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:	Castlebridge Manor Nursing Home
Name of provider:	Castlebridge Manor Private Clinic Limited
Address of centre:	Ballyboggan Lower, Castlebridge, Wexford
Type of inspection:	Unannounced
Date of inspection:	23 August 2023
Centre ID:	OSV-0005826
Fieldwork ID:	MON-0040858

About the designated centre

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

Castlebridge Manor Nursing Home is a two-storey building, purpose built in 2018, with a ground floor and first floor accessed by lift and stairs. It is located in a rural setting surrounded by landscaped gardens on the outskirts of Castlebridge village near Wexford town. Resident accommodation consists of 77 single rooms and 9 twin rooms. All bedrooms contained en-suite bathrooms and there were assisted bathroom's on each of the two floors where residents reside. The provider is a limited company called Castlebridge Manor Private Clinic Ltd. The centre provides care and support for both female and male adults over the age of 18 years requiring long-term, transitional care, respite or convalescent care with low, medium, high and maximum dependency levels. The range of needs include the general care of the older person, residents with dementia/cognitive impairment, older persons requiring complex care and palliative care. The centres stated aim is to meet the needs of residents by providing them with the highest level of person centered care in an environment that is safe, friendly and homely. Pre-admission assessments are completed to assess a potential resident's needs and whenever possible residents will be involved in the decision to live in the centre. The centre currently employs approximately 98 staff and there is 24-hour care and support provided by registered nursing and healthcare assistant staff with the support of housekeeping, catering, administration, laundry and maintenance staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	82

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 23 August 2023	20:30hrs to 23:10hrs	Bairbre Moynihan	Lead
Thursday 24 August 2023	09:30hrs to 17:10hrs	Bairbre Moynihan	Lead
Wednesday 23 August 2023	20:30hrs to 23:10hrs	Noel Sheehan	Support
Thursday 24 August 2023	09:30hrs to 17:10hrs	Noel Sheehan	Support

What residents told us and what inspectors observed

The overall feedback from residents was one of dissatisfaction with the quality of care in the centre. Inspectors' greeted and chatted to a number of residents and spoke in more depth with 11 residents to gain an insight into living in Castlebridge Manor Nursing Home. Residents informed inspectors about poor staffing levels and supervision of staff. Findings of this inspection were that significant action is required in the areas of governance and management, assessment and care planning and residents' rights to support the provision of a safe and quality service to residents.

Inspectors arrived unannounced at the centre during the evening time and were greeted by a nurse in charge. Following a brief introductory meeting, inspectors walked through the centre and spent time talking to residents and staff, and observing the care provided to residents, and the care environment. The person in charge arrived at the centre at night to support the inspection process. Also, a nurse that was due to finish their shift at 9pm stayed on past that time. Seven residents were in the communal area in Amber/Edenvale when the inspectors arrived. All other residents in the centre were in their rooms at 8:30pm. An inspector was informed that 14 out of the 18 residents in Slaney unit were in bed at the start of the night shift at 8:00pm. Inspectors spent time talking with residents in their bedrooms. Overall, residents expressed concerns that staff were 'always rushing'. A resident stated that "it is not fair on residents and staff". Residents told the inspectors that they often experienced long delays waiting for assistance. A resident stated that at least one staff member resigns from the centre once a week and the resident stated that the staffing in Slaney unit was reduced by one staff member at night. Another resident expressed their fear that the staff that they have a rapport with and who know and respect their likes/dislikes and routines will leave like all the other staff. Another resident said that there was shower list in place and they could not have shower at a time of their choosing.

The centre was a purpose built nursing home, laid out over two floors and contained four units. On the ground floor was Amber Unit and Edenvale which operate as one unit and on the first floor was Slaney and Ferrycarrig unit. The centre had 77 single rooms and 9 twin rooms all containing en-suite facilities. The ground floor had two enclosed gardens. Residents rooms were personalised with photographs, pictures and personal belongings from home. Communal facilities included a large open plan sitting and dining room on the ground floor where residents from all four units gathered to take part in activities. In addition each unit contained a sitting room and dining rooms. An oratory was located in Amber unit and a visitors room in Edenvale unit. Residents were observed sitting in there relaxing and enjoying the peacefulness.

While residents were complimentary of individual staff, they described their daily routine as being inconsistent, and described waiting long periods of time to receive assistance from staff. Some residents also expressed dissatisfaction with aspects of

the service, such as not having their feedback listened to or taken on board by management. Residents reported that staff are kind and caring in their interactions, however there are communication difficulties due to a language barrier. A number of residents and visitors spoken to by the inspectors said that this was a very good centre until recent changes in management. Other residents reported examples of poor care and in attention on the part of staff; "when I press the call bell staff are very slow to respond and I am left wet all the time", "staff are doing their own thing", "we have a problem with staffing here".

Inspectors observed that the supervision and allocation of staff was inadequate especially for residents in their bedrooms. Inspectors observed that a number of residents did not have their call bell within their reach while in bed, or when sitting out on a chair in their bedroom. On two occasions during the inspection, inspectors were required to locate staff on behalf of residents who required assistance.

Inspectors observed that residents were offered very poor social engagement during the inspection. Some of the lower dependency residents attended group activities in the main activities room on the ground floor. Limited group activities were also facilitated in the dayrooms of each wing. Higher dependency residents spent the day in their rooms with the TV on in the background and very little engagement with staff. The inspectors did not observe any residents getting any one to one engagement over the course of the inspection.

The dining experience in the centre was observed at lunch-time on the second day of inspection. 17 residents were in the dining area in Amber/Edenvale. The inspector was informed that six carers were assisting at lunchtime. However, the inspector observed one carer assisting intermittently and an activities co-ordinator. All other staff were delivering meals to residents on a tray. A resident informed the inspector that the food had improved since the last inspection but that there was no one to assist at lunchtime. The resident stated that they required the meat to be cut but that there was no staff available to do this and the resident had to use a spoon to eat. The inspector walked around Amber/Edenvale during the lunchtime to observe if residents in their room were receiving assistance. A resident called the inspector and stated she wanted to go to the toilet. The residents' bell was not within reach and the resident informed the inspector "there is no point ringing the bell as they won't come". The inspector rang the bell and went onto the corridor to observe staff. The residents bell was not answered in a timely manner and the inspector had to request assistance from the staff. Staff during this time were delivering trays. The inspector observed another resident with a modified meal placed in front of them and the resident was calling out "help". The inspector spoke to a staff nurse who stated that "the resident can feed himself and if carers have not come in and he has not fed himself they will feed him". The staff nurse did not view this important role as the role of the staff nurse. Furthermore, there was no supervision of the resident on a modified diet.

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

This inspection was conducted over the course of night time from 20:30 to 23:10 and the following day by inspectors of social services. It was a risk-based inspection to monitor ongoing compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and follow up on the actions taken by the provider to address significant issues of non-compliance identified during an inspection of the centre in June 2023. Overall, inspectors found that the systems put in place by the registered provider were not sufficient to ensure that the care and welfare needs of the residents were fully met. The inspectors identified a number of examples of poor practice as outlined under Regulations: 15 Staffing; 16 Training and staff development, 23 Governance and management, 5: Individual assessment and care planning and 09 Residents rights. In addition, feedback received by inspectors from residents, staff and relatives was that they were dissatisfied with the staffing levels in the centre and in the quality of care being delivered.

Inspectors also used information received by the office of the Chief Inspector, both solicited and unsolicited, to inform lines of enquiry for the inspection. Since the inspection in June 2023 the Chief Inspector of Social Services had received seven pieces of unsolicited information relating to concerns in relation to safeguarding, staffing and the general care of residents. These were all followed up through either a provider assurance report or through a corresponding notification. This information was also used to support the development of lines of enquiry for this inspection. The provider has shown a lack of capability to address the staffing and culture issues identified by this information. The findings of the inspection are detailed in this report and validate the concerns expressed in the unsolicited information received by the office of the Chief Inspector.

The registered provider was Castlebridge Manor Private Clinic Limited. There was a change in the operational management of the centre in October 2022 but the registered provider remained as Castlebridge Manor Private Clinic Limited. The centre is part of a wider group that own and manage a number of centres in Ireland. Reporting relationships were outlined to inspectors. The person in charge reported to a regional operations manager. The regional operations manager was onsite on the day of inspection and attended the feedback meeting. The regional operations manager reported to an operations manager and upwards to the chief executive officer who was also the registered provider representative. The person in charge worked full-time and was supported by an acting assistant director of nursing and two acting clinical nurse managers who worked 24 hours per week each in a supernumery capacity. The supernumery role was a temporary measure until a new sanctioned additional assistant director of nursing commenced. In addition, staff nurses, healthcare assistants, housekeeping, activities co-ordinators, catering,

administration, laundry and maintenance staff supported the person in charge. Since the last inspection, management and staff informed inspectors that agency staff was sanctioned if a staff member was on unplanned leave. This was to ensure that the clinical nurse managers remained in a supernumery capacity in order to supervise staff. However, on the second day of inspection the clinical nurse manager was busy supervising a new staff member and was unable to provide effective oversight of both Slaney and Ferrycarrig unit.

Since the previous inspection, the registered provider had further reduced the staffing numbers on the night shift. An inspector was informed that if a resident requires the assistance of two staff members in Slaney unit that there is no staff member available if a resident falls or requires assistance. The staff member stated they would not hear a resident fall if they were in a room with another resident. The staffing rosters on the day shift were also reviewed in Ferrycarrig unit and an inspector was informed that there were now six healthcare assistants on in the morning time which is an increase of one, however, there was a reduction in staffing in the evening time with four healthcare assistants on duty after 2pm. Staff informed the inspector that four healthcare assistants was not enough to provide care to meet the care needs of 16 maximum dependency residents, 4 high dependency residents and two residents with wandering behaviours in Ferrycarrig unit. Furthermore, staff stated that six residents required full assistance with eating in Ferrycarrig unit and that residents could not be provided with their meal in a timely manner as there was not enough staff to assist residents. In addition, the four healthcare assistants were required to put all the residents in bed before the end of their shift at 8:00pm. Staff stated that there was low morale amongst staff, staff were not supported and that things had changed "drastically" since the centre was acquired by a new group.

The systems in place for oversight of both staff and residents were not sufficiently robust enough to ensure sufficient oversight and supervision of staff and to respond to residents' needs in a timely manner. This was evidenced by:

- Inadequate staffing that was impacting on their ability to ensure oversight and monitoring of the service delivered.
- Care plans were not consistently completed in accordance with Regulation 5 requirements.
- Adequate arrangements were not in place for the supervision of staff resulting in a culture that was task orientated and not resident centred.
- There were poor outcomes for residents, particularly those of higher dependency as set out under Regulation 09 Residents Rights below.

There were 82 residents on the day of inspection with the needs of residents assessed as 39 maximum dependency residents, 18 high dependency residents, 13 medium dependency residents, 10 low dependency residents and one independent resident. One resident's assessment was not completed. Registered nurses, healthcare assistants, activities, catering, household and administrative staff make up the complement of staff responsible for the delivery of care and support to residents. Staff were observed to be task orientated, spending little time to socially interact with residents which resulted in inspectors observing residents spending a

significant amount of time in their bedrooms with limited stimulation other than televisions playing in the background that was of interest to only a small number of residents. This is also set out under Regulation 09: Residents' rights below.

Inspectors found that the provider had failed to organise and manage the staffing resource effectively within the centre. Consequently, the provider had failed to ensure that the designated centre had sufficient resources to ensure that safe care and services were provided, in accordance with the centre's statement of purpose. A review of the staffing rosters evidenced that staffing resources were not available to cover planned and unplanned leave, or maintain planned rosters. The provider was aware of the deficits in the staffing resources, and had continued to admit new residents to the centre in the absence of stable and safe staffing levels. The provider had not assessed this potential risk to residents, or progressed to consider alternative arrangements to ensure the planned staffing levels could be maintained. The impact of inadequate staffing levels is discussed further under Regulation 15: Staffing.

The registered provider had a training matrix in place. Staff had access to mandatory training including cardio-pulmonary resuscitation and manual handling. All staff had completed safeguarding training and fire safety awareness training and were up- to-date. Inspectors specifically followed up staff access to enteral feeding training with gaps identified.

The complaints policy and procedures required review and updated to meet amendments to the regulations that had come into effect in March 2023 (S.I. 298 2022). An inspector viewed a number individual complaints that were logged and had been responded to, however, in line with findings from the inspection in June 2023 tracking and trending of complaints had not commenced to identify emerging themes such as complaints relating to care issues and staffing.

Regulation 15: Staffing

In line with findings from the inspection in June 2023, staffing levels in the centre remained unchanged. The statement of purpose which Castlebridge Manor Private Clinic Limited was registered against states that there should be 52 healthcare assistants and 20 staff nurses. The resident profile is of 18 high and 39 maximum dependencies residents in the centre.

- On the day of inspection the registered provider had employed 34 WTE (wholetime equivalents) and 8 part-time healthcare assistants who worked approximately 1-3 days per week. This was a further decrease of two WTE healthcare assistants since the inspection in June 2023.
- On June 1st the registered provider decreased the healthcare assistant staffing on nights by one in Slaney and Ferrycarrig unit. Each unit was now assigned one staff nurse and one healthcare assistant and one healthcare assistant worked between Slaney and Ferrycarrig unit.

- There were an additional two vacant staff nurse posts since the inspection in June 2023 which totalled four staff nurse vacancies.
- A review of rosters for the 23 August in 2021, 2022 and 2023 was undertaken. This review indicated that staffing was reduced by approximately 1 staff nurse and 3 to 4 healthcare assistants for the day time and one staff nurse and one to two healthcare assistants on nights. This information is supported by what inspectors were told by staff.
- Inspectors were informed that the registered provider had commenced addressing the unplanned leave through the absence management policy. However, a review of the leave indicated that thirty different staff members were on sick leave during the month of July with five staff members out sick in one day in July. Minutes of a staff meeting observed by inspectors showed no effective action plan was devised or implemented on the part of the person in charge to address this issue.
- In order to cover the gaps in sick leave, staff were working extra shifts. On a review of the rosters, one healthcare assistant had worked 120 hours over a two week period. This is not sustainable.
- While inspectors were informed the regional operations manager was onsite two to three days per week and had been onsite everyday while the person in charge was on annual leave there was no evidence from rosters reviewed of the presence of the regional operations manager.

This is a repeated non-compliance from the previous inspection.

Judgment: Not compliant

Regulation 16: Training and staff development

Gaps in training and staff development were identified:

- There was inadequate supervision of staff resulting in a culture that was task orientated and not resident centred. See the findings under regulation 09 below.
- Adequate clinical supervision arrangements were not in place to ensure that care was delivered in accordance with each resident's care plan.
- A small number of residents required enteral feeding. Six staff nurses had not completed training in this area.
- 39 staff had not completed training in ski sheet evacuation.
- The training matrix for managing behaviours that challenge required review as it was not clear on documentation provided on the day of inspection and provided after the inspection, the date on which staff had completed the training. From a review of the documentation 30 staff were currently undertaking dementia training and the remaining staff had completed it but the date for completion was not provided.

Judgment: Not compliant

Regulation 23: Governance and management

Staffing resources in the centre were not in line with the statement of purpose with an impact on the quality of care provided to residents. This is evidenced by:

- Management had failed to address the deficit in staffing levels between the statement of purpose and the actual staffing levels. In addition, the registered provider had further reduced the staffing levels on nights.
- Residents were not appropriately supervised at night. For example; inspector's observed one staff member available on the floor on Ferrycarrig unit at 10pm. Two other staff members were assisting residents. In addition, staff informed inspectors that in Slaney unit if both staff were assisting a resident that there was no supervision of residents on the floor at that time.
- Residents were not appropriately supervised at mealtimes. For example, a resident that was assessed as a risk from aspiration and hence needing supervision while eating was left alone in their room to eat their lunch.
- Inspectors observed that residents were offered very poor social engagement during the inspection. Higher dependency residents spent the day in their rooms with the TV on in the background and very little engagement with staff.
- A high level of staff absenteeism remained and the registered provider was endeavouring to address it. Staff informed inspectors that they felt "burnt out" from covering additional shifts to cover staff absenteeism.

The registered provider had failed to address the findings from the inspection in June 2023 in relation to staffing and the governance and management systems in place. These were not safe, appropriate, consistent and effectively monitored. This was evidenced by:

- Feedback to management highlighting the staffing concerns through staff meetings and residents meetings were not addressed.
- While individual complaints were managed in line with the regulation, tracking and trending of complaints was not taking place to identify emerging themes such as complaints relating to care issues and staffing. A review of the complaints log indicated that recurring themes remained such as issues around care and staffing.
- Ineffective systems to ensure key clinical information regarding residents' care needs was not effectively communicated to staff. For example; staff in one unit were unaware of a resident having a pressure ulcer. In addition, The handover book for the night had not been completed by the day staff.
- Overall analysis of falls to identify the contributing factors had commenced since the inspection in June 2023, for example; the time of the fall or whether staffing was reduced on that day. However, this information was not being used to drive quality improvement.

- Not all incidents were recorded or investigated, for example a recent fall of a resident.
- Systems of communication were not sufficiently robust, for example governance meetings, quality and safety meetings, staff meetings were infrequent. Records of management meetings that were held were poorly detailed and did not show how change and improvement would be driven in the centre. At a recent staff meeting, staff brought to the attention of management that sick leave was resulting in staff shortages on shifts. The response, while recognising that there was a problem, did not say how the problem would be addressed.
- There were inadequate mechanisms of oversight to ensure that the care needs of residents were met at all times. For example; a resident had an unwitnessed fall and was found on the floor of their room, was found in wet clothes in their room on the following day.
- Audit action plans were not comprehensive enough to drive quality improvement. There was no evidence of cascade of learning from audits or reviews of care through the governance structure.

The registered provider had not ensured that roles of staff were clearly defined for all areas of care provision in line with sub regulation 23 (b).

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

The registered provider had not agreed in writing with a recently admitted resident, a contract of care setting out the terms on which that resident would reside in the centre.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

A copy of the complaints procedure was displayed in a prominent position at the reception area in the designated centre and had named complaints officer and appeals officer, however it required revision to meet amendments to the regulations that had come into effect in March 2023 (S.I. 298 of 2022).

Judgment: Substantially compliant

Quality and safety

Overall, inspector's identified that a human-rights based approach to care in the centre was not evident. Residents were not afforded the right to fairness, respect, dignity and autonomy as a result of of poor governance and management, poor oversight and ongoing staffing deficits in the centre. The lack of effective governance and management in the centre was impacting on the quality and safety of care in key areas such as residents' rights, healthcare, managing behaviours that challenge and individual assessment and care planning.

Residents continued to have good access to a local general practitioner and medical officer who attended in the evening time. There was evidence in records reviewed of timely access. Access to health and social care providers was available following a referral, however, while there was evidence that a small number of residents were referred to, for example; dietitian, other residents were referred in a timely manner. Furthermore, records reviewed identified a resident that required supervision at mealtimes and this was not provided.

The centre was a two-storey purpose built nursing home built to modern specifications. The centre was bright with wide corridors and assistive handrails throughout. The majority of rooms in the centre were single en-suite rooms with a small number of twin en-suite rooms. Many of these were occupied by one resident. Residents' rooms all had call bell access however, not all residents had access to their call bells within reach. This discussed under Regulation 9: Residents' rights.

A system of electronic care planning and documentation was used by staff. Some care plans viewed were person-centred and could guide care, if care was provided as per the care plan. However, there was inconsistency in some care plans with regard to the information contained within. Notwithstanding this, all care plans and validated assessment tools were updated at four monthly intervals in line with regulations, however, in line with findings from the inspection in November 2022 some information contained in the care plans was not up-to-date. There was also a need to ensure that adequate records were maintained of care delivered to residents. Assessments carried out by nursing staff included a range of validated clinical assessments such as risk falls, pressure ulcers and malnutrition.

Some residents had responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). Behavioural assessments which assist staff to identify and determine any underlying emotion or unmet need which could trigger the behaviour were not consistently used in all records reviewed. Opportunities were therefore not always identified which would support staff to work therapeutically with residents, to manage the behaviours effectively and improve the residents' quality of life.

Residents were consulted about the centre through residents' meetings and an annual satisfaction survey. One meeting had taken place since the inspection in June

2023. Residents had highlighted a number of concerns in relation to staffing in the centre and the feedback from residents to inspectors was that the feedback was not taken on board by management. One visitor informed the inspector that there was no point highlighting issues as nothing changes.The activity planner was on display in the centre. On the day of inspection activities included mass and 1:1 sensory stimulation with lights and music. In the afternoon there was live music in the centre. It was evident that residents enjoyed the live music and were singing along and participating. A number of visitors were also present for the music. Notwithstanding this, significant action was required under Regulation 9: Residents' Right in order to come into compliance with the regulation.

Regulation 25: Temporary absence or discharge of residents

For a resident that was recently admitted to the acute hospital the person in charge did not evidence that all relevant information about the resident was provided to the hospital.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Discrepancies were identified between care plans reviewed and the actual care given. For example;

- One resident was identified in their care plan as being continent however, an incontinence assessment carried out identified that the resident required incontinence wear.
- One resident's pressure ulcer was described as a grade 3 on the care plan but on review of the progress notes it was documented as a grade 4 pressure ulcer.
- Named nursing personnel who were no longer employed in the centre were recorded on the electronic care planning system as the key workers for a recently admitted resident.

Additional areas for action were identified as care was not provided in line with the care plans:

- A care plan of a resident stated that the resident should be toileted every two hours however, there was no evidence from review of the residents' progress notes that this occurred.
- No care plans were in place to encourage continence promotion. This is not in line with the centres' own policy.

- A residents' care plan identified that a resident required one to one supervision over the 24 hour period, however, on the week of inspection the one to one supervision of the resident was removed on the night shift. Management stated that it was no longer required, however, the care plans were not updated to reflect this.

Judgment: Not compliant

Regulation 6: Health care

Actions were required in order to ensure that healthcare needs of residents were met in line with the regulation:

- A resident with a pressure ulcer which was acquired within the previous month, had a malnutrition universal screening score of 2 was not referred to a dietitian in line with the centres' wound management policy. Furthermore, there was no evidence from records reviewed that the resident was reviewed by a tissue viability nurse.
- A resident that was assessed as at risk from aspiration and therefore needing supervision while eating was left alone in their room to eat their lunch unsupervised.
- A nutrition care plan was updated at four monthly intervals but the information detailed in it was from 2021 which was documented following review by a dietitian. There was no evidence that the resident was reviewed by a dietitian since then and the resident had a designated centre acquired pressure ulcer.

Judgment: Not compliant

Regulation 7: Managing behaviour that is challenging

Some residents had responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). In two records reviewed there was no evidence that episodes of responsive behaviours were assessed in order to identify triggers and develop strategies to deescalate and prevent further recurrences. Physical and environmental causes of responsive behaviours were not assessed and therefore residents were not receiving care in accordance with their assessed needs or in line with best practice.

In addition, inspectors were informed that restraints such as bedrails were reviewed and released every two hours while in place. However, records reviewed indicated that it was not consistently documented that these checks were taking place.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Residents' right to exercise choice was not always upheld by the registered provider. For example;

- A resident informed an inspector that they went to bed at 7pm because if they waited for the night staff they would not get to bed.
- Residents' informed inspectors that they were not toileted at a time of their choosing as they had to wait for up-to 3-4 hours to be attended to. As a result residents wore incontinence wear when it was not required. In addition, a resident informed an inspector that they were frequently left wet having rang the call bell as staff did not get to attend the need on time.
- Institutional practices were evident in the centre. For example; approximately three to four residents' personal hygiene for the day was attended to at 5 am in order to assist the day staff.
- A significant number of call bells were located beyond residents reach, for example, only four residents in Ferrycarrig had their call bell within reach on the night of inspection. A staff member told an inspector that all residents did not need to reach the call bell as they were incontinent.
- Inspectors observed that residents were offered very poor social engagement during the inspection. Higher dependency residents spent the day in their rooms with the TV on in the background and very little engagement with staff.
- Residents did not have a choice to shower daily if they requested it. All residents were on a weekly rota. While management stated that the rota was to ensure that all residents had a shower weekly, a number of residents expressed that they would like a shower more frequently.

Residents' right to privacy and dignity was not upheld by the registered provider. For example;

- The centre had a falls and pressure ulcer safety cross on display in all units to identify the number of falls that had occurred in the month and newly acquired pressure ulcers. While this is good practice, residents' names were written on the safety cross for all residents and visitors to observe. This practice did not afford the resident with the right to privacy.
- The dignity of the residents was not consistently upheld. For example, staff told the inspector that the routine for changing residents' incontinence wear in the evening was to change it at 6pm and 11.30pm. This meant that staff

practices and routines were dictating the care provided, which is not in line with a person-centred approach to care delivery.

Ongoing issues with the laundry remained. This was raised at the residents' meeting and residents raised the issue with inspectors. For example; clothes were going missing or were returned to the resident and were damaged.

Due to unplanned leave, no one to one activities were taking place with residents in Ferrycarrig and Slaney. Management stated that healthcare assistants also carried out this role, however, inspectors were informed that prior to the reduction in staff they had 15-20 minutes each day where they would do one to one activities with residents, however, they no longer have the time to complete it.

This is a repeated non-compliance.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Substantially compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 25: Temporary absence or discharge of residents	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Not compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Castlebridge Manor Nursing Home OSV-0005826

Inspection ID: MON-0040858

Date of inspection: 24/08/2023

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 15: Staffing	Not Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
• We are recruiting to fill any vacancies to bring the home in line with the Statement of Purpose. We are expecting 5 HCA this month and a further 3 RGN to join our team between now and February. Since the last inspection we have the following staffing, this does not include any of the above-mentioned staff nor the staff members currently on maternity leave:

Position Number of Whole-Time equivalents Number of staff
Person in charge
Assistant Person in charge 1
2 1
2
CNM 3 3
RGN 18.2 18
Health Care Assistant 42.8 45
Activities Staff 2.2 3
Household, Catering, other 18.4 20
Administration, Reception 4 5
Maintenance 2 2

Staffing:
• HCA: By the end of October, we anticipate our staff numbers will increase from 45 – 50 and increase again to 52 by the end of the year.
• RGN: Between November & Feb: predicted staff number will increase to 24.
• CNM: We have 3 CNM that are working full time and supernumerary Monday to Sunday: Our CNM are being assigned particular units each week for continuity.
• DPIC: Full time supernumerary & our second dpic will be joining us on the 11.10.23.

With all of the above, we are continuing our recruitment drive for the home, to assist in future planning for staff vacancies and adhoc contingencies.

Absence Management:
• We have an absence management policy and procedure in place and are working through the process with a number of staff. This involves informal counselling sessions with the staff member, then if further absences occur a disciplinary process is commenced – an investigation hearing and then a disciplinary hearing.
• We continue to offer any available shifts to our own staff who can choose themselves if they wish to take on additional shifts in the roster and then we will book agency staff to cover the shift. The advantage of advance booking with agencies is that we are able to request/block book the same agency staff member which both assists our own staff and our Residents in that the agency staff member is familiar with both the home and the Residents.
• Whilst we refer to the absence management in our regular meetings, as the policy is active and onsite, we had not detailed the various steps in each and every meeting. We will do so in the future.

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
Staff Supervision:
• We have 3 CNM who are supernumerary and work a roster Monday to Sunday to ensure 7 days p/w supervision for staff.
• In addition to these staff members, we have our deputy person in charge who is supernumerary and have recruited a second deputy person in charge who will also be supernumerary. Both of these posts are to assist the person in charge to drive a change in the task orientated culture within the home and return it to a Resident centered.
Training;
• Since the inspection we have been able to conduct training in the following topics:
Manual handling
• Fire safety & fire warden training (further sessions booked for October)
• Enteral feeding
• Evacuation using a ski sheet
• Restrictive Practices (further sessions booked for end of October)
• Positive Behavioural Support
• Understanding Dementia ongoing, next session due to start in November
• Nurses in-service/re-orientation training (2 sessions in September)

Our training matrix will be updated with all training once completed.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

Staffing:

• We have increased our nighttime staffing levels and also our daytime staffing levels and our supervisory shifts throughout the week. We are recruiting to fill vacancies to have staffing levels in line with our SOP. We have been backfilling any gaps with agency but need to be prudent in relation to the number of agency staff that we have onsite each day.

• We have introduced a mealtime planner for all staff and have reviewed our dining rooms and various places where our Residents choose to eat, to afford choice, safety, and supervision.

• Our activity co-ordinators provide 95 sessions of 1:1 time during the week in addition to over 15 group activities. We are recruiting more members for this team and are looking to expand on our "outside" activity contributions also.

• Staff absenteeism is being handled through our absence management policy. We are engaging with individual members of staff from an informal counselling basis to disciplinary hearings. In the meantime, we are booking agency staff to cover any gaps in the roster that we know of and also to cover the adhoc absences also. We do offer our own staff the opportunity to take other shifts if they wish and anticipate with our own staff coming inhouse within the next few weeks and months that the need for both additional shift cover and agency staff will reduce dramatically.

Systems:

• As mentioned in reg 15, we are continuing our recruitment process, to ensure contingency cover for all departments and are working towards achieving the levels stated in the SoP attached to the registration.

• We have completed our Resident satisfaction survey and the results are being processed and will be collaborated with our family/next of kin satisfaction survey which is circulating at present.

• Our Resident meetings will continue and we are open to suggestions in all aspects of daily life here in CBNH.

• We are reviewing all of our complaints and will address each on an individual basis whilst still reviewing the content of all for improvements.

• We have and will conduct training with our Staff nurses to ensure full and correct handover at each shift change and have a clinical handover communication sheet on each unit that is distributed by the CNM on duty.

• All audit findings will be communicated back to all staff through weekly safety pause meetings on each unit. We have recently purchased an electronic auditing platform which will assist staff and managers in completing and overseeing this task.

• As part of our staff nurse training, the importance and the responsibility to correctly document and report any slip/trip/fall/accident has been emphasized and we anticipate with the supernumerary shifts in place, that this area will improve greatly.

• We have reviewed our meeting templates available and have improved on these to ensure agenda, r/v of prev minutes and new minutes with action plan and person responsible is documented.

• With our PIC, DPIC (2) and CNM(3) all supernumerary we are confident with this

oversight that the day to day life and comfort of our Residents will be the strong focus of all of our staff.
• We have added to our audit suite and as mentioned will be discussing the findings at a safety pause on each unit.
Management Structure changes
• Please see the Organisations Structure which shows the changes made today along with the reporting and supporting lines in place.
• The PIC is now working alongside her staff for a portion of the day to provide support, supervision and mentoring as well as to allow better engagement with residents and visitors.
• We are re-enforcing specific roles and responsibilities within the home, starting with our RGN. The RGN is the leader of the care team on each shift and is responsible for the care and wellbeing of the Residents from their unit, each shift.
•

Regulation 24: Contract for the provision of services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 24: Contract for the provision of services:
• We will ensure that all Residents have an agreed contract of care which clearly states the terms on which the Resident will reside within the home, and will carry out audits of compliance with this requirement monthly.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
We have amended our complaints procedure to reflect the amendments to the regulations that came into effect in March 2023 (S.I. 298 of 2022)

Regulation 25: Temporary absence or discharge of residents	Not Compliant

Outline how you are going to come into compliance with Regulation 25: Temporary absence or discharge of residents:
• We use the national transfer documentation for our discharges and transfers out, however we have developed our own checklist to prompt staff what supporting information should accompany all Residents.
• We have also a new practice in place where we ask the ambulance service to sign that they have received the various documentation from us when escorting our Residents from the home.

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:
Care planning development is one of the topics which is being discussed at our staff nurse re-orientation training days. The importance of ensuring that the careplan accurately reflects both the outcome of the assessment carried out and the information supplied by family/next of kin/home carer is being emphasized

With the additional hours now for oversight from the CNM (7days p/w) and the DPIC, we will be able to audit & monitor careplans and their relevance. We have also commenced conducting care review meetings with Residents and their nominated representative where we will discuss careplans also. This will help ensure that the information captured within a careplan is accurate.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
• We have developed "prompts" for staff to refer to when caring for a Resident with a pressure sore, nutritional vulnerability. These prompts are to assist staff what steps must be followed to ensure comprehensive assessment and care is given.
We have a detailed handover between CNM/DPIC & PIC each day to ensure that overall care for each Resident is being managed appropriately.

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:
• Our staff have had training in positive behavioral support since the inspection to be able to further support our Residents. This is conjunction with our staff nurse training and our additional supervisory hours each day, will assist our nurses and HCA in identifying responsive behaviour, patterns, triggers etc and how to care for our Residents during these incidents.
• Documentation will be reviewed for bedrail placement and release to ensure all checks are fully documented.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• We endevour to tend to the individual needs of our Residents as they arise and through the care review meetings we will be able to further gauge the timings and wishes of our Residents.
• We will continue to offer to our Residents each day a timely assistance to bed and offer showers/bathing as they wish each day with personal hygiene.
• We have a suggested shower list however as discussed on the day of inspection this is to ensure that at a minimum all Residents are offered shower/bath once a week. Residents may of course have a shower any day that they wish.
• We have conducted since the inspection a further continence assessment for all of our Residents and will do our utmost to be available to all of our Residents as they require us to be.
• We have conducted a full call bell placement audit and are in process of moving some of the bells to a more accessible placement to enable our Resident to access same from either bed or chair with ease.
• We have recruited and are continuing to recruit activity staff to add to our team. Through the Resident meetings and surveys, we are able to adjust our planner to ensure that all those who wish to engage are able to do so as often as they wish. We currently have 95 1:1 sessions throughout the week and over 15 group activities also. This is always under review as Residents preferences can vary from week to week.
• We have removed all Residents names from our safety cross.
• We will continue to improve on our laundry service and ensure that clothes are returned in a timely manner to the correct Resident.

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.	Not Compliant	Orange	30/01/2024
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	30/10/2023
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/09/2023
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the	Not Compliant	Orange	30/11/2023

	effective delivery of care in accordance with the statement of purpose.			
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	30/11/2023
Regulation 24(1)	The registered provider shall agree in writing with each resident, on the admission of that resident to the designated centre concerned, the terms, including terms relating to the bedroom to be provided to the resident and the number of other occupants (if any) of that bedroom, on which that resident shall reside in that centre.	Substantially Compliant	Yellow	30/09/2023
Regulation 25(1)	When a resident is temporarily absent from a designated centre for treatment at another designated centre, hospital or elsewhere, the person in charge of the designated centre from which	Not Compliant	Orange	30/09/2023

	the resident is temporarily absent shall ensure that all relevant information about the resident is provided to the receiving designated centre, hospital or place.			
Regulation 34(2)(b)	The registered provider shall ensure that the complaints procedure provides that complaints are investigated and concluded, as soon as possible and in any case no later than 30 working days after the receipt of the complaint.	Substantially Compliant	Yellow	22/09/2023
Regulation 34(2)(c)	The registered provider shall ensure that the complaints procedure provides for the provision of a written response informing the complainant whether or not their complaint has been upheld, the reasons for that decision, any improvements recommended and details of the review process.	Substantially Compliant	Yellow	22/09/2023
Regulation 34(2)(e)	The registered provider shall ensure that the complaints procedure provides that a review is conducted and	Substantially Compliant	Yellow	22/09/2023

	concluded, as soon as possible and no later than 20 working days after the receipt of the request for review.			
Regulation 34(2)(f)	The registered provider shall ensure that the complaints procedure provides for the provision of a written response informing the complainant of the outcome of the review.	Substantially Compliant	Yellow	22/09/2023
Regulation 34(2)(g)	The registered provider shall ensure that the complaints procedure provides for the provision of a written response informing the complainant when the complainant will receive a written response in accordance with paragraph (b) or (e), as appropriate, in the event that the timelines set out in those paragraphs cannot be complied with and the reason for any delay in complying with the applicable timeline.	Substantially Compliant	Yellow	22/09/2023
Regulation 34(2)(h)	The registered provider shall ensure that the complaints procedure provides for the persons nominated under	Substantially Compliant	Yellow	22/09/2023

	paragraph (a) and (d) should not be involved in the subject matter of the complaint, and as far as is practicable, shall not be involved in the direct care of the resident.			
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Not Compliant	Orange	30/10/2023
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 that resident's family.	Substantially Compliant	Yellow	30/10/2023
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of	Not Compliant	Orange	30/10/2023

	evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.			
Regulation 7(2)	Where a resident behaves in a manner that is challenging or poses a risk to the resident concerned or to other persons, the person in charge shall manage and respond to that behaviour, in so far as possible, in a manner that is not restrictive.	Substantially Compliant	Yellow	30/10/2023
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Substantially Compliant	Yellow	30/10/2023
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Not Compliant	Orange	30/10/2023
Regulation 9(3)(d)	A registered provider shall, in	Substantially Compliant	Yellow	30/10/2023

	so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned.			