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:	Cahercalla Community Care
Name of provider:	Cahercalla Community Hospital Company Limited By Guarantee
Address of centre:	Cahercalla Road, Ennis, Clare
Type of inspection:	Unannounced
Date of inspection:	07 June 2023
Centre ID:	OSV-0000444
Fieldwork ID:	MON-0040400

About the designated centre

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

Cahercalla Community Care is located on the outskirts of the town of Ennis. It provides care to long-term, respite, and convalescence residents and also has five designated hospice beds. The centre was originally opened as a hospital in 1951, and while there had been significant extensions and renovations since then, the overall the design and layout of the premises was largely reflective of a hospital from this period. The original building consists of a three storey units, Ground floor, St. Joseph's and Sacred Heart. An unused clinical unit beside the ground floor unit has recently been refurbished. This new unit consists of three twin rooms, two single rooms, a large day room and a large dining room. The centre also has a two storey building with two units, Garden wing ground floor and Garden wing first floor. The centre is registered to accommodate 112 residents.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	107

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 7 June 2023	09:45hrs to 19:20hrs	Una Fitzgerald	Lead
Wednesday 7 June 2023	09:45hrs to 19:20hrs	Rachel Seoighthe	Support

What residents told us and what inspectors observed

Overall, the findings of this inspection were that residents were satisfied with the direct care. Residents felt safe. The feedback from residents spoken with was very mixed. Residents told the inspectors that they were satisfied with the activities held and that there was choice on how to pass the day. One resident told the inspectors that "Cahercalla give very good care". A second resident told inspectors that 'they never ring the call bell for assistance, as the staff routinely check on how they are throughout the day'. In contrast, residents also told inspectors that they were not satisfied with the dining experience in relation to the overall cleanliness of the utensils. A resident informed the inspectors that 'clean cups, saucers and jugs would be nice' adding that there were 'no extra cups' available. On the day of inspection, inspectors observed multiple items of cutlery & crockery, which were intended for resident use, were visibly unclean and ingrained with food debris.

Following an introductory meeting, the inspectors walked through the premises meeting with residents and staff. The atmosphere was observed to be friendly and inviting. On entering the building there was a large reception area. There were multiple notice boards with information for residents and visitors. Group activities had been reviewed and positive initiatives had been introduced that were very appreciated by the residents. There was ample pictorial evidence of group activities that had occurred both in the centre, and on day trips outside the centre. For example; a group of residents had recently visited a local beach and had enjoyed dipping their feet in the sea. The residents had celebrated national nurses day and had marked the day by presenting some of the nursing staff with flowers. Multiple other activities had been held. Residents spoken with were satisfied with the group activities held.

Resident bedroom and living accommodation was over three floors with lift and stair access between each floor. The inspectors observed that many residents' bedrooms were personalised with their items of personal significance, including their photographs, artwork and ornaments. There was access to television and call bells in all bedrooms inspected. Residents had adequate wardrobe and storage space for their clothes and personal belongings. However, the inspectors found that the privacy of residents occupying some twin rooms could not be assured, as residents could not access their wardrobe without entering the bed space of the resident with whom they shared the bedroom. The negative impact of this finding was confirmed by one resident who told the inspectors that they 'try to get dressed first, before the resident that they share their bedroom with, wants to access the wardrobe.' This is a repeated finding from the last inspection in October 2022.

There are a variety of communal areas for residents to use including a large oratory and secure outdoor area. Inspectors observed a number of spacious sitting rooms which were in constant use by residents throughout the inspection. The dining areas were spacious with sufficient seating for resident comfort. Daily menus were displayed and residents who spoke with inspectors were mostly complimentary of

the meals provided. However, inspectors observed that two of the kitchenettes that resident food was served from were in a very poor unhygienic state. Inspectors observed that many items of equipment were heavily stained and visibly unclean. In addition, some residents were served drinks in paper or plastic cups at meal-times. The inspectors were informed by staff that disposable cups were in use as there were not enough glasses available for all of the residents living in the centre.

The corridors were sufficiently wide with grab rails in place to assist the residents to mobilise independently. Inspectors observed that the maintenance systems that were in place had not ensured that the all areas of the premises were well maintained. Floor coverings were damaged in a number of resident bedrooms, and wall surfaces were scuffed and in need of repair. Additionally, there was a lack of storage available and some residents' assistive equipment and clinical supplies were being stored in the residents' communal shower/toilets. This restricted resident access to one shower area, and posed a risk of cross contamination.

Visiting was facilitated in line with national guidelines, and inspectors observed a number of visitors coming and going throughout the day of the inspection.

The next two sections of the report will present the findings in relation to governance and management in the centre and how this impacts on the quality and safety of the service being delivered. The areas identified as requiring improvement are discussed under the relevant regulations.

Capacity and capability

The totality of the findings evidenced that the provider did not have adequate systems in place monitoring the service. The premises were in a poor state and did not promote good infection prevention and control practice to ensure resident safety. The provider had failed to implement the compliance plan submitted to the Chief Inspector following the last inspection of the centre in October 2022. The impact of these findings are discussed throughout the report.

Cahercalla Community Hospital Company Limited By Guarantee is the registered provider of Cahercalla Community Care, formally known as Cahercalla Community Hospital and Hospice. There was a clearly defined management structure in place, with identified lines of authority and accountability. Mowlam Healthcare Services Unlimited Company is participating in the management of the centre. The director of nursing, who was the person in charge, facilitated this inspection. The person in charge was supported in the role by a full-time assistant director of nursing, working in a supervisory role, with a team of clinical nurse managers on duty seven days a week. Senior management support was also provided by a regional manager from the Mowlam Health care group.

On the day of inspection there were 107 residents living in the centre with five vacancies. There were 31 residents assessed with maximum care needs, 41 residents with high dependency care needs, 25 residents with medium dependency care needs and ten residents with low dependency care needs. On the day of the inspection, there were sufficient numbers of suitably qualified staff available to support residents' assessed needs. The team providing direct care to residents consisted of five registered nurse on duty at all times, a team of health care assistants and a team of activities staff. Staffing numbers in the direct provision of care was adequate.

On the day of inspection, there was three catering staff with responsibility for five unit kitchenettes, that was catering for the needs of 107 residents. The inspectors found that the supervision of staff and work practices in the cleaning and catering department was inadequate. This was evidenced in the overall cleanliness of the premises and the cleanliness of the kitchenettes which food was served from. The centre is a large campus spread out across three floors.

Staff files contained all of the information required under Schedule 2 of the regulations. All new staff go through a process of induction into the centre. The documentation to support this induction process was completed on all files reviewed. The person in charge had completed annual performance appraisals with all clinical staff as part of the supervision system in place.

Staff had access to education, appropriate to their role. This included infection prevention and control training, manual handling, and safeguarding training. Staff responses to questions asked displayed a good level of knowledge. Notwithstanding this positive finding, a training record, reviewed by inspectors had significant gaps in the annual fire training records.

Incidents were appropriately notified to the Chief Inspector within the required time frame.

The provider had adopted and implemented an auditing management system as part of the systems in place monitoring the service. The person in charge, supported by the clinical nurse management team was completing monthly audits. The system included clinical and operational audits. However, the environmental audits were not capturing that the building, resident equipment and resident cutlery and crockery were not clean. The inspectors found that the audit system in place was not effective to support identification of risk and deficits in the quality and safety of the service. Consequently, quality improvement plans could not be developed in this area. The infection prevention and control audit, reviewed on the day of inspection, that was completed on the 17th May 2023, was marked as 91% compliant. The 9% non compliance identified related to the sluice rooms. When asked about what action was taken post the audit to address the findings the inspectors were told that the staff were updated on the need to keep sluice rooms clean. This instruction was not being followed as was evident under the findings of Regulation 27: Infection control.

Regulation 15: Staffing

On the day of inspection, the number and skill mix of staff was appropriate with regard to the needs of the current residents, and the size and layout of the designated centre. The deficit in the cleaning of the building and the failure of the provider to ensure sufficient kitchenette staff is addressed under Regulation 23: Governance and Management.

Judgment: Compliant

Regulation 16: Training and staff development

Not all staff had completed training appropriate to their role. For example, some staff had not completed annual training for fire safety, and moving and handling training.

Staff were not appropriately supervised to ensure that they carried out their work to the required standards. This was evidenced by the following findings;

- Cleaning and infection prevention and control practices were not completed to the required standards, as evidenced by inadequate cleaning of a number of rooms.
- The cleaning records did not provide assurance that the cleaning in some areas was completed to the required standard, as evidenced by gaps in daily cleaning records. Furthermore, several resident bedrooms and sluice rooms which were visibly unclean, had been signed off as cleaned. This had not been identified by the management team.
- Continued poor practice found on previous inspections whereby, items of resident equipment that was on shelves and ready for use were not clean.
- On the day of inspection, at 11.30 am, the inspectors observed that the kitchenette was not clean. For example; food from the previous evening was still left on the counter top, the microwave was visibly dirty, utensils and crockery were visibly unclean. In addition, the floor was layered with food particles. The heavily soiled mop from the previous evening remained in the kitchen. The counter tops and workspace was not clean.

Judgment: Substantially compliant

Regulation 23: Governance and management

The management systems in place to monitor the quality of the service did not ensure that the service provided to residents to residents was safe, appropriate, consistent and effectively monitored. For example:

- There was poor oversight of cleanliness and state of repair of the building. The maintenance of the premises specific to flooring and items of resident bedroom furniture were in a poor state.
- The auditing system was not effective in identifying deficits and risk in the service. For example, audits of skin integrity were a yes/no tick box exercise with no follow up or recommendation identified. When the inspector questioned what the audit finding were, the local management with responsibility for oversight of the direct care could not explain the document content.

The compliance plan submitted following the previous inspection was not fully implemented, or was found to be ineffective, resulting in repeated non-compliance with Regulation 16: Training and staff development, Regulation 23: Governance and management, Regulation 4: written policies and procedures, Regulation 27: Infection prevention and control, Regulation 5: Individual assessment and care planning and Regulation 9: Residents' rights.

Judgment: Not compliant

Regulation 31: Notification of incidents

The person in charge submitted notifications, as required by the regulations.

Judgment: Compliant

Regulation 4: Written policies and procedures

Although the centre had policies and procedures as outlined in Schedule 5 of the regulations, the inspectors found that the following policies were were not implemented in practice;

- Wound care management
- Resident introduction, assessment and care initiation.

This is a repeated non-compliance found on the last inspection.

Judgment: Substantially compliant

Quality and safety

The inspectors observed that the interactions between residents and staff were kind and respectful throughout the inspection. The majority of residents were satisfied with the quality of care they received, and staff spoken to were knowledgeable of residents' needs. Nonetheless, inspectors found that non-compliance in relation to infection control and the upkeep of the premises negatively impacted on residents' safety and well-being. Further action was also required to ensure compliance with Regulation 9: Residents' rights, Regulation 5: individual assessment and care planning and Regulation 6: Health care.

The centre had an electronic resident care record system. Pre-admission assessments were undertaken by the person in charge to ensure that the centre could provide appropriate care and services to the person being admitted. A range of validated nursing tools were in use to identify residents' care needs. The inspectors viewed a sample of residents' files, with a range of needs, and found that while the care plans viewed were generally informative, some lacked sufficient detail to guide staff in the delivery of care. For example; the inspectors found that a care plan was not developed to guide staff upon the interventions required to effectively guide and direct the care of a resident with a urinary catheter (a tube that empties the bladder and collects urine in a drainage bag), and there was a risk that their care needs would not be met.

Inspectors reviewed the documentation in place on the management of resident wounds. Findings were that some of the wound care plans did not include sufficient up-to-date information in relation to the resident's current needs. As a result, these care plans did not provide staff with the knowledge they needed to give safe and appropriate care. The inspectors found that wound care practices in the centre required improvement to ensure that residents' with pressure related skin wounds were provided with a high standard of evidence based nursing care. For example; records showed that a recommendation made by a tissue viability nurse for a specific wound dressing to be applied to treat a resident's pressure related wound was not implemented. Records viewed by inspectors showed that three different primary wound dressings were applied to the residents wound from 28th May to 6th June 2023. However, the rationale for this change in treatment was not recorded in the residents care plan.

The inspectors found that the provider had not ensured that the environment was managed in a way that minimised the risk of transmitting a health care-associated infection. While there was a cleaning schedule in place, inspectors observed that some areas of the centre were not clean and there were gaps in the cleaning records. Inspectors observed equipment that were in use by residents was visibly unclean. This posed a risk of cross contamination and therefore risk of infection to residents. Infection prevention and control practices in the centre required review to ensure that they were in line with the national standards. This detail is outlined under Regulation 27: Infection control.

The provider had systems in place to ensure that residents were protected from the risk of abuse. Visiting arrangements were flexible, with visitors being welcomed into the centre throughout the day of the inspection. The inspectors saw that residents could receive visitors in their bedrooms or in a number of communal rooms.

Residents had access to local television, radio and newspapers. Residents were provided with opportunities to express their feedback about the quality of the service through scheduled resident meetings. The last survey outcome was very positive. However, residents told the inspector that their feedback was not always acted upon in a timely manner. For example, residents had expressed dissatisfaction with the use of paper and plastic cups.

Advocacy services were available to residents, and there was evidence that residents were supported to avail of these services, as needed. Residents had access to religious services and resources, and were supported to practice their religious faiths in the centre.

Regulation 11: Visits

Inspectors found that the registered provider had ensured visiting arrangements were in place for residents to meet with their visitors as they wished.

Judgment: Compliant

Regulation 17: Premises

The registered provider had failed to ensure that the premises were appropriate to the number and needs of the residents and the matters as set out in Schedule 6 of the regulations. This was evidenced by:

- Adequate storage for residents' assistive equipment and other equipment in the centre was not available. For example, a trolley containing a residents continence products was stored in one communal bathroom/toilet, a broken chair was stored in another communal shower/toilet in use by residents and several linen skip trolleys were stored in sluice rooms.
- Paintwork on the wall surfaces in a number of residents' bedrooms and along some corridors was scuffed, chipped and damaged and required repair to ensure these surfaces were maintained to an adequate standard and could be effectively cleaned.
- Hand rails were not in place by the sinks in one communal bathrooms. This posed a risk of fall to residents and did not promote their independence.
- Ceiling tiles in a number of areas showed signs of water leakage damage and required replacement.

Judgment: Not compliant

Regulation 27: Infection control

The inspectors found that some procedures were not consistent with the national standards for the prevention and control of health care associated infections published by the authority including:

- Equipment drying racks in the sluice rooms (sluice room is a room found in health-care facilities such as hospitals and nursing homes, that is specifically designed for the disposal of human waste products and disinfection of associated items) were rusted and this did not support effective cleaning.
- A urinal bottle which contained residual urine was stored on a drying rack in a sluice room with clean equipment. This posed a risk of cross infection.
- The floor surface in the sluice rooms was visibly unclean and items of equipment were stored on the floor which hindered effective cleaning.
- Several bottles of prepared cleaning chemicals which were in use were not labelled and dated to ensure the recommended shelf life did not expire.
- A hazardous waste bin was not available in the sluice room and therefore there was a risk that potentially hazardous waste would not be appropriately segregated.
- Items of equipment including shower chairs, bedpans and commode basins were visibly unclean. This posed a risk of cross contamination.
- Floor covering that was continued to form skirting at the base of the walls in a number of residents' bedrooms was peeling away from wall surfaces. These findings did not ensure that the floor surfaces were adequately maintained or that effective cleaning procedures could be completed.
- The area around the water outlets in most sinks used by staff for hand hygiene was visibly stained. This finding did not give assurances that these areas had been thoroughly cleaned and this posed a risk of cross infection.
- The laminate surface of a residents bedside table had lifted off and was not secure. There was a risk that effective cleaning was not possible.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

The inspectors reviewed a sample of residents' care documentation and found the following;

- Care plans were not updated to ensure that outdated information which was no longer relevant had been removed. Additionally, some pertinent information in relation to residents had not been added to their care plan. For

example, a resident's mobility care plan did not reflect current arrangements regarding use of specialist seating. This posed a risk that this information would not be communicated to all staff. Furthermore, the residents mobility assessment had not been updated to reflect the requirement for the use of assistive equipment to ensure their safe mobility.

- A plan of care developed for a resident did not include care interventions in relation to meeting their wound care needs.
- Some residents care plans were not informed by assessment of their needs. For example, meaningful activities assessments were not completed for seven residents and, as a consequence residents' social activity care plans lacked sufficient detail to direct staff regarding the activity programme they must facilitate to meet these residents social activity preferences and capacities.

Judgment: Substantially compliant

Regulation 6: Health care

The provider did not ensure that residents received a high standard of care to meet their needs. This was evidenced by the following findings;

- Nursing care was not documented in line with professional guidelines. Inspectors found gaps in repositioning records for three residents with pressure related skin wounds, and this posed a risk to residents' skin integrity.
- Inspectors found that residents' wound assessments were not completed in line with the centres own wound care policy. For example, wound assessments did not record the wound measurements. This made it difficult to ascertain if the current wound dressing plan was having a positive impact on the healing process or if further review was required.

Judgment: Not compliant

Regulation 8: Protection

Measures were in place to safeguard residents from abuse. These included arrangements in place to ensure all allegations of abuse were addressed and appropriately managed to ensure residents were safeguarded. Staff who spoke with the inspector were aware of their responsibility to report any allegations, disclosures or suspicions of abuse and were familiar with the reporting structures in place.

Judgment: Compliant

Regulation 9: Residents' rights

The provider had not ensured that some residents could carry out personal activities in private. This was evidenced by the following finding;

- Residents' in a number of twin rooms could not undertake activities, such as dressing, in private. This was because accessing their wardrobe space, intruded on the neighbouring residents private space. This is a repeated finding from inspections in May and October 2022.

Judgment: Substantially 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	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Not compliant
Regulation 27: Infection control	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Cahercalla Community Care OSV-0000444

Inspection ID: MON-0040400

Date of inspection: 07/06/2023

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 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:

• The Person in Charge (PIC) has completed a review of all staff training records. Since the inspection all outstanding mandatory training courses have been completed and refresher updates have been scheduled for staff in advance of their due dates.

• The PIC will ensure that staff have a thorough understanding of how to apply theoretical learning to practice, especially in relation to Fire Safety and Manual Handling.

• The PIC and GSM will develop an overall quality improvement plan for household staff and the GSM will oversee the implementation of this plan. Progress updates will be discussed with household staff at monthly quality and safety meetings.

• The PIC will collaborate with the General Services Manager (GSM) to undertake a review of the housekeeping service, cleaning schedules and practices in the centre, and will facilitate sufficient supervision of household staff to ensure that the housekeeping procedures are consistently carried out to the required standards throughout the centre.

• The housekeeping review will include random spot checks by the PIC and GSM. They will also conduct regular daily rounds of the centre to ensure ongoing compliance in Infection Prevention & Control standards. The GSM will ensure that where deficits are identified, these are brought to the attention of the household staff so that corrective action can be taken and lessons learned to prevent recurrence.

• The schedule of audits will be discussed at the weekly management meetings where the results and corrective actions will be signed off by the PIC.

• Cleaning schedules and findings from hygiene audits will be discussed at Safety Pauses, Infection Prevention & Control and monthly management team meetings.

• The Housekeeping Supervisor, supported by the General Services Manager (GSM) will ensure that prepared cleaning chemicals will be labelled and dated to ensure compliance with expected shelf life.

Regulation 23: Governance and management	Not Compliant

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

• The PIC and GSM will agree a quality improvement plan to address the deficits identified in household cleaning practices and procedures, and to ensure the adequate supervision of staff and their ability to maintain the centre to the standards of cleanliness expected in accordance with best practice. The implementation of this plan is detailed above under Regulation 16: Training & Staff Development.

• The PIC will liaise with the Facilities Manager regarding the required schedule of works to be carried out to maintain the centre to an appropriate standard in relation to repairs or replacement of damaged flooring, identifying decorative works to be undertaken and the replacement of damaged items of furniture. Worn and scuffed surfaces will be repaired and painted to ensure compliance with IPC guidelines and to provide a clean and homely environment for resident.

• The Facilities Manager will also outline a plan to address the works required in the twin rooms, identifying work plans and completion dates. This review will ensure that regulations regarding individual resident living space will be met.

• The review will consider the individual rights of each resident in a shared room, including placement of residents' individual furniture and fixtures, ensuring that they are placed within proximity to them; that each occupant can exit or enter the room or access the bathroom without adversely impacting on the other occupant's space or privacy; and that privacy screening arrangements are appropriate to maintain complete privacy and dignity of each occupant.

• As part of the scheduled preventative maintenance and improvement programme, all items of furniture that are worn, torn or faulty will be repaired or replaced, including resident bedside tables and room furniture .

• The PIC, supported by the Healthcare Manager (HCM) will ensure that all members of the management team demonstrate an understanding of the auditing systems within the home. The PIC will ensure that appropriate Quality Improvement plans are developed, implemented and reviewed following each audit.

• The PIC will complete a review of compliance plans developed from previous inspections and ensure that all actions identified within them will be achieved in a timely manner and will ensure compliance on an ongoing basis.

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:

• The PIC, with support of the management team, will ensure that any resident who presents with or develops a wound will have a wound assessment completed and an appropriate plan of care will be developed in line with best wound management practice guidelines. The individual wound care plan will be clearly outlined, progress updates will be documented and regularly updated.
• The PIC and nursing management team will provide support, guidance and direction to nursing staff on clinical documentation, and will monitor the accuracy and quality of the clinical records. Where deficits are noted, they will work with the individual nurses to ensure that the overall quality of the records improves and that all nurses are competent and confident with these requirements.
• The PIC will complete a weekly review of clinical documentation to ensure that the care plan guides the delivery of care, and that the care delivered is reviewed and evaluated appropriately and in accordance with policy.
• Findings and recommended improvements will be discussed at nursing staff meetings, daily handover/safety pause and at monthly management team meetings. Any changes or developments in the resident's condition or plan of care will be updated as they occur.
• Care plan audits are scheduled every quarter. Each nurse will meet with the PIC or ADON each quarter for clinical/reflective practice, which will enhance oversight of care planning. All care plans will contain appropriate person-centred details in relation to the current care needs of each individual resident.
• The PIC will ensure all care plan reviews will consider all aspects of the residents' physical and mental wellbeing, personal and social care needs and any supports required to meet those needs, as identified by initial and ongoing assessment.
• The PIC will ensure that reviews are completed to monitor the effectiveness of the residents' support and treatment provision.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• The PIC, with support of the GSM, will complete a review of storage of all equipment by ensuring that cupboards and storage facilities have been decluttered and tidied up; only equipment necessary for resident care and consumables will be stored in the centre; all obsolete or damaged items will be discarded/replaced as required, and additional space will be created to store assistive equipment will be available.
• There will be no inappropriate storage of equipment or products in bathrooms or communal spaces. Since the inspection, the communal bathroom has been cleared of inappropriately stored items. The broken chair has been discarded and removed from the premises and trolleys are now stored appropriately and safely. There is no inappropriate storage in sluice rooms.
• Handrails will be installed adjacent to sinks in the areas identified during inspection by 04/08/23.
• The damaged ceiling tiles will be replaced.
• The PIC will review the plan of painting works to ensure that walls, skirting, and scruff marks are painted and kept in a good state of repair.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:

• The PIC, supported by the Lead Nurse in Infection Control, will complete a review of all sluice rooms to ensure that sufficient equipment is available for disposal of items. We will ensure that suitable and sufficient racking will be provided for storage of appropriate items in the sluice room.

• There will be no items stored on the floor of the sluice room. The floor will be deep cleaned. Any areas of damaged flooring will be repaired or replaced as required to facilitate effective cleaning and maintain a hygienic area.

• All cleaning products in use will be labelled with the name of the solution and expiry date. This will be completed by 31.07.23.

• We will ensure that a hazardous waste bin is available in the sluice room to facilitate segregation of potentially hazardous waste.

• The quality improvement plan for housekeeping will include the cleaning procedures required to maintain all commodes and shower chairs in a hygienic condition.

• PIC with the IPC lead will ensure the current cleaning system is monitored and all staff are reminded of the need to ensure compliance with equipment cleaning procedures.

• The PIC walkabouts will include the visible checking of equipment in the sluice rooms to ensure they are clean and available for use when required.

• The PIC will ensure that IPC standards will be discussed at monthly IPC meetings.

• The PIC will ensure that all cleaning staff have completed Clean Pass training and are aware of the required Infection Prevention and Control standards.

• Damaged furniture will be replaced or repaired to facilitate effective cleaning.

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 residents in the nursing home are assessed prior to admission to ensure that their care needs can be safely met in the nursing home.

• The PIC and ADON will provide clinical oversight to ensure that all residents' assessments and care plans have been completed and are individualised and person centred. They will ensure that the assessment informs the plan of care and considers the resident's current medical, health and lifestyle status. The care plans will be updated to ensure that outdated information that is no longer relevant is archived and that the

current information accurately guides the delivery of care.
• The PIC will complete a weekly audit of clinical documentation to ensure that each resident's required care needs are addressed, that the care plan guides the delivery of care and that the care delivered is reviewed and evaluated appropriately and is in accordance with the resident's expressed preferences.
• Interventions required for the management of wounds will be recorded and updated accordingly.
• Findings and recommended improvements will be discussed at nursing staff meetings, daily handover/safety pause and at monthly management team meetings.
• We will undertake a social assessment for all residents, including short-stay residents to ensure that meaningful social care plans can be developed and implemented.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
• Since the inspection, the care records have been reviewed and updated to reflect the residents' individual nursing care needs. The PIC will ensure that documentation is accurate and consistent with current needs of residents. All residents will have an assessment of skin integrity and a plan to maintain skin integrity and reduce the risk of pressure ulcers.
• Wound assessments will accurately describe the status of the resident's wound, including measurements, and progress updates will be recorded within the wound care plan.
• Findings and recommended improvements will be discussed at nursing staff meetings, daily handover/safety pause, including the need for regular repositioning to prevent or alleviate the effects of pressure. Wound care will be reviewed for all residents with compromised skin integrity at monthly management team meetings. Any changes or developments in the resident's condition or plan of care will be updated as they occur.
• All wounds will be managed in accordance with best practice guidelines. Advice will be sought from Tissue Viability Nurse where indicated and PIC will have clinical oversight of the management of wounds.
• Assessments and recommendations from Allied Healthcare professionals will be recorded, implemented and reviewed accordingly.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• In conjunction with the group Facilities team a review of the planned works to be completed in the twin rooms in the nursing home with respect to the rights, preferences,

privacy and dignity of both occupants of the room will be completed with assigned works scheduled for completion by 31/12/2023.
• The review will consider the individual rights of each resident in a shared room, including placement of residents' individual furniture and fixtures, ensuring that they are placed within proximity to them; that both occupants of each twin room can exit or enter the room without adversely impacting on the other occupant's space or privacy; and that privacy screening arrangements are appropriate to maintain full privacy and dignity of each occupant.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	03/08/2023
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/08/2023
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Orange	31/12/2023
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and	Not Compliant	Orange	31/08/2023

	effectively monitored.			
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Not Compliant	Orange	31/08/2023
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.	Substantially Compliant	Yellow	31/08/2023
Regulation 5(2)	The person in charge shall 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.	Substantially Compliant	Yellow	31/07/2023
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care	Substantially Compliant	Yellow	31/08/2023

	plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.			
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.	Not Compliant	Orange	31/08/2023
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Substantially Compliant	Yellow	31/12/2023