by staff of PPE. Over spilling hand hygiene sinks and unclean areas were not included in the cleaning schedule.

• Staff PPE use was inconsistent as numerous staff members were seen to wear surgical masks and not FFP2 masks. One staff member was observed to wear their mask incorrectly.

• Five staff members were not bare below the elbow, with items such as stoned rings, watches, bracelets and nail embellishments seen.

• Communal items such as hairbrushes were seen in the store room and hygiene products were not labelled in shared bathrooms, which posed a risk of cross-infection from one resident to another.

• Single use dressings were seen to be open within treatment areas and had not been disposed of.

• Clinical waste and bins were seen to be overflowing in a number of areas including at the entrance point to the designated centre.

• Some storage practices in the centre required review from an infection prevention and control perspective. For example, many items of equipment and boxes were seen stored on floors in store rooms. This prevented effective cleaning of these areas.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

A comprehensive assessment was not carried out on every resident prior to admission to the centre. Inspectors reviewed a sample of three care plans and found that only two had pre assessments completed.

Care plans were not prepared within 48 hours of admission to the designated centre. Resident care plans of two recent admissions were not seen to be completed within a 48 hour period. This included a resident admitted in January 2022, who did not have their care plan completed for five days.

Care plans were not reviewed and updated on residents' needs within four months for example one resident's care plan had not being updated since October 2021.

Judgment: Not compliant

Regulation 6: Health care

Residents had regular access to GP and specialist care services such as psychiatry of later life and palliative care services. Records seen indicated that when residents required access to medical intervention that this was sought in a timely manner. Records also showed evidence of referrals to allied health services including occupational therapy, physiotherapy, dietetics and chiropody services.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Restraint used in the centre was not in accordance with national policy as published by the Department of Health. Three residents' care plans that were reviewed in relation to the use physical restraints had a multi- disciplinary restraint and enabler assessment carried out, but the assessments reviewed did not indicate the type of physical restraint deemed appropriate to the individual resident.

Judgment: Substantially compliant

Regulation 8: Protection

The registered provider failed to take all reasonable measures to protect residents from abuse. A safeguarding notification was followed up on inspection, the resident had no safeguarding plan recorded in their care plan.

The action plan following a separate safeguarding investigation was not seen to be completed and closed off.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Inspectors were not assured that all residents had opportunities to participate in activities in accordance with their interests and capacities.

- The planned activity schedule on the day of the inspection was not adhered to.
- Inspectors saw residents on three floors had limited access to any activities or meaningful use of time.
- Following a review of activity records, this showed that there were some days where no activities were provided to residents of certain floors.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Fire drills did not provide assurances staff were aware of the procedure to be followed in the case of fire. The provider had not simulated a full evacuation of the largest fire compartment with the lowest level of staff available. This was identified in the previous inspection.

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	Substantially compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Substantially compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Not compliant
Regulation 27: Infection control	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant

Compliance Plan for Cara Care Centre OSV-0000735

Inspection ID: MON-0036333

Date of inspection: 01/03/2022

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	Substantially Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:

• There had been a recent resignation from an activity coordinator at the time of inspection. Recruitment was underway and since the inspection, the position has been filled and the staff member is due to commence duty by the 31st May 2022. There are three Activity Co Coordinator staff that provide the activities programs over the 7 days and across the home, with flexibility from a part-time role to cover extra hours for planned and unplanned leave.

• Planned and unplanned leave is closely monitored by the ADON and PIC, with a plan in place for managing the continuity of meaningful activities when such leave or absences occurs through a range of options such as allocation of extra hours from part-time SCL, allocation of HCA staff on a daily basis (with that staff member having no other duties except for delivery of the activity programs), seeking staff who wish to nominate for extra shifts and supported by CNM as required.

• Such allocation when leave occurs will be delegated on the roster and reviewed daily by the CNMs to ensure the weekly program is provided as planned.

• Activity coordinators (and any staff allocated to the activity program) will allocate time daily to document all planned activities that residents participated in and any feedback on same in EPIC.

• The CNMs/ADON will conduct a weekly Activity Audit to measure engagement of residents, planning and implementing the planned activities, reporting the outcomes and any follow on actions to the PIC. The audit frequency will be reviewed pending outcomes of the audit following a one-month period.

• All HCA and Nursing staff will be provided with an overview and introduction to meaningful activities training as part of the induction process and during staff meetings scheduled for the week of 2nd May 2022 and 9th May 2022.

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
Regulation 16 (1) (a)

• The process of recording and retaining training records was reviewed with a system put in place and agreed for implementation that will enhance effective monitoring and oversight.
• The HR officer will update records on the week's training that has taken place. Each Head of Department will review and report to the PIC on training completed and training due for their team at the monthly governance meeting.
• The PIC will monitor overall compliance of staff mandatory and non-mandatory training on a monthly basis and agree any corrective actions with the team.
• Training for Fire Safety and Safeguarding has been scheduled for those staff requiring same, and ensuring full compliance by 16th June 2022.

Regulation 16 (1) (b)

• While staff supervision, appraisals and reviews are in place, an enhanced system of ensuring that all documentation and records are on each staff members file is being implemented by the HR officer.
• The schedule of annual appraisals has been updated and will be monitored with Heads of Department every 3 months. This schedule will be discussed at the monthly Governance meetings.
• There is an induction checklist available for new staff, and will be provided to the allocated mentor by the CNM in advance of the new staff member commencing in the home. The mentor and new staff member will sign off daily on the checklist which will be reviewed by the CNM. At the end of the induction period the checklist will be scanned and saved to the HR personnel file.
• The HR officer will conduct a HR staff file audit, monthly x 5 files and report compliance to the PIC at the Governance meeting.
• New staff members will continue to remain supernumerary for a set time period depending on grade and position, according to P&P. New staff and mentors are now identified on the roster. The CNMs will oversee compliance.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• To support the current PIC and ADON in the overall governance and management of the centre, a second ADON has been recruited and will commence duty by 30th June

2022.
• Prior to the inspection, a full and robust review of all policies and procedures had been undertaken by a contracted external company with a plan in place to implement a full new suite of policies and procedures from the 31st May 2022. There is a robust plan in place to introduce the incoming suite of policies and procedures to all staff.
• As per our policy and procedure, all residents will be weighed monthly or more frequently if their individual care plan indicates.
• This is monitored by an enhanced monthly nutritional audit which will be discussed further under Regulation 18.
• The PIC has scheduled meetings with all staff nurses and HCAs on the week of 2nd May 2022 and 9th May 2022 to discuss all learnings from the recent inspection.
• A copy of all transfer letters will be kept in each resident's medical file. This will be monitored by the CNM in the monthly transfer audit.
• As referenced under Regulation 16, the process of recording and retaining training records was reviewed with a system put in place and agreed for implementation that will demonstrate enhanced and effective oversight.
• The HR officer will be responsible for updating all training records, and the Heads of Departments will review and report to the PIC on training completed and outstanding for their team at the monthly governance meeting.
• The PIC will monitor overall compliance of staff mandatory training on a monthly basis and agree any corrective actions with the team.
• Complaints will be managed in line with the new policy and procedure for complaint management with all complaints being logged on the EpicCare system, with all other recording systems now ceased and archived. Complaint management will be monitored by the PIC monthly and discussed with Regional Director at the Governance meetings.
• The transfer of information onto one risk register has been completed and will be maintained as one system for all risks. The risk register is monitored monthly and is presented at the Governance meetings for discussion with each Head of Department.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
• The Statement of Purpose has been updated to reflect:
1. The age, range and sex of residents
2. The number of beds available for respite care
3. The three conditions that are in accordance with the designated Centre's current registration.

The updated SOP was submitted to the authority following the inspection.

Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:

Regulation 31 (1)

• Notification of the incident, whereby a resident exited through a side entrance and re-entered through the front door, has been notified to the Chief Inspector.

• Regular reviews of incidents and oversight of reporting requirements under Schedule 4 will be monitored at the monthly governance meeting including compliance with the 3-day period for notifications of any incident as set out in Schedule 4 Paragraph 7 (1) (a) to (j) will be monitored.

Regulation 31 (3)

• Crash mats and low-low beds have been included in the most recent quarterly report.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:

Regulation 34 (1) (c)

• A new suite of Schedule 5 Policies and Procedures have been completed and available from the 31st May 2022. The Complaints policy, procedure and all associated information have been updated to include the new PIC name and details as the Complaints Officer, as well as a separate appeals officer, are all updated and aligned.

• The partial obstruction of the comment box had been rectified on the day following the inspection.

Regulation 34 (1) (d)

• All open complaints have been reviewed and where appropriate the complaint has been investigated and closed.

• As above, the policy and procedure has been reviewed and updated, with the timeframe to investigate complaints clearly set out.

• Complaints are logged in Epic and will be monitored by the ADON and PIC daily.

• PIC, as the Complaints Officer oversees all complaints documented weekly to ensure compliance with our policy and procedures. All complaints are discussed at the monthly governance meetings.

• Complaints management training is scheduled for all nurses and CNMs for 30th June 2022.

Regulation 34 (1) (f)

• Complaints are logged in one system, EpicCare, with all other systems ceased and archived.
• As part of the process a record is maintained of the details of the investigation, outcome and whether the person making the complaint was satisfied or not.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• While the two identified twin rooms in the home are of a size that does comply with the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) (Amendment) Regulations 2016 S.I. 293 which took effect on 1 January 2022, the twin rooms required reconfiguration to ensure that all requisite furniture was most appropriately placed. All twin en-suite bedrooms measure between 21m2 to 23.48m2. A review is scheduled by the 30th June 2022 to ensure that the layout is in accordance with the resident's and as appropriate their relative's preferences and is in full compliance with the relevant legislation.
• An environmental walk of the home was completed by the PIC and Regional Director on the 5th May 2022 to identify any environmental or maintenance issues. A priority list of outstanding maintenance work has been identified and an action plan has been devised.
• Maintenance logs are maintained electronically and updated on an ongoing basis as issues are identified. Works are signed off according to a priority schedule and discussed at every Governance meeting or beforehand depending on priority.
• An environmental audit is completed quarterly by the Household/Catering Manager supported by the CNM which incorporates bedrooms, communal rooms, clinical rooms, storage spaces and corridors. This audit is completed on an electronic audit system and all actions are emailed to the relevant person. The results and action plan are discussed at monthly governance meetings.
• The areas identified for lighting, fan in the sluice room and the bedroom door closure have all been actioned.
• Since the inspection an ongoing schedule is in place for painting of all bedrooms and communal areas to ensure the environment is maintained to a high level.

Regulation 18: Food and nutrition	Not Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
Regulation 18 (1) (a)

• Fresh water dispensers are available in each dining area. Jugs of fresh drinking water are provided in every resident's room daily by the catering team. All staff are reminded of this requirement during daily handover and monitored by the CNMs daily.

Regulation 18 (1) (b)

• All meals are able to be modified for residents as required. On the day of inspection, the resident had changed their choice at the meal time and unfortunately that particular dish had all been served out, therefore not available. All residents are asked mid-morning to confirm their choice which then acts as a guide for the kitchen in terms of numbers of meals to be prepared per dish. Since the inspection, the Head Chef has reviewed the daily availability and quantities of all meal choices in all modifications to ensure choice is always available, even at short notice.

Regulation 18 (1) (c) (iii)

• A current review of all nutritional care plans for all residents is being completed by staff nurses with CNMs providing oversight. This will be completed by 15th May 2022.
• Weights are recorded for every resident on a monthly basis or more frequently if identified in the individual care plan and residents are referred to GP and dietitian as appropriate.
• The monthly nutritional audit has been enhanced to include each resident's monthly weight, MUST score, any change in weight over the previous 1, 3 and 6 months, last SALT review, last GP review in relation to nutrition and last dietitian review. This is completed monthly by the CNMs and submitted to the ADON and PIC and discussed at monthly governance meetings. This data is also included in our monthly quality indicators that are presented to the Chief Quality Officer.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
• Hand wash sinks that meet the standards of HBN 00-10 Part C Sanitary Assemblies will replace existing clinical hand wash sinks on a phased basis and all clinical hand wash sinks will be compliant by 31st Dec 2022.
• A review of the laundry area and system will be reviewed by the facilities team by the 30th May 2022, which will outline actions to address dirty to clean system flows, including entry and exit. The Housekeeping and Catering Manager will implement and test these systems, including audit, for the following 3 months to evaluate new processes and will provide updates at the monthly governance meeting to the PIC.

• A weekly environmental walk around the centre will be completed by the PIC. The PIC will document any findings and discuss any actions during the weekly Head of Department meeting and ensure all actions are being followed up. This has already been introduced on the week of the 2nd May 2022. This is in addition to the housekeeping and catering manager's spot checks of the cleaning schedules on a daily basis.
• A quarterly environmental audit of the entire home is completed by the housekeeping and catering manager and the CNM, which includes bedrooms, communal spaces, storage areas, and clinical areas. This audit is completed on an electronic audit system and all actions are emailed to the relevant person. The results and action plans are discussed at monthly governance meetings.
• A robust cleaning schedule is in place, which describes the duties and area of responsibility of each member of the housekeeping team on duty. This has already been introduced to the centre.
• Infection Prevention and Control training has been rolled out with special attention to hand hygiene. All staff have been reminded during team meetings scheduled for May 2022 of the policy and procedure re: bare below the elbow with no jewellery and nail embellishments allowed. CNM will audit compliance on a daily basis during handover times. A hand hygiene audit will be completed bi-weekly on a random selection of staff by the CNM to audit compliance. The results of these audits will be analysed by the ADON and will be shared during the weekly Head of Department meeting.
• All staff have been informed of the requirement to wear FFP2 masks and this is discussed daily at start of shift handover. The PIC supported by the ADON and CNMs monitor compliance daily.
• Staff have been instructed at daily handover re: to cease the use of communal items and the correct labelling of items in shared bathrooms. A review of all shared bathrooms and storage areas has been conducted with items removed and labels affixed to items as required. Store rooms and bathrooms will be monitored for compliance during the weekly environmental walk around by the PIC. This will also be captured during the quarterly environmental audit, conducted by the Housekeeping and Catering Manager, supported by the CNM.
• 'Single use only' symbol signage has been displayed in each clinical room. Education around the correct use has been provided to all clinical staff. This has also been included in the induction checklist.
• Storage systems in the centre are currently under review to ensure there is no risk from an IPC perspective. This will be completed by 30th June 22.

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:
Regulation 5 (2)

• The PIC is supported by the ADON and CNMs in completion of the pre-admission

assessments. The pre-admission assessment documentation is handed over to the admitting nurse for correct filing in the resident's medical file.
• Following the admission process, the admitting nurse must complete an admission checklist and submit to the ADON/DON for review. This allows the ADON/DON to ensure all documentation is in place and assessments and care plans are completed within the correct timeframe. This is currently in place.

Regulation 5 (3)

• Staff Nurses have been informed and will be reminded in the scheduled staff meeting for May 2022 of the legal requirement to complete care plans within 48 hours of admission. Staff nurses complete the admission process according to regulatory requirements. This process is supported by the CNM who review all new admissions within 72hrs to ensure compliance. The admission process is also overseen by the ADON/DON as discussed in Regulation 5 (2).

Regulation 5 (4)

• KPI audits are completed quarterly by the CNMs on a random selection of resident's care plans from each floor, which identify overall compliance. Immediate actions are identified to the allocated staff nurse. The KPI results and action plans are then analysed by the ADON/DON and presented at monthly governance meetings.

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:
• The MDT who are providing best practice assessments have been instructed to include as part of their assessment to indicate on that form the type of physical restraint deemed appropriate to the individual resident.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• All safeguarding allegations are taken very seriously in Cara Care Centre. All allegations are investigated thoroughly as per local policy. The allegation is notified to the Community Safeguarding Team and HIQA and immediate safeguarding care plans are devised for all residents involved. Before the investigation can be closed off, the PIC will

ensure the resident's care plan has been created and implemented.
• The safeguarding notification identified during the inspection has been further reviewed by the PIC and a safeguarding care plan has been recorded for the resident involved.
• The safeguarding investigation discussed during the inspection has been closed off since inspection.
• Safeguarding training is provided to all staff members. It is anticipated that all staff will have completed updated safeguarding training by the 16th June 2022.
• All action plans and learning from safeguarding allegations will be discussed at monthly governance with the regional team.
• The contact details for the designated safeguarding officer are now displayed on each floor. This has been completed.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• There had been a recent resignation from an activity coordinator at the time of inspection. Recruitment was underway and since the inspection, the position has been filled and the staff member is due to commence duty on the 31st May 2022. There are three SCL staff that provide the activities programs over the 7 days and across the home, with flexibility from a part-time role to cover extra hours for planned and unplanned leave.
• Planned and unplanned leave is closely monitored by the ADON and PIC, with a plan in place for managing the continuity of meaningful activities when such leave or absences occur through a range of options such as allocation of extra hours by the part-time SCL, extra hours by HCA staff on a daily basis (with that staff member having no other duties except for delivery of the activity programs), seeking staff who wish to nominate for extra shifts and supported by CNM as required.
• Such allocation when leave occurs will be delegated on the roster and reviewed daily by the CNMs to ensure the weekly program is provided as planned.
• Activity coordinators (and any staff allocated to the activity program) will allocate time daily to document all planned activities that residents participated in and any feedback on same in EPIC.
• The CNMs/ADON will conduct a weekly Activity Audit to measure engagement of residents, planning and implementing the planned activities, reporting the outcomes and any follow actions to the PIC. The audit frequency will be reviewed following a one-month period.
• All HCA and Nursing staff will be provided with an overview and introduction to meaningful activities training as part of the induction process and during staff meetings scheduled for the week of 2nd May 2022 and 9th May 2022.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• A fire safety information book is being devised; this will further enhance the fire training provided to all staff. The booklet will be circulated to all staff by 15th May 2022.
• A fire drill is scheduled for Quarter 2 with night staffing level (lowest level of staffing) to simulate an evacuation of the largest compartment in the nursing home and will be scheduled in each quarter for both day and night staff.

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 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.	Substantially Compliant	Yellow	31/05/2022
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	16/06/2022
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	02/05/2022
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises	Not Compliant	Orange	31/07/2022

	which conform to the matters set out in Schedule 6.			
Regulation 18(1)(a)	The person in charge shall ensure that each resident has access to a safe supply of fresh drinking water at all times.	Substantially Compliant	Yellow	02/05/2022
Regulation 18(1)(b)	The person in charge shall ensure that each resident is offered choice at mealtimes.	Substantially Compliant	Yellow	02/05/2022
Regulation 18(1)(c)(iii)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietetic staff, based on nutritional assessment in accordance with the individual care plan of the resident concerned.	Not Compliant	Orange	16/05/2022
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	Not Compliant	Orange	30/06/2022

	effectively monitored.			
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	31/12/2022
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	30/06/2022
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose relating to the designated centre concerned and containing the information set out in Schedule 1.	Substantially Compliant	Yellow	02/05/2022
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (j) of	Substantially Compliant	Yellow	02/05/2022

	Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence.			
Regulation 31(3)	The person in charge shall provide a written report to the Chief Inspector at the end of each quarter in relation to the occurrence of an incident set out in paragraphs 7(2) (k) to (n) of Schedule 4.	Substantially Compliant	Yellow	28/04/2022
Regulation 34(1)(c)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall nominate a person who is not involved in the matter the subject of the complaint to deal with complaints.	Substantially Compliant	Yellow	31/05/2022
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.	Substantially Compliant	Yellow	30/06/2022

Regulation 34(1)(f)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.	Substantially Compliant	Yellow	10/05/2022
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 intends to be a resident immediately before or on the person's admission to a designated centre.	Not Compliant	Orange	10/05/2022
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	Not Compliant	Orange	03/05/2022

	that resident's admission to the designated centre concerned.			
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.	Not Compliant	Orange	30/06/2022
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.	Substantially Compliant	Yellow	30/06/2022
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Substantially Compliant	Yellow	31/05/2022
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with	Substantially Compliant	Yellow	30/06/2022

	their interests and capacities.			