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: | Cashel Residential Older Persons Services |
| Name of provider: | Health Service Executive |
| Address of centre: | Our Lady's Campus, The Green, Cashel, Tipperary |
| Type of inspection: | Unannounced |
| Date of inspection: | 18 January 2023 |
| Centre ID: | OSV-0007812 |
| Fieldwork ID: | MON-0035427 |

## About the designated centre

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

Cashel Residential Older Persons Service is a new centre operated by the Health Service Executive (HSE) set in the grounds of our Lady's hospital Cashel. It is set out over three floors and consists of three units providing a total of 60 beds. One of the units St Clare's is a stand alone unit for 11 female residents and specializes in dementia care. The other two units are in the main building in Our Lady's hospital one on the first floor which can accommodate 29 residents and one on the second floor that can accommodate 20 residents. The bedroom accommodation is provided in a mixture of single bedrooms, two rooms, three bedded rooms and one four bedded room. The majority of the bedrooms contained full en-suite bathrooms and additional shower rooms and toilets were located in close proximity to bedrooms. The communal space included a number of sitting rooms and dining rooms in each of the units and additional multipurpose rooms including a large sitting/activity room and an oratory were located on the ground floor. A large enclosed garden area was available at the front of the building that provided walkways and seating for residents and a smaller rooftop garden was available on the second floor. St Clare's unit have their own separate, well-maintained and enclosed garden. Cashel Residential older persons service provides 24 hour nursing care for female and male residents. It provides for residents of all dependencies from low to maximum. There is a good ratio of nurses on duty during the day and at night time. The nurses are supported by care, catering, household and activity staff. Medical and allied healthcare professionals provide ongoing healthcare for residents.

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

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| Number of residents on the date of inspection: | 53 |

## How we inspect

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

As part of our inspection, where possible, we:

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

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

**1. Capacity and capability of the service:**

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

**2. Quality and safety of the service:**

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

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

**This inspection was carried out during the following times:**

| Date | Times of Inspection | Inspector | Role |
|---|---|---|---|
| Wednesday 18 January 2023 | 09:30hrs to 17:00hrs | Mary Veale | Lead |
| Thursday 19 January 2023 | 09:30hrs to 17:00hrs | Mary Veale | Lead |

## What residents told us and what inspectors observed

This was an unannounced inspection which took place over two days. Based on the observations of the inspector, and discussions with residents and staff, Cashel Residential Older Persons Services was a nice place to live. Residents' appeared to enjoy a good quality of life and had many opportunities for social engagement and meaningful activities. Resident's were supported by a kind and dedicated team of staff.

On arrival the inspector carried out the necessary infection prevention and control precautions, such as hand hygiene and application of a face mask procedure. After an opening meeting with the person in charge, the inspector was accompanied on a tour of the premises. Alcohol hand gels and PPE (personal protective equipment) were readily available throughout the centre to promote good hand hygiene. Staff were observed wearing the correct PPE and frequently performing hand hygiene.

The main campus was a three storey building. The ground floor had a reception area, oratory room, staff office, a meeting room and staff canteen. Tir na Óg unit was on the first floor and Croí Óir unit was on the second floor. The main campus had 14 single bedrooms, 2 twin bedrooms, 9 three bedded bedrooms, and 1 four bedded room. On the main campus five single some bedrooms did not have en-suite facilities but had toilet facilities in close proximity. The remaining bedrooms had access to shared or en-suite facilities with a shower, toilet and wash hand basin. Residents' bedrooms were clean, tidy and had ample personal storage space. Bedrooms were personal to the resident's containing family photographs, art pieces and personal belongings. St Clare's unit was a stand alone unit on the grounds of Our Lady's Hospital campus. St Clare's unit provided care for residents with dementia. This unit had 9 single rooms and 1 twin room. All rooms had en-suite facilities with a shower, toilet and wash hand basin. Pressure reliving specialist mattresses and cushions were seen in residents' bedrooms.

There was a choice of communal spaces. For example; in the main campus, there were two day rooms on the first and second floors and two dining rooms on the first floor. Dining and day rooms had Abel tables which allowed easy access for residents in wheelchairs, and the tables could be raised, and lowered in accordance with the requirements of the residents. St Clare's unit had two large bright day room spaces. Both spaces had dual functions as a dining room or sitting room space, and alternated in use to take advantage of natural light during the winter to summer months. There was a designated outdoor smoking area. A balcony areas identified off one bedroom on the Tír na Óg unit was a designated smoking area for one resident.

Residents' had access to enclosed garden areas. The main campus had a large enclosed garden area at the front of the building which was easily accessible. The large garden had level walkways, a large wall mural, and seating for residents. Croí Óir unit had a small roof top garden overlooking the Rock of Cashel. There were

three rooms with balcony areas on Tír na Óg unit. St Clare's unit had an attractive, enclosed garden space.

Overall, the inspector observed that the premises was laid out to meet the needs of the residents. There were appropriate handrails and grab rails available in the bathrooms areas, and along the corridors, to maintain residents' safety. The building was well lit, warm and adequately ventilated throughout. Bedrooms were appropriately decorated with many residents who had decorated their rooms or bedroom spaces with personal items.

The inspectors spoke with a total of 12 residents in detail, over the course of the two days and the feedback was positive. Residents who spoke with the inspector said that staff were good to them and treated them well. Residents' said they felt safe and trusted staff. A number of residents were living with a cognitive impairment and were unable to fully express their opinions to the inspector. However, these residents appeared to be content, appropriately dressed and well-groomed. The inspector also spent time in communal areas observing resident and staff interaction and found that staff were kind and caring towards residents at all times.

Visitors were observed attending the centre on the days of the inspection. Visits took place in communal areas and residents bedrooms where appropriate. The inspector was informed that there was no booking system for visits from the residents nominated visitor, but that all other visitors had to book a visit. Some resident's whom the inspector spoke with confirmed that their relative's and friend's could visit anytime, and some resident's were unsure if their loved ones had to book a visit.

Residents' spoken with said they were very happy with the activities programme in the centre. The weekly activities programme was displayed in the reception area. Over the two days the inspector observed residents' partaking in arts and crafts, attending live-streamed mass, and a number of resident's went on a shopping trip to Clonmel. For resident's who could not attend group activities, one to one activities were provided. The inspector observed staff and residents having good humoured banter during activities and observed the staff chatting with residents about their personal interests and family members. The inspector observed many residents walking around the corridor areas of the centre. Due to the cold weather at the time of inspection, most residents preferred to stay indoors. The inspector observed residents reading newspapers, watching television, knitting, listening to the radio, and engaging in conversation. Books and games were available to residents. There were photographs on the notice boards of residents enjoying day trips to a nearby stud farm, Tramore, Mount Melleray abbey, Glengarra woods and the Vee. The hairdresser and barber attended the centre weekly.

The next two sections of this report will present findings in relation to governance and management in the centre, and how this impacts on the quality and safety of the service being delivered.

## Capacity and capability

The inspector found that overall this was a well-managed centre where the resident's were supported and facilitated to have a good quality of life. The provider had progressed some areas of the compliance plan following the previous inspection in June 2022, and improvements were found in Regulation 18: food and nutrition, Regulation 19: director of residents, Regulation: 27: infection prevention and control, and Regulation 28: fire precautions. On this inspection, the inspector found that actions were required by the registered provider to address Regulation 6: health care and Regulation 24: contract of service provisions, and areas of Regulation 5: individual assessment and care plan, Regulation 17: premises, Regulation 21: Records, Regulation 23: governance and management, Regulation 27: infection prevention and control, and Regulation 34: complaints procedure.

The registered provider had applied to renew the registration of Cashel Residential Older Persons service. The application was timely made, appropriate fee's were paid and prescribed documentation was submitted to support the application to renew registration.

This centre is operated by the Health Service Executive (HSE), who is the registered provider. The person in charge had responsibility for this centre and was supported in her role by a director of nursing, clinical nurse managers (CNM's), nursing staff, health care assistants, activity staff, kitchen staff, housekeeping, and administration staff. The manager of the service, who was the registered provider representative also provided support to the person in charge. The director of nursing (DON) who was a person participating in management (PPIM), had oversight responsibility for this centre, a rehabilitation unit in Cashel and another residential care unit in Clonmel.

There was an ongoing schedule of training in the centre and management had good oversight of mandatory training needs. An extensive suite of mandatory training was available to all staff in the centre and training was up-to-date. Staff with whom the inspector spoke with, were knowledgeable regarding safe guarding procedures. The inspector noted that staff had completed online fire safety training and on-site training was scheduled to take place in the weeks following the inspection. The centre had access to an advanced nurse practitioner in dementia care who was planning to provide training in dementia care in 2023 as part of the centres ongoing training schedule.

There were sufficient staff on duty to meet the needs of residents living in the centre on the days of inspection. Staff turnover was low. Many staff had worked in the centre since it opened in 2020 and were proud to work there. Staff were supported to perform their respective roles and were knowledgeable of the needs of older persons in their care and respectful of their wishes and preferences.

Overall electronic and paper based records were well maintained. Requested records were made available to the inspector throughout the days of inspection and records

were appropriately maintained, safe and accessible. The centre had recently moved the employee personnel files to a new software employee records system. This system was difficult to navigate. Improvements were required in the centres records and this is discussed further under Regulation 21: records.

Management systems in place to monitor the centre's quality and safety required review. Since the previous inspection, a small number of audits had been completed in the centre, for example; a fire warden audit, infection prevention and control audits, and medication management audits. Audits viewed identified improvements. There was no evidence of falls, restrictive practice, wound management, or care planning audits carried out since the previous inspection. The provider had implemented a falls prevention quality initiative since the last inspection and it was evident from reviewing the centre's clinical incidents that the number of resident's falls had decreased significantly in 2022. The centre had an extensive suite of meetings such as governance management meetings, quality and safety meetings, local management meetings and staff meetings. Meetings took place monthly in the centre. Records of management meetings showed evident of actions required from complaints, clinical incidents and audits completed which provided a structure to drive improvement. Governance meeting took place quarterly with agenda items such as fire safety, infection prevention and control, training, staffing and KPI's (key performance indicators). There was a comprehensive annual review of the quality and safety of care delivered to residents completed for 2022 with an associated quality improvement plan for 2023.

The provider supported a third of the residents to manage their pension and this was done in line with the department of social protection guidelines. Procedures were in place for the management of residents' monies and locked storage was provided for residents' valuables.

The contract for the provision of services had not been reviewed since the last inspection. Improvements required to the contracts of care are discussed further under Regulation 24: contact of service provision.

Incidents and reports as set out in schedule 4 of the regulations were notified to the Chief Inspector within the required time frames. The inspector followed up on incidents that were notified and found these were managed in accordance with the centre's policies.

There was a complaints procedure displayed in the reception area of St. Clare's unit in the centre. The complaints procedure displayed the names of a nominated person who dealt with complaints and a nominated person to oversee the management of complaints. Each unit kept a log of complaints. Records of complaints viewed found evidence of effective management of complaints, however the satisfaction of the complainant was not consistently recorded. Improvements required to the complaints procedure are discussed further under Regulation 34: complaints procedure.

## Registration Regulation 4: Application for registration or renewal of registration

All documents requested for renewal of registration were submitted in a timely manner.

Judgment: Compliant

## Registration Regulation 8: Annual fee payable by the registered provider of a designated centre for older people

All the requested fees were received.

Judgment: Compliant

## Regulation 14: Persons in charge

The person in charge worked full-time in the centre and was compliant with regulation 14. She was aware of her responsibilities under the Act and displayed good oversight of the service and good knowledge of the residents.

Judgment: Compliant

## Regulation 15: Staffing

Staffing was found to be sufficient to meet the needs of the residents on the days of the inspection.

Judgment: Compliant

## Regulation 16: Training and staff development

Staff had access to training appropriate to their role. Staff had completed training in safeguarding residents from abuse, fire safety, behaviours that are challenging and infection prevention and control. There was an ongoing schedule of training in place to ensure all staff had relevant and up-to-date training to enable them to perform their respective roles. Staff were appropriately supervised and supported to perform

their respective roles.

Judgment: Compliant

## Regulation 19: Directory of residents

The registered provider had established and maintained a Directory of residence which included all the information as specified in Schedule 3 of the regulations.

Judgment: Compliant

## Regulation 21: Records

Improvements were required with records in the centre. For example:

- In a sample of four staff files viewed, one of the staff files did not have a satisfactory history of gaps in employment in line with schedule 2 requirements.
- Food menus were not made available for residents' in line with schedule 4 requirements.

Judgment: Substantially compliant

## Regulation 22: Insurance

There was a valid contract of insurance against injury to residents and additional liabilities.

Judgment: Compliant

## Regulation 23: Governance and management

Systems for monitoring the quality and safety of the service required review to ensure they were consistently informing ongoing safety improvements in the centre. For example:

- Clinical care audits such as wound management, care planning and restrictive practice had not been undertaken since the previous inspection. The centre

had an audit schedule but had not adhered to the schedule.
- The provider had not identified risks found on inspection associated with fire safety which was impacting on the safety of residents and staff.

Judgment: Substantially compliant

## Regulation 24: Contract for the provision of services

The contract for the provision of services required review to ensure it contained clear information for residents on the services available and the extent of service provision. For example:

- The residents room number was not included in the contract of care.
- Details of the cost of care was not recorded in two contracts of care viewed.
- Details of additional fees to be charged for services, for example, hairdressing and chiropody charges were not included in three contracts of care.

Judgment: Not compliant

## Regulation 3: Statement of purpose

Amendments were made to the centre's statement of purpose during the inspection. The statement now contained all of the information set out in schedule 1 of the regulations and in accordance with the guidance.

Judgment: Compliant

## Regulation 31: Notification of incidents

Incidents and reports as set out in schedule 4 of the regulations were notified to the Chief Inspector within the required time frames. The inspector followed up on incidents that were notified and found these were managed in accordance with the centre’s policies.

Judgment: Compliant

## Regulation 34: Complaints procedure

Actions were required to improve the centres complaints procedure. For example:

- The complaints procedure was not displayed in the main campus.
- The complaints policy did not include the details of nominated persons.
- Complaints viewed by the inspector on two units did not consistently record if the complainants were satisfied with the outcome.

Judgment: Substantially compliant

## Quality and safety

Resident's well-being and welfare was maintained by a good standard of evidence-based care and support. Improvements had been noted in the area of food and nutrition and fire procedures since the last inspection. On this inspection actions was required by the provider to comply with Regulation 6: healthcare and Regulation 28: fire precautions. Risks associated with fire precautions had not been identified, and required immediate actions to ensure the on-going safety of residents and staff. Improvements were required in care planning, premises and infection prevention and control.

While some visitors were require to book a visit, there was no restriction to visits in the centre. Visitors were seen to take place in communal rooms and resident bedrooms. There were ongoing safety procedures in place for example; temperature checks, questionnaires and hand washing procedures.

The centre was an agent for a third of the resident's pension. Residents had access to and control over their monies. Residents who were unable to manage their finances were assisted by a care representative or family member. All transactions were accounted for and double signed by the resident or representative and a staff member. There was ample storage in bedrooms for residents' personal clothing and belongings. The residents' laundry services was contracted to a private provider in the centre.

Apart from improvements required to storage in some of the en-suite facilities in the centre, the premises was meeting the requirement of the regulations and appropriate to the needs of residents. The centre was bright, clean and general tidy. The centre was cleaned to a high standard, alcohol hand gel was available outside all bedroom corridors. Bedrooms were personalised and residents in shared rooms had privacy curtains and ample space for their belongings. Overall the premises supported the privacy and comfort of residents. Grab rails were available in all corridor areas, toilets and shower areas. Residents has access to a call bell in their bedrooms. However; some improvements were required in relation to the centres premises this will be discussed further under Regulation 17.

Dani- centres were available on all floors to store personal protective equipment (PPE). Staff were observed to have good hygiene practices and correct use of PPE.

Sufficient housekeeping resources were in place. Housekeeping staff were knowledgeable of correct cleaning and infection control procedures. Intensive cleaning schedules had been incorporated into the regular cleaning programme in the centre. The centre had five infection prevention control (IPC) link nurses. The link nurses had received training in IPC. There was an up to date IPC policy which included COVID 19 and mutli-drug restistant organism (MDRO) infections. There was evidence of IPC meetings taking place regularly with agenda items such as shared learning discussions and actions required from specific IPC audits, for example; hand hygiene and environmental audits.

The centre had a risk management policy that contained actions and measures to control specified risks. The centre had a risk register which had been reviewed and updated in December 2022. The risk registered contained site specific risks such as risks associated with individual residents and centre specific risks, for example; risks to residents due to staff vacancies, infection prevention and control risks, and risk associated with fire safety. The risk register met the criteria set out in regulation 26.

Improvements were found in the residents dining experience, residents were seen to enjoy their meals in the dining rooms or day rooms over the two days of inspection. The dining experience was relaxed. A small number of residents were observed having their meals in their bedrooms. It was evident on minutes of meetings that the managers of the service were engaging with the catering department to improve the choices of food for residents requiring a modified diet. There were adequate staff to provide assistance and ensure a pleasant experience for resident at meal times. Residents' weights were routinely monitored.

Residents had access to medical care by the medical officer in the centre. The centre had employed a physiotherapist to assist residents mobilisation and rehabilitation . However; at the time of inspection, the physiotherapist had been temporary relocated to another service. Residents did not have access to other allied health professionals which is discussed under regulation 6: healthcare. Residents had access to a consultant geriatrician, a psychiatric team, nurse specialists and palliative home care services. Residents had access to local dental and optician services. Residents who were eligible for national screening programmes were also supported and encouraged to access these.

Oversight of fire safety required review. All bedrooms and compartments had automated door closures. All fire doors were checked over the days of inspection and some were found not to the close properly to form a seal to contain smoke and fire. On the second day of inspection, works were been undertaken to adjust two bedroom doors on Tir na Óg unit. Fire training was completed annually by staff. The centre had an L1 fire alarm system. Each resident had a personal emergency evacuation plan (PEEP) in place which were updated regularly. The PEEP's identified the different evacuation methods applicable to individual residents. All fire safety equipment service records were up to date. There were fire evacuation maps displayed throughout the centre, in each compartment. Some staff spoken with were not familiar with the centres evacuation procedure. There was evidence that fire safety was an agenda item on the health and safety meetings in the centre. There was a smoking room available for residents. On the days of inspection there

were three residents who smoked and a detailed smoking risk assessment was available for these resident. A fire extinguisher and fire blanket were in place in the centre's smoking room. Oversight of fire drills and fire safety procedures required improvement, this is discussed further in the report under Regulation 28.

Residents individual assessments and care plans were updated within the required time frames. Since the previous inspection, St. Clare's unit had implemented a nursing documentation system of person centred care planning. This documentation system was planned to be implemented on the main campus and was in the planning phase at the time of inspection. Training has been provide to nursing staff on the documentation of person centred care planning in the main campus. The inspector viewed a selection of nursing notes on Tir Na Óg and Croí Oir units. Residents individual assessments and care plans were not always updated within the required time frames. Some care plans were not sufficiently detailed to guide staff on the care of residents with difficulty sleeping. Care plans viewed required review to ensure a person-centred approach to care was provided. Some care plans were generic with pre populated interventions. From the sample of nursing notes viewed it was also not evident that four monthly reviews of care plans with residents had taken place. This was discussed with staff in the centre during the inspection.

The centre had arrangements in place to protect residents from abuse. The centre was using the national safeguarding policy to guide staff on the management of allegations of suspected and confirmed abuse. Safeguarding training had been provided to all staff in the centre and staff were familiar with the types and signs of abuse and with the procedures for reporting concerns. All staff spoken with would have no hesitation in reporting any concern regarding residents' safety or welfare to the centre's management team. The provider assured the inspector that all staff had valid Garda vetting disclosures in place and that volunteers were not attending the centre.

There was a rights based approach to care in this centre. Residents rights, and choices were respected. Residents were actively involved in the organisation of the service. Regular resident meetings and informal feedback from residents informed the service. The centre promoted the residents independence and their rights. The residents had access to an independent advocate. The advocacy service details and activities planner were displayed in the centre. A number of residents were going on a shopping trip to Clonmel each week . Residents' were complimentary of the activities provided by activities staff. Residents confirmed that their religious and civil rights were supported. Group activities of exercise classes' and one to one activities took place during the days of inspection. Residents has access to daily national newspapers, WIFI, books, televisions, and radio's.

## Regulation 11: Visits

Indoor visiting had resumed in line with the most up to date guidance for residential centres. The centre had arrangements in place to ensure the ongoing safety of

residents. Visitors continued to have temperature checks and screening questions to determine their risk of exposure to COVID-19 on entry to the centre.

Judgment: Compliant

## Regulation 12: Personal possessions

Residents had adequate space in their bedrooms to store their clothes and display their possessions. Residents clothes were laundered by a private provider who supplied a service Monday to Saturday in the centre. The residents had access and control over their personal possessions and finances.

Judgment: Compliant

## Regulation 17: Premises

Parts of the premises did not conform to the matters set out in schedule 6 of the regulations, for example;

- Call bells were required in two en-suite toilets.
- Some residents en-suite bathrooms in the main campus and all en-suite bathrooms in Clare's unit did not have suitable storage for personal items.

Judgment: Substantially compliant

## Regulation 18: Food and nutrition

A validated assessment tool was used to screen residents regularly for risk of malnutrition and dehydration. Residents' weights were closely monitored. Meals were pleasantly presented and appropriate assistance was provided to residents during meal-times. Residents had choice for their meals on both inspection days.

Judgment: Compliant

## Regulation 26: Risk management

There was good oversight of risk in the centre. Arrangements were in place to guide staff on the identification and management of risks. The centre’s had a risk

management policy which contained appropriate guidance on identification and management of risks.

Judgment: Compliant

## Regulation 27: Infection control

Action were required to ensure the environment was as safe as possible for residents and staff. For example;

- A review of the centres shower chairs and commodes was required as a number of shower chairs and commodes had visible rust on the leg or wheel area. This posed a risk of cross-contamination as staff could not effectively clean the rusted parts of the shower chairs.
- A review of the centres communal rooms and toilets required review as miscellaneous items such as urinals and residents toiletries were found in these rooms. This posed a risk of cross- infection for residents who used these rooms.

Judgment: Substantially compliant

## Regulation 28: Fire precautions

Action was required by the provider to ensure that adequate arrangements were in place to protect residents from the risk of fire. For example:

- Bedroom doors labelled on the floor plans 1/107, 1/111, 1/117, 1/127, 1/135, 1/136 & 1/238 were not closing to form a seal in some bedrooms on Tir na Óg and Croi Óir units.
- A review of the centres bedroom doors was required to ensure automated closure devices were in working order as some doors did not close properly to ensure that smoke or fire could be contained in the event of a fire.
- Oversight of fire drill procedures required review. Fire drill records viewed on Croí Óir unit required review as there was no record of the number of staff who were involved in the drill, the room evacuated or the number of residents evacuated. There was no evidence of fire drill records on Tir na Óg since the previous inspection .
- Enhanced oversight of staff practices to ensure that the means of escape were unobstructed at all times, as the inspector had to request removal of obstructing items on the first day of inspection on Croí Óir unit.
- Improvements were required to the centres evacuation procedures, some staff spoken with were unsure of the location of assembly points. A recent audit undertaken by the fire warden identified that there was no emergency

plan in place.
- The centres fire alarm system was not tested weekly as per the centres fire safety register.
- The centres designated smoking areas did not have call bells.

Judgment: Not compliant

## Regulation 5: Individual assessment and care plan

Care plan reviews were completed on a four monthly basis to ensure care was appropriate to the resident's changing needs. However actions were required to improve the residents individual assessment and care plan. For example:

- it was not always documented if the resident or their care representative were involved in the care plan reviews in line with the regulations.
- Some residents care plans required review as they were generic in format and not person- centred to the individual resident.

Judgment: Substantially compliant

## Regulation 6: Health care

Actions were required by the registered provider to provide additional professional expertise and access to these services for residents. For example:

- At the time of inspection the residents did not have access to a physiotherapist.
- Residents did not have access to a speech and language therapist, occupational therapist or dietician.

Judgment: Not compliant

## Regulation 8: Protection

Measures were in place to protect residents from abuse including staff training and an up to date policy. Staff were aware of the signs of abuse and of the procedures for reporting concerns.

Judgment: Compliant

## Regulation 9: Residents' rights

Residents' rights and choice were promoted and respected within the confines of the centre. Activities were provided in accordance with the needs' and preference of residents and there were daily opportunities for residents to participate in group or individual activities. Facilities promoted privacy and service provision was directed by the needs of the residents.

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** | |
| Registration Regulation 4: Application for registration or renewal of registration | Compliant |
| Registration Regulation 8: Annual fee payable by the registered provider of a designated centre for older people | Compliant |
| Regulation 14: Persons in charge | Compliant |
| Regulation 15: Staffing | Compliant |
| Regulation 16: Training and staff development | Compliant |
| Regulation 19: Directory of residents | Compliant |
| Regulation 21: Records | Substantially compliant |
| Regulation 22: Insurance | Compliant |
| Regulation 23: Governance and management | Substantially compliant |
| Regulation 24: Contract for the provision of services | Not compliant |
| Regulation 3: Statement of purpose | Compliant |
| Regulation 31: Notification of incidents | Compliant |
| Regulation 34: Complaints procedure | Substantially compliant |
| **Quality and safety** | |
| Regulation 11: Visits | Compliant |
| Regulation 12: Personal possessions | Compliant |
| Regulation 17: Premises | Substantially compliant |
| Regulation 18: Food and nutrition | Compliant |
| Regulation 26: Risk management | Compliant |
| Regulation 27: Infection control | Substantially compliant |
| Regulation 28: Fire precautions | Not compliant |
| Regulation 5: Individual assessment and care plan | Substantially compliant |
| Regulation 6: Health care | Not compliant |
| Regulation 8: Protection | Compliant |
| Regulation 9: Residents' rights | Compliant |

# Compliance Plan for Cashel Residential Older Persons Services OSV-0007812

## Inspection ID: MON-0035427

## Date of inspection: 19/01/2023

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

This document is divided into two sections:

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

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

A finding of:

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

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

## Section 1

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

**Compliance plan provider's response:**

| **Regulation Heading** | **Judgment** |
|---|---|
| Regulation 21: Records | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 21: Records:<br>Food Menus available now for Residents in printed format under schedule 4 requirements<br>Staff files now contain required information as laid out under Schedule 2 requirements | |
| Regulation 23: Governance and management | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 23: Governance and management:<br>All senior staff nurses & CNMs currently undertaking training in Clinical Audit & will be undertaking this practice at ward level with a designated schedule for audits to be carried out at 3monthly/6 monthly and yearly timeframes. More auditors will ensure audit schedule is adhered to. Fire warden's audit in use currently to be revised to capture identified risks found on inspection. | |
| Regulation 24: Contract for the provision of services | Not Compliant |
| Outline how you are going to come into compliance with Regulation 24: Contract for the provision of services:<br>Contract of Care revised immediately with details now included with Resident Room | |

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| Numbers, Cost of care and details of additional fees to be charged for services included |

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| Regulation 34: Complaints procedure | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
Complaints Procedure to to be displayed in Front Reception Area of Our Lady's Hospital with picture of Complaints Officer consisting of name and details of contact.

Complaints register documentation with details of complaints logged to be reviewed with particular reference to outcomes whether satisfactorily responded to or further review required.

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| Regulation 17: Premises | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 17: Premises:
Call Bells now present in all Bedrooms, Ensuite Areas and Communal areas.

Call Bells to be installed in Smoking Areas where Residents Smoke.

Installation of Shelving for Residents Personal Belongings in Ensuite Bathrooms to be completed.

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| Regulation 27: Infection control | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 27: Infection control:
Scheduled Replacement of shower chairs/commodes that have rust currently in place

Miscellaneous Items removed with immediate effect from all communal and toilet areas.

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| Regulation 28: Fire precautions | Not Compliant |

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
All seals renewed and replaced as needed on Residents Bedroom Doors in Tar na Nog and Croi Oir. Automated Closure Devices reviewed and replaced on. All Fire procedures, fire drills, fire alarm system testing reviewed with immediate effect. Fire and evacuation training took place on both Tir na Nog and Croi Oir Wards.

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| Regulation 5: Individual assessment and care plan | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
Introduction of assigned sticker as evidence that Residents Care Representative has being involved in the Care Plan.

Allocation of Staff Nurse in each ward areas to have responsibility for completion of Care Plans/Documentation and Review at 3 monthly intervals to ensure best practice and person centered care is being provided.

Piloting scheme in Clares Unit with person centered care plans from Cork/Kerry region has been successful. All nursing staff on Croi oir and Tir na nog have been organized to attend training for this documentation which will be rolled out on all long stay units by 1st July. These care plans are much more appropriate to person centered care

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| Regulation 6: Health care | Not Compliant |

Outline how you are going to come into compliance with Regulation 6: Health care:
A full assessment of needs has been carried out for all existing vacancies, with business cases submitted for consideration under the HSE Winter Initiative 2023/2024. In the interim the services will attempt to source and recruit for theses posts through agency partners.

## 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 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. | Substantially Compliant | Yellow | 22/03/2023 |
| Regulation 21(1) | The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector. | Substantially Compliant | Yellow | 22/04/2023 |
| Regulation 23(c) | The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and | Substantially Compliant | Yellow | 20/03/2023 |

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| | effectively monitored. | | | |
| Regulation 24(2)(a) | The agreement referred to in paragraph (1) shall relate to the care and welfare of the resident in the designated centre concerned and include details of the services to be provided, whether under the Nursing Homes Support Scheme or otherwise, to the resident concerned. | Not Compliant | Orange | 25/01/2023 |
| Regulation 24(2)(b) | The agreement referred to in paragraph (1) shall relate to the care and welfare of the resident in the designated centre concerned and include details of the fees, if any, to be charged for such services. | Not Compliant | Orange | 25/01/2023 |
| Regulation 27 | The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff. | Substantially Compliant | Yellow | 25/04/2023 |
| Regulation 28(1)(a) | The registered provider shall take adequate | Not Compliant | Orange | 20/02/2023 |

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| | precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings. | | | |
| Regulation 28(1)(c)(ii) | The registered provider shall make adequate arrangements for reviewing fire precautions. | Not Compliant | Orange | 20/02/2023 |
| Regulation 28(1)(c)(iii) | The registered provider shall make adequate arrangements for testing fire equipment. | Not Compliant | Orange | 20/02/2023 |
| Regulation 28(2)(i) | The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires. | Not Compliant | Orange | 20/02/2023 |
| Regulation 34(1)(b) | The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall display a copy of the complaints procedure in a prominent position in the designated centre. | Substantially Compliant | Yellow | 25/01/2023 |
| Regulation 34(1)(c) | The registered provider shall provide an accessible and | Substantially Compliant | Yellow | 25/01/2023 |

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| | 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. | | | |
| 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 | 21/02/2023 |
| 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 | Substantially Compliant | Yellow | 10/05/2023 |

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| | that resident's family. | | | |
| Regulation 6(2)(c) | The person in charge shall, in so far as is reasonably practical, make available to a resident where the care referred to in paragraph (1) or other health care service requires additional professional expertise, access to such treatment. | Not Compliant | Orange | 16/04/2023 |