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 Hospital & Hospice
Name of provider:	Cahercalla Community Hospital Company Limited By Guarantee
Address of centre:	Cahercalla Road, Ennis, Clare
Type of inspection:	Unannounced
Date of inspection:	19 October 2022
Centre ID:	OSV-0000444
Fieldwork ID:	MON-0038188

About the designated centre

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

Cahercalla Community Hospital and Hospice 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:	108

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 19 October 2022	09:00hrs to 17:30hrs	Una Fitzgerald	Lead
Wednesday 19 October 2022	09:00hrs to 17:30hrs	Marguerite Kelly	Support
Wednesday 19 October 2022	09:00hrs to 17:30hrs	Brid McGoldrick	Support

What residents told us and what inspectors observed

Inspectors spent time chatting with residents and observing staff and resident engagement. Overall, the feedback was positive. Residents were satisfied with the length of time it took to have their call bells answered. Visiting in the centre was unrestricted which was welcomed by the residents spoken with. Inspectors observed the dining experience to be a social and enjoyable experience for residents. Residents were observed enjoying the company of one another in the dining rooms. Mealtimes were unhurried and staff were present to provide assistance and support to residents with their meals when needed. Residents were provided with a choice at mealtimes and could also chose to have their meals in the privacy of their own bedroom, if they wished.

Inspectors spent time observing residents in the many communal day rooms in the centre. Residents appeared relaxed and comfortable in their environment. Staff were present to provide assistance and support to residents. Inspectors were informed that group activities were held. On the day of inspection, inspectors did not observe any activities in two of the units. On these units, inspectors observed that residents spent long periods of time with no facility for activity or social engagement.This meant that there were limitations on the number of residents that had the opportunity to participate in activities in accordance with their interests and capacities.

Following an opening meeting, inspectors walked the premises, meeting with residents and staff. Overall, the premises were found to be clean. Resident bedrooms were seen to be personalised and residents were encouraged to bring in items of importance to personalise the space. Several of the multi-occupancy bedrooms viewed by the inspectors contained wardrobes, which were placed in another resident's bed area. Furthermore, in one bedroom viewed the bed and wardrobe were very close together with no space between, impinging not only on resident's privacy but also presented an infection prevention and control risk.

Inspectors observed that many resident bedrooms had either a hand wash sink or a clinical sink; and in some cases both types of sinks. One resident told the inspectors they use any of the sinks as they didn't know the difference. This practice of dual use of sinks can increase the risk of cross infection. Staff did have access to wall mounted alcohol gel dispensers, but they were not accessible to all bedrooms and areas, and so did not support hand hygiene practices.

The housekeeping room set up required review as the location of the washing machine and drier for mops and cloths within the housekeeping room was a risk of cross infection. There was no named staff member allocated to the laundry of mops on the day of inspection and the inspectors observed housekeeping staff moving between the laundry of these cleaning items and housekeeping. This posed a risk of cross contamination.

There were plenty of supplies of PPE's and the inspectors observed masks and gloves were, in the main, being used appropriately. However, the inspectors did observe some staff wearing gloves and aprons inappropriately, which could lead to cross contamination for residents.

The next two sections of the report present the findings of this inspection in relation to the capacity and capability in place in the centre, and how these arrangements impacted on the quality and safety of the service being delivered.

Capacity and capability

The findings of this inspection were that the provider failed to ensure that there were effective management systems to protect residents from the risk of abuse. Inspectors found poor oversight of the implementation of the centre's policies that included safeguarding policies and supporting procedures. Non-compliance was identified under the following regulations;

- Regulation 4: Written policies and procedures
- Regulation 5: Individual assessment and care planning
- Regulation 8: Protection
- Regulation 9: Residents rights
- Regulation 16: Training and staff development
- Regulation 21: Records
- Regulation 23: Governance and management

Substantial compliance was found under Regulation 27: Infection control.

This one day unnanounced risk inspection was completed by inspectors of social services to assess compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended).

Inspectors followed up on a notification of an allegation of abuse submitted by the person in charge and unsolicited information received by the office of the Chief Inspector specific to an allegation of abuse. As a result of the information received the Chief Inspector issued a provider assurance report seeking assurances on the policies and procedures in place to protect residents. The response did not give sufficient assurances that procedures were being followed fully and as a result the provider was afforded a second opportunity to provide assurances. Inspectors focused this inspection on the systems in place that safeguard residents.

This inspection found that a serious incident that had occurred was not documented in line with professional guidelines, regulatory requirements or the centre's own policy. The action taken by the management and staff following the incident was not in line with the centre's own policy. As a result, the provider could not provide assurance that the residents concerned were safe or that the safeguarding systems

in place ensured the safety of all the residents in the centre.

Cahercalla Community Hospital and Hospice Limited by Guarantee is the registered provider of the centre. The centre is spread out accross four units and has capacity for 112 residents. Mowlam Healthcare Services are participating in the management of the centre. The senior management team consists of a regional manager, who provided governance oversight and support to the person in charge. Within the centre, the nursing management team consisted of the person in charge, supported by an assistant director of nursing and a team of three clinical nurse managers. On the day of inspection, the post for assistant director of nursing was vacant. This position was replaced on a temporary basis by a clinical nurse manager. This clinical nurse management team rotated from their individual units to cover all units. Inspectors found that progress made from the January 2022 and May 2022 inspections had not been sustained. The impact of this finding is discussed throughout the report.

The centre had a risk management policy that met the requirements of the regulations. However, inspectors were not assured that the provider implemented the risk management policy to proactively managed risks or put adequate measures in place to protect residents from the risk of harm.

The management systems failed to ensure that the service provided was safe, consistent and effectively monitored. The system in place to manage risk was not effective. Inspectors found that the management systems in place were not used effectively. This was evidenced by:

- The communication system had not been implemented as per policy. For example, the escalation process, the safeguarding policy and risk management system did not ensure that an incident of abuse once known to the management, was appropriately managed. This lead to inadequate actions, controls or mitigation steps being put in place to safeguard all residents.
- The systems in place to ensure the centre had adequate staffing resources did not ensure an appropriate response to staffing arrangements. This meant that there was an over reliance on the use of agency staff. Staff turnover was high with 34 staff recruited since the last inspection in May 22 and 17 staff had left. Rosters for the week after the inspection were not complete as the management team were awaiting details from the agency provider to fill the vacant positions with staff names to cover 180 hours of direct care. Inspectors acknowledge that agency staff are utilised in the centre.
- The risk management system did not function effectively. Operational and risk management assessments were of a poor standard and were not reflective of findings on the day.
- The management of records and documentation systems did not ensure required standards. For example; care delivery and documentation was not appropriate. The documentation reviewed was was not in line with professional guidelines and did not evidence a high quality service was delivered to residents.
- Changes had been made to names of unit in the absence of a risk

assessment. These changes were not reflected on the fire alarm panel or on floor plan next to the fire panel .This could lead to confusion and delay in evacuation in the case of emergency or fire.

The policies and procedures, as required by Schedule 5 of the regulations, were made available to inspectors. The policies had been reviewed by the provider at intervals not exceeding three years and were made available to staff. However, the registered provider had failed to ensure that some policies and procedures were implemented. Staff had access to education and training. There were, however, gaps in staff attendance in mandatory training sessions such as safeguarding of vulnerable adults. Some staff demonstrated a poor awareness of the systems in place to safeguard residents. For example; senior staff did not know what their responsibility was to ensure reporting of incidents of alledged abuse. Inspectors found that the arrangements in place to supervise and support staff to implement the centres policies and procedures and maintain records was not effective.

Overall accountability for infection prevention and control within the centre rested with the person in charge who was also the designated COVID-19 lead. This role had an extensive remit when factoring in the size and layout of the building, resident numbers and staffing numbers. This role is supported by the assistant director of nursing and clinical nurse managers. However, the assistant director of nursing post was vacant and clinical nurse managers were rotating into the role.

Inspectors reviewed meeting records specific to infection prevention and control. The centre had access to the Health Services Executive (HSE) infection prevention and control specialist team for outbreak advice and support, but not for other infection control guidance and support. The meeting minutes shown to the inspectors included discussions surrounding infection control. However, infection prevention and control and environmental audits undertaken did not always guide changes to support the safety and quality of the care provided, as deficits were not always actioned after the audits.

Regulation 16: Training and staff development

Staff did not demonstrate an appropriate awareness of their training in relation to the detection, prevention and responses to abuse. From the documentation reviewed and staff spoken to inspectors found that staff had poor knowledge of safeguarding. Safeguarding training had not been effective to ensure staff were aware of their role and responsibilities in identifying triggers, responding to, and managing a safeguarding incident.

The findings of this inspection found that training on documentation and care planning was required. This was evidenced by the failure of staff to maintain accurate nursing care records. In addition, inspectors found that there was a failure to appropriately document an incident, in line with the centre's incident reporting

system.

The induction of new employees was not robust. Supervision and oversight was not adequate to support newly hired employees and for those assuming new roles. Induction documentation was a list of activities that were all signed off as completed on one day. In addition, senior care staff were delegated responsibility for the induction of new employees, however training and competencies were not provided for this delegated role.

Inspectors observed that a number of staff were not wearing personal protective equipment correctly. This was not identified and addressed by senior staff in supervisory roles.

Judgment: Not compliant

Regulation 21: Records

The management of records was not in line with regulatory requirements. The nursing records for residents' health and treatment given were not completed in accordance with the requirements of Schedule 3. A record had not been documented for residents following an incident in the centre. This meant that inspectors could not be assured that appropriate assessment, treatment and care was delivered to the effected residents.

The staff rotas provided to the inspectors were not an accurate record of the actual rosters worked by staff. Rotas were maintained in multiple files and the information did not align. For example; staff on duty were not on the worked rotas.

Judgment: Not compliant

Regulation 23: Governance and management

The registered provider did not ensure that the service had sufficient staffing resources to;

- ensure the management structure, and support for the person in charge, was maintained in line with the centre's statement of purpose.
- maintain nursing and healthcare staffing resources in line with the centre's statement of purpose. On the day of inspection there were 4.5 full time nursing posts unfilled. While inspectors acknowledge that the staff were replaced by agency the negative impact was that staff did not know crucial information about residents and the nursing documentation and records to

provide this crucial information was not recorded.
- There was a vacant position in the nursing management team, the activities team and in household services.

The registered provider had failed to ensure that there was a clear management structure and that roles and responsibilities were clear and that staff with the appropriate training and knowledge were assigned responsibility reflective to that role. For example: following a serious incident, staff that were tasked with speaking with the residents to ascertain the facts were not appropriately trained to complete this task to ensure the best outcome.

Governance and management systems were not effectively monitored to ensure the service provided to residents was safe and consistent. This was evidenced by;

- Record-keeping and file management systems were not accurate. For example; staffing rotas were not maintained in line with regulatory requirements.
- The system in place to manage risk. For example;The centre maintains a risk register. Individual risk assessment were not completed in a timely manner post significant incidents. This meant that not all appropriate steps had been taken to minimise any repeated incidents.
- There was poor monitoring and oversight of infection prevention and control and the cleaning procedure as outlined under Regulation 27: Infection control.
- The auditing system was insufficient. An environmental audit dated August 2022 noted similar deficits as on the day of inspection. For example; equipment stored on the floor and the inspector observed a box of feeding sets were seen in a box on the floor in the nurses room. The audit noted that laundry should be stored appropriately and transported safely, however, the inspector found bags of dirty laundry stored in sluices and in open cages outside.

Judgment: Not compliant

Regulation 4: Written policies and procedures

The registered provider had failed to adopt and implement policies and procedures designed to protect residents. For example; Safeguarding of vulnerable persons at risk of abuse. Also the risk management policy was not fully implemented in practice.

The providers infection prevention and control policies were not up to date for staff to use. All HSE/HPSC Infection Control guidance provided to the inspectors had been superseded. The version in the folder was V1.2 06.01.2022 instead of the current version of V1.8. Similarly the HPSC visiting guidance was not current.

Judgment: Not compliant

Quality and safety

Overall inspectors found that the provision of care was not of a consistently high quality. The findings of this inspection were that the quality and safety of the care provided to residents was impacted by inadequate oversight and implementation of the management systems and policies in place to protect residents. This poor quality was reflected in the delivery and documentation of care to residents' and in the ability to provide assurances that residents were safe in the centre. While many resident described a satisfactory quality of life in the centre, a review of the quality and safety of the service found that action was required to ensure compliance with assessment and care planning, management of serious incidents and infection prevention and control practices.

The procedure to safeguard residents was underpinned by a safeguarding policy that provided guidance and support to staff on the appropriate actions and measures to take to protect residents should a safeguarding concern arise. Inspectors found that the policy had not been followed in practice and appropriate action had not been taken to investigate an allegation of abuse.

A review of a sample of resident records did not provide assurance that residents' needs were met in line with professional and best practice guidelines. The inspectors found significant gaps in the nursing documentation reviewed. There was an electronic care planning system in place, which was used by the nursing staff to record the assessments, care plans and daily progress notes of all residents. The inspectors found that the information documented lacked person-centred detail and was not specific to the care needs of individual residents.

The care plans for residents with a urinary catheter (a tube that empties the bladder and collects urine in a drainage bag) was reviewed. Inspectors found that one had gaps in the resident’s catheter management, such as no catheter change date, no mention of how to clean and manage this device and no mention of whether an overnight bag was used in the nursing notes or plan.The second care plan reviewed for a resident with a catheter and wound did not have these care plans in place. Inspectors acknowledge that the third care plan for a urinary catheter was appropriate and detailed.

Staff spoken with, were aware of residents who were prescribed antibiotics, and they were documenting a simple antibiotic monitoring system.

The centre had previously experienced a COVID-19 outbreak. A brief review of the management of this COVID-19 outbreak had been completed and included lessons learned to ensure preparedness for any further outbreaks.

Regulation 27: Infection control

While the provider had some measures and resources in place to manage infection prevention and control in line with national standards and guidance, a number of actions are required by the provider in order to comply with this regulation. This was evidenced by

- Infection prevention and control and environmental audits undertaken did not guide changes to support the safety and quality of the care provided, as deficits were not always actioned after the audits.
- Hand-wash sinks did not support effective hand hygiene practices to minimise the risk of acquiring or transmitting infection. Additionally, there was no hand-wash sinks in the nurses room. This practice increases the risk of cross infection.
- There was inappropriate storage of equipment in the housekeeping room and sluice. This arrangement increases the risk of environmental contamination and cross infection
- Prepared cleaning chemicals were not labelled and dated to ensure expected shelf life did not expire.
- Sharps boxes were seen not signed when opened, stored on the floor and in some cases the temporary closure mechanism was not engaged when in use. These should be in place in order to safeguard both residents and staff.
- Nebuliser compressors and medication chambers were not managed to to reduce the risk of cross contamination for residents.
- Cloth tourniquets were seen in place which could be a risk of blood borne diseases for residents as they cannot be cleaned in-between resident's use.
- Hand Hygiene audits seen were tick boxes with no numbers to guide improvement plans.
- Several open-but-unused portions of wound dressings marked 'single-use' were observed by the inspectors, which would increase the risk of cross contamination and impact on the effectiveness of the dressing.

Storage within 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) was not in line with best practice, due to the risk of contamination from the disposal of body fluids process that takes place in a sluice room. Commode bowls, bedpans and urinals were stored on window shelves and on the stainless steel sinks which would not allow for the drying process to occur after removal from bedpan washers. Similarly, washing up liquid was provided in sluice rooms to clean commodes, of which the label to direct when the solution was made up was dated May, 2022.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

A review of resident's electronic care records found that the assessment of residents health, personal and social care needs were not comprehensive and did not inform the development of a care plan. This meant that the information available to health care and nursing staff did not contain the detail required to deliver safe and effective care. A review of records found that;

- resident assessments of health and social care need were not completed when changes occurred.
- care plans were not updated to reflect the changing needs of residents.
- significant changes to the overall health of residents was not reflected in their care plans.
- daily progress notes had significant gaps and therefore were not a reflection of the health status of the resident.
- Care plans for residents with a urinary catheter and wound management did not outline the required care needed.
- poorly recorded safety location charts did not provide assurance that an appropriate care plan was in place. For example, a resident that was on increased monitoring had significant gaps in the location charts.

Judgment: Not compliant

Regulation 8: Protection

The registered provider failed to take reasonable measures to protect residents from abuse and to provide for appropriate and effective safeguards to prevent abuse. This was evidenced by the;

- failure to take reasonable measures to protect residents from abuse
- training delivered was not effective to ensure staff had the required skills to detect, prevent and respond to abuse
- failure to recognise and respond appropriately in a timely manner to an allegation of abuse.
- failure to instigate an investigation into an allegation of abuse in a timely manner.

Judgment: Not compliant

Regulation 9: Residents' rights

The provider failed to ensure that all residents had appropriate and timely access to independent advocacy services. The provider failed to ensure that residents, or their representatives, were supported to make an informed decision and exercise their

choice with regard to their care and support needs following an incident in the centre.

Inspectors were informed that group activities were held. On the day of inspection, inspectors did not observe any activities in two of the units. On these units, inspectors observed that residents spent long periods of time with no facility for activity or social engagement. This meant that residents in these units did not have any opportunity to participate in activities in accordance with their interests and capacities. This is a repeated non compliance from the last inspection in May 2022.

Inspectors observed that in multiple twin rooms, residents 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 also a repeated non compliance from the May 2022 inspection.

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 16: Training and staff development	Not compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 27: Infection control	Substantially compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Cahercalla Community Hospital & Hospice OSV-0000444

Inspection ID: MON-0038188

Date of inspection: 19/10/2022

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Not 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 mandatory staff training, and all outstanding training and refresher updates have been scheduled for staff as required. • Safeguarding the Vulnerable Adult training sessions have been undertaken since the inspection and additional sessions have been scheduled to ensure that Safeguarding training programmes are completed by all staff within the required timelines. • The PIC will introduce a new clinical documentation audit which will assess the quality, completeness and person-centredness of care records. The PIC, supported by the Healthcare Manager will implement quality improvement plans to assist staff in improving the resident records. Regular clinical supervision meetings will be held between the nursing management team and staff nurses to provide guidance and feedback regarding the nurses' competency and accuracy in maintaining effective care records. • Safeguarding plans and protection measures will be discussed at each safety pause in relation to individual residents who have been assessed as being particularly vulnerable, supervision measures in relation to residents who are assessed as being a potential risk to others, to ensure that care plans are effective in meeting protection care needs. • The Healthcare Manager and PIC will undertake regular practical assessments of the knowledge and awareness of staff regarding recognition, response and escalation of any issues of concern regarding the safety and wellbeing of residents. These assessments will assess the knowledge and application of theory to practice using a scenario-based model and reflective practice. These Safeguarding Drills' be undertaken on a one to one and group basis, and the scenarios will be evaluated to what went well and to identify quality improvements for future safeguarding drills . • The Healthcare Manager has scheduled a Safeguarding workshop specifically for the management team in the centre. The aim of the workshop is to support staff and managers in preventing harm, reflecting on their own safety practices and fostering a safety culture within the centre. • The PIC will ensure that the induction of new staff is overseen by a member of the management team (Assistant Director of Nursing (ADON) and Clinical Nurse Managers	

(CNMs). New staff will complete mandatory training. They will be assigned to work with an experienced colleague who will assist in orientating them to the centre's work practices and routines. Care standards and clinical practice will be monitored by a CNM or senior nurse. They will meet with new staff regularly during the probationary period to identify areas of learning and development and the induction record will be completed comprehensively.
• The PIC will arrange on-site training in Infection Prevention & Control, including the appropriate wearing donning, doffing and disposal of PPE.

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
• New staff will receive education on assessment, care planning and updating resident records as part of their induction and introduction to the electronic resident record system in place in the centre.
• The PIC will introduce a new audit toll to assess the quality, completeness and person-centredness of nursing and care records for individual residents. The management team will conduct weekly audits by reviewing a sample of records on each unit. They will discuss areas requiring improvement with the named nurse to allow opportunities for nurses to learn and improve their clinical documentation.
• The PIC, supported by the Healthcare Manager will complete a review of staff rostering in the centre to ensure that they are clear and accurately reflect the names and designation of all staff on duty. The Assistant Director of Nursing (ADON) will review the rosters prior to issuing them to the wards.
• The PIC will ensure that each area will be issued with their own roster. Any changes to the planned roster will be submitted to the PIC/ADON. and a copy of the centre's overall roster will be available and reflective of the working hours of all staff.
• The roster will clearly indicate the management team on duty each day to ensure that everyone is aware of who is responsible for the overall supervision of the centre.
• The PIC will ensure that newly appointed employees will have appropriate time allocated for induction and will work alongside a designated staff member to complete a comprehensive induction. The induction form will be a record of each staff member's competency, which will be used as a reference point for staff performance, and this will be discussed and reviewed at the time of individual performance review/appraisal. The induction record, confirming that all the required aspects of induction and orientation have been satisfactorily completed will be signed off by the PIC/ADON/CNM and the individual employee upon completion.

Regulation 23: Governance and	Not Compliant

management	

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

• There is now a clearly defined management structure in the home. The PIC will continue to receive support from the regional Healthcare Manager who visits the home at least twice weekly and is always available for advice, discussion and consultation.
• The ADON position has been filled since the inspection.
• The ADON and CNMs are visible and accessible on the wards; they conduct monitoring rounds every day to review resident care and clinical practice. They supervise workflow and care practices to ensure that staff are facilitated to provide high quality, safe and effective care to all the residents.
• There is an active recruitment programme in progress and new staff have been appointed since the inspection, including Assistant Director of Nursing, Staff Nurses (4 appointed) and Healthcare Care Assistants. Recruitment is ongoing for a Social Care Practitioner and an Activities assistant.
• There is an auditing system in place and the PIC has been fully trained in its use and application.
• The Healthcare Manager (HCM) will assist the PIC in conducting a comprehensive review of incidents management to ensure that all incidents recorded are correctly classified, escalated without delay, appropriately investigated where required and accurately recorded.
• The Healthcare Manager will meet the PIC and management team each week to monitor the status of the centre, monitoring key performance indicators, reviewing complaints, incidents. The PIC will provide assurance that the appropriate and timely identification, reporting, recording, further escalation, investigation and resolution of incidents and appropriate notification to the Authority and other external agencies takes place as required.
• There is a monthly management team meeting in the home which reviews all operational aspects of the home, including key performance indicators, risk management, audits and progress on identified actions and updates on quality improvement initiatives. This meeting is well attended and includes at least one representative from each department.
• The HCM will provide further assurance of the supervision process by conducting oversight audits of the records of the supervision meetings, and subsequent feedback on the results will be provided to management in the home, and the senior corporate management team at the monthly care and quality management team meetings.

Regulation 4: Written policies and procedures	Not Compliant

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

• We will introduce a 'Red Alert' quick reference guide that is easily accessible to staff in

the event of any untoward incident. The alert system will outline the appropriate actions to take and procedures to follow in the event of a significant untoward/adverse event, such as a suspicion or allegation of abuse, observation of inappropriate behaviours by residents or staff or emergency situation. The guide will include agreeing who is the initial lead in responding to the incident, and will describe the escalation process, detailing who should be informed.
• The PIC will ensure that all staff are aware of and adhere to the centre's Safeguarding Policy. Safeguarding/Protection will be discussed at all weekly and monthly management and departmental meetings.
• The PIC will ensure that all staff are aware of their duties and responsibilities in relation to identification, reporting, recording and response to any untoward events or unanticipated incidents, and that appropriate, detailed and accurate records are maintained in line with the requirements of Schedule 3 of the Health Act.
• The PIC will ensure that all nursing or medical care provided to the resident, including a record of the resident's condition and any treatment or other intervention will be recorded and will review all incidents every week to determine the accuracy and completeness of the records and that all appropriate interventions have been implemented.
• The PIC/ADON/CNM will complete weekly audits of residents' records to ensure they accurately detail each resident's health and wellbeing, providing accurate and timely documentation of any changes to residents' condition.
• The PIC will ensure that all risks recorded are completed in line with the risk management process outlined in the centre's risk management policy.
• The PIC supported by the HCM will ensure that incidents recorded have an outlined risk assessment detailing an analysis of the risk identified and that high level risks are identified and escalated without delay.
• Individual risk assessments will have a clearly defined assessment, evaluation , identification, and risk level identified, with measures initiated to reduce risks that pose as a harm to residents.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
• The PIC will review the housekeeping service in the home and will allocate sufficient hours to enable household staff to undertake their duties, facilitating safe cleaning practices and procedures for housekeeping staff and the provision of appropriate supervision to household staff.
• The PIC will identify an appropriate Infection Prevention & Control (IPC) Lead Nurse, who will complete IPC audits and generate action plans to identify areas of required improvement, monitoring the implementation of required actions and reporting on compliance.
• The PIC will liaise closely with the General Services Manager on the development and implementation of quality improvement plans where household staff are required to

address any identified deficits.
• 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.
• The PIC/ADON and IPC Lead Nurse will ensure supervision of IPC practices daily and will ensure appropriate compliance in the use of PPE.
• The PIC has completed a review of the sinks within each resident's room and has indicated by signage which sink is assigned for residents' own use and which are intended for staff to use as clinical handwash sinks.
• The PIC has completed a review of the storage of equipment within the housekeeping room and inappropriate items have been removed to facilitate safe IPC practice within these areas. The housekeeping supervisor will continue to monitor these areas and ensure continued compliance with IPC practices.
• 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
• The Lead IPC Nurse will ensure that hand hygiene audits will include improvement plans where necessary, and these audit results will be shared with the team to highlight best practise in the technique of hand hygiene.
• The IPC Lead Nurse will monitor the risks of cross contamination by promoting the appropriate single use of equipment.
• The PIC and IPC Lead Nurse will ensure that all current HSE/HPSC infection control guidance will be available and accessible for all staff to use as a guide to best practice.

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
• The PIC will complete a review of documentation training with all nursing staff by 31/12/2022.
• The education will enable each nurse to ensure that each identified care need of a resident shall be used to create an individual care plan that considers all aspects of their physical and mental health, personal and social care needs, and any supports required to meet those needs.
• The PIC/ADON and CNMs will review the assessments and care plans in conjunction with the named nurses to ensure that assessments inform the plan of care, that the care plan is individualised and person-centred, considering the resident's current medical, health and lifestyle status, and that the care plans are reviewed at intervals not less than 4 monthly or as indicated by the resident's condition or circumstances.
• As part of the audit management system, all care plans will be regularly audited and reviewed by the PIC/ADON/CNMs to ensure that they are sufficiently detailed and reflect the residents' current health status and required care interventions.
• 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.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• The PIC will ensure that all staff receive regular mandatory safeguarding training, including training in the National Standards for Adult Safeguarding.
• The HCM, Quality & Safety will chair an After-Action Review of recent significant incidents to highlight to the staff and the entire management team the importance of recognising, reporting, escalating, investigating and resolving all forms of abuse
• The PIC, supported by the Healthcare Manager will be aware of their responsibilities in recognising, reporting and responding to any allegations including escalating any concerns appropriately.
• The HCM will work with the PIC to ensure that recommendations and quality improvements are implemented.
• The HCM has scheduled a Safeguarding workshop for the management team to facilitate open discussion and provide clarity regarding their roles and responsibilities in the management of safeguarding risks and each individual staff member's responsibilities in the event of a safeguarding incident in terms of immediate actions, escalation, preliminary screening, and investigation.
• The PIC will ensure that any suspicion, concern, or allegation of abuse will be thoroughly investigated (including the notification of all such suspicions or allegations to the Authority) in accordance with policies and procedures to safeguard residents including the following: Policy (PR-001) Safeguarding Vulnerable Persons at Risk of Abuse
Policy (PR-002) Safeguarding Vulnerable Persons at Risk Responding to Allegations of Allegations of Abuse.

Regulation 9: Residents' rights	Not 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 twin rooms in the nursing home with respect to the rights, preferences, privacy and dignity of both occupants of the room has been completed with assigned works scheduled for quarter 1 of 2023.
• This review will ensure that the layout of the room is sufficient to allow for the resident's bedside locker and storage space for personal possessions to be accommodated with the individual residents' area.
• The PIC will complete a review of activities within the centre to ensure that all residents

can attend activities in accordance with their preferences and that there is a schedule of varied, interesting and meaningful activities available on each unit.
• The PIC will ensure that residents have appropriate and timely access to advocacy services. Information leaflets will be readily available for residents . The PIC will ensure that these services are always offered and accessible to residents.
• The PIC supported by the ADON will ensure that all staff are aware of advocacy services and ensure that when required, residents will be afforded the opportunity to have their voice heard on issues that are important to them, protecting and promoting their rights and will consult residents about their views/ wishes when decisions are being made that may affect them.

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.	Not Compliant	Orange	31/12/2022
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/11/2022
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Not Compliant	Orange	31/12/2022
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	Not Compliant	Orange	31/12/2022

	the statement of purpose.			
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Not Compliant	Orange	30/11/2022
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	31/12/2022
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.	Substantially Compliant	Yellow	31/12/2022
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on	Not Compliant	Orange	31/12/2022

	the matters set out in Schedule 5.			
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Not Compliant	Orange	30/11/2022
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Orange	30/11/2022
Regulation 8(2)	The measures referred to in paragraph (1) shall include staff training in relation to the detection and prevention of and responses to abuse.	Not Compliant	Orange	31/12/2022
Regulation 8(3)	The person in charge shall investigate any incident or allegation of abuse.	Not Compliant	Orange	30/11/2022
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and	Not Compliant	Orange	31/12/2022

	capacities.			
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.	Not Compliant	Orange	31/12/2022
Regulation 9(3)(f)	A registered provider shall, in so far as is reasonably practical, ensure that a resident has access to independent advocacy services.	Not Compliant	Orange	30/11/2022