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:	20 January 2021
Centre ID:	OSV-0000444
Fieldwork ID:	MON-0031683

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:	89

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 20 January 2021	11:00hrs to 17:30hrs	Catherine Sweeney	Lead
Saturday 30 January 2021	11:30hrs to 16:00hrs	Catherine Sweeney	Lead
Monday 1 February 2021	10:30hrs to 17:30hrs	Brid McGoldrick	Lead
Monday 1 February 2021	10:30hrs to 17:30hrs	Una Fitzgerald	Support
Wednesday 20 January 2021	11:00hrs to 17:30hrs	Kathryn Hanly	Support
Wednesday 20 January 2021	11:00hrs to 17:30hrs	Brid McGoldrick	Support
Saturday 30 January 2021	11:30hrs to 16:00hrs	Susan Cliffe	Support
Saturday 30 January 2021	11:30hrs to 16:00hrs	Brid McGoldrick	Support
Monday 1 February 2021	10:30hrs to 17:30hrs	Helen Lindsey	Support

What residents told us and what inspectors observed

The centre was experiencing an outbreak of COVID-19 at the time of the inspection with necessary restrictions impacting on the day-to-day lived experience of residents. Inspectors were sensitive to this situation at all times during the inspection. Throughout the three days of this inspection inspectors spoke with residents and observed staff interactions with residents.

National level five restrictions impacted on how the residents could communicate and interact with family members and their ability to move freely through different parts of the designated centre. Some residents spoken with found these restrictions had a negative impact on their quality of life, however, they understood the reason for them.

Inspectors observed residents with complex health care needs associated with their diagnosis of COVID-19 spending extended periods of time alone in their bedroom with no evidence of clinical monitoring or nursing supervision. One resident remained in an isolation unit on their own for five days after their requirement to be isolated had passed. The resident told inspectors that they were waiting to return to their usual room but staff were too busy to organise this, however, inspectors were aware that, on the same day, there was an extra member of staff on that unit. Another resident told the inspectors that they were nervous when they had to mobilise to the bathroom alone as they felt very unsteady on their feet and there was no way to call for help if they fell when mobilising. Other residents reported waiting extended periods of time for their call bells to be answered.

Inspectors observed some kind and respectful interactions between staff and residents and, some residents reported that staff treated them with kindness and respect. However, inspectors also observed staff speaking with residents in a disrespectful and abrupt manner and talking over residents, not giving them time to speak.

Inspectors also observed a lack of awareness of institutional practices that impacted on residents rights to privacy and dignity. For example, inspectors observed a resident using a commode by their bedside with their bedroom door open. The resident was unable to mobilise across their bedroom to close the door while they used the commode. This made it difficult for the resident to maintain their own continence in a dignified and respectful manner. Uncovered commodes were also observed in other bedrooms, where they appeared to be part of the furniture of the residents room. Inspectors also observed a resident having lunch with an uncovered urinal sitting on the windowsill beside the bed table holding their lunch tray.

In a communal area at mealtime, meals were observed to be served in large portions, with a number of residents telling the inspectors that they were served too much. The portions served did not reflect the needs of the residents to whom they were served. Although residents were offered a choice of meals, not all meal options

appeared appetising and nutritious.

During the same meal time inspectors observed a resident sitting with their meal on a tray beside them waiting for assistance. The staff did not communicate with the resident who looked on while other residents enjoyed their meal.
Inspectors observed that improved coordination was required when meals are served to residents to allow all residents receive timely assistance when their meal is still hot and palatable.

A system of communication was in place throughout the centre that included loud speakers on every unit. This was used to call members of staff to different areas of the centre. Inspectors found this system to be intrusive distracting and incongruent with an environment that is meant to be a residents home.

Inspectors observed some residents watching television or listening to the radio to pass the day. However, over the three days of inspection there was limited social engagement observed between residents and staff. One resident explained that she had not had access to a newspaper for a couple of weeks and that while she had a radio and access to television, a read of the newspaper everyday kept her going. Limited access to meaningful activities and little opportunity for social engagement are repeat findings from the inspection last September.

The care of residents was negatively affected by an institutional approach to staffing which favoured staff preferences over residents needs. For example, an agency staff nurse worked on her own on a unit at the weekend when there was a day during that week when two Cahercalla nurses worked on the unit together. Staff considered this normal practice because it "wasn't their weekend to work". Such rostering practices did not support safe resident care at a time when staff knowledge of residents baseline health status is key to the early recognition of any new onset of or deterioration in COVID-19 related illness.

On a similar note, the rosters provided to inspectors did not evidence effective continuity of care with ward managers working every second weekend with long gaps during those weeks where there is an absence of senior nursing management and supervision on the unit and this was reflected in the poor quality care inspectors observed being provided to residents.

The absence of a single centre wide approach to staffing had real consequences for residents, for example, residents remained in bed and showers were not provided in one unit while another unit, which was operating with a reduced number of residents, had an extra staff member which staff had not reported to the manager in charge on that day.

In conclusion, not withstanding the restrictions in place during the COVID-19 outbreak, what residents told the inspectors and what the inspectors observed are symptomatic of a lack of insight into what constitutes a good service and a lack of supervision to ensure that staff deliver a good service. A greater focus on person-centred care is required.

Capacity and capability

This was an unannounced risk inspection, conducted over three days by inspectors of social services triggered in response to:

- an outbreak of COVID-19 in the centre
- the absence of a person in charge in the centre
- delays in updating the Chief Inspector in relation to the COVID-19 status of residents
- delays in submitting the required notifications following the unexpected death of a number of residents
- repeated engagement with the registered provider with regard to their management of the centre

The Chief Inspector was notified of a COVID-19 outbreak in the centre on the 22 December 2020. The information currently available to the Chief Inspector is that during the course of the outbreak 23 residents and 23 staff had a positive diagnosis of COVID-19, and three residents had sadly passed away.

The provider of this centre is Cahercalla Community Hospital Company Limited by Guarantee. The board of the company consists of five volunteers and a company secretary.

The organisational structure of the designated centre committed to in the statement of purpose for the centre is no longer in place. In that structure a general manager was to effectively run the centre reporting directly to the Board of Directors. The position of general manager has been unfilled since last November and at the time of the inspection, the registered provider had not made any alternative arrangements for this post nor did the individual directors consider that they had the necessary skills and competence to oversee the day to day running of the centre. In addition, the registered provider has failed to ensure that there is a person in charge in the centre with the requisite experience in nursing older persons. The post of person in charge has also been vacant since last November. The registered provider had employed an assistant director of nursing who assumed Director of Nursing role in November 2020.

An inadequate system of governance and management severely impacted the providers ability to recognise, respond to and contain the recent outbreak of COVID-19. Initial requests to the Health Service Executive (HSE) for assistance with staffing escalated to requests for experienced management staff to run the centre. Some staff who came to work in the centre communicated concerns about the operation of the centre to the registered provider and to the Chief Inspector. Such concerns included:

- poor governance and ineffective systems of management
- inadequate clinical governance

- inadequate staffing and staff management
- poor staff knowledge of infection prevention and control practices

Prior to the COVID-19 outbreak the centre was inspected in May 2019 and in September 2020 where multiple non-compliance's were found including governance and management, staffing, health care, resident's rights and fire safety. Following the inspection in September 2020 inspectors of social services had significant engagement with the provider to ensure that the non-compliance's identified would be addressed to ensure that residents received a safe service which was effectively monitored. However, the registered provider had failed to ensure that the compliance plans they had submitted following both inspections had been fully implemented.

Information received by the Chief Inspector from the provider during the COVID-19 outbreak and prior to the inspection detailed that there were insufficient numbers of staff available to work in Cahercalla for an extended period of time during the outbreak of COVID-19. Inspectors found during extensive engagement throughout the outbreak and over the three days of inspection, that there was an absence of accurate information with regard to the numbers of staff available to work in the centre from one shift to the next. No one person had clear oversight of staffing arrangements and inspectors were provided with conflicting rosters for the same day. On the 30 January, there were three different rosters in the centre and nobody could tell inspectors which was the official and/or accurate roster. On the same day, inspectors found that while one unit had an extra carer which staff had not reported to the manager on duty another unit was short a carer and as a result staff advised that some residents would have to stay in bed for the day and others would not have a shower.

Over the course of the three days of this inspection there were many occasions where it was apparent that there were insufficient staff available to ensure residents needs were met but in the absence of accurate rosters and effective management of staff absences it is unclear whether this is due to insufficient staffing levels or ineffective management of staffing resources. Information submitted to the Chief Inspector following the inspection showed that there are more than enough staff employed in the centre to meet the planned rosters of the centre, however, there was an absence of the normal people management infrastructure you would expect to see in a centre of this size, including access to human resource management expertise, occupational health expertise and robust staff rostering systems to name a few.

Lines of accountability and responsibility in the centre were not clear. An example of this was observed in relation to the management of the staff roster. There was no member of management allocated to the management of the roster. There was no system in place to manage staff attendance or communicate the roster requirements to staff. This chaotic roster management system resulted in poor allocation and skill mix of staff across the five units in the centre.

Staff spoken with were not clear about who was in charge of the centre. Some staff referred to the director of nursing, some to the assistant director of nursing, others

to the ward managers or the financial controller. Other staff told the inspectors that there was no clear management structure in the centre.

Significant gaps were apparent in staff knowledge of infection prevention and control procedures, and identification of typical and atypical symptom of COVID-19 across all units in the centre. This posed a significant risk to the well-being of residents in the centre during an outbreak of COVID-19 and to staff themselves. This issue was further impacted by the inadequate systems of clinical leadership and oversight in the centre.

Staff were inadequately supported and supervised. This resulted in poor care for residents, inadequate documentation of care delivered or required, and poor communication especially in relation to communicating care needs of residents to HSE and agency staff who came to help during the outbreak of COVID-19.

The findings of this inspection are that the registered provider was not meeting its obligations as outlined in relevant legislation, regulations, national policies and standards to protect each resident and promote their welfare. Leadership, governance and management arrangements were not effective. Over the three days of inspection the management arrangements were not in line with the centre's statement of purpose and did not ensure the safety of all residents accommodated in the centre.

An urgent action plan was requested in relation to infection prevention and control, governance and management and health care following the first day of inspection. The response to this action plan did not provide the assurance required that the provider had either the capacity or capability of addressing the issues identified.

A written warning was issued to the provider on 25 January 2021, advising the provider of their legal obligations to put in place governance and management arrangements and to ensure effective oversight of the care and welfare of residents and supervision of staff providing the care.

Regulation 14: Persons in charge

There was no person in charge as required by regulation 14.

Judgment: Not compliant

Regulation 15: Staffing

The centre was comprised of five units. Each unit had its own roster and was staffed independently. Staff who spoke with inspectors described minimal flexibility in

relation to staff members willing to be re-deployed to other units.

Information submitted to the Chief Inspector following the inspections showed that the centre employed more than the number of staff committed to in the statement of purpose. However, no information was available to suggest that in the absence of a person in charge the registered provider had a comprehensive staffing strategy to ensure that the number and skill mix of staff available was 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.

Undoubtedly, staffing levels were impacted by the outbreak of COVID-19 in the centre. At times during the outbreak, a number of nursing shifts could not be covered resulting in units having no nurse on duty for periods of up to 12 hours. On these occasions the residents were cared for by care assistants with medication administered by a nurse who remained on duty after their shift or who came from another unit for that purpose only.

Inspectors concluded that the oversight arrangements for deployment of staff were not sufficient to determine whether the current staffing levels are commensurate with a high standard of person-centred care for residents.

Judgment: Not compliant

Regulation 16: Training and staff development

Throughout the three days of inspection inspectors observed poor supervision of nursing and care staff. In the absence of a person in charge the registered provider failed to ensure that there was a system in place to supervise junior nursing staff, or the nursing and care staff assigned from the HSE, or agency to ensure that residents needs were met. The lines of authority were not clear and there was no clear communication pathway in place to inform nursing management of issues of concern. This was a repeated non-compliance from the inspection in September 2020.

Inspectors were not assured that staff were appropriately trained and supervised, with particular regard to infection prevention and control practice. Significant gaps were found in the training records of staff.

For example,

- no infection prevention and control update training had been provided since May 2020
- there was no plan or training schedule in place to ensure that all staff were kept updated with best practice in infection prevention and control or in the care of residents in relation to the management of COVID-19.
- Inspectors observed repeated incidents where staff did not follow basic infection prevention precautions such as social distancing, wearing masks and

the appropriate use of Personal Protective Equipment (PPE).

- a review of the resident's nursing notes found that residents displaying symptoms of COVID-19 were not identified as such by the nursing staff, and therefore not referred for testing. In one case, the resident displayed typical symptoms of COVID-19 for five days prior to being tested as part of a routine screen for all residents.

Judgment: Not compliant

Regulation 21: Records

Rosters reviewed by inspectors during the inspection were inaccurate and at times contained conflicting information. As a result, it was not possible to determine from the records reviewed if there was sufficient staff working in the centre on a given day.

In addition, over the three days of the inspection, Inspectors found that a change to the electronic nursing documentation system, due to be completed in October 2020 had not been completed and that resident's records were recorded in both the electronic system and the paper system. This resulted in nursing staff being unable to either input or retrieve information in a timely manner when caring for residents. Furthermore, members of the management team were unable to retrieve reports required for effective clinical and nursing oversight. For example, observational records pertaining to one resident who had been diagnosed with COVID-19 were not available for review. The management had to contact an external provider to collate the required information. When the information was provided, inspectors found significant gaps in the record of the resident's temperature and oxygen saturation during a period when close clinical observation was required.

In addition, agency nurses working during the outbreak were not provided with individual sign-in details for the electronic recording system. This meant that passwords linked to an individual's protected digital signature were inappropriately shared completely undermining the provenance of such documentation.

Judgment: Not compliant

Regulation 23: Governance and management

Inspectors found that the provider had not taken actions set out in the regulatory compliance plans following the inspection in September 2020 or the assurances given during the provider's meetings with the Chief Inspector.

There was no person in charge or general manager at the time of the outbreak. The management team consisted of a director of nursing, appointed to the role in November 2020, a financial controller and a ward manager, also appointed to the role of assistant director of nursing in November 2020. The persisting non-compliance's in governance and management from the previous inspections contributed to a situation on 08 January where the provider advised inspectors that they had to request managerial expertise from the HSE.

Over the three days of the inspection the inspectors found significant failures in the governance arrangements including the absence of:

- a clearly defined and resourced management structure that identifies the lines of authority and accountability
- a system to review staff numbers and rostering practices to ensure the effective delivery of care in accordance with the statement of purpose
- an effective human resource management infrastructure
- a system of staff management and clinical supervision to ensure that the service provided is safe, appropriate, consistent and effectively monitored with specific reference to medication management, information governance and fire safety
- enhanced resident, family and staff communication systems,
- enhanced oversight and management of infection prevention and control issues
- effective management of risk in the centre; the risk register had not been updated to reflect current risks and actions taken to mitigate the risks

The Registered Provider failed to implement its own contingency plan to manage an outbreak of COVID-19. An isolation unit had been identified on St. Joseph's wing, however, this was not utilised quickly enough at the beginning of the outbreak to contain the outbreak to one unit.

Due to the inadequate documentation and tracking of residents who had tested positive for COVID-19, Inspectors were unable to clearly assess the number of residents with active symptoms of COVID-19. Dates of testing and onset of symptoms were not documented in a way that provided the information to adequately manage the outbreak. In addition, there was no system in place to document and track staff in relation to their date of testing, date of onset of symptoms, recovery and return to work dates.

The centre was in the process of upgrading the nursing documentation to an electronic system, a process that was due to be completed by the end of October 2020. The management of this change project was inadequate with staff poorly informed about the new system, its use and the schedule for the transfer of information from one system to the other. There was no updated risk assessment in place to manage the changeover from paper to electronic documentation.

Judgment: Not compliant

Regulation 31: Notification of incidents

Notifications in relation to the COVID-19 outbreak and any unexpected deaths in the centre were not submitted.to the Chief Inspector as required

Judgment: Not compliant

Quality and safety

Inspectors found that the quality and safety of residents in the centre was significantly compromised by poor systems of leadership, governance and management, inadequate staff management and poor health care being provided in the centre.

A review of residents nursing notes found that residents, including those with complex physical and social care needs did not have appropriate assessments of their needs completed. Furthermore, an individualised care plan was not in place for each resident. This meant that when units were supported by staff from the Health Service Executive or from an agency there was no system in place to ensure that residents received person-centred care based on their assessed needs, for example:

- A resident who was displaying responsive behaviours did not have any care plans in place that identified potential triggers or effective interventions to manage their responsive behaviours.
- A resident who required assistance during a seizure did not have a care plan in place to guide staff in relation to their care needs.
- A resident with a diagnosis of COVID-19 did not have a care plan in place to identify their care needs during a period where close monitoring was required.

A review of medication management found that action was required to ensure compliance with both Regulation 29 and Nursing and Midwifery board of Ireland (NMBI) medication management guidelines.

At the time of the inspection Cahercalla Hospital did not have formalised local governance arrangements for the management of the COVID-19 outbreak. Contrary to the centre's COVID-19 contingency plan a local outbreak control team had not been convened to advise and oversee the management of the outbreak of COVID-19. No COVID-19 lead had been identified. This resulted in the management of the outbreak being chaotic and disorganised. Line listings for confirmed COVID-19 positive residents and staff were not maintained. Inspectors were informed that staff with confirmed COVID-19 infection were unsure of when their period of isolation ended. It was also reported that this hindered the implementation of a

cohesive contract tracing process of staff.

On one unit, Inspectors observed staff members without masks taking their dinner breaks, in the residents communal areas, and in the company of residents. Inspectors also observed a number of incidents of poor hand hygiene and the inappropriate use of personal protective equipment both of which posed an infection control risk to the residents.

Previous inspections in May 2019 and September 2020 found that residents rights were poorly supported. Inspectors found repeated non-compliance's in relation to residents rights during this inspection. For example, poor provision of meaningful activities or social engagement and residents spending excessive time in bed with little opportunity for social engagement.

Inspectors were not assured that residents were receiving the highest standard of evidence based nursing care. Action was required by the provider to ensure staff supervision arrangements, staff training and nursing documentation system was in place and effective.

Repeated non-compliance was found in relation to fire safety systems.

Regulation 27: Infection control

Residents were at risk of infection as a result of the provider failing to ensure that procedures, consistent with the standards for infection prevention and control, were implemented by staff. In particular the provider did not demonstrate adherence to and compliance with the Interim Public Health, Infection Prevention & Control Guidelines on the Prevention and Management of COVID-19 Cases and Outbreaks in Residential Care Facilities and Similar Units, a guideline issued by the Health Protection (HPSC) to safeguard and protect residents from infection. For example:

- management reported delays in the initial cohorting of residents with confirmed COVID-19 infection. On the day of the inspection, residents with confirmed COVID-19 were spread across three different units and at a time where there were vacant beds in the unit identified for use for isolating and cohorting residents. This meant that residents who did not have COVID-19 were in close proximity to residents who did have it.
- there was no system in place to check whether staff coming on duty were displaying symptoms of COVID-19. A state of the art temperature checking device was available and some staff were observed checking their temperatures but nobody knew if the temperatures were recorded and where the records could be accessed. No manager had oversight of the recorded temperatures on a day to day basis. Some units also sporadically recorded temperatures on a sheet on the unit but there was no system of follow-up in

the event that a staff member had a high temperature.

There was inconsistent application and supervision of transmission based precautions throughout the centre. As a result, efforts to prevent and control COVID-19 transmission at the centre were severely restricted. This was evidenced by:

- inappropriate use of PPE- specifically masks and gloves
- poor adherence to hand hygiene practices
- staff crossover between COVID and non-COVID areas
- the requirement for the same staff member to care for COVID-19 positive and non-detected residents
- lack of oversight and supervision of cleaning processes
- isolation signage was not consistently placed at the entrance to rooms of residents with confirmed or suspected COVID-19 to restrict entry and clearly indicate the level of transmission-based precautions required
- physical environment did not facilitate effective cleaning as paintwork, wood finishes and flooring in residential units were worn and poorly maintained
- a lack of storage space in units resulted in the inappropriate storage of equipment and supplies in 'dirty' utility rooms.
- bed pan washers on some of the units were not working
- poor management of clinical waste

In addition inspectors found isolation signage was not appropriately placed on the room of a resident who was in receipt of treatment for an infectious skin condition and there was poor adherence to infection control practices designed to protect staff members and other residents from acquiring this skin condition.

An urgent action plan was issued following the first day of inspection relating to a number of infection control issues that required urgent action. The action plan submitted by the provider did not provide assurance that the issues had been appropriately addressed.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

A review of the medication management systems in the centre showed that they did not meet the requirements under regulation 29. Medications were not administered in line with Nursing and Midwifery Board of Ireland (NMBI) guidelines. Inspectors observed dispensed resident medications sitting on bedside lockers a significant period of time after they should have been taken by the resident. The unsecured medication also posed a risk to other residents who might consume it.

Management of controlled medication was poor with gaps noted in the documentation of sample signatures, incorrectly numbered stock control books, and

poor stock control. Unused mediation had not been returned to the pharmacy.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

A new electronic system of nursing documentation was introduced last October. The transition to this new system was poorly managed which is also discussed further under Regulation 23: Governance and management. Inspectors found that there was no effective system in place to ensure that all residents had a comprehensive assessment of their health and social care needs completed.

Some residents did have care plans in place, however, these care plans did not reflect the observed needs of the resident. For example, one resident with a complex medical condition who required significant support did not have an assessment completed in relation to his condition and subsequently no care plan had been developed to direct and guide staff to deliver the physical, social and psychological support required. This resulted in confusion and delayed responses when an emergency situation arose.

Other residents had care plans completed without associated assessments or the residents needs. This resulted in care plans that were not resident-centred and evidenced poor understanding of the nursing process and the importance of ensuring that care plans are based on the assessed needs of the residents.

Furthermore, care plans specific to the management of responsive behaviours did not guide care. For example, in one file, the daily notes recorded a pattern of agitation and distress. There was no guidance on intervention management strategies to support the resident. The notes recorded that 'reassurance given had no effect' and that the resident 'remained restless'. Inspectors found that appropriate action was not been followed up in a timely manner to minimise the residents distress. The notes evidence institutional acceptance of such behaviours, poor knowledge of best practice and an absence of supervision and oversight of resident care.

Judgment: Not compliant

Regulation 6: Health care

A review of the care records and the observation of residents on the days of inspection did not provide assurance that residents were receiving a high standard of evidence based nursing care, in accordance with professional guidelines. The progress and observation reports of residents with a diagnosis of COVID-19 lacked

the nursing documentation required to be assured that care was delivered to a high standard.

This was evidenced by:

- poor recognition of symptoms of COVID-19 resulting in a delay in diagnosis
- poor monitoring of residents with COVID-19
- poor wound management and pain control
- inadequate end of life care, including failure to prepare anticipatory medication prescriptions and ensure availability of supply
- inappropriate management of a resident with responsive behaviours.
- poor falls management
- inadequate and poorly maintained support equipment including individual hoist slings, pulse and oxygen monitors and blood pressure monitors
- inadequate monitoring of weights to identify unintentional weight loss for residents who were Covid-19 positive

An urgent action plan was required to ensure that arrangement would be made to ensure that all residents with a diagnosis of COVID-19 were reviewed by a medical practitioner. This action was completed following the first day of inspection.

The Provider was requested on the third day of inspection to review residents who were Positive for Covid 19 for unintentional weight loss and to confirm that appropriate referrals were made to support their recovery.

Judgment: Not compliant

Regulation 9: Residents' rights

Notwithstanding the social and environmental restrictions in place during the outbreak, residents were spending extended periods of time alone in their bedrooms. Some residents spoken with complained that they didn't have access to opportunities for social engagement or activities to help them pass the day. One resident told the inspectors that the delivery of her newspaper had stopped and that they found the days long and boring. There was little evidence of residents being supported or being facilitated to participate in any activities in accordance with their interests.

Inspectors observed examples of where residents were not able to undertake personal activities such as using the toilet in private.

Staff spoken with described institutional approaches to care, for example individual residents had a day for their shower. If staff were too busy on that day they would try and ensure the resident was showered on another day otherwise the resident would have to wait until their turn next week. There was little insight into a resident's right to have a shower at a time and date of their choosing.

Judgment: Not compliant

Regulation 28: Fire precautions

Inspectors found that fire safety systems were not robust and did not ensure that all residents, staff and visitors to the centre were safe. For example,

- there was no system in place for staff to sign into the designated centre on arrival. This meant that all persons in the centre could not be accounted for in the event of a fire or an emergency.
- personal emergency evacuation plans which were reviewed pertained to residents who no longer lived in the centre while at the same time, there were no such records for some residents who did live in the centre
- some fire door seals were damaged and would not allow for fire protection.
- fire exits were blocked with trolleys
- staff on duty were unaware of fire procedures and compartment layout.

There were also a number of repeated non-compliance's in relation to fire safety.

- fire safety documentation was not up-to-date
- fire drills and their records required improvement. The last recorded fire drill was April 2020. The documentation lacked detail of the time taken to evacuate or if there were sufficient resources including staff available.
- fire maps did not identify the correct location of fire doors. This could cause confusion in the event of a fire as compartment boundaries were not correctly identified.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Not compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 27: Infection control	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Not compliant
Regulation 9: Residents' rights	Not compliant
Regulation 28: Fire precautions	Not compliant

Compliance Plan for Cahercalla Community Hospital & Hospice OSV-0000444

Inspection ID: MON-0031683

Date of inspection: 20/01/2021

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 14: Persons in charge	Not Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: • The Board of Cahercalla Community Hospital Company Limited by Guarantee entered into a Clinical Services Agreement with Mowlam Healthcare Services. On Monday 22nd February 2021 Mowlam took over the day-to-day operations of the Hospital. • A new suitably qualified and experienced Person-in-Charge (PIC) was appointed. • Mowlam Healthcare Services became Persons Participating in Management (PPIM) with three named executives taking charge.	
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • The organisational structure has been reviewed. There is now a full-time, experienced PIC in post who will be responsible for the operational management of the facility. • We will introduce a single centre-wide approach to staffing. This will include a comprehensive review of the staffing rosters to ensure that there is always a sufficient number and skill mix of staff on duty on all units to meet the assessed care needs of the residents, bearing in mind the number and dependency levels of the residents and the layout of the centre. • We will implement a more flexible rostering system and encourage the existing staff to be available primarily according to the residents' care needs. • The Person in Charge (PIC), supported by a regional Healthcare Manager, ensures that there is a workforce plan in place to ensure that the staffing complement detailed in the Statement of Purpose is adhered to and that the care and service needs of all residents can be met safely and effectively. • There are policies and procedures in place to ensure that the nursing home has the	

appropriate number of suitably skilled staff to provide a high level of care and service to all residents.
• The staffing levels will be set in the following way:
The PIC will produce a staff roster which sets out the required staffing numbers and skill mix for each department and unit over a 24-hour period, based on the number of residents, their dependency levels, care needs and preferences, while bearing in mind the geographical layout of the nursing home.
• Rosters will be produced in fortnightly cycles and will be published in advance of the start date to ensure that staff are aware of their rostered shifts.
• The PIC and Clinical Nurse Managers (CNMs) will ensure that staff are appropriately deployed and that they are allocated appropriate duties commensurate with their skills, qualifications and abilities.
• The PIC will ensure that there is cover for planned staff absences by proactive roster scheduling and by recruiting staff for all posts as soon as a post-holder resigns the position.
• We will be vigilant regarding monitoring the available workforce and the PIC will be supported by the Human Resources team to assist in this process where required.
• In the event of unplanned or unanticipated staff absence, the PIC or designated deputy will in the first instance seek to provide staff cover by contacting staff of the same grade who are not rostered for duty. Based on initial discussions with current staff, they are willing to support this request. If there are no staff available, the PIC will seek authorisation from the Healthcare Manager to arrange cover through an agency if there is no other alternative. The PIC will assist in providing additional care herself to ensure that the residents' care needs continue to be met without compromising standards.
• The CNMs will supervise workflow and practices to ensure that staff are facilitated to provide safe and effective care to all the residents in the centre.

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
• Staff Training Needs Analysis: A comprehensive review of all staff training will be undertaken and completed by 30/04/2021. Following this review, we will develop a targeted staff training and development plan which will address any updated training needs with further staff training scheduled as required.
• All staff have access to a suite of mandatory training and education programmes as part of the induction process and regular refresher courses take place as required.
• We will maintain an up-to-date training matrix in the home.
• Training and development courses will be provided on topics including, but not limited to: Fire safety, Infection Control, Handwashing, Manual Handling/People Handling, Protection of Vulnerable Persons at Risk of Abuse, Care of Residents with Dementia, Management of Responsive Behaviours.
• As part of the training and education review, we will provide updated, validated training

and education to staff in Infection Prevention & Control (IPC). In addition to an on-site education programme, all staff will register for the IPC training module on HSELand, and they will be required to provide evidence of completion of this course. We will also provide staff with access to the IPC training module recently published by the Authority.
• We will ensure that all household staff are trained in appropriate cleaning techniques and procedures by completing a Clean Pass programme.
• A formal induction programme will be carried out for all new staff and mandatory training is provided for all staff during their induction period as well as regular updates thereafter, in line with training needs analysis, requests and regulation.
• During induction, all staff are advised of the centre's policies which govern practice, and these policies are read, understood and signed by the new staff member.
• All newly appointed staff complete specific competency assessments during their Induction and any deficits are immediately addressed.

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
• We will introduce a new electronic care record and will ensure that all staff are provided with appropriate training and support to enable them to use this system effectively.
• This system includes a range of evidence-based clinical assessments which will inform the plan of care for each resident.
• The system facilitates the recording of incidents and complaints.
• The PIC, supported by the management team, will oversee the residents' records and monitor the quality of the documentation.
• We will ensure that residents' assessments and care plans are specific to each individual resident and this will facilitate a person-centred approach to care by all staff.
• The care record will incorporate the social assessment of each resident and enable staff to understand the whole person with respect to their preferred daily routines, likes, dislikes and expressed choices, and how they wish to engage in social activities.
• We will introduce a new electronic suite of audit documents that will be accessible to senior management for review and quality monitoring.
• We will introduce a weekly report record which provides oversight of the key clinical performance indicators, including falls, wounds, infections and other clinical metrics.
• We will introduce standard templates to record all monthly management team meetings and an Action Register will be updated each month to document and monitor the progress of quality improvements.
• The Clinical Reflective Practice meetings with staff will be recorded on a standard template and these meeting records will be referenced in the annual appraisal records.
• The staff rosters will be improved to ensure that they are a clear and accurate representation of the hours worked by all staff in each department. There will be a record of the planned roster and the actual roster, but changes to the roster will only be permitted by designated managers and there will be one version of the actual roster in operation at all times.

• The PIC will review and approve all rosters prior to circulating to departments to ensure there are sufficient staff on duty and an appropriate skill-mix to meet the residents' assessed care needs.

Regulation 23: Governance and management	Not Compliant

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

• Governance & Management Structure: A clearly defined management structure was put in place and the implementation of robust systems around clinical management, risk, audit, human resources management, clinical supervision and effective communication is being implemented.

• PPIM: Mowlam as PPIM will provide monthly progress update reports to the Board of Cahercalla, the Registered Provider.

• A full-time PIC has been appointed on 22/02/2021, who has the requisite experience and qualifications to be the person in charge of the hospital.

• The PIC will be supported by a regional Healthcare Manager (HCM) who is available at any time and will visit the hospital at least weekly to monitor the progress of the regulatory compliance plan.

• The Director of Care Services will support the PIC and the HCM in the achievement of the overall objectives of the regulatory compliance plan. There will be a monthly meeting of this senior management team.

• A review of supervision arrangements is in progress to ensure there are systems in place to supervise and support nursing and care staff.

• Clinical supervision is provided on each unit by the assigned CNM, who will communicate with staff at each handover and safety pause regarding their individual roles, responsibilities and priorities for the day. The CNM will provide guidance, direction and supervision to nursing and care staff, ensuring that resident care needs are being met in a caring and timely manner, consistent with the preferences and choices outlined in the individual care plans.

• The PIC and ADON will conduct 'walkabout rounds' daily with CNM on each unit and will communicate expectations with staff on each unit.

• Structured Clinical Reflective Practice: Supported by the HCM, the PIC and Assistant Director of Nursing (ADON) will hold structured one-to-one meetings with all nursing staff (initially) on a regular scheduled basis (every two weeks initially) to support them and ensure that they have an opportunity to enhance the required clinical knowledge and skills needed to meet the needs of residents in the home. The purpose is to achieve optimum outcomes for residents and ensure best practice and compliance with the hospital's policies and procedures. It also enables staff nurses to feel valued and supported, to have their views heard and to improve their knowledge and skills. There will be a written record maintained for each meeting completed.

• All nursing staff and managers involved in resident care will participate in the reflective practice process. This assurance process is designed to review and set care

priorities/objectives, discuss individual resident's clinical needs/incidents in depth, change or modify practice and identify any staff training needs. The ultimate aim will be to ensure accountable professional standards and improved resident care outcomes.
• We will provide support to staff to ensure that they have all the information they need about each resident to ensure the delivery of high-quality care.
• To ensure effective communication systems, we will foster an open culture and work with the hospital staff to build a cohesive and effective team, who will work in accordance with the residents' care needs and expressed preferences in mind. These communication systems include, but are not limited to:
• An electronic care record, containing all relevant demographic, medical, nursing, allied health records, risk assessments, adverse events/incidents and progress updates.
• Effective handover reports at the beginning and end of shifts.
• Safety Pause mid-shift to facilitate relevant progress updates.
• Monthly management team meetings to review quality and safety, capacity and capability, and to agree a quality improvement plan which will be recorded on an Action Register. The Action Register will be accessible by all members of the senior management team.
• Annual quality and safety review meetings will be an opportunity to look back at the last year and set a strategy for the coming year.
• Clinical Governance: There are formal governance structures in place in the hospital that ensure timely and effective reviews of all near misses, incidents or accidents in the home. By utlising the compertised incident management system in the home, all incidents will be reviewed by the PIC in a timely manner and a comprehensive and accessible review report is produced. These reports are reviewed in consultation with the Healthcare Manager to ensure that the report accurately describes what happened and why it happened, and makes recommendations to reduce risk and improve resident safety and service quality.
• The PIC will be available and accessible to residents and families and will schedule time with them to review individual care plans and to ensure that appropriate consultation takes place, involving residents where possible in agreeing their own plan of care and respecting their individual choices and preferences.
• We will review and update the risk register in the hospital, identifying and recording environmental, physical and clinical risks and the policies and actions in place to mitigate the risks.
• The PIC will ensure that a risk assessment is in place that outlines the management of the transition from paper to electronic nursing documentation systems.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
• The PIC will be responsible for submitting all Notifications to the Authority, including any notifiable events regarding Covid-19.
• All incidents will be notified to the Chief Inspector within the appropriate timeframes

and ensuring that a comprehensive report of the incident, response and outcome is provided, in accordance with regulation 31.
• The PIC will ensure that any unexpected death is notified to the Authority within 3 working days as per the legislative requirement.
• Incident Management Process: The Clinical Nurse Manager (CNM) on each unit will become the designated accountable staff member for the management and oversight of risk in their own clinical area, including fire safety, any incidents, accidents, near misses and complaints occurring on each ward.
• The PIC, with support from the management team, including the Assistant Director of Nursing, will provide management support and oversight of this process.
• We will ensure that all incidents are consistently investigated, and the lessons learned from each incident are embedded into improvements in resident care provision.
• Any complaint that could conceivably have been considered as potential abuse will be further reviewed to ensure suitable assurances are available and any further safeguarding actions, including retrospective notification or improvements required, will be implemented.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
• All staff are required to wear a face mask when on duty. Social distancing is also implemented in the workplace as far as practicable for staff and residents. There are occasions when staff are required to maintain close contact with resident when delivering care, but they are adhering to hand washing and sanitising procedures as well as appropriate wearing of PPE. The PIC and ADON are supervising staff to ensure full compliance with these protective measures.
• The PIC will establish an Infection Prevention & Control (IPC) Committee and identify an appropriate IPC Lead nurse. This Committee will meet on a monthly basis.
• The IPC/Covid-19 Contingency Plan has been updated and clearly outlines steps to take to manage an outbreak of Covid-19 in the hospital.
• We will introduce a regular Covid-19 practice drill to ensure a constant state of alertness about the appropriate actions to take in the event of a staff member or resident testing positive for Covid-19. This will enhance staff awareness and vigilance.
• A line listing system has been introduced to document and track residents who test positive for Covid-19; this line listing includes date of onset of symptoms, type of symptoms, date of test, result of test, expected completion of isolation.
• A similar line listing is also introduced to document and track staff that test positive for Covid-19 and in addition to above will include expected return to work date.
• On each unit there is a folder of resource materials, reference information and current HSPC regarding Covid-19 and this is now available for all staff and will be discussed at regular handover meetings. This includes information regarding the signs and symptoms of Covid-19, the need to assess any resident who displays any change from their usual baseline status and the frequency of vital signs and observations to be recorded,

including Temperature, Blood Pressure, respirations and oxygen saturation levels.
• The IPC/Covid-19 Contingency Plan has been updated to accurately reflect how to manage an outbreak in accordance with Public Health guidance and recommendations.
• We will ensure that any resident displaying symptoms of Covid-19 are immediately isolated and referred for testing.
• There is a plan in place to ensure that residents who test positive for Covid-19 can be appropriately isolated in a designated area and segregated from residents who have not tested positive.
• The isolation and segregation plan includes the provision of a separate cohort of nursing, care and household staff to eliminate the risk of cross-contamination.
• The PIC has introduced a staff sign-in sheet that allows for documentation of temperature, signs and symptoms of Covid-19 and whether they have been in close contact with a positive case.
• Staff temperature will be recorded twice per day.
• The PIC and ADON will monitor the correct use of PPE and ensure that all staff are wearing masks appropriately and gloves as required.
• The ADON will conduct regular hand hygiene audits to ensure adherence to appropriate hand hygiene practices in accordance with SARI guidelines.
• We will ensure that all items and equipment are stored appropriately.
• The PIC will undertake a comprehensive review of cleaning schedules and for those areas deemed difficult to clean a risk assessment will be completed.
• We will schedule Clean Pass training for all household staff.
• The PIC will review isolation signage and ensure it is in place in all areas where it is required.
• The line listing referenced in urgent compliance plan will be maintained and updated by the PIC.
• All staff will complete HSELand, HIQA and Mowlam IPC training and practice around appropriate use of PPE will be monitored by PIC and ADON. This will include observations of practice around donning and doffing of PPE.
• 3 new bedpan washers have been installed.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
• We will ensure that all nursing staff have completed medication management training and medication management competency assessments in accordance with our medication management policy. All nurses are required to adhere to the NMBI guidelines on medication management.
• We will complete monthly Medication management audits internally and quarterly by the pharmacy supplier to ensure that we maintain best practice. Any areas of non-compliance identified will be addressed as part of an action plan. Medication management audits will be reviewed as part of the monthly management team meeting

which reviews all aspects of quality and safety.
• We will ensure that analgesia is administered to residents in accordance with the prescriber's instructions and the Abbey Pain Scale Assessment Tool is used to assess and monitor pain and the effectiveness of analgesia administered.
• Nursing and care staff will be encouraged to regularly ask residents whether they have any pain to ensure that they receive analgesia as required.
• Prescriptions will be reviewed regularly to ensure that the appropriate analgesics are prescribed on a regular or as required basis, depending on the individual resident's needs.
• Patients are assessed on admission and reviewed by the Doctor.
• We will ensure that nursing staff are supported to complete the medication administration rounds within an appropriate timeframe, in accordance with medication administration policy, prescriber's instructions and the NMBI Code of Conduct.
• The PIC will review the management of controlled medication and will ensure that stock control books are appropriately completed with two signatures and that stock levels are recorded accurately.
• All unused medication will be returned to Pharmacy and recorded in accordance with the Return of Unused Medicines policy.

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:
• All care plans will be reviewed to ensure that all residents' assessed care needs are documented. Progress notes will be reviewed to confirm that all these needs are met and that care is delivered in accordance with the resident's person-centred care plan.
• The PIC will ensure that specific medical conditions are included so that care is provided safely, effectively and consistently.
• A review of clinical documentation will be undertaken by the PIC to ensure that all assessments have been completed as required and that a person-centred care plan has been prepared for each resident within 48 hours of admission to the centre.
• A weekly audit of clinical records will be conducted by the PIC/ADON to ensure that each resident's required care needs are addressed, that the care plan guides the delivery of care and that the care delivered is evaluated and reviewed appropriately. Findings and recommended improvements will be discussed at nursing staff meetings, at daily handovers and at monthly management team meetings. Any changes or developments in the resident's condition or plan of care will be updated as they occur.
• Care plans will be prepared in consultation with residents and/or their designated representative and will reflect each individual resident's preferences and choices. A record of consultation will be documented in the electronic care file.
• All nursing staff will receive training in the use of the electronic care record to enable them to navigate the system and to ensure that all required fields are completed.
• We will ensure that all nursing and care staff are aware of the Behavioural Symptoms

of Dementia (BPSD) and that they are competent in implementing appropriate care interventions to address these symptoms.
• We will ensure that there is appropriate documentation in place to analyse responsive behaviour, including the use of Antecedent, Behaviour and Consequence Charts (ABC), which will identify triggers that may cause behaviours to escalate and to describe actions to de-escalate the behaviours and to reduce anxiety, agitation or aggression. The documentation will ensure a consistent approach by all staff and will guide person-centred care.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
• The PIC will ensure that residents are receiving a high standard of evidence-based nursing care, using validated clinical assessment tools as a basis for producing a person-centred care plan that respects the individual lifestyle choices, preferences and activities of each resident, in consultation with them and with appropriate close family members, as appropriate.
• Staff nurses will receive further guidance and training on recognising Early Warning Symptoms and communication of findings using SBAR tool.
• The PIC will ensure that all staff are familiar with Covid-19 resource folders and their contents.
• Residents with Covid-19 will be monitored in accordance with Public Health guidelines
• The PIC/ADON will liaise with GPs and Pharmacy to ensure anticipatory medication prescriptions are written and that prescribed medication is available.
• We will undertake a comprehensive review of Falls and data obtained will determine the frequency of Falls Committee meetings. For those residents with frequent falls, we will consult the Physiotherapist and engage their assistance in producing a Falls Prevention and Management action plan.
• We will review the availability of assistive and support equipment such as slings, pulse oximeters and blood pressure monitors, and ensure that there are enough in place. The PIC will put system in place to ensure said support equipment is serviced and maintained in good working order.
• We will ensure that all residents' nutritional needs are met in an appropriate and safe environment. The menus are nutritious and varied and residents will be offered choice in accordance with their expressed preferences.
• As per regulation 18, residents will be facilitated to receive their meals in an area of their choice where possible, and where assistance is required, this is provided.
• Where residents prefer to dine in areas other than the dining room, their needs will be met on an individual basis, ensuring they have the support and supervision they may require.
• We will encourage effective communication between nursing and catering staff regarding individual resident's preferences and special dietary requirements; Where required, meals will be fortified and/or nutritional supplements may be prescribed if a need is identified.

• Nursing staff will monitor the dietary intake of individual residents and the MUST assessments will be recorded and reviewed regularly. If the score indicates that the nutritional status is compromised, a referral is made to the dietitian and/or medical review is requested.
• We will ensure that there is always a sufficient number of staff available to assist the residents at mealtimes.
• Residents at risk of unintentional weight loss will be discussed at handover and Safety Pause.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• We will promote a culture that respects the privacy, dignity and the rights of all residents in the hospital.
• We will ensure that residents are assessed appropriately and that they are consulted and involved on the development of a plan of care that meets their needs and respects their individual choices and expressed preferences.
• We will structure the care plan around how the resident wishes to spend their day and night and will encourage and teach staff how to place the resident at the heart of everything we do, as opposed to planning the day around nursing and care routines.
• We will ensure that residents have access to newspapers, magazines, TV or radio, in accordance with their expressed choices.
• We will provide guidance to staff about the importance of skilled safety checks, so that when they enter a resident's room, they can check that the resident is safe, comfortable and content, and that they have everything they need within easy reach, including the call bell. We will train staff to ensure that residents are treated with dignity, that the commode is not a piece of furniture and that the resident's bedroom is a homely and welcoming space for them.
• We will ensure that residents are facilitated to avail of the communal space in the hospital and that they have plenty of opportunities for outdoor visits as they wish, and in accordance with HPSC guidelines in the event of an infection outbreak.
• The PIC will liaise with the Activities Coordinator (AC) to develop a programme of activities that includes 1:1 sessions if residents are confined to their rooms.
• The AC will meet with individual residents to establish their likes and dislikes, activities choices and preferences.
• We will ensure that there is a Social Assessment for each resident as part of the overall assessment and that this forms the basis of their daily activities. We will use the 'Key to Me' social assessment tool.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• All staff employed in the hospital are required to undertake mandatory fire safety awareness sessions and a certified fire safety training programme, which also instructs staff regarding the indications for evacuation as well as instructing them on how to safely evacuate residents, depending on the type of evacuation required.
• Fire safety training is updated on an annual basis for all staff.
• We will ensure that the arrangements for ensuring fire safety arrangements in the hospital are sufficient to ensure resident and staff safety.
• All staff will participate in regular fire safety drills which will be conducted monthly (including night-time conditions) as well as simulated fire evacuation drills, which take place every 3 months. These drills will include simulated evacuation of the bedroom and compartments and we will record the time taken to undertake the evacuation.
• All fire safety drills will be documented and evaluated and there will be a de-brief following each drill to ensure that there are opportunities for learning and improvements.
• The fire safety policy will reflect the principles of HIQA Fire Precautions in Designated Centres for Older People.
• We will improve the PEEPs and ensure that they accurately reflect current residents.
• We will ensure that all fire exits are free from clutter.
• The Facilities Team will provide fire maps that will be displayed in each compartment with location and directional signs.

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 14(1)	There shall be a person in charge of a designated centre.	Not Compliant	Orange	22/02/2021
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	31/03/2021
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	30/04/2021
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/04/2021
Regulation 21(1)	The registered provider shall ensure that the	Not Compliant	Orange	30/06/2021

	records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.			
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Red	31/03/2021
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	Red	03/03/2021
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	Red	30/04/2021
Regulation 27	The registered provider shall ensure that	Not Compliant	Red	31/03/2021

	procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.			
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	30/04/2021
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	30/04/2021
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire	Not Compliant	Orange	30/04/2021

	control techniques and the procedures to be followed should the clothes of a resident catch fire.			
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Orange	31/05/2021
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.	Not Compliant	Orange	31/05/2021
Regulation 29(5)	The person in charge shall ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that	Not Compliant	Orange	31/03/2021

	resident's pharmacist regarding the appropriate use of the product.			
Regulation 29(6)	The person in charge shall ensure that a medicinal product which is out of date or has been dispensed to a resident but is no longer required by that resident shall be stored in a secure manner, segregated from other medicinal products and disposed of in accordance with national legislation or guidance in a manner that will not cause danger to public health or risk to the environment and will ensure that the product concerned can no longer be used as a medicinal product.	Not Compliant	Orange	31/03/2021
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence.	Not Compliant	Orange	31/03/2021
Regulation 31(2)	The person in charge shall ensure that, when	Not Compliant	Orange	31/03/2021

	the cause of an unexpected death has been established, the Chief Inspector is informed of that cause in writing.			
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).	Not Compliant	Orange	30/05/2021
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.	Not Compliant	Orange	31/05/2021
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Not Compliant	Orange	31/05/2021

Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.	Not Compliant	Red	31/03/2021
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Not Compliant	Yellow	31/03/2021
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Not Compliant	Yellow	30/04/2021
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Not Compliant	Yellow	30/04/2021

Regulation 9(3)(c)(ii)	A registered provider shall, in so far as is reasonably practical, ensure that a resident radio, television, newspapers and other media.	Not Compliant	Yellow	31/03/2021