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:	Castleturvin House Nursing Home
Name of provider:	Castleturvin Home Limited
Address of centre:	Athenry, Galway
Type of inspection:	Unannounced
Date of inspection:	03 May 2022
Centre ID:	OSV-0000327
Fieldwork ID:	MON-0036813

About the designated centre

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

Castleturvin House Nursing Home is registered to provide care for 42 residents. It is purpose-built and located in a rural setting a short drive from the town of Athenry. The building was laid out over two storeys with lift access provided to the first floor. Accommodation is provided in 22 single and 10 double rooms, all of which have en-suite facilities. There are communal areas on both floors. Externally there are extensive grounds with a large garden area that is accessible to residents. Many rooms have doors that lead directly onto the garden. Residents that have high, medium or low care needs are accommodated and care is provided on a long or short term basis.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	34

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 3 May 2022	09:30hrs to 18:50hrs	Oliver O'Halloran	Lead
Tuesday 3 May 2022	09:30hrs to 18:50hrs	Catherine Sweeney	Support

What residents told us and what inspectors observed

Inspectors spoke with residents and observed staff interactions with residents throughout this inspection. Overall, inspectors found that residents enjoyed a good quality of life in the centre. Residents spoken with said that staff were kind and respectful. Inspectors observed staff assisting residents in a respectfully and engaging manner. Staff were observed to be kind and patient in all their interactions with residents.

This unannounced risk inspection took place over one day. There were 34 residents accommodated in the centre on the day of inspection.

On arrival to the centre, inspectors were met by the assistant director of nursing, who guided them through the infection prevention and control measures in place. Following an introductory meeting, inspectors walked around the centre with the person in charge.

Inspectors observed some residents spending time in their bedrooms, other residents were walking about the centre, and a number of residents were seen spending their day in the communal day rooms in the centre. Inspectors observed residents visiting each other in their bedrooms and having tea served to them by staff while they chatted.

The centre is set out over two floors. Approximately two thirds of residents in the centre were living with a cognitive impairment. A dementia unit, the Waldron Unit, which has been designed to meet the needs of residents living with cognitive impairment, is situated on the ground floor and accommodates six residents.

The design and layout of the building was suitable to meet the residents' individual and collective needs. The reception area of the centre had a furnished seating area. The centre was found to be well lit and warm on the day of inspection. Corridor areas were wide with grab rails to assist resident mobility. The centre appeared visibly clean. There was a large resident day room upstairs, with a dining room and day room downstairs. In the Waldron unit, the residents' day room also functioned as the residents' dining room. This day room area had direct access to an enclosed garden area, which residents could access independently.

The centre had two internal garden areas with mature trees and garden furniture, both were accessible directly from some ground floor bedrooms. There was a conservatory in one of the internal courtyards. A number of residents were observed to be spending time in the garden areas during the inspection. Resident's bedrooms were seen to be personalised with the residents own photographs and ornaments.

Residents were observed to be socially engaged throughout the day of inspection. Group and one-to-one activities were scheduled and were facilitated by two activity

coordinators. Residents told the inspectors that there was always something to do.

The lunch-time experience was observed on the Waldron unit by inspectors. Inspectors observed some residents being supported with their meals in a dignified and respectful manner. The lunch-time meal appeared to be freshly prepared and nutritious. Residents spoken to were, in the main, complimentary about the food, describing it as 'good' and 'nice'. Residents confirmed that snacks and drinks were readily available between meals, if requested. One resident told the inspectors that they would prefer if the menus were shared with the residents in the evenings for the following day, so that they could plan their day around their meal-times. The person in charge agreed that this could be facilitated.

The next two sections of this report detail the findings of this inspection in relation to the capacity and capability of the centre and how this supports the quality and safety of the service provided to residents.

Capacity and capability

The findings of this inspection was that, overall, care was delivered at a satisfactory standard, however, some action was required to ensure compliance with regulations in relation to

- governance and management
- fire precautions
- managing behaviours that challenge
- individual assessment and care plans
- residents' rights

Unsolicited information received by the Chief Inspector was reviewed and found to be substantiated with regard to care and welfare of residents who experience behaviour that is challenging.

This was an unannounced risk inspection, carried out over one day, by inspectors of social services to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended).

Castleturvin Home Limited is the registered provider of the centre. There was a clear management structure in place. The centre was managed on a daily basis by an appropriately qualified and experienced person in charge. The person in charge was supported in this role by an assistant director of nursing. A change to senior management structure had taken place with the recruitment of an operations manager working on-site in the centre.

On the day of inspection, staffing levels were appropriate to meet the assessed needs of the residents in the centre. However, inspectors found that the staffing grade and numbers committed to by the provider in the statement of purpose on

the registration of the centre, did not reflect the current staffing arrangements. The statement of purpose stated that the staffing arrangement for the centre included a social care manager and three social care practitioners. These roles were not in place.

In addition, following the findings of a previous inspection in relation to fire safety, the provider had committed to increasing the night time staffing levels to mitigate the risk associated with incomplete fire safety works. A review of the roster found that this additional member of staff was not consistently rostered every night in the centre.

There was a training schedule in place that included mandatory training for all staff in fire safety, infection prevention and control, safeguarding vulnerable adults from abuse and manual handling techniques. A review of the staff training record found that staff had completed this training. However, staff had not received training in the management of behaviour that challenged. This had a direct impact on the care of residents with complex behaviour. This issue is detailed further under regulation 7: Managing behaviours that challenge.

The governance systems in place to monitor the quality of the service provided was not robust. While there was an auditing system in place, audits reviewed were not fully completed. Information was gathered, however, the information was not analysed and therefore, there was no quality improvement plan developed and communicated to staff.

Inspectors found that regular management and staff meeting were held and an annual review of the quality and safety of care delivered had been completed. However, without a management system that included quality improvement plans, it was not clear how issues arising from audits were addressed.

The centre had a complaints policy which clearly outlined the process of raising a complaint or concern. Complaints were managed in line with regulatory requirements.

Regulation 15: Staffing

On the day of inspection, there were sufficient staff on duty to meet the assessed needs of the residents. There was a registered nurse on duty at all times.

The staffing resources identified in the centre's statement of purpose were not available. This issue is addressed under Regulation 23(a): Governance and Management.

Judgment: Compliant

Regulation 16: Training and staff development

A review of the staff training record that staff had attended training including Fire safety, Manual handling, Safeguarding of vulnerable adults and infection prevention and control. Staff had not completed training in dementia care or the management of responsive behaviours. This is addressed under Regulation 7: Managing behaviours that challenge.

There were adequate levels of supervision in place and staff reported to be well supported by the management team.

Judgment: Compliant

Regulation 23: Governance and management

The provider did not have the staff resources in place as outlined in the staffing arrangements of the centre's statement of purpose. For example, the statement of purpose included four social care staff that were not recruited to work in the centre.

Furthermore, night-time staffing levels committed to by the provider following the last inspection were not consistently available. For example, a review of the roster from the week of the inspection found that four members of staff was rostered at night time from Monday to Wednesday, reducing the three from Thursday to Sunday. This meant that the contingency plan for the safe evacuation of the centre in the event of an emergency was not consistently in place.

Systems for evaluating the quality of the service were not effective. This was evidenced by:

- The system of audit was incomplete, and therefore, could not be used to develop appropriate quality improvement plans. For example, an infection control audit completed in April 2022 identified that nurses were not aware of the waste segregation procedures. However, no actions were identified to address the issues found during the audit.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

All notifications were submitted to the office of the Chief Inspector in line with requirements under Regulation 31.

Judgment: Compliant

Regulation 34: Complaints procedure

There was a centre-specific complaints policy in place, which was in line with regulatory requirements. A complaints log was maintained, which evidenced that all complaints were acknowledged and investigated in a timely manner.

Judgment: Compliant

Quality and safety

On the day of inspection, inspectors found that, in the main, a good standard of care and support was provided to residents. However, inspectors found that the care delivered to a number of residents with complex health and social care needs was not always based on an approach that respected the resident's human rights to the peaceful enjoyment of their possessions (Protocol 1, Article 1, European convention of Human rights, 2021) . Care plans for some residents were found to be prescriptive and did not include the resident, or their representative, such as their family member, as a decision-maker in decisions made to restrict the resident's freedom or choice.

Resident's records and daily progress notes were maintained on a computerised system. While some residents had a pre-admission assessment completed, the quality of the assessment was poorly detailed and did not identify the resources that would be required to meet residents needs. This meant that residents who were exhibiting complex behaviours prior to admission did not have a clear care plan developed on admission to the centre.

All residents had a comprehensive assessment of needs completed on admission. Inspectors found that some assessments were poorly completed and did not reflect the actual care needs of the residents. Assessments were used to develop a care plan to address residents needs. Staff spoken with were familiar with residents and their needs, however, the inconsistent and incomplete information within the residents pre-admission and care assessments, resulted in poorly developed care plans that did not appropriately direct person-centred care.

Inspectors found that restrictive practices were used in the centre as part of the management plan for some residents. The restrictions in place were not always based on appropriate risk assessment or in line with the requirements under Regulation 7: Managing behaviour that is challenging, and the national policy 'Towards a restraint free environment in Nursing Homes' in relation to restraint. A review of the risk register found that the detail recorded was not adequate to

provide assurance that restraint was used in accordance with the national policy. For example, the use of bed rails was inconsistently documented, and other forms of restrictive practices, such as locked doors and with-holding personal property from residents, was not appropriately risk assessed and did not contain assurance that the resident or their representatives were consulted in relation to restrictions imposed on them.

Inspectors found that a significant number of staff had not been provided with training in caring for people with responsive behaviours (responsive behaviours is a term used to refer to actions, words or gestures, presented by a person living with dementia, as a way of responding to something negative, frustrating or confusing in their social and physical environment). Furthermore, inspectors found that staff did not demonstrate appropriate knowledge in the area of managing behaviour that is challenging.

Residents had access to opportunities to participate in meaningful social engagement. Residents were provided with opportunities to be kept informed of and consulted with about the operation of the centre through participation in regular resident's meetings. Residents had access to an independent advocate in the centre.

The provider had completed a significant amount of fire safety works in the centre. Fire systems were regularly checked, and staff were up-to-date with fire procedures. Staff spoken with demonstrated a good knowledge of fire safety and described the evacuation procedure they would use in the event of an emergency. There was evidence that fire drills, incorporating day and night time staffing levels, took place in recent months. However, some fire safety actions from previous inspections had not been completed. Furthermore, the action that the provider had put in place to mitigate the risk associated with the remaining risk was not consistently in place.

Some of the communal indoor space, the library and prayer room downstairs and a resident day room upstairs had been re-purposed due to Covid-19 management in the centre and as yet had not been converted back to communal space for resident use. However, there was adequate communal space available for the residents to use throughout the day.

Regulation 28: Fire precautions

On the day of inspection, there remained an outstanding action from the previous inspection to provide assurance that residents were protected from the risk of fire. For example, a regularisation certificate from the local fire authority was to be available for review. This actions had not been fully completed. The provider submitted the certificate after the inspection.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

The assessment of residents care needs prior to, and at admission, was not comprehensive and did not contain the detail required to plan or guide care. For example, a resident with complex needs was admitted to the centre with a poorly detailed assessment which lacked clarity in relation to the staffing levels, equipment resources and training requirements of staff to ensure that a high quality of care was delivered.

Judgment: Substantially compliant

Regulation 6: Health care

Inspectors found that arrangements were in place for residents to access their general practitioner (GP) as required or requested. There was evidence that residents had access to a range of allied health and social care professionals.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Inspectors found that did not have up-to-date knowledge, appropriate to their role, to respond to and manage behaviour that was challenging. Furthermore,

- the restraint register records were inconsistent and not consistently documented.
- a review of resident's clinical records found that where a resident behaved in a manner that posed a risk to the resident concerned or to other persons that such behaviour was responded to in a manner that was least restrictive.

Judgment: Not compliant

Regulation 9: Residents' rights

Resident's rights were not always found to be upheld in the centre. Restrictive practice was used without assessment or evidence that the resident, or their representative, actively participated in any decision to impose restrictions as part of the resident's care plan. This meant that residents were not always free to exercise choice, in a safe, risk assessed manner, that supported the human rights of the

residents. For example, a resident's access to cigarettes was restricted, without appropriate consultation with the resident in relation to risk.
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	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Castleturvin House Nursing Home OSV-0000327

Inspection ID: MON-0036813

Date of inspection: 03/05/2022

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: An updated statement of purpose was submitted to HIQA on 23/05/22. Complete At the time of inspection, a part time MTA was recruited but was still going through the recruitment process. This is now complete. A full schedule of audits covering a wide range of areas are now in place. A QIP for each audit is in place and discussed at management and staff meetings.	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: Fire regularization Certificate submitted to HIQA on 23/05/22 The provider is committed to fire safety and has put in place additional staffing at night time specifically for fire safety purposes.	
Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan: All nurses attended a care planning training session with external provider on 21/05/22. The pre-admission assessment has been updated to include level of resources required. All care plans and assessments have been reviewed as we have moved to a new electronic recording system which is going live on July 1st 2022	
Regulation 7: Managing behaviour that is challenging	Not Compliant
Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging: Staff have completed e-learning training in Dementia & Responsive Behaviours In house training for Responsive Behaviours is scheduled for the 4th July 2022. It will be provided by an external service provider. The restraint register has been reviewed and updated. The restraint register is now on the new electronic system for ease and consistency of recording.	
Regulation 9: Residents' rights	Not Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: Staff have completed Human rights Based Approach E-Learning training provided by HIQA. An audit of restrictive practices and follow up actions has been completed to ensure compliance.	

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 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Substantially Compliant	Yellow	23/05/2022
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Substantially Compliant	Yellow	30/06/2022
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	23/05/2022
Regulation 5(2)	The person in charge shall	Substantially Compliant	Yellow	30/05/2022

	arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.			
Regulation 7(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.	Not Compliant	Orange	04/07/2022
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.	Not Compliant	Orange	30/06/2022
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy	Not Compliant	Orange	30/06/2022

	as published on the website of the Department of Health from time to time.			
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	30/06/2022