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:	CareChoice Ballynoe
Name of provider:	Carechoice Ballynoe Limited
Address of centre:	Whites Cross, Cork
Type of inspection:	Unannounced
Date of inspection:	07 September 2021
Centre ID:	OSV-0000210
Fieldwork ID:	MON-0032965

About the designated centre

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

Carechoice Ballynoe (known as Ballynoe) is a designated centre which is part of the Carechoice group. It is located in a rural setting of Whites Cross and is a short distance from the suburban areas of Ballyvolane and Blackpool, Cork city. It is registered to accommodate 51 residents. Ballynoe is a two-storey facility with lift and stairs to enable access to the upstairs accommodation. It is set out in three corridors on the ground floor called after local place names of Glen, Shandon and Lee; and Honan on the first floor. Bedroom accommodation comprises five single rooms with wash-hand basins, six twin rooms and 34 single rooms with en suite facilities of toilet and wash-hand basin; 15 residents are accommodated upstairs. Additional shower, bath and toilet facilities are available throughout the centre. Communal areas comprise a comfortable sitting room, Morrissey Bistro dining room, large day room and a large quiet room with comfortable seating. The hairdressing salon is located near the main day room. There is a substantial internal courtyard with lovely seating and many residents have patio-door access to this from their bedrooms; there is a second smaller secure courtyard accessible from the quiet room. At the entrance to the centre there is a mature garden that can be viewed and enjoyed from the sitting room, dining room and some bedrooms. Carechoice Ballynoe provides 24-hour nursing care to both male and female residents whose dependency range from low to maximum care needs. Long-term care, convalescence care, respite and palliative care is provided.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	26

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 7 September 2021	09:00hrs to 19:15hrs	Breeda Desmond	Lead
Tuesday 7 September 2021	09:00hrs to 19:15hrs	Mary O'Mahony	Support

What residents told us and what inspectors observed

Overall, inspectors observed improvement in the centre since the last inspection in April 2021. Inspectors spoke with several residents in the day room, in their bedrooms and garden throughout the day, and two visitors in the garden. Feedback from residents was positive about the care they received. Residents said that staff were excellent, very attentive and caring. Visitors were happy with the visiting arrangements as they were able to visit and chat in the quiet of their bedrooms. Relatives said there was good communication by the centre on the care and well-being of their relative as well as the changing COVID-19 precautions. Residents were complimentary about the quality of their meals and reported that, in general, there was a good variety of activities available to them.

There were 26 residents residing in CareChoice Ballynoe at the time of inspection. On arrival for this unannounced inspection, inspectors were guided through the centre's infection prevention and control (IPC) procedures by a member of staff, which included a signing in process, disclosure of medical wellness or otherwise, hand hygiene, face covering, and electronic temperature check. There was a hand-wash hub at main reception for visitors and staff to complete hand washing on entry to the centre. A hands-free waste bin was located alongside the hand-wash sink.

This was a two storey facility with resident accommodation on both floors, with lift and stairs access to the first floor. The main entrance was wheelchair accessible. The upstairs remained closed and the person in charge informed inspectors that redecorating the upstairs was in progress as part of their refurbishment plan to upgrade the premises.

At reception, the statement of purpose, residents' guide, national standards and annual review were displayed. The main day room was located to the right of reception. This was a large room laid out in four pods with seating arranged to facilitate social distancing while at the same time enabling residents to sit and relax and meet up with their friends to socialise. The person in charge explained that an audit was completed of the furnishings and following on from that audit, a lot of the furniture was being replaced and this included seating in the day room. Downstairs, there were two smaller sitting rooms; one of which had an outdoor visitors' snug with seating to support window visits. This was a comfortable cosy room with beautiful furnishings, seating and fireplace for residents and visitors to relax. The second sitting room was currently used by staff as part of the COVID-19 social distancing precautions.

There was an activities board by the main day room with information for residents such as the minutes of the last residents' meeting, the satisfaction survey, and the monthly Ballynoe news letter. The weekly activities programme was an expansive board with easily accessible pictorial and written information for residents. Activities were seen to be facilitated over a seven-day period with activities such as fit-for-life exercise programme, flower arranging, arts and crafts, board games and music

appreciation for example. The activities co-ordinator was observed to chat and encourage residents to participate in the activities; mass was live streamed and many residents were happy with this. Following mass, tea, juices and snacks were offered to residents. Some residents were enjoying knitting and showed off their work.

Overall, the premises was bright and clean, and had been recently painted and looked well. During the morning and afternoon walkabouts, most residents were up and about in the day room and garden, while a few residents remained in their bedrooms in accordance with their choice.

There was orientation signage displayed around the centre to orientate residents to rooms such as the dining room and day room to allay confusion and disorientation. Nursing offices were by reception, and the dining room was found to the left of reception. Residents' bedroom accommodation was beyond reception in adjoining corridors. Residents' bedrooms comprised single and twin bedrooms. Additional shower rooms were being installed at the time of inspection to enable residents easy access to shower facilities near their bedrooms, and to come into compliance with Condition 4 of their registration. The hairdressers' room was painted, with new curtain rails in place, and they were awaiting delivery of new curtains. Store rooms had new shelving which enabled appropriate storing and cleaning. Upstairs, residents' bedroom accommodation comprised 12 single occupancy bedrooms; all with toilet and wash-hand basin en suite facilities. The number of bedrooms upstairs had reduced with bedrooms converted into communal rooms of a new sitting room and dining room. Both rooms were bright, comfortable and relaxing; the new dining room had kitchenette facilities, dining furniture as well as seating by the window. The bathroom upstairs was refurbished with bespoke porcelain facilities. The nurses station was opened up to enable staff to be more accessible to residents and visitors. Downstairs, bedrooms were personalised and decorated in accordance with residents wishes. Storage for residents' personal possessions comprised double wardrobes, chest of drawers and bedside lockers. Privacy screens in shared rooms were effective and ensured residents' privacy. The doors to residents' bedrooms resembled a 'front door' with wrought iron-like number and door knocker, and each was coloured differently as an aid to residents to identify their own 'front door'.

The dining room was freshly painted and was bright and uplifting. Shelving was removed from the dining room making it brighter, less cluttered and more airy. Tables were set prior to residents coming for their meal and had small vases with fresh flower to brighten tables. Medications were seen to be administered after dinner so that mealtime was protected for residents. Improvement was noted as waiting times had significantly reduced for residents to be served from when they were seated for their meal. However, residents sitting together at tables were not always served at the same time. Two residents were given chicken for their dinner even though they both said they never ate chicken. In addition, throughout the day, staff differentiated long-stay and short-stay residents and referred to short-stay residents as 'the HSEs', which was not in keeping with a person-centred approach to care.

Following mealtime in the dining room, residents returned to the day room, and a

transfer of a resident from wheelchair to armchair was observed. Two staff were involved in the transfer and they explained to the resident what was happening and gently directed the resident regarding the transfer in a respectful manner. Other interactions observed in the day room were not as respectful, as a nurse stood over a resident while providing assistance with fluids; a second staff was updating records on an i-pad while assisting the resident with their meal.

One resident was moved to a different room due to refurbishment in her bedroom. The resident's belongings were observed on the resident's bed. When the inspector asked if the resident was being discharged she was informed that the resident had transferred into this room. This transfer happened just before lunch time so all her belongings were left on the bed as staff were assisting with mealtime. This was brought to the attention of a member of staff, and while she immediately went to the room to stow away the resident's clothes, she did not engage with the resident to see where she would like her belongings to be displayed and stored.

Observations on inspection showed that staff had good insight into responding to and managing communication needs and provided support in a respectful professional manner. For example, taking residents for walks and orientating them to the time and day to allay confusion and anxiety.

There were two enclosed garden areas for residents to enjoy. The main garden was bright and colourful and had comfortable seating, tables and parasols. There were raised garden beds around the perimeter, all painted brightly. The array of flowers, trees and shrubs was gorgeous and colourful. Inspectors met with several residents and relatives out here throughout the day as it was a lovely warm sunny day. One resident had their dinner there and was joined by a visitor. In the afternoon, 16 residents enjoyed the sunshine and activities. The activities staff ensured that residents had ample fluids, sun hats and sun screen, and parasols were opened for those who preferred to stay in the shade. In the smaller garden, residents had planted herbs and vegetables. The residents' smoking area was located within this enclosed garden. It had a fire blanket, apron and metal receptacle for disposing cigarettes and matches.

Wall-mounted hand sanitisers were displayed throughout the centre and staff were observed to comply with best practice hand hygiene. Staff and visitors were observed completing hand washing on entry to the building as well. There were separate staff changing rooms and canteen facilities available. Storage of personal protective equipment (PPE) was in designated spaces which did not impact residents' space or areas. The cleaners room had a hand-wash sink and a low sluicing sink; mops were stored off the ground.

Appropriate signage was in place indicating storage of oxygen in a secure location. Medication trolleys were securely maintained and did not obstruct emergency escape routes. Fire doors previously identified as mal-aligned, were all rectified and new heat and smoke seals were seen on fire doors. Emergency evacuation plans were displayed in the centre; these were large and colour-coded with zones identified, however, evacuation routes were not identified; some were not orientated to reflect their relative position in the building. There was an old armchair

stored in the boiler house and inspectors requested that it be removed as it was a potential fire hazard and this was removed immediately.

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

Improvement was noted in the delivery of services in CareChoice Ballynoe following from the previous two inspections in February and April 2021. Nonetheless, an urgent compliance plan was issued on the day of inspection requesting that evacuations of compartment, cognisant of night duty staff levels, be carried out to be assured that all staff could complete an evacuation in a timely and safe manner.

CareChoice Ballynoe was a residential care setting operated by CareChoice Ballynoe Limited and was registered to accommodate 51 residents. CareChoice Ballynoe was part of the CareChoice group which operated a number of other nursing homes throughout the country. The governance structure of CareChoice comprised a board of directors with the CEO appointed as the nominated person representing the registered provider. The management team within the centre was supported by a national and regional management team of quality, finance, catering, maintenance and human resources (HR). On site, there was a recently appointed person in charge who was full time in post and she was supported by two recently appointed assistant directors of nursing, and clinical nurse managers (CNMs).

This unannounced risk inspection was undertaken to follow up on the non compliance findings of the inspections on 11 February and 27 April 2021. Improvement was noted with regulations relating to governance and management as clear governance arrangements with associated deputising arrangements were in place, and staff were familiar with these arrangements. There was ongoing monitoring of the service evidenced including medication management, statutory notifications, management and oversight of the complaints procedure, risk management, a post COVID-19 outbreak review was undertaken, and satisfaction surveys were completed in August with residents, seeking their feedback on all aspects of their life in the centre. However, similar to the previous inspection failings, there continued to be a lack of robust recruitment practices as well as lack of oversight of HR practices relating to staff appraisals, performance management and staff supervision. An additional non compliance was identified regarding fire safety.

There was evidence of improved governance and oversight of the centre with monthly clinical governance meetings, where issues such as human resources, complaints, incidents, audits, and key performance indicators were discussed and monitored. A new template for minutes of these meetings was being rolled out at the time of inspection to facilitate more robust record keeping. The template seen

ensured that the date, time, attendees and absentees could be recorded as well as facilitate recording of discussions. This was welcomed as the current template did not facilitate these measures. Improvements identified had associated action plans with responsibilities assigned and the progress status relating to the actions. A monthly clinical governance meeting was scheduled for the day following the inspection and minutes of these meetings were requested. They were submitted and demonstrated thorough review and discussion of agenda items. In addition, remedial action plans were detailed for areas identified for improvement; responsibilities were assigned to designated staff; and there was ability to record time-lines and progress status.

The audit schedule for 2021 was evidenced and showed clinical, observational and practice audits. The audit programme enabled good oversight of the service and audit results fed into the monthly governance meetings. The person in charge understood the value of auditing the service and how the results of audits and satisfaction surveys would influence quality improvement. Regarding the building, there was a project plan in place for upgrading the premises including painting and decorating, and new furniture procurement.

The regional manager informed inspectors that the staff levels was under continuous review with the changing needs of residents and the change in bed allocation with respite and convalescent residents accommodated. On the day of inspection there were adequate staff to the size and layout of the centre and the assessed needs of residents.

A sample of staff files were reviewed. The registered provider had not ensured that Schedule 2 documents (documents to be held in respect of the person in charge and each member of staff) were in place for all staff prior to their commencement of employment, as part of their safeguarding arrangements. This was a repeat finding.

The statement of purpose was updated on inspection to ensure compliance with the regulations. Policies and procedures as listed in Schedule 5 of the regulations were available and up-to-date. A current insurance policy was displayed in the centre.

The complaints' records were examined and improvement was noted in the complaints process and complaints were recorded in line with regulatory requirements.

Regulation 14: Persons in charge

The person in charge was appointed in June 2021 and had the necessary experience and qualifications as required in the regulations. She was a registered nurse who was full time in post and actively engaged in the governance and operational management of the service.

Judgment: Compliant

Regulation 15: Staffing

The staff roster showed that the number and skill mix of staff was appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the centre.

Judgment: Compliant

Regulation 16: Training and staff development

The training matrix examined showed that staff training was up to date for mandatory and other training. Nonetheless, appropriate supervision arrangements were not in place. For example, one nurse was observed to stand over a residents while assisting with their fluids; another staff was completing recording on the I pad while providing assistance to a resident when having their tea.

Judgment: Substantially compliant

Regulation 21: Records

The duty roster shown to inspectors had those employed, on sick leave and staff who were no longer working in the centre, and a staff member from another centre included in the duty roster. While the HR manager outlined that the roster was a payroll template, staff on the ground did not have easy access to the 'working' duty roster. The 'worked' roster did not reflect all the current staff on duty on the day of inspection. For example, the current ADONs were not identified on the duty roster; the previous DON was included and not acknowledged as being on leave; the current person in charge was identified as a regional quality and compliance manager. So it was difficult to see who was on duty at any given time or who was responsible for the service on a daily basis.

Schedule 2 staff files showed that two staff had returned to the service following a term working elsewhere, however, they had just one reference each, and one of these was a statement of employment dates rather than a reference. While the HR manager explained that references were verified, this evidence was not demonstrated or accessible on inspection.

Judgment: Substantially compliant

Regulation 22: Insurance

A current insurance certificate was displayed in the centre.

Judgment: Compliant

Regulation 23: Governance and management

The inspectors identified that while improvement was noted in the overall delivery of services, it would take time for the new governance structure to bed down and for quality systems to become embedded to ensure the service provided was safe, appropriate, consistent and effectively monitored. Some issues were identified with the governance and management during the inspection:

- a urgent compliance plan was issued on inspection relating to fire safety precautions. This was further detailed under Regulation 28, Fire precautions.
- the management systems in place around the recruitment and oversight of staff recruitment were not sufficiently robust to ensure effective safeguarding measures for all residents. This was a repeat non compliance.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose was updated on inspection to accurately reflect the whole-time equivalent staff numbers, the current deputising arrangements for times when the person in charge was absent from the centre, dependency descriptors, and facilities included in the floor plans.

Judgment: Compliant

Regulation 31: Notification of incidents

Improvement was noted in the submission of notifications to the Chief Inspector. Notification submitted since the last inspection of April were timely submitted.

Judgment: Compliant

Regulation 34: Complaints procedure

Improvement was noted in the complaints procedure; it was implemented in practice and complaints were maintained in line with regulatory requirements. Furthermore, a thorough review of complaints was completed; a synopsis of each complaint was detailed and trends identified. An action plan was compiled with responsibilities assigned. This included better structures to ensure a robust process regarding communication, visiting, laundry, maintenance of personal belongings and outbreak management of infection.

Judgment: Compliant

Regulation 4: Written policies and procedures

Schedule 5 policies and procedures were available to staff.

Judgment: Compliant

Quality and safety

Inspectors observed that, in general, care and support given to residents was respectful; staff were kind and were familiar with residents preferences and choices and facilitated these in a friendly manner. Issues identified on the inspection in April requiring immediate attention such as the mal-alignment of fire doors, or the placement of the medication trolleys obstructing fire doors, were remedied. Improvement was noted in fire safety check records with daily check, weekly emergency lighting checks and monthly fire door checks comprehensively maintained. Nonetheless, while simulated evacuations had occurred, an evacuation of a compartment was not completed and an urgent action was given on inspection regarding this.

Visiting was in line with current HPSC guidance of September 2021 and visitors to the centre were seen throughout the day in various locations such as bedrooms, garden and day room. Appropriate IPC precautions were adhered with coming and going from the centre.

Minutes of residents' meetings showed that these were well attended and lots of areas were discussed relating to their quality of care and quality of life; issues were followed up in subsequent meetings.

The GP attended the centre and documentation showed that medications were regularly reviewed along with assessment of the resident. The GP had his own user code for the on-line care documentation system and could remotely access residents' notes to update or activate prescriptions. Residents had timely access to psychiatry of old age, surgical reviews, dietitian, speech and language therapist, geriatrician and palliative care. The physiotherapist was part-time in the centre and completed 'fit for life' assessment and care plans to enable residents maintain their current level of mobility as well as strengthen their muscle tone.

Pre-admission assessments were undertaken by the director of nursing to ensure that the service could provide appropriate care to the person being admitted. As part of this pre-admission assessment the family completed a 'brief life history', this was then followed up by the activities person to further enhance the information available so that staff could actively engage with residents, chat about their interests and include their interests in the activities programme. The daily narrative was comprehensive in the care documentation examined. Sometimes there were several entries during the day which provided a holistic picture of the care required and given. A sample of care plan documentation was reviewed. Residents had evidence-based risk assessments to guide care and documentation showed that residents were consulted with regarding their care; these assessments were completed in line with regulatory requirements. The transfer letter template was part of the on-line care documentation available to staff to complete when an resident was transferred out of the centre so they could be appropriately cared for by the receiving facility. Controlled drug records were securely maintained.

New safety huddles were introduced to highlight safety and risk issues such as residents at high risk of falls, absconsion, infection, food and fluid encouragement for example and staff reported that this worked well. Staff spoken with and practice observed showed that staff had good insight into residents' specific care needs relating to behaviours and communication needs, and measures put in place to support residents.

Household staff described best practice regarding cleaning regimes and the use of colour-coded cloths and solutions. Laundry was segregated at source and laundry staff described best practice work-flows in the laundry to prevent cross infection in line with the national standards for infection control.

Regulation 11: Visits

Visiting was facilitated in line with September 2021 HPSC guidance. Measures were taken to protect residents and staff regarding visitors to the centre with a hand-wash hub inside the main entrance; face masks, hand sanitising gels and advisory signage were available throughout the centre.

Judgment: Compliant

Regulation 12: Personal possessions

Storage for personal possessions included a double wardrobe, chest of drawers and bedside locker for each resident. A lockable unit formed part of the storage available to residents.

Judgment: Compliant

Regulation 13: End of life

A sample of care plans reviewed showed that staff had actively engaged with residents to obtain their end-of-life care wishes. A holistic approach was taken to this and information recorded. End-of-life care documentation showed that residents had timely access to palliative care specialist, GP services and other allied health professional support.

Judgment: Compliant

Regulation 17: Premises

New shower facilities were being installed at the time of inspection to ensure residents had easy access to shower facilities. This work was due to be completed by the end of September in compliance with Condition 4 of their registration.

Judgment: Compliant

Regulation 18: Food and nutrition

The 'kitchen staff information guide' was a good reference document for staff with photographs of residents and their allergies, specialist and textured diets. The chef and catering manager had completed an in-depth audit of the dining experience and were in the process of changing practices to enable a better dining experience for residents. The nutritional status of residents was monitored through regular weights and nutritional assessments.

Meals were well presented, including textured meals. Residents were offered drinks and snacks throughout the day between meals. Mealtime was protected as medications were administered after meals to ensure residents enjoyed their dining

experience un-interrupted.

Judgment: Compliant

Regulation 25: Temporary absence or discharge of residents

Transfer letters were evidenced on inspection to be assured that information was available when a resident required acute care or transfer to another institution so they could be appropriately cared for by the receiving facility. Following discharge back to the centre, comprehensive information was available when the resident returned to the centre.

Judgment: Compliant

Regulation 26: Risk management

A current safety statement and risk management policy were available. The risk management policy had the specified risks as listed in regulation 26.

Judgment: Compliant

Regulation 27: Infection control

A post COVID-19 outbreak review was undertaken to identify areas for learning and improvement. Areas identified had action plans with time-lines and responsibilities assigned. This was reviewed in conjunction with the review of complains as the trended information for complaints included outbreak management as well as communication deficits; all these were acknowledge in the outbreak review. Control measures put in place included staff designated to communicate with families and residents regarding the changing COVID-19 precautions in line with current HPSC guidance.

Dani centres were removed from sluice rooms and placed outside the sluice rooms for staff to access personal protective equipment (PPE).

The laundry was neat and tidy and clothes were segregated appropriately. Other precautions in place for infected laundry included the use of alginate bags. Sluice rooms and clinical rooms were secure access to prevent unauthorised access to hazardous waste and clinical products.

Judgment: Compliant

Regulation 28: Fire precautions

Simulations of evacuations of compartments were not completed to be assured that all staff could complete an evacuation in a timely and safe manner. An urgent compliance plan was issued on inspection requesting evacuations of compartments cognisant of night duty staff levels. The compliance plan returned provided assurances that the service actioned the plan in a robust manner to ensure the safety of residents and staff. Further drills were scheduled on a weekly basis to ensure all staff were competent.

Emergency floor plans were displayed; they were colour-coded displaying fire alarm zones with a point of reference highlighted, however, evacuation pathways were not detailed to ensure persons had access to the building layout and escape routes available.

The fire hydrant monthly test records given to inspectors as part of the fire safety documentation, did not have the hydrant checks recorded.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

Issues identified on the last inspection were remedied. Medications and associated documentation were maintained in line with legislation and professional guidelines. New controlled drug ledgers were introduced since the last inspection to enable more robust records and mitigate risk of potential errors or near miss episodes.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Improvement was noted in the sample of care plan documentation examined. Care plans were updated every four months along with the changing needs of residents. They were person-centred and demonstrated good insight into residents and their psycho-social needs including friendships and relationships important to the resident as well as their interests, previous work life and holidays they enjoyed.

Judgment: Compliant

Regulation 6: Health care

Residents had regular access to on-site GP consultation. Residents medications were reviewed as part of their consultation with their GP and ongoing monitoring and responses to medication were seen. In the sample of residents' care documentation examined, appropriate records were seen regarding supports for communication needs. Residents had access to specialist services such as psychiatry of old age, palliative care, speech and language, dietitian and optician. Residents documentation showed that families were involved in care and the decision-making process. Wound care management seen was comprehensive with current assessments and photos to support the ongoing assessment of wound progress status. Care plans were updated following specialist input from services such as the dietitian and speech and language therapist. Fluid balance charts were maintained in accordance with the care needs of residents.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Observational and behavioural charts were in place for residents requiring additional supports to help in identifying causes of upset or anxiety. Observation on inspection showed that staff had good insight and knew residents well and re-directed in a kind and respectful manner and provided re-assurances which allayed upset and frustration.

Judgment: Compliant

Regulation 8: Protection

Safeguarding training was provided to staff and this was up to date for all staff. Inspectors observed that residents were relaxed, well dressed and had freedom of movement.

Judgment: Compliant

Regulation 9: Residents' rights

Residents had access to meaningful activities over seven days of the week; the

activities co-ordinator knew residents interests and encouraged people to take part in the activity programme. Minutes of residents' meeting were seen. The last meeting was held on 11 August 2021 where 16 residents attended and six declined. The meeting was attended by the person in charge, deputy person in charge, and nurse managers and activities co-ordinator. Many issues were discussed including the refurbishment of the centre, painting and re-decorating and choosing colours for their bedrooms and the centre. The activities programme discussion included the 'September evening of Music', the CareChoice Art competition, outings, in-house music and mass. Residents feedback was recorded and issues raised such as noise and banging doors during the night were followed by the person in charge. Minutes of these meetings were available and on display on the activities board by the main day room for residents to independently access.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 13: End of life	Compliant
Regulation 17: Premises	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for CareChoice Ballynoe OSV-0000210

Inspection ID: MON-0032965

Date of inspection: 07/09/2021

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:

<table>
<tr><th>Regulation Heading</th><th>Judgment</th></tr>
<tr><td>Regulation 16: Training and staff development</td><td>Substantially Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 16: Training and staff development:
• The nursing home will provide ongoing training to staff on person centered mealtimes and ensure that appropriate supervision is in place to enhance the mealtimes experience. Mealtimes are supervised by the clinical management team with ADON support on a daily basis.

• As part of ongoing review of the mealtimes all staff will attend IDDSI training, and this was completed 11/10/2021.

• To ensure there is positive engagement for residents at mealtimes, the engagement and interaction between staff and residents at mealtimes will be assessed and reviewed using the QUIS Audit. The findings of these assessments will be relayed to staff during the staff huddles.

• As part of ongoing clinical training an enhanced system has been implemented to reflect monthly topic on the staff education board. The topic of Nutrition and mealtimes is scheduled to be completed in December.

• Inhouse walk arounds by Nurses and ADON and DON are introduced at varying frequencies during the day to ensure clinical oversight & governance are in place. Feedback will be provided to the DON as appropriate and review and follow up implemented as necessary.</td></tr>
<tr><td>Regulation 21: Records</td><td>Substantially Compliant</td></tr>
</table>

Outline how you are going to come into compliance with Regulation 21: Records: • The staff roster is maintained on an electronic system. All staff have individual access to their current roster via individual log in. The clinical management team have access to view and print a current working roster and have been provided with further training on how to print this roster appropriately. • The worked roster is reviewed on a daily basis by the PIC and HR generalist to ensure that it reflects all the current staff on duty, relevant job titles and acknowledgment of individual staff leave. The Registered provider has requested that the noncompliance be reviewed for this regulation in light of the following: • The two staff files referred to as non-compliant as part of staff files reviewed by the inspector had returned to work in the nursing home in July after leaving the previous month to work elsewhere. Each file has two verified references on file which are from their last two employers, in addition to a verification of employment from the company they most recently worked for. The HR generalist had recorded that this company explained that they no longer complete individual references and only issue verification of employment. • We have reviewed our policies to reflect the acceptance of statement of employment which meets the minimum requirements in providing a reference. We have retrained all HR generalists to reflect same.	

Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: In relation to regulation 28: • The nursing home is completing evacuation drills to simulate full compartment drills weekly. These will be reviewed in the future by a fire consultant to determine when it is appropriate to move to monthly compartment fire drills. The home will ensure that all staff have taken part in regular compartment fire evacuation drills. As part of the daily safety huddles a support training questionnaire has been developed and is discussed to assist with staff awareness and knowledge of the fire management & evacuation strategy in the home. The provider has requested that the severity of the judgement on governance and management be reconsidered based on the following: • The two staff files referred to as non-compliant as part of staff files reviewed by the inspector had returned to work in the nursing home in July after leaving the previous month to work elsewhere. Each file had two verified references on file which are from	

their last two employers prior to leaving in June. This was in addition to a verification of employment from the company they most recently worked for. The HR generalist had recorded that this company explained they no longer complete individual references and only issue verification of employment.

• The home as a robust electronic personnel file system in place. Each employee has a document tab on their profile on this System. The document section for each employee contains a number of subheadings such as resume & reference which includes their most recent CV, two reference checks (one from the most recent employer), Job description, Gaps in employment if any & Interview notes. There is also a Garda Vetting folder which includes Vetting disclosure, Photo ID, proof of address, and 100 points check.

• The HR team receive training and a guidance document on storing of these documents has been provided. Continuous audit of employee's files to ensure compliance is underway.

• The clinical management team in the home will undergo retraining to ensure that they are proficient in the use of the HR system.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• Full compartment drills are simulated and are taking place weekly. These will be reviewed in the future by the H&S officer in conjunction with a fire consultant to determine when it is appropriate to move to monthly compartment fire drills. The home will ensure that all staff have taken part in regular compartment fire evacuation drills. As part of the daily safety huddles a support training questionnaire has been developed and is discussed to assist with staff awareness and knowledge of the fire management & evacuation strategy in the home.

• Emergency floor plans are being reviewed to reflect colour coding, display fire alarm zones with a point of reference highlighted and include detail evacuation pathways to ensure persons had access to the building layout and escape routes available.

• Documentation in relation to recording the fire hydrant checks has been reviewed and monthly fire hydrant test records are in place and will be verified on a monthly basis.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	01/11/2021
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	01/10/2021
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	01/10/2021
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for	Substantially Compliant	Yellow	01/11/2021

	reviewing fire precautions.			
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Orange	10/09/2021