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:	15 September 2021
Centre ID:	OSV-0000444
Fieldwork ID:	MON-0034065

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:	86

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 15 September 2021	10:00hrs to 17:30hrs	Una Fitzgerald	Lead
Thursday 16 September 2021	10:00hrs to 17:30hrs	Una Fitzgerald	Lead
Wednesday 15 September 2021	10:00hrs to 17:30hrs	Noel Sheehan	Support

What residents told us and what inspectors observed

Overall, residents felt that this was a nice place to live and the inspectors found that the residents received a good standard of care and support that met their assessed needs. Residents' medical and healthcare needs were being met. Inspectors observed a relaxed and welcoming atmosphere. Residents appeared well groomed. Residents spoke highly of individual staff members and were very appreciative of the care received. Inspectors observed group activities and found that they were interactive and engaging. However, inspectors also observed that group activities could only be held for a small number of residents at any time. Inspectors observed that the social care needs of residents who did not attend group activities were very limited and required review to ensure that the social care needs of all residents can be met.

This was an unannounced inspection. On arrival, the inspectors were guided through the infection prevention and control measures necessary on entering the designated centre. These processes were comprehensive and included a signing in process, disclosure of medical wellness, hand hygiene, face covering and temperature checks. Residents and relatives who spoke with the inspectors said that they found these measures to be reassuring and necessary to ensure the safety of all persons in the designated centre. Residents said they had been kept up-to-date regarding the visiting restrictions and the COVID-19 pandemic. The person in charge held monthly resident meetings on each unit. On the day of inspection, residents had completed the vaccination programme.

The centre is currently divided into four units where residents are accommodated. Each unit has a dining and communal sitting room for resident use. These communal rooms were seen to be in use throughout the two days. Inspectors were informed that communal rooms are supervised at all times. On the day of inspection, inspectors observed periods of time whereby the communal rooms were not supervised. For example, Inspectors observed an unsupervised resident eating their meal in a tilted chair facing the ceiling which increased the risk of choking.

Inspectors spent time on all four units meeting residents, staff and relatives. Inspectors observed that the nurses station on two units was a gathering place for residents throughout the day. Residents were seen to sit and observe the coming and going of all staff. Interactions were observed to be respectful and kind. There was a familiar rapport observed and staff greeted residents by name when walking past. The atmosphere was welcoming. Social interaction observed included a resident playing a musical instrument for inspectors and a resident sang a song.

The inspectors spent time observing residents with dementia and their engagement with staff. While none of the residents met with were able to tell the inspector their views on the quality and safety of the service, the inspectors observed that the residents appeared content and relaxed in their environment.

Residents reported that the food was good and that they were happy with the choice and variety of food offered. Inspectors observed that the main meal of the day was rushed and that residents would benefit from a review of the dining experience. Inspectors observed the following;

- On day one, the residents in one unit had all finished their lunch by 12.25pm.
- On day two, a resident that was asking for breakfast was told it was nearly lunchtime. The time was 10.36am
- On day two, the main meal on one unit was served with residents observed to be finishing their meal at 11.57am

Residents told the inspectors that they were happy with the length of time it took to have their call bell answered when seeking assistance. Inspectors observed that a review of the availability and access to resident call bells was required. For example; in one unit, two residents had no call bell, while a further three residents had no bell within reach and so could not call for assistance. Inspectors acknowledge that immediate action was taken to address same.

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

Inspectors found, that while progress has been made in moving towards compliance with the regulations and standards since the previous inspection of 16 March 2021, further enhancement and strengthening of the new structure and systems is still required to ensure that the service is safe, appropriate, consistent and effectively monitored. The staffing numbers available in multiple departments were not only short of the numbers outlined in the statement of purpose but were also not in line with the commitments made to the Office of the Chief Inspector from the previous March 2021 inspection compliance plan response. Inspectors found that the current person in charge did not have a clinical management support team to ensure sufficient oversight and supervision of staff and to respond to residents needs. In addition, there were insufficient staff employed delivering the direct care and to ensure residents were supported to engage in activities and meaningful occupation. Inspectors acknowledge that the provider had positively engaged with the office of the chief inspector and that one unit had been temporarily closed as part of the management strategy to facilitate the process of change that was occurring in the centre.

Inspectors found repeated non-compliance's with the regulations reviewed and that the compliance plan response to the previous inspection findings had not been implemented. Inspectors found that Regulations 23 Governance and Management, Regulation 15 Staffing, Regulation 16 Training and staff development, Regulation 5 Individual assessment and care plan, and Regulation 9 Residents Right remain either

substantially compliant or not complaint.

This was an unannounced risk-based inspection undertaken to follow up on

- the previous inspection findings in March 2021
- unsolicited information received by the office of the Chief Inspector specific to the quality of the care
- the ongoing progress in the implementation of the written representation made by the registered provider to the notice of proposal to cancel the registration of the centre issued by the chief inspector in February 2021.

Cahercalla Community Hospital Company Limited by Guarantee is the registered provider of the centre. Mowlam Healthcare Services are participating in the management of the service and are operating the day to day running of the centre. The person in charge was being supported by a regional manager and the wider Mowlam organisation, a general service manager, an Assistant Director of Nursing, two Clinical Nurse Managers (CNM), registered nurses, healthcare assistants, activities staff and a team of non clinical staff.

There was evidence of good systems of communication that included monthly governance meetings with the provider and the management team, quality and safety meetings, staff meetings and daily handover and safety pauses. There was evidence that the management team discuss all clinical and operational matters on an ongoing basis. To ensure the centre was operating in line with the regulations and standards, the provider had implemented a number of oversight arrangements including the Mowlam audit management system (MAMS). Audits reviewed by inspectors were comprehensive and where gaps were identified actions plans to address the gaps were in place. The audit schedule now in place provides improved oversight of the service delivered to the residents.

Notwithstanding the progress made, inspectors found that the person in charge did not have sufficient clinical nurse management support. The systems in place are not sufficiently robust enough to ensure sufficient oversight and supervision of staff and to respond to residents needs. This was evidenced by:

- Staffing - there were insufficient staff numbers on duty. For example the shortages in the clinical nurse manager team. This was impacting on their ability to ensure oversight and monitoring of the service delivered.
- Staff induction was not sufficiently robust. The induction programme for newly recruited managers was a check list and no detail was populated in the files of what was covered.
- Care plans were not consistently completed in accordance with Regulation 5 requirements. Inspectors found gaps in the oversight and monitoring of the management of pain.
- The person in charge had recently reviewed and updated the risk register that formed part of the risk management strategy in the centre. Some risks required review such as the risk associated with the recruitment and retention of staff in the context of the ongoing challenges with staffing in the centre.

- The assistant director of nursing was working on the floor on the first day of inspection to cover a nurse absence.
- There was one nurse and one carer rostered on each unit for night duty. One of the nurses on night duty was allocated to be the nurse in charge of the centre each night. However, when the nurse in charge has to leave the unit to support other units, it meant that the unit was left with only one staff member. This poses a risk. A review of staffing numbers for night duty was required to ensure that staffing levels were adequate for the delivery of care and the supervision of staff and for the size and layout of the building. This issue was also identified on the previous inspection.

The management team were committed to providing ongoing training to staff. There was a training schedule in place and training was scheduled on an on-going basis. The training matrix reviewed identified that staff had received mandatory training in safeguarding vulnerable adults from abuse, fire safety, people moving and handling, infection prevention and control, hand hygiene and the management of responsive behaviours.

It was apparent that the registered provider and person in charge encouraged and were responsive to feedback about the service from residents and families. Inspectors reviewed the complaints log and found that there was a total of 28 complaints logged in 2021. Records available contained details on the nature of the complaint, investigation carried out and follow up communication with the resident and family as required. There was evidence that the outcome of a complaint was documented and this included the complainant's level of satisfaction with the result. The complaints procedure was displayed at the main entrance. Residents reported feeling comfortable with speaking to any staff member if they had a concern.

Regulation 15: Staffing

The management team on the day of inspection confirmed that a significant number of staff had recently left the centre for varied reasons. Inspectors were told that the recruitment of staff was on-going.

Inspectors found that the number of staff available cross referenced with the staffing requirement as detailed in the centres Statement of Purpose submitted and accepted by the office of the Chief Inspector evidenced significant shortfalls. The management team had proposed decreasing the numbers of staff across multiple grades. The Statement of Purpose outlines the whole time equivalent staffing numbers required for a Capacity of 112 residents. While inspectors accept that the provider had temporarily closed a unit and had a reduced capacity of eighty six residents, the staffing numbers were not adequate as evidenced by the vacancies on the day of inspection.

As a result of the ongoing staffing shortages, the negative impact was:

- the nursing management team were at times redirected to deliver the care and so were unable to supervise and monitor the service
- there were periods of time when communal areas occupied by residents were unsupervised.
- rosters evidenced that over 23 days there were 14 days where by the numbers of health care staff on duty was insufficient. This shortfall varied from between 6 -24 hours short.
- There was one activities staff allocated to meet the needs of the 84 residents in the centre.
- Planned staff leave had not been replaced.

Judgment: Not compliant

Regulation 16: Training and staff development

Appropriate arrangements for supervision of staff were not in place as a result of inadequate numbers of management personnel in place.

The system of staff induction and supervision was not sufficiently robust. For example, a newly recruited manager's file evidenced a check list to cover induction. This was primarily ticked off around the time of commencement of employment. There was no other evidence of development or support until a training update 5 months into employment.

Judgment: Not compliant

Regulation 21: Records

Inspectors reviewed staff files and found that staff files contained all of the documents required by the regulations.

Judgment: Compliant

Regulation 23: Governance and management

While improvements were noted from the previous inspection in March 2021, Inspectors found that further development of management systems in place to monitor the overall quality and safety of the service continued to require further strengthening. For example:

- Repeated non compliance found under Regulations 23 Governance and Management, Regulation 15 Staffing, Regulation 16 Training and staff development. Regulation 5 Individual assessment and care plan, and Regulation 9 Residents Rights.
- The registered provider continues to operate the designated centre in contravention of condition 04 of registration.
- Insufficient progress in the appointment of clinical nurse managers to support the person in charge to ensure that appropriate supervision was in place.
- Sufficient staffing levels were not maintained on a daily basis to meet the needs of the current residents.
- Insufficient monitoring of the cleanliness of resident equipment
- Insufficient monitoring of the induction and follow up provided to new staff
- Medication administration systems require review and strengthening. For example, the registered provider had said that staff nurses were facilitated to complete uninterrupted medication rounds monitored by nurse managers, however resources in place could not support this commitment.

Judgment: Not compliant

Regulation 31: Notification of incidents

Notifications to the Chief Inspector were submitted in accordance with time frames specified in the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

The inspectors reviewed the complaints log. There was evidence that when a complaint is logged appropriate steps are taken as per the centre's policy. The documentation in place evidenced that the management engaged with the complainant to ensure that all reasonable measures were taken to ensure a satisfactory outcome.

Judgment: Compliant

Quality and safety

Residents wellbeing and welfare was maintained by a good standard of evidence-

based care and support. However, improvements were required in the development of person centered care plans. Inspectors found that care plans did not always contain the information required to guide the care. In addition, further development and enhancement of the activities within the centre was required.

Each resident had an assessment completed prior to admission to identify their care needs using a variety of validated assessment tools. This included assessment of dependency needs, falls risk, nutritional risk and risk of impaired skin integrity. Care plans were developed in consultation with the resident and/or their family members and the staff had access to these care plans. Inspectors reviewed a sample of seven resident files. In the main, care plans were found to be person-centred and included personal information.

The clinical management team were actively promoting a restrictive free environment. A restrictive practice register was maintained in the centre and residents that requested the use of bedrails had a supporting risk assessment completed, consent forms and monitoring of safety completed. The use of bedrails had decreased from a high of 22 in the last quarterly notifications submitted down to four on the day of inspection.

Medicines management and practices had been reviewed. Unsolicited information received into the office of the Chief Inspector had highlighted concerns with the administration of medicines. As a result the provider submitted a provider assurance report which outlined that the PIC will ensure that staff nurses are facilitated to complete uninterrupted medication rounds. Inspectors were not assured that this was implemented in practice. Rosters evidenced that on night duty there is only one nurse on duty with one healthcare assistant. Therefore, if a resident requires the assistance of two staff, the healthcare assistant has no option but to interrupt the nurse dispensing medications during this time. Further review of risk management strategies is required.

Inspectors observed medicine administration practices. Medicines were stored safely and were regularly reviewed by doctors. Medicine errors were recorded and fully investigated. Regular medicines management audits were carried out by nursing management. Training records evidenced that all nurses had completed online medication management training. Inspectors observed the nurses administering medications and found that they were patient in their interactions with residents giving them appropriate time to take their medicines. Nothwithstanding the positive observations a review of the time frames in which medicines are administered is also required. Nurses on day two were seen administering morning medications well in excess of the 08.00am prescribed administration time.

Inspectors walked the premises. Following the last inspection the provider had developed and implemented a quality improvement plan to address regulation non compliances under regulation 27 Infection control. The centre was visibly clean. There was sufficient staffing to ensure that the premises were cleaned daily. There was a colour coded cloth and mop system in place that utilises one cloth per room to ensure that each area is cleaned with a new cloth/mop on every occasion. The inspectors spoke with staff who were very clear on the policy, procedures and

practices in place. The supervision of the cleaning of resident individual equipment required attention. Inspectors observed multiple examples were resident equipment was not cleaned appropriately.

Residents had access to information and news, a selection of newspapers and Wi-Fi were available. Independent advocacy services were also available. There were pictures along corridors of group activities that had been organised in recent months. For example; the activities team had held a event title "Tattoo and Booze". Photographs seen of the event evidenced that the event had been enjoyed by all that attended. Inspectors observed a baking session held in one of the communal rooms. The residents that attended were observed to enjoy same. Despite this, inspectors found that a review of the staffing allocation to enable all residents avail of activities or one to one sessions that meet their individual needs is required.

The provider had made good progress on fire safety precautions and procedures within the centre. Fire drills were completed that included night time simulated drills to reflect night time conditions. Records documented the scenarios created and how staff responded. Staff spoken with were clear on what action to take in the event of the fire alarm being activated. Each resident had a completed personal emergency evacuation plan in place to guide staff. Appropriate documentation was maintained for daily, weekly, monthly and yearly checks and servicing of fire equipment. The fire alarm system met the L1 standard which is in line with current guidance for existing designated centres. Annual fire training had taken place in 2021 and was attended by all staff. Not withstanding the progress made, inspectors found that further improvements are required to bring the centre into full compliance with the regulations. The detail is outlined under regulation 28 Fire precautions.

Regulation 11: Visits

Residents were supported to maintain personal relationships with family and friends. The centre was facilitating visiting in line with the current COVID-19 Health Protection and Surveillance Centre (HPSC) guidance on visits to long term residential care facilities. Open visiting had resumed in the centre and relatives spoken with were very appreciative of the visiting arrangements in place.

Judgment: Compliant

Regulation 26: Risk management

The risk policy contained all of the requirements set out under Regulation 26(1). The local risk register was kept under review by the person in charge. The risk register identified risks and included the additional control measures in place to minimise the risk.

Judgment: Compliant

Regulation 27: Infection control

Overall the building was found to be clean. Cleaning staff were knowledgeable on the cleaning system in place and were observed to adhere to same.

The inspectors spent time observing staff practices regarding the use of PPE and found good practice. Staff were familiar with the five moments of hand hygiene. Training records reviewed indicated that all staff had completed infection prevention and control training.

Protocols were in place for symptom monitoring and health checks for residents and staff. In addition, the management team had put in place the following measures to protect residents:

- appropriate signage was in place to remind staff of the need to complete hand hygiene and observe social distancing when apropriate
- appropriate use of face masks was observed by staff
- on the day of inspection there were sufficient supplies of PPE in stock
- there was hand hygiene gel dispensers strategically placed along corridors.

Judgment: Compliant

Regulation 28: Fire precautions

The inspectors released multiple fire compartment doors and observed that the doors seals did not always meet. Inspectors were able to see through the gap between the fire doors. This meant that in the event of a fire the smoke would not be contained in the compartment.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

Inspectors reviewed a sample of resident's medication kardex and medication administration records and observed that medication management practices in the main complied with professional regulatory requirements, guidelines and the centres own policies.

During this inspection, inspectors observed that morning medications were not

always administered within the allowed time frame of the prescribed time. This non compliance is addressed under regulation 23 Governance and Management.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

The centre had implemented an electronic care planning system in the centre and this had been a significant change initiative. Notwithstanding this, further development of the detail inputted into the care plans is required to ensure that the assessments of need are then reflected in the care plan. This will ensure that staff can deliver the most appropriate care based on the assessed need.

Inspectors identified that clinical needs were not always updated into the relevant sections of the care plan. For example; residents with pain that were requiring regular pain medication did not have any pain care plans to guide staff. Two files reviewed evidenced that pain assessments were not competed prior to or post the administration of pain medication. The records did not identify where the pain was located and if pain medication administered was effective.

Not all assessments were completed using the most accurate information available. For example, post having a fall the care plans needed to be updated to identify the increased risk and the measures put in place to manage same.

Judgment: Substantially compliant

Regulation 6: Health care

The inspectors found that residents had access to medical and allied health care support to meet their needs. Residents had a choice of general practitioners (GP).

Visiting by health care professionals had resumed at the time of inspection. Services such as physiotherapy and dietetics were also available. Records reviewed evidenced that in the main, advise received was followed which in turn had positive outcomes for the residents.

Judgment: Compliant

Regulation 9: Residents' rights

Residents did not have access to meaningful activities in line with their interests.

The last inspection compliance plan response stated that there will be activities scheduled seven days per week and all staff will be allocated time to be involved in social engagement with residents. Findings from this inspection found that activities were available six days a week; and that there had only been one staff member allocated to the provision of activities (for 86 residents) for the three weeks leading up to inspection.

While the healthcare staff spoken with had good insight and knowledge into the importance of social engagement for residents they informed inspectors that this is not part of their role. In addition, staff stated they do not have time to complete activities with residents. The records reviewed identified gaps in the provision of activities for residents that did not partake in group activities.

Times of meals were set by staff rather than residents which is not person centred practice as referred to in section one of the report.

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	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Cahercalla Community Hospital & Hospice OSV-0000444

Inspection ID: MON-0034065

Date of inspection: 16/09/2021

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • There is a robust recruitment plan in place to address identified staffing deficits. The PIC will continue to recruit staff into current vacant positions: 1 CNM has been offered 1 Staff Nurse vacancy has been filled Recruitment continues to fill remaining 1 Staff Nurse, 2 HCAs and 1 Activity Coordinator positions. • The PIC will ensure that appropriate supervision arrangements are in place to facilitate the nursing management team to provide appropriate supervision and to monitor the quality and safety of resident care. • The ADON will work in a supernumerary capacity full-time, Monday to Friday. When the ADON is on leave, these hours will be backfilled by a CNM. • In addition to the ADON, there will be a supernumerary CNM on duty every day, including weekends. • We will reorganise the service in the centre to provide 3 distinct units, as outlined in the Statement of Purpose for the centre. Each unit will have a Clinical Nurse Manager in place. Further detail is provided under Governance & Management. • Nursing staff and Healthcare Assistants will be rostered on each unit, and the PIC will ensure that there are always sufficient staff numbers and skill mix on duty to meet the assessed care needs of all residents. • In the event of unanticipated staff shortage, due to sickness leave for example, the PIC will review the roster to bridge the gap with existing nursing or HCA staff; if this is not possible, we will use agency staff to fill any vacant shifts. • These arrangements will ensure that the nursing management team will be consistently available to supervise and monitor the delivery of care and the quality and effectiveness of the overall service to residents. • The arrangements for supervision of communal areas have now been reviewed and the PIC will ensure that supervision is provided by an appropriate staff member as required and that staff engage meaningfully with residents in these areas. • A review of the Activities Coordinator (AC) roster will be undertaken to ensure that all residents will have an opportunity to avail of meaningful activities based on their	

preferences and choices, including one-to-one and group activities.
• A schedule of varied activities is available throughout the week on each ward and all residents will be consulted regarding their preferences and offered the chance to participate. Residents may choose to decline to participate, and their decisions will be respected.

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 PIC will ensure that the ADON remains supernumerary to the roster and provides oversight and supervision.
• As outlined in Regulation 15, Staffing, there will be a supernumerary CNM on duty 7 days per week and they will supervise the delivery of care and monitor quality and safety.
• This level of managerial oversight will facilitate appropriate mentorship of staff and provide opportunities to improve the quality of individualised care to residents, ensuring a strong focus on a human-rights based approach to care delivery.
• There are weekly management team meetings between the PIC, ADON and CNMs for the purpose of setting priority objectives for the week, and each nurse manager will complete regular safety rounds in the clinical areas to monitor practice and to provide support and guidance to staff.
• The PIC will ensure that all staff have received up to date mandatory training and education in line with legislative and regulatory requirements.
• There are role-specific induction programmes in place, and we will maintain a record of these for each staff member in the individual personnel files.
• The PIC will ensure that the Induction programme is completed during the initial 4 weeks of employment. Regular probationary meetings will be held with the new employee and their designated mentor/line manager during the probationary period and the employee's progress will be documented, including identification of development needs and completion of key objectives. This will form part of the individual performance appraisal process.
• The PIC has ensured that training programmes have been undertaken for staff to maintain safe practice in key areas, including fire safety, safeguarding and protection of residents, and care planning/documentation.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management: Governance & Management • We will realign the services within the centre to provide 3 distinct units: Continuing Care (Long-Term Care), Community Care (Reablement, Respite, Short-Term Care) and Memory Care (Dementia/Cognitive Impairment Care). The purpose and function of these units is further detailed in the centre's Statement of Purpose. • The PIC is supported by the Healthcare Manager and the Director of Care Services in the achievement of all required objectives and in ensuring the provision of safe, effective systems of Governance and Management. • The PIC oversees all operations within the facility and attends Safety Pauses and handovers daily. • The PIC will ensure where possible that Medication rounds are uninterrupted. This will be monitored by the CNM, taking into consideration the resident needs at any given time. • A management team meeting is held each month, and this is attended by a representative of each department in the home; at this meeting, a review of all operational aspects of the home is undertaken, including key performance indicators (KPIs), risk management, audits, progress on identified actions and updates on quality improvement initiatives. • The Annual Review of quality and safety has been undertaken in consultation with residents, and their comments, suggestions and feedback have been incorporated into the review. • The PIC will conduct audits on all equipment and any equipment found to be not fit for purpose will be decommissioned and replaced. • Cleaning of all clinical equipment is scheduled on night shift and is monitored by the Senior Responsible Person (SRP) on duty. Staffing • The ADON and a CNM will be facilitated to work in a supernumerary capacity each day to provide clinical leadership and supervision, ensuring that there are always sufficient numbers and skill mix of staff; staff are appropriately deployed; that the needs of all residents are met in a timely manner in accordance with their individual assessed care needs and preferences; and that the quality and safety of the services are effective and appropriate. • The PIC will ensure that a CNM is rostered in a supernumerary capacity at weekends to provide clinical leadership. • A CNM will be allocated to each of the units. • The PIC will ensure that there are always sufficient numbers and skill mix of staff available to deliver care in accordance with the dependency levels, occupancy and general requirements of residents. • Any short-notice staff absences will be covered either by staff of a similar grade from the existing establishment, or agency staff will be booked to provide cover. Staff Training & Development • In addition to regular daily communication updates, the PIC has a scheduled weekly team meeting with the ADON and CNMs to agree priorities and implement improved clinical management oversight, including supervision, shadowing and coaching staff members as required on a one-to-one basis as part of competency assessment and performance development. • The PIC will ensure that induction of all new staff is effectively monitored.	

• All staff will receive mandatory training programmes and refresher updates as required, and a record of these programmes will be maintained.
Individual Assessment & Care Plan
• The PIC, supported by the nursing management team, will continue to monitor the quality of the residents' individual assessments and care plans, ensuring that they accurately reflect each resident's assessed care needs and preferences, and that they are reviewed and updated as required.
• The PIC completes reports on all key performance indicators (KPIs) on a weekly basis so that there is a good awareness of all safety and quality issues and will ensure that quality improvement initiatives are implemented and maintained within the home.
Residents' Rights
• The nursing management team will be available and accessible to enhance communication and consultations with residents and families to ensure that care is being delivered in accordance with the plan.
• Activities and meaningful social engagement will be enhanced as the Activities Team will be fully staffed and there will be a schedule of varied and interesting activities for residents on a one-to-one or group basis.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• The PIC will ensure that the Facilities Manager completes a full review of all Fire Doors and arrange for seals to be replaced as required.

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:
• The PIC will ensure that all residents have individual care plans documented which take account of all aspects of their physical and mental health, personal and social care needs and any supports required to meet those needs, as identified by initial and ongoing assessment.
• The PIC and ADON will provide clinical oversight of these assessments and care plans and conduct regular audits and reviews to ensure that the residents' care records are person-centred, sufficiently detailed, and that they accurately reflect the assessed care needs of each resident and suitably outline the required nursing and care interventions.
• Care plans are devised, discussed and implemented in consultation with residents and/or relatives and will be sufficiently comprehensive to direct care, all information

contained in the assessment will inform the individualised plan of care.
• The PIC will ensure that pain assessments are completed prior to and following administration of analgesia and will ensure that its effectiveness is documented.
• The PIC reviews all incidents, including falls, and will ensure that a Root Cause Analysis is used to identify any increased risk, and that recommendations identified are implemented and documented in the Care plan.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• The PIC will ensure that the activity schedule covers 7 days per week.
• All residents have been consulted regarding Activities, and their choices, preferences, likes/dislikes are documented.
• The CNM will monitor weekend activities and recommend improvements as required, which will be implemented in conjunction with Activities Coordinator.
• The dining room on each unit is supervised at mealtimes to ensure that the dining experience is an unhurried social occasion and person centred.
• The PIC will ensure that all residents have an opportunity to discuss their mealtime preferences.
• The PIC will ensure that any resident who prefers to have their meals at an alternative time will be accommodated to do so, and this will be documented in the Care Plan and discussed with the Catering team.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	31/12/2021
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/11/2021
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	30/11/2021
Regulation 28(2)(i)	The registered	Substantially	Yellow	31/12/2021

	provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Compliant		
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Substantially Compliant	Yellow	30/11/2021
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.	Substantially Compliant	Yellow	31/10/2021
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Substantially Compliant	Yellow	30/11/2021