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:	21 November 2023
Centre ID:	OSV-0005826
Fieldwork ID:	MON-0041287

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:	81

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 21 November 2023	19:45hrs to 22:55hrs	Mary Veale	Lead
Wednesday 22 November 2023	08:55hrs to 16:30hrs	Mary Veale	Lead
Tuesday 21 November 2023	19:45hrs to 22:55hrs	Noel Sheehan	Support
Wednesday 22 November 2023	08:55hrs to 16:30hrs	Noel Sheehan	Support

What residents told us and what inspectors observed

The inspection took place in Castlebridge Manor Nursing Home over the course of an evening and the following day. During this time, the inspectors took the opportunity to speak with residents and staff to gain an insight into what it was like living in the centre and to get feedback about the service. Inspectors greeted and chatted to a number of residents and spoke in more depth with nine residents and four visitors. Some residents expressed that they were happy with their experience of living in the centre and informed inspectors that there had been improvements in staffing levels and supervision of staff since the previous inspection. However, a number of residents expressed their dissatisfaction with the quality of food, and said they found it difficult to verbally communication with some staff about their care needs.

Inspectors arrived unannounced at the centre during the evening time and were greeted by the nurse in charge of the night shift. Following a brief introductory meeting, inspectors walked through the centre and spent time speaking with residents and staff, and observing the care environment and interactions between residents and staff. Both deputy persons in charge arrived at the centre at night to assist with the inspection and to support staff. The person in charge was on leave but returned from leave on the second day of the inspection.

The night handover was taking place when the inspectors arrived to the centre. Overall, the inspectors observed that many highly dependant residents were in bed at this time while those who were lower dependency were sitting in their rooms beside their beds. Of the 81 residents in the nursing home only nine residents (eight were in the communal area in Amber and Edenvale units and one resident was watching television in the sitting room in Ferrycarrig unit) with a further two residents walking the corridor in the Slaney Unit. All other residents in the centre were in their bedrooms at 8:00pm.

Inspectors spent time talking with residents in their bedrooms. Overall, residents expressed that there had been improvements in staffing levels. A resident stated that "it's a lovely place but sometimes could be short of staff". A resident said that while there had been improvements in staffing levels there had been a high number of different agency staff working in the centre, " this was not good for the residents or staff as those agency staff needed to be trained on the daily routine which was difficult for the staff who worked in the centre and exhausting for the residents".

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 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. Parts of the premises had been re-painted, for example; some corridor walls on Slaney unit had been painted and plans were in place to relocate call-bells in some of the residents bedroom so as the call-bells could be accessible.

Residents' views and opinions were sought through resident meetings and satisfaction surveys, records of which were observed by the inspectors. Residents reported that staff were very kind and caring but that they found it difficult to understand what staff were saying during conversations. Residents whom the inspectors spoke with gave positive feedback about the choice and quality of activities provided in the centre. Inspectors observed that residents enjoyed different activities during the second day of inspection, residents on the Ferrycarrig and Slaney unit were observed enjoying art activities and residents attended a bingo session in the afternoon in the ground floor open plan sitting area.

Inspectors observed staff and resident interactions throughout the second day of inspection and found that staff were familiar with residents and were kind and responsive to their needs. Inspectors observed that the supervision and allocation of staff had improved since the previous inspection. Residents told the inspectors that there was an improvement in the length of time they would wait for their call-bells to be answered. Call bells that rang during the first night of inspection were noted to be answered promptly. However, similar to previous inspections, inspectors observed a number of call bells were out of reach from residents albeit a much lesser number then seen previously. The inspectors observed the deputy persons in change assigned to each floor provided support and guidance to staff on the specific care and social needs of the residents. A resident told the inspectors that there was a night time practice in which their incontinence wear was changed at a specific time, this resident said that they had communicated with staff not to have their incontinence wear changed at these specific times so as they could have a restful sleep. Similar to the findings of previous inspections, inspectors observed that some staff practices in the centre during the night time were task-oriented rather than person-centered. This is discussed under Regulation 9: Residents' rights.

On the second day of inspection, inspectors observed the dining experience in the dining rooms on both floors. The food served appeared to be wholesome and nutritious. Improvements were found in the meal time experience for residents. A mealtime co-ordination role had been established and a staff member on each floor had responsibility for the residents meal time experience. The inspectors also observed that residents who chose to remain in their rooms for their meals were assisted respectfully by staff. The inspectors observed that there was very little left over food waste returned to the kitchen from the meals served in the bedrooms.

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 19:55 to 22:55 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 inspections of the centre in June 2023 and August 2023. Since the previous inspection there had been escalatory engagement with the registered provider. Overall, inspectors found that although the systems put in place by the registered provider had improved they remained inadequate to ensure that the care and welfare needs of the residents were fully met. And while recognising improvements made, the inspectors identified similar examples of poor practice as identified in previous inspection which are 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 remained dissatisfied with the staffing levels in the centre and in the quality of care being delivered. A significant finding was that staff could not clearly explain safeguarding procedures, and fire safety procedures.

The findings of the two previous inspections of this designated centre, in June 2023 and August 2023 were that that governance and oversight of the centre was not effective and did not ensure that services were provided in line with the centre's statement of purpose. The inspectors found that the registered provider had made improvements to staffing levels, skill-mix and supervision the of staff. Notwithstanding these improvements further progress was required to ensure that the number and skill mix of staff is appropriate to meet the care and welfare needs of the residents were fully met. The systems of oversight to monitor the service were not sufficiently robust to identify or address deficits in quality and safety, as evidenced by the findings of repeated regulatory non-compliance.

The provider had progressed the compliance plan following the inspection in August 2023, and improvements were found in Regulation 5: individual assessment and care planning, Regulation 6: health care, Regulation 7: managing behaviours that are challenging, Regulation 8: protection, Regulation 9: residents rights, Regulation 15: staffing, Regulation 16: Training and staff development, Regulation 23: Governance and management, Regulation 25: temporary absence or discharge of residents, and Regulation 34: complaints procedure. Although improvements were found, the inspectors found that actions was still required by the registered provider to address Regulation 5: individual assessment and care planning, Regulation 6: health care, Regulation 7: managing behaviours that are challenging, Regulation 8: protection, Regulation 9: residents rights, Regulation 15: staffing, Regulation 16: Training and staff development, and Regulation 23: governance and management.

Inspectors used information received by the office of the Chief Inspector, both solicited and unsolicited, to inform lines of enquiry for this inspection. Since the

inspection in August 2023 the Chief Inspector of Social Services had received one piece of unsolicited information relating to concerns in relation to safeguarding, staffing and the general care of residents. This information was used to support the development of lines of enquiry for this inspection.

The registered provider was Castlebridge Manor Private Clinic Limited. There had been a change in the directors of Castlebridge Manor Private Clinic Limited in October 2022. The centre is part of a large group that own and manage a number of designated centres in Ireland. There had been a change in the person in charge of the centre since the previous inspection. The person in charge, on the day of inspection, was previously the regional operations manager. The person in charge reported to an operations manager and upwards to the chief executive officer who was the registered provider representative. The person in charge worked full-time and was supported by two deputy persons in charge and three clinical nurse managers. Following the previous inspection, a deputy person in charge had been redeployed from another centre in the provider group to support the centre to address the non compliance's found on the inspection in August 2023. Since the previous inspection the deputy person in charge position had increased from one to two whole time equivalents (WTE) and the role was supernumerary in capacity. Inspectors were informed that there was a clinical nurse manager (CNM) supernumerary on each floor seven days a week to provide clinical supervision and oversight of residents care needs. In addition the person in charge was supported by a team of staff nurses, healthcare assistants, housekeeping, activities co-ordinators, catering, administration, laundry and maintenance staff supported the person in charge.

Following the previous inspection, the registered provider had increased staffing at night time. On the night of inspection there was one nurse allocated to Ferrycarrig unit, one nurse allocated to Slaney unit and one nurse allocated between Amber and Edenvale units. There was two healthcare assistants allocated to Ferrycarrig unit, two healthcare assistants allocated to Slaney unit and two healthcare assistants allocated to Amber and Edenvale unit. Nursing staff on night duty worked 8pm to 8am and healthcare assistants worked 9pm to 9am. Two residents were allocated 1:1 supervision by a healthcare assistant from 9am to 9pm. This healthcare assitant who provided supervision was not part of the staff roster on day duty. The inspectors were informed that both residents did not require supervision at night time as both residents slept well. The inspectors observed healthcare assistants who were part of the compliment of staff on night duty providing supervision to both these residents prior to the inspectors leaving the centre on the first day of inspection. An inspector was informed that if a resident requires the assistance of two staff members in Ferrycarrig unit that there was now a minimum of two staff members available on each unit during the night if a resident falls or requires assistance. Staffing rosters on the day shift were observed in all units and the inspectors observed that there were two nurses and seven healthcare assistants on duty on Ferrycarrig unit which was an increase of one. There was an increase in staffing levels in the evening time with five healthcare assistants on duty after 2pm. There was one nurse and four healthcare assistants on duty on Slaney unit. There was one nurse and six healthcare assistants observed on the Amber and Edenvale units. On the second day of inspection, the inspectors observed that there were two

CNM's on duty, one allocated to each floor in a supernumerary capacity in addition to the deputy persons in charge.

In addition to the supernumerary hours allocated to nurse management, improvements were found in the oversight of staffing levels and supervision of staff to provide a response to residents needs in a timely manner. This was evidenced by:

- A recruitment campaign which was in progress and at the time of inspection there were 16.5 whole time equivalents (WTE) nursing posts and 41 WTE healthcare assistants employed in the centre.
- The use of agency hours had reduced to cover ten shifts a week Monday to Friday with appropriate nursing supervision.
- The provider had reviewed and had made improvements in the process of the management of staff absenteeism. There was now an escalation pathway to manage sick leave in the centre. Inspectors were informed that return to work interviews were conducted by the CNM when possible or a senior staff nurse. There was evidence that staff absenteeism had reduced through 2023.
- There was evidence that nurse management had met with nursing and care staff discuss individual roles and responsibilities.
- A person in charge had been recruited and was due to commence in the role in February 2024.
- A staff member was allocated to each dining room daily as a mealtime co-ordinator who was responsible for preparing the dining room, allocating staff to residents who required assistance, serving meals and overseeing modified diets.

Although improvement were found in staffing further progress was required to come into compliance with staffing which is discussed further in this report under Regulation 15: staffing.

There were 81 residents living in the centre on the days of the inspection. The needs of residents were assessed as 33 requiring maximum dependency, 19 high dependency, 12 medium dependency, 13 low dependency and three independent residents. One resident's assessment was not completed. Staff were observed to be task orientated on the night of inspection. Inspectors observing a majority of residents in their beds or sitting in their bedrooms with limited stimulation other than televisions playing in the background or reading. Further improvements were required as arrangements were not in place for the supervision of staff at night time 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 was an ongoing schedule of training in the centre. An extensive suite of mandatory training was available to all staff in the centre. There was a high level of staff attendance at training in areas such as fire safety, safe-guarding, restrictive practice, cardio-pulmonary resuscitation (CPR), manual handling, positive behaviour support and infection prevention and control. Not all staff whom the inspectors spoke with were knowledgeable regarding fire evacuation procedures and safe guarding procedure. Following the previous inspection training had been provided to

all staff in ski sheet evacuation and all nursing staff had completed training in care planning and enteral feeding. Education and information prompt folders had been provided to nursing staff on each unit on care planning, and infection prevention and control. However; further improvements were required in staff training and supervision, this is discussed further in this report under Regulation 16: staff training and development.

The centre had a suite of meetings such as local management meetings, staff meetings which included nurses meetings, health care assistant meetings, maintenance meetings, and catering staff meetings. Local meeting meeting agenda items included staffing, Key performance indicators (KPI's), staff training, staff responsibilities, staff supervision and outbreak management. Key performance indicators such as residents weights had been reviewed and were now undertaken monthly or three monthly. Daily quality safety checks were in place and frequent walk rounds by nursing management. The annual review for 2022 had been completed. It set out the improvements completed in 2022 and improvement plans for 2023. There was evidence of audits in areas including care planning, wound care and restrictive practice. However, management systems in place to monitor the centre's quality and safety required review. A number of audits were not scored, tracked and trended to monitor progress to drive improvement nor were audits discussed at governance meeting.

The registered provider had integrated the update to the regulations (S.I 298 of 2022), which came into effect on 1 March 2023, into the centre's complaints policy. The management team had a good understanding of their responsibility in this regard. The inspectors reviewed the records of complaints raised by residents and relatives since the previous inspection. Details of the investigation completed, communication with the complainant and their level of satisfaction with the outcome were included. The complaints procedure was amended to include the update to the regulations on the second day of inspection. The complaints procedure was available in the main entrance area and prominent areas throughout the centre. Residents spoken with were aware of how and whom to make a complaint to. There was evidence that the nominated persons had received suitable training to deal with complaints.

Regulation 14: Persons in charge

The person in charge had the necessary experience and qualifications to fulfill the regulatory requirements of the role.The person in charge informed the inspectors that they worked full-time Monday to Friday in the centre, however there was no evidence of the person in charge on the staff rosters.

Judgment: Compliant

Regulation 15: Staffing

Further actions were required by the registered provider to come in line with the WTE (wholetime equivalents) as set out in the statement of purpose which Castlebridge Manor Private Clinic Limited was registered against. This is a repeated non-compliance from the previous two inspections. The statement of purpose states that there should be 52 healthcare assistants and 20 staff nurses employed in the centre to provide safe care.

- On the days of inspection the registered provider had 41. 5 WTE (wholetime equivalents) healthcare assistants posts employed in the centre. There were 10.5 WTE vacant healthcare assistants posts.
- The registered provider had employed 16.5 WTE (wholetime equivalents) nursing posts. There were 3.5 WTE vacant nursing posts.

The consequence of not having sufficient staff in place was impacting on the care needs of residents as set out under Regulation 05 and 09 below.

While inspectors were informed that the person in charge was in the centre Monday to Friday each week there was no record of the person in charge on the staff roster.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff did not have appropriate supervision and were not appropriately trained to deliver effective and safe care to residents. This was evidenced by;

- There was inadequate supervision of staff on night duty resulting in a culture that was task orientated and not resident centred. See the findings under regulation 09 below.
- Care plans were reviewed and the centre was in the process of moving to holistic nursing care plans, however, this was a work in progress and clinical supervision arrangements required further improvement to ensure that care was delivered in accordance with each resident's care plan.
- A review of a sample of staff files found that previously, where staff had breached policy, a performance improvement plan was not implemented and staff continued to work without any special oversight or supervision arrangements.
- The training matrix for managing responsive behaviour required review as it was not clear from the documentation provided on the second day of inspection if staff had completed training in responsive behaviour or that staff training was out of date having previously been completed. From a review of the training documentation all staff were undertaking responsive behaviour training.

- Not all staff whom the inspectors spoke to were knowledgeable about fire safety procedures. Lack of knowledge relating to fire safety could be a barrier to the residents being safely and appropriately evacuated according to their mobility needs in an emergency.
- Not all staff whom the inspectors spoke with were knowledgeable about the complaints procedures.

Judgment: Not compliant

Regulation 21: Records

The management of records was not in line with the regulatory requirements. For example;

- In a sample of four staff files viewed, one of the files did not have a satisfactory history of gaps in employment in line with schedule 2 requirements.
- Two of the files did not have two written references, including a reference from the person's most recent employer.
- The roster was not an accurate reflection of all persons working at the designated centre or a record of whether the roster was actually worked.

Judgment: Not compliant

Regulation 23: Governance and management

In particular the Office of the Chief Inspector is not assured that the registered provider has:

- Put in place a robust governance system and a clearly defined management structure that supports the delivery of safe care for residents. This is evidenced by inadequate staffing levels and the management of staff absenteeism to ensure there was sufficient staff to provide safe timely care to the residents.
- Put in place effective management systems and processes to ensure it is competent to provide a service to residents that is safe, appropriate, consistent and effectively monitored. This was evident in the centres auditing system and minutes of governance meetings. A number of audits were not scored, tracked, trended to monitor progress and drive improvements in resident care. The centres governance meeting minutes were not robust to drive quality improvement. Records of governance meetings did not show evident of actions required from audits being discussed. There were minutes

of one governance meeting made available to inspectors, these minutes did not evidence the attendance of relevant operation managers.

- The provider did not demonstrated the ability to implement or sustain actions in order to achieve compliance. This is informed by the registered providers' response to address key areas of non compliance. This is evidenced in the findings from inspections and inspection reports carried out in June 2023 and August 2023.
- Similar to the findings of previous inspections, 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.
- Similar findings of previous inspections, the registered provider had failed to respond to feedback from residents relating to call bells, quality of food and communication difficulties.
- Systems of communication around the handover process for morning and evening shifts required improvement as there were three handover sheets in use. This is particularly significant in light of high staff turnover and use of agency staff to cover a number of shifts. Inspectors were told that there were plans in place to consolidate handover on to one sheet in January 2024.
- The post of regional manager is vacant at present while the post holder fills the post of PIC. The inspectors were told that a new PIC had been recruited and was due to start in early 2024.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

The inspectors reviewed a sample of residents' contracts of care. These were seen to be agreed on admission to the centre and detailed the services provided to each resident along with fees, including for services which the resident was not entitled to under any other health entitlement. However, the type of accommodation whether single or multiple occupancy and the room number were not always stated.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

A clear complaints procedure was in place and this was displayed prominently in the centre. The record of complaints was reviewed by the inspectors. These records identified that complaints were recorded and investigated in a timely way and that complainants were advised of the outcome of their complaint. A record of the complainant's satisfaction with how the complaint had been managed was also documented.

Judgment: Compliant

Quality and safety

Overall, residents told inspectors that there had been improvements in the centres staffing levels and were happy living in the centre. However, a number of residents with high dependency needs said that they were not satisfied with the length of time it took staff to attend to their personal care, that sometimes it was difficult to reach their call bell and there was a task orientated routine of care at night time.

Some improvements were noted in the areas of care planning, health care, residents rights, behaviours that are challenging, and temporary absence or discharge of residents since the previous inspection. On this inspection further action was required in the areas of care planning, and residents rights. Further progress was required by the registered provider to ensure that there is an effective governance structure and management systems to provide a good quality of life for the residents living in Castlebridge Manor Nursing Home.

Residents had good access to appropriate health care services in accordance with their assessed need and preference. General Practitioners (GP's) and a medical officer attended the centre. It was evident that residents had regular medical and mental health reviews. Residents had access to a consultant geriatrician, a psychiatric team, nurse specialists and palliative home care services. A range of allied health professionals were accessible to residents as required an in accordance with their assessed needs, for example, physiotherapist, speech and language therapist, dietician and chiropodist. Residents had access to a mobile x-ray service in the home. Residents had access to local dental and optician services. Residents who were eligible for national screening programmes were also supported and encouraged to access these.

The inspectors observed that the resident's nursing assessments and care plans were maintained on an electronic system. The inspectors observed improvements in the documentation of nursing assessments, care plans and nursing care transfer documentation. It was evident from the sample of nursing notes viewed that residents' needs were comprehensively assessed prior to and following admission. Resident's assessments were undertaken using a variety of validated tools and care plans were developed following these assessments. The inspectors were informed that all the residents individual care plans were under review and work was underway to prepare holistic care plans for all residents. Some care plans viewed by the inspectors had been updated to a holistic care plan which were person- centred and included a specific plan of care for the individual residents. There was evidence that the care plans were reviewed by nursing staff four monthly. Consultation had taken place with the resident or where appropriate that resident's family to review the care plan at intervals not exceeding 4 months. However, further improvements

were required in nursing documentation which is discussed further under Regulation 5: Individual assessment and care planning.

Improvements were found in the nursing transfer documentation to acute hospitals. The person in charge had introduced a nursing transfer letter which was in line with best practice national transfer guidance. The deputy person in charge had developed a prompt sheet for nursing staff to assist them to navigate the centres electronic nursing documentation system to populate a transfer letter which included residents nursing assessments, care needs and medication.

Improvements were found in the management of behaviour that is challenging. The deputy persons in charge had provided training and education to nursing staff and care staff on each unit specific to behaviours that are challenging in their supernumerary capacity. There was policy in place to inform management of responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort with their social or physical environment) and restrictive practices in the centre. Residents' had timely access to psychiatry of later life. For resident's with identified responsive behaviours, nursing staff had identified the trigger causing the responsive behaviour using a validated antecedent- behaviour- consequence (ABC) tool. There was a clear care plan for the management of resident's responsive behaviour. It was evident that the care plans were being implemented. Risk assessments were completed, a restrictive practice register was maintained, and the use of restrictive practice was reviewed regularly. Less restrictive alternatives to bed rails were in use such as sensor mats and low beds. While the front door to the centre was locked the intention was to provide a secure environment for residents with cognitive impairment, and not to restrict movement of the other residents living in the centre.

While inspectors received a lot of negative feedback on the quality of the food in the centre, on the second day of inspection the food served at lunchtime looked tasty and wholesome. Residents feedback on lunch on the second day of inspection was very positive. Inspectors observed that residents who were assessed and requiring supervision while eating were appropriately supervised. However, it was evident from residents survey results, residents meeting minutes and some residents told the inspectors that they were not satisfied with the quality of some food received. This is discussed further under Regulation 9: residents rights.

Residents were consulted about the centre through residents' meetings and an annual satisfaction survey. One meeting had taken place since the inspection in August 2023. Residents had highlighted a number of concerns in relation to laundry, the choice and quality of food, activities and blood sugar monitoring. The residents survey results were viewed by the inspectors, results highlighted a dissatisfaction amongst residents relating to the overall care provided, communication, services and recreation. The activity planner was on display in the centre. On the second day of inspection activities included live-streamed mass and 1:1 sensory stimulation and art in the morning. In the afternoon there was bingo in the centre. The residents told the inspectors that they looked forward to and enjoyed bingo in the centre.

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

There was evidence that all relevant information about residents requiring transfer was provided to the hospital.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Action was required in individual assessment and care plans to ensure the needs of each resident are assessed and an appropriate care plan is prepared to meet these needs. Some residents care plans had been reviewed and had a holistic care plan in place. However, further improvements were required to ensure all residents had a holistic nursing care plan in line with their specific nursing needs.

Judgment: Substantially compliant

Regulation 6: Health care

Findings on this inspection was that, overall, there were good standards of evidence based healthcare provided in this centre. GP's and a medical officer routinely attended the centre and were available to residents. Allied health professionals also supported the residents on site where possible and remotely when appropriate. There was evidence of ongoing referral and review by allied health professional as appropriate. However, in one care plan reviewed by inspectors, a resident that had lost weight earlier in 2023 was not referred for dietican review.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

There was a centre-specific policy and procedure in place for the management of behaviour that is challenging. A validated antecedent- behaviour- consequence (ABC) tool, and care plan supported the resident with responsive behaviour. The use of restraint in the centre was used in accordance with the national policy. Staff were

knowledgeable of the residents behaviour, and were compassionate, and patient in their approach with residents.

Staff were familiar with the residents rights and choices in relation to restraint use. Alternatives measures to restraint were tried, and consent was obtained when restraint was in use. Records confirmed that staff carried out regular safety checks when bed rails were in use.

Judgment: Compliant

Regulation 9: Residents' rights

Similar to the findings of previous inspections, residents' right to exercise choice was not always upheld by the registered provider. For example;

- Inspectors observed that some of the higher dependency residents were offered very poor social engagement during the inspection. Higher dependency residents spent the day in their rooms with the television on in the background with very little engagement with staff.
- Residents choice of when they went to bed was not supported. For example, a resident reported being put into bed at 8pm, when they would like to have stayed up. Nine residents out of total of 81 were in the communal day areas when inspectors arrived in the centre at 8pm. A resident told the inspectors that there was a night time practice in which their incontinence wear was changed at a specific time, this resident said that they had communicated with staff not to have their incontinence wear changed at these specific times so as they could have a restful sleep.
- The residents survey results were viewed by the inspectors, results highlighted a dissatisfaction amongst residents relating to the overall care provided, communication, services and recreation. The categories for overall care provided, communication, services and recreation did not outline any detail of the the issues the residents were not satisfied with.

Similar to the findings of previous inspections relating to call bells, quality of food and communication difficulties on this inspection:

- A small number of call bells were found to be out of residents reach on this inspection. This resulted in residents not been able to call staff when care was required or in an emergency.
- A number of residents and visitors complained to the inspectors about the quality of food. A number of residents told inspectors that the food was sometimes cold, did not taste nice and the fruit offered was not always fresh. However, the registered provider had failed to respond to resident feedback, survey results and residents meetings in this respect.

• Residents reported difficulties in verbal communication and understanding of some staff when communicating their needs.
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 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Castlebridge Manor Nursing Home OSV-0005826

Inspection ID: MON-0041287

Date of inspection: 22/11/2023

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:
• As discussed with the inspectors during the inspection in November, we are continuing with our recruitment drive to both fill vacancies and provide contingency arrangements. We currently have the following available for duty:

Position Whole time equivalent Number of posts
PIC 1 1
PPIM 0.25 1
DPIC 1 1
CNM 3 3
RGN 17.6 17
HCA 51 54
Activity 2.8 4
Household Catering etc 17.9 19
Administration 4 5
Maintenance 2 2

Staffing:
• HCA: We have a further 2 HCA already recruited & is due to arrive by the end of February. These team members will increase the overall HCA figures to 54/53.
• RGN: Between Feb & March, we will have recruited a further 3 RGN who will increase our staff number to 20/20.6. We will have another RGN join our team in April and we have 1 rgn on maternity leave who is due back in May. These nurses are not included in the above numbers.
• CNM: We currently have 3 CNM that are full time and are working in a supernumerary role from Monday to Sunday. We have 1 CNM who is on maternity who is due back in July. This CNM is not included in the above numbers.
• Agency: We have not required agency staff support in the home since the beginning of December. This enables us to work closely and mentor our own existing staff in a holistic care approach to all Residents.

• Our roster for February will have the same staffing hours as per our 2021 SOP. We have adjusted the shift patterns to allow for the current dependency and needs of our current Residents. This is broken down as follows:

Nurses: 96 hours on duty – per 24hr period.
HCA: 300 hours on duty – per 24hr period.

As per our Barthel dependency score (above) the minimum hours that we would expect to safely care for our Residents is 1765 hours per week. With our roster for February, we will be providing 2772 hours per week. This figure is solely the nurses and carers on the floor with our Residents. It does not include management supernumerary hours nor activity hours.

Roster:
• The pic/dpic/cnm are all included on the roster. At the time of inspection, we were transferring onto a new rostering/time management system. The pic was included on the new rostering system.

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:
• With new staff members joining our team, this allows for the rotation of staff from day to night duty. This will enable more one - one training for those rotating shifts and supervision of practices/routines. Our recent training topics have included restrictive practices and responsive behaviours.
• We have 3 CNM that are supernumerary and are assigned to each floor. Monday to Friday there are 2 CNM on duty and 1 CNM is on duty over the weekend. Our CNM work the same shift times as the RGN are full-time and are assigned to supervise and support the staff every day. Our PIC has a senior management weekly meeting with CNM & DPIC and all KPI's throughout the home are discussed.
• Our PIC participates in daily handover and is able to direct staff on a daily basis both during the handover and with regular walk arounds on each unit. These are conducted with the staff nurse on duty to further develop their awareness of the needs of their Residents, their scope of practice and to offer support with anything that may arise.
• As mentioned in the inspection report, we have implemented a new role specific to mealtime co-ordination/supervision. This staff member is assigned to each unit/dining room and will co-ordinate the meals for each Resident. We have found through regular informal feedback with our Residents and families that this has been a positive change to the dining experience for our Residents.

• The reduction of the use of agency staff has had a positive impact on our own staff and on the day to day lives of our Residents as our own staff increase their own knowledge of each individual Resident.
• Our DPIC/CNM have been able to conduct regular safety pause meetings with each unit within the home and topics included have ranged from communication & personal care to continence awareness. We have found these forums a great assistance in assessing the knowledge & understanding of a variety of topics within our staff.
• We have developed a number of toolbox/prompt sheets that are held on each unit which again is a further opportunity for staff to review and be directed to act confidently on what may arise.
• We now have 1 handover diary on each unit which allows for a comprehensive overview and tracking of information and actions.

Careplanning:
• We have continued with our process of moving to holistic careplans and do anticipate that we will have completed this changeover by the mid February. We have developed prompt sheets for the completion of holistic care plans which will guide our nurses on assessing & planning for individual activities of daily living. These prompts are held on each unit so are readily accessible for staff at any time. We have conducted 1-1 training with each nurse on careplanning & assessments, restrictive practices & responsive behaviours.

Staff Files:
• Any staff member who is involved in a performance improvement plan will have their file reviewed in full to ensure that any previous breaches of policy are noted. The investigation and pip will be reviewed in full by our HR administrator to ensure that all relevant information is included.

Training Matrix:
• We are reviewing the layout & scope of our training matrix to ensure that ease of use and clarity of information is available at all times. We will ensure that our nursing software system is also updated with relevant training dates/topics to allow our PIC/PPIM to have full oversight at all times.

The application of all the above improvement / changes to processes, will be overseen and monitored by the PIC, the Senior staff and the Regional Operations Manager in the course of her oversight responsibilities.

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
• Since the inspection we are in the process of reviewing all staff files again to ensure that there are no gaps in employment and all scheduled 2 requirements are met.
• The roster is now fully operational on our "new" rostering/time management system. It

is a clear and accurate reflection of the planned roster and actual roster.

The application of all the above improvement / changes to processes will be overseen and monitored by the PIC, the Senior staff and the Regional Operations Manager in the course of her oversight responsibilities.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Staffing & Supervision:
• We have increased both our overall staffing numbers and our staff numbers on duty both day and night. We have recruited further staff members who will be joining our team in the coming months and will continue to recruit to ensure staffing levels are maintained and will provide for contingency.
• With the increase in our staffing numbers we will be able to rotate staff from day duty to night duty and vice versa. We believe that this will be essential in staff education and practice and subsequent improvement in delivery of care to our Residents.
• Since the inspection in November, our PIC has commenced her role within the home. The regional operations manager has returned to their post. During the time that the regional operations manager was in post as pic, She reported directly to the chief operations officer and the registered provider representative.

Audits/Oversight:
• Our PIC, deputy pic, cnm are all supernumerary shifts throughout the week. We have assigned CNM to specific units within the home for continuity of care.
• We have implemented a new audit suite. All senior staff have received training on this and the importance of full documentation. The audits and the completion of same/findings/actions required will be reviewed by the PIC and PPIM at their weekly onsite meetings.
• We do have a template for all meetings and will ensure that this template is used to accurately document all meetings, minutes and subsequent action plans/persons responsible.

Handover:
• As discussed on the day of inspection, we had planned and have implemented a comprehensive handover system from one shift to another & across the care departments. All RGN have received one: one instruction on this and this is being monitored daily by senior staff.
• Our PIC attends daily handovers from night to day staff so is able to review and direct staff on a daily personal level as required.
• Our PIC has a senior management meeting weekly with dpic & cnm to review all KPI within the home and the progress of each.

• As mentioned in reg 16, we have one handover diary for each unit, which allows for the comprehensive information exchange from shift to shift. It enables our senior staff to "spot check" on the quality of handover also to identify where/if support or changes need to be implemented.

Feedback to Residents & Families:
• We have been able to implement an "open door" policy for both Residents and families. As issues have arisen, we have been able to address these quickly and comprehensively. We are giving feedback to Residents and Families on day-day/week by week basis.
• We have spoken with our kitchen staff, have menus reviewed and have spoken with Residents regarding their meals. As noted in the report, the Residents feedback on lunch on the second day of the inspections was very positive.
• We have taken onboard and are addressing communication/language difficulties between staff and Residents daily. As our staff become more confident and familiar with our Residents, the communication difficulties should resolve. We always ensure that there is a "familiar"/well known member of staff on duty each shift so that should difficulties present that Residents will be at ease in speaking to this staff member.
• Any complaints received have been recorded and dealt with as per policy. The satisfaction of the outcome of the complaint is recorded also.

The application of all the above improvement / changes to processes will be overseen and monitored by the PIC, the Senior staff and the Regional Operations Manager in the course of her oversight responsibilities.

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 review all of our current contracts and ensure that all details are recorded as per policy and regulation.

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:

• As discussed on the day of the inspection we are reviewing all Resident careplans and assessments. We are nearly complete with the implementation of the holistic care plan model.
• We have conducted 1-1 training for all nurses on the holistic care plan and assessment approach.
• We have developed a prompt sheet for nurses on the completion of the holistic care plan and indicators of which assessments will complement each aspect of the care plan.

The application of all the above improvement / changes to processes will be overseen and monitored by the PIC, the Senior staff and the Regional Operations Manager in the course of her oversight responsibilities.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
• We have implemented a schedule for all weight management within the home. This includes weekly and monthly weights. The weights are reviewed by both the nurses and cnm on the unit and a plan is actioned as necessary. All Residents with a noted weight loss will be referred to the dietician and gp. This will be documented on the nursing software to be able to track actions & follow up requirements.

The application of all the above improvement / changes to processes will be overseen and monitored by the PIC, the Senior staff and the Regional Operations Manager in the course of her oversight responsibilities.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• Through our Resident meetings and annual survey feedback we will be able to change/put in place an activity planner for our Residents individual to their wishes.
• Our survey will enable Residents & families to state their choices in regard to settling down times, personal hygiene care and activities. The feedback will be used to both inform Residents & families and also staff in relation to our practice.
• We have reviewed and referred to our Residents in relation to their continence wear – changing of same and the timing of this also. This has been incorporated into their careplans and is informed to all staff during handover and safety pause meetings.
• We are continuing with the placement of call bells within our Resident rooms – this is to ensure that the bell can be reached from either the bed or chair as wished by the Resident. Audits are being conducted to ensure that the bells are operational and within

reach of the Resident at all times.
• We have sent out the annual survey to all Residents and Families for completion and return to us. The contents of the survery will be included in our annual report to be published this quarter.
• While we get feedback daily from our Residents in relation to the menu and quality of food being served, we will develop a more formal feedback form and request for Residents to submit this after each day. This will be relayed back to our kitchen staff to see where/which improvements are to be made. We will relay this back to our Residents with feedback on our notice boards throughout the home.

The application of all the above improvement / changes to processes will be overseen and monitored by the PIC, the Senior staff and the Regional Operations Manager in the course of her oversight responsibilities.

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	05/02/2024
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	30/03/2024
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/03/2024
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	Not Compliant	Orange	29/02/2024

	and are available for inspection by the Chief Inspector.			
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.	Not Compliant	Orange	30/03/2024
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	30/03/2024
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	29/02/2024

Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Substantially Compliant	Yellow	16/02/2024
Regulation 6(2)(c)	The person in charge shall, in so far as is reasonably practical, make available to a resident where the care referred to in paragraph (1) or other health care service requires additional professional expertise, access to such treatment.	Substantially Compliant	Yellow	01/02/2024
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	29/02/2024
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	29/02/2024

Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned.	Substantially Compliant	Yellow	29/02/2024