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:	Short Notice Announced
Date of inspection:	24 September 2020
Centre ID:	OSV-0000444
Fieldwork ID:	MON-0027810

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:	100

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
Thursday 24 September 2020	10:00hrs to 18:30hrs	Catherine Sweeney	Lead
Friday 25 September 2020	09:00hrs to 15:00hrs	Catherine Sweeney	Lead
Thursday 24 September 2020	10:00hrs to 18:30hrs	Leanne Crowe	Support
Friday 25 September 2020	08:00hrs to 15:00hrs	Leanne Crowe	Support

What residents told us and what inspectors observed

The inspection took place during the COVID-19 pandemic. Visiting restrictions were in place. Visits to residents were facilitated in line with the Health Protection Surveillance Centre (HPSC) Interim Public Health, Infection Prevention and Control Guidelines on the Prevention and Management of COVID-19 Cases and Outbreaks in Residential Care Facilities. Residents told the inspectors that they enjoyed the visits from their families, 'especially during this worrying time'.

Residents spoken with said that the staff in the centre were kind and treated them well. Residents told inspectors that 'staff were very kind' and 'staff were good' to them. A resident said that she feels 'very comfortable' in the centre. Residents also spoke positively about the food that was served in the centre, including the choices that were available to them. Many residents were happy with their bedrooms and confirmed that they were supported to bring belongings from home into the centre, such as furniture and a wide screen TV.

Residents were observed to spend long periods of time in bed and unsupervised in the day rooms. Residents told inspectors that there was not much to do during the day and that they didn't know what activities were happening. Residents spoken with told inspectors that there used to be lots of activities, but that their access to activities has been restricted since the COVID-19 pandemic began. Residents spoke about playing bingo and saying the rosary in their respective units. While residents understood that infection control restrictions prevented them from visiting other units within the centre, they spoke about missing their friends that are staying in the other units. One resident stated that he was 'bored' and that 'there's nothing to do, not just today, any day'. Several residents said that they would like more activities to participate in. One resident spoke about receiving art supplies from the activity staff member, but required support to be able to paint and therefore was only drawing at the moment.

The centre had a large enclosed garden with a seating area and a permanent gazebo available. However, access to this garden was restricted by a locked door. Residents were required to ask a staff member to gain access to the outdoor area. One resident told inspectors that they like to go outside but 'they are not allowed to go out' unless a staff member is with them. Staff informed inspectors that the doors were left open in good weather but that residents were 'not allowed out if the weather was bad'.

Capacity and capability

This inspection took place during the COVID-19 pandemic. The centre had remained

COVID-19 free since the start of the pandemic. This was a short-notice announced inspection by the Office of the Chief Inspector to follow up on the actions of a compliance plan that was submitted following the last inspection of the centre on 23 May 2019. The last inspection found a number of non-compliance's in relation to the overall governance and management of the centre, individual assessment and care planning, the provision of activities, the management of complaints and residents' rights. A compliance plan update had been received in November 2019 with assurance that action had been taken to bring the centre into regulatory compliance.

Inspectors also followed up on unsolicited information received by the Chief inspector regarding concerns in relation to residents' rights and the management of complaints. On review, inspectors found the concerns outlined to be substantiated.

During this inspection, inspectors found continued non-compliance in governance and management, assessment and care planning, residents' rights and the management of complaints. Further non-compliance's were found in staffing and the supervision of staff.

The organisation structure in the centre was made up of a person in charge, who was supported by an assistant director of nursing. The management of the centre was overseen by a general manager. Inspectors found that the management systems were not effective to ensure safe delivery of care to the residents as evidenced by multiple and repeated non-compliance to the regulations.

The clinical oversight of care in the centre was poor. The management systems in place were inconsistent in quality and did not serve to identify issues that required quality improvement plans to be developed. For example, a care plan audit developed to address the non-compliance's of the last inspection failed to identify any quality improvement interventions in relation to the documentation of care plans.

Inspectors found that staffing was inadequate to meet the needs of the residents and for the size and layout of the building. There was a general manager, a person in charge and an assistant director of nursing overseeing care delivery in the centre. The centre had five units. Each unit had a nursing ward manager and a separate roster. Although there was a ward manager on day duty in each unit, on most shifts they fulfilled the duties of a staff nurse and were allocated one day per fortnight to oversee and supervise the delivery and documentation of care on each unit. The nurse was supported by varying numbers of care assistants on each unit.

Ward managers had the responsibility of supervising the nursing and care staff on each unit. A review of documentation and resident observation found that the supervision of nurses and carers was poor and ineffective. Staff on night duty were not supervised by senior nursing management.

Inspectors observed that residents with complex mobility needs were left unsupervised in communal rooms. On two occasions, inspectors observed unsupervised residents in the communal areas, who were assessed as being at high risk of falling, attempting to mobilise independently. Care staff explained that they were not available to supervise residents as they were also required to attend to

kitchen duties such as dining room service and tray preparation for meals, which resulted in less time to deliver direct care.

The centre did not have sufficient numbers of trained staff to support an activity programme that was suitable for all residents. Many residents were observed spending extended periods of time in bed. This issue was identified in the weekly care review submitted to the management team by each unit, however, no action had been taken.

Staff had completed mandatory training in fire safety, safeguarding, and manual handling. All staff had also received up-to-date training in relation to COVID-19 infection control and prevention, the staff use of personal protective equipment (PPE) and hand washing techniques.

A review of the residents' nursing records found that the quality of the nursing documentation was poor. Nursing documentation was not in line with professional guidance or regulatory requirements in relation to records.

A review of the centres' risk register found that some clinical and environmental risks had been identified and control to mitigate against risks were in place. Risks found on the last inspection had been added to the risk register.

Quality and safety meetings were held monthly and were attended by members of management and representatives of all the departments in the centre. Meetings with the registered provider were held quarterly in 2019, and items from the quality and safety meetings were discussed, as well items such as other operational activities and complaints.

A annual review of 2019 was available for review, however the report did not contain a review of the quality and safety of care delivered to residents and there was no evidence that the report had been prepared in consultation with the residents and their families. This is a restated non-compliance from the last inspection.

An electronic system of documentation management had been sourced and training for nurses had been scheduled for October 2020. The management team gave assurance that the transition to electronic documentation would be completed by October 2020.

Information governance was found to be poor. Out of date infection control information, complaints procedures and fire safety information were displayed around the centre. A review of information management was required to ensure residents, staff and visitors to the centre have access to up-to-date and appropriate information.

Inspectors acknowledged that some improvement had been found with regard to the complaints management in the centre. A revised procedure and system of documentation was in place and some complaints were documented in line with regulatory requirements. However, a number of complaints made by residents were not documented in the complaints log. Furthermore, one complaint that had been

documented did not detail the investigation that took place, the action taken to address any deficits in the service or the learning that had resulted from the investigation of the complaint.

Regulation 15: Staffing

Inspectors found that staffing levels and skill mix were not suitable to meet the needs of the residents or for the size and layout of the centre. This was evidenced by

- residents spending extended periods of time unsupervised by staff
- staff rostered to facilitate activities were sometimes redirected to care assistant duties
- care staff were responsible for completing kitchen duties
- reduced hours allocated to activities
- high un-witnessed fall rates
- poor oversight of assessment and care planning
- poor supervision of staff
- staffing on the roster did not reflect staffing as identified in the centre's statement of purpose. For example, the statement of purpose identifies one full time and one part time activity coordinator for the centre. On the day of inspection, only one part time activity coordinator was available.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff had completed mandatory training in fire safety, manual handling and safeguarding of residents. All staff had also received up-to-date infection control training in relation to COVID-19. There was good evidence of robust recruitment and induction procedures for new staff. Staff files reviewed found that a system of staff appraisal was also in place. However, actions from some staff appraisals had not been completed. This meant that any improvements required were not documented, monitored or improved.

The supervision of staff in the centre required review. Staff on each unit were not appropriately supervised, particularly during night duty.

Judgment: Not compliant

Regulation 21: Records

Significant gaps were found in the records required under Schedule 3 of the regulations. For example,

- the nursing record of a resident's health and condition and treatment given was not completed on a daily basis in accordance with the Nursing and Midwifery Board of Ireland (NMBI) professional guidelines
- care plans did not detail changes to a resident's health and social care needs
- no record of when a resident refused treatment.

Judgment: Not compliant

Regulation 23: Governance and management

Since the last inspection, some action had been taken to achieve compliance with the regulations. For example:

- all short term care residents were found to have a signed contract in their file
- the occupancy of a double bedroom had been reduced
- new directional signage was in place
- clocks and calendars had been installed in each unit
- an electronic nurse documentation system has been sourced and is expected to be in place by October 2020

However, significant gaps were found in the governance and management of the centre including issues identified on the last inspection. These included:

- inconsistent management of some complaints
- inadequate resources to deliver safe care
- annual review of the quality and safety of care delivered was of poor quality and was not prepared in consultation with residents and their families
- poor information governance
- poor supervision of staff

Judgment: Not compliant

Regulation 24: Contract for the provision of services

All residents in the centre, including short stay residents, had a contract on file in line with the requirements under regulation 24. This action has been completed since the last inspection.

Judgment: Compliant

Regulation 34: Complaints procedure

Action had been taken by the provider to review the complaints procedure and update the complaints policy. The complaints policy was in line with the requirements of regulation 34. However, inspectors found that the management of complaints in the centre still required improvement. For example;

- some complaints from residents were not documented in the complaints log. In one instance reviewed by inspectors, this resulted in a delay in meeting the needs of the resident
- investigation into a complaint was not documented
- a complainant were not informed promptly of the outcome of any investigation
- there was inconsistency in relation to the person nominated to oversee the complaints process and the person investigating the complaint as outlined in the complaints policy
- no external training in the management of complaints had been sourced or delivered.

These are repeated non-compliance's from the last inspection.

Judgment: Not compliant

Quality and safety

Overall, inspectors found that significant improvement was required in the assessment of residents' health and social care and care planning, timely access to health care professionals and residents' rights.

There was some evidence of good practice. The inspection took place during the COVID-19 pandemic. The centre had a robust COVID-19 contingency plan in place. Staff spoken with demonstrated a good knowledge of the systems in place to prevent and control any outbreak of COVID-19 including symptom identification, isolation procedures, the use of PPE and hand hygiene.

Visiting was facilitated in line with the HPSC National guidelines. Residents informed inspectors that they had regular contact with their friends and families throughout the pandemic period. When in-person visiting was restricted, window visits and video calls were facilitated. Relatives spoken with were complimentary of the efforts made by staff to facilitate visiting throughout this period.

Inspectors also acknowledge that some action had been taken following the last inspection including:

- the installation of new fire doors where required
- lock removed from exit gate in internal garden
- a mural had been removed from a fire door.

All staff had received up-to-date fire safety training and staff spoke with demonstrated a good understanding of fire safety procedures. A number of drills simulated evacuations using night time staffing levels. However, inspectors were not assured that a drill to evacuate an entire fire compartment had been completed. Improvement was also required in the documentation of fire evacuation drills. While some described the drill scenario and any improvements required, the quality of these records were not consistent. Some drill records did not outline the time taken to carry out the drill, the actions taken by staff and any learning from the drill.

Overall, the quality of resident assessment and care planning required review. A review of residents files found that care plans were not based on appropriate assessment, generic, lacked the detail required to guide care, and did not reflect a person-centred approach to care planning. There was no evidence of resident and family involvement in the care planning process.

Resident assessments were not completed appropriately and were not in line with the needs of the residents. For example, a review of the files of a number of residents with recent weight loss found that although a residents' weight was documented monthly, no nutritional assessment or care plans review had been completed.

Furthermore, residents requiring skin integrity management did not have a risk assessment completed, nor was their care needs incorporated into their care plan. Care interventions had been put in place to address skin integrity issues without consultation with the resident or an appropriate assessment or care plan in place.

The residents in the centre had access to their general practitioner (GP). This access continued throughout the COVID-19 pandemic. A review of residents' files found that residents had access to allied health care professionals such as a dietitian, a speech and language therapist and a physiotherapist. However, in the files reviewed, recommendations prescribed by the allied health care professionals were not integrated into the residents' care plans or communicated within the residents' progress notes. Furthermore, the residents did not have timely access to occupational therapy as outlined in the centre's statement of purpose.

Inspectors acknowledge that the COVID-19 restrictions in place such as social distancing and visiting restrictions had added to the challenge of supporting a good quality of life for residents in the designated centre. However, inspectors found that the provider had failed to ensure that the centre had adequate staffing to facilitate sufficient activities or social engagement for residents, and to support residents' choice.

Some action had been taken to address the non-compliance regarding residents' rights from the previous inspection. For example,

- access to advocacy services was now on display on notice boards throughout the centre
- a full-time activities co-ordinator had been recruited
- the occupancy of a small double room had reduced to a single room
- residents now had access to national newspapers, together with television and radio
- a resident and relative survey had been conducted in September 2019 and the results were shared with residents and relatives.

However, inspectors found that the provision of meaningful activities and social engagement was not prioritised for residents. While a full-time activities co-ordinator had been facilitating an activity programme since 2019, they had been on leave since March 2020. Reduced access to an activity coordinator was further compounded by COVID-19 restrictions preventing external service providers from visiting the centre, such as musicians and pet therapy. Inspectors found that there was no evidence that the provider had supplemented the reduction in activity co-ordinator rostered hours since March. At the time of the inspection, one activity staff member was rostered to provide 15-16 hours of activities per week across the entire centre. This staff member also worked as a care assistant and there was evidence that they were regularly reallocated to care assistant duties if there was a shortage of care staff. Residents who spoke with inspectors stated that bingo took place on each unit every week. A live music session had taken place in a courtyard, and was live-streamed to units in the centre. However, all residents spoken with felt that other than bingo, there was little social engagement and more activities were required.

Furthermore, residents did not have the opportunity to be consulted about and participate in the organisation of the designated centre. A residents' forum had taken place in December 2019. This forum and the survey in September 2019 was used to develop an action plan, and progress regarding this action plan was shared with residents and relatives in a newsletter in early 2020. However, any further forums had been postponed due to COVID-19. While some residents had a COVID-19 care plan on file, there was no evidence that other residents had been consulted in relation to their physical, social and psychological well-being throughout the COVID-19 pandemic. Residents relative's had completed surveys throughout 2020 and evidence of these were reviewed by inspectors. However, no surveys had been completed with residents during this period. The assistant director of nursing informed inspectors that they were planning to survey residents in the coming weeks. The provider's lack of consultation with residents regarding the organisation of the centre was a restated action from the last inspection.

There was evidence that residents were not always supported to exercise choices regarding their day-to-day lives. Access to outdoor areas was restricted. Staff and residents spoken with informed inspectors that doors to the outdoor areas were unlocked in good weather, however, residents were not allowed to go outside if the weather was poor. One resident spoke about not being allowed to go outside

without a staff member, and that staff were rarely available to accompany them outside. A resident's right to refuse medical treatment was not respected by staff.

Over the two days of inspection, inspectors noted that some residents spent extended periods of time in bed. A review of a sample of residents care plans identified the residents' preference to stay in bed but did not detail a social care plan to address the risks that may be associated with social isolation.

Regulation 11: Visits

Visits were facilitated in line with the HPSC national guidelines and was in line with the requirements under regulation 11.

Judgment: Compliant

Regulation 27: Infection control

The centre had a COVID-19 contingency plan in place.

The centre was visibly clean on the day of inspection. All staff had received appropriate training in infection control.

Judgment: Compliant

Regulation 28: Fire precautions

All staff had received training in fire safety.Staff spoken to were knowledgeable about the action to take in relation to a fire in the centre. The centre had fire safety systems in place to reduce the risk of fire in the centre.

However, there were a number of repeated non-compliance's in relation to fire safety.

- fire compartment maps continue to identify compartments that do not reflect the actual layout of the centre.
- fire safety documentation was not up-to-date
- fire drills and their records required improvement.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

A review of the assessment and care planning for all residents required review. Care plans were generic, lacked person-centred detail and did not guide staff to deliver high quality care in line with the residents' wishes. This was evidenced by:

- no care plan developed for short stay resident
- care plans were not reviewed in a timely manner
- care plans did not reflect care received by residents
- care plans were not updated to reflect the most up to date assessments
- a resident assessed as high risk of falls did not have the risk assessment outcome integrated into their care plan
- no evidence of resident participation in the development of care plan.

Judgment: Not compliant

Regulation 6: Health care

Residents had access to allied health care professionals such as physiotherapy, dietitian and speech and language therapy. However, the recommendations made following referral were not incorporated into the residents' care plans. This meant that systems were not in place to ensure that residents received a high standard of evidence based care. For example, where a higher calorie diet was prescribed by a dietitian, there was no system in place to ensure that this change to a residents care plan was communicated to staff.

Resident did not have timely access to an occupational therapist as stated in the centres' statement of purpose. Inspectors were informed that resident's were referred to occupational therapy if they had a medical card, however waiting lists were long. This resulted in residents who required assessment for issues such as seating or pressure area support were not appropriately assessed in a timely manner. No alternative access to occupational therapy had been considered.

Judgment: Not compliant

Regulation 9: Residents' rights

Significant improvement was required under regulation 9. This is evidenced by:

- residents were restricted in accessing outdoor areas
- no formal consultation with residents since December 2019
- residents' choice was not respected in relation to the use of supportive

equipment
- poor provision of meaningful activities or social engagement
- residents spending excessive time in bed with little opportunity for social engagement.

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 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 27: Infection control	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Cahercalla Community Hospital & Hospice OSV-0000444

Inspection ID: MON-0027810

Date of inspection: 25/09/2020

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:
The appointment of an Assistant Director of Nursing was approved by the Board of Directors in June 2020. This is a new full time position which will support the Director of Nursing in the supervision of all clinical staff. Areas for improvement which are identified through our monthly Quality & Safety meetings will be allocated to the ward managers for action and review on their management days. This will include oversight of the assessment and care planning processes and staff performance.

At the time of the inspection our activities co-ordinator was on maternity leave. Since the inspection 2 new staff have been added to the activities team – totaling 57 hours per week or 1.5 WTEs. This will bring the activities team compliment up to 2.5 WTEs. From now on activities staff will only be involved in the provision of activities. The team will develop a full activities programme in consultation with the residents and the programme will be communicated to all residents so they are aware of what is taking place on each day. The programme will be on display in each of the sitting rooms and main reception.

A meeting has taken place with the catering manager and from 1st December care staff will no longer be required in the kitchen areas of the units.

The increased activities staff and reduced catering responsibilities for care staff will ensure residents are better supervised and have more meaningful activities available to them.

The introduction of the electronic system for documentation will stream line the recording process for nurses and care staff which will also allow them more time to spend in direct resident care.

Since the inspection staff meetings have taken place in all units. Items discussed at these meetings included:
- Falls prevention and management procedures including the importance of supervision
- New catering procedures which will free up time for care staff to spend with residents.

A falls analysis will continue to be conducted monthly and reviewed by our Quality and Safety team.
One of our staff nurses completing the Higher Diploma in Gerontology has chosen falls for her area of service improvement in the centre. She will be putting a pilot scheme in place on one unit with a view to identifying quality improvements to reduce falls.

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
A full review of the performance appraisal system will be conducted by the Director of Nursing in conjunction with the Assistant Director of Nursing. All nursing and care staff will be assigned to a ward manager for performance management. The Director of Nursing will oversee that all performance improvement actions identified through the appraisal system are taken and performance is monitored.

Staff identified with performance issues will be supervised by a member of senior nurse management.

We have reviewed our training matrix and are currently identifying areas where training would benefit the staff. This includes complaints management training, person-centred care and care planning.

Two of our staff nurses commenced the Higher Diploma in Gerontology in September 2020. One of these nurses has chosen staff induction as her area of service improvement in the centre. She will be reviewing our current induction procedure and will be putting forward a proposal on how we can improve the process.

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
A daily nursing record is now being completed for each resident which documents the resident's health, condition and treatment given. A resident's right to decline care and treatment will be respected at all times. This will be discussed fully with the resident and documented in the care plan.
A full review of all care plans is being undertaken as they are being moved to the new electronic system. Going forward care plans will be person-centred and detail any

changes in the resident's health and social care needs. The care plans will be completed in conjunction with the resident and their families and will enable the residents to maximize their quality of life in accordance with their wishes and in accordance with best practice. Audits of the resident's records will be carried out quarterly. An external trainer will be sourced to provide training sessions in relation to person centred care planning. The movement of records to the electronic system will be managed in accordance with the risk assessment completed.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The appointment of an Assistant Director of Nursing was approved by the Board of Directors in June 2020. This is a new full time position which will support the Director of Nursing in the supervision of all clinical staff.

The Board of Directors is working to put in place a stronger management structure which will have clear lines of reporting, accountability and responsibility. This management structure will oversee and supervise the delivery of a safe, appropriate, consistent and effective service for our residents which meets their individual needs and preferences and which uses the feedback from resident to continue to review and develop the service. This management structure will provide the Board of Directors with regular reports including reports on the actions outlined to reach compliance and details of complaints received and the actions taken to address the issues identified in those complaints.

The management structure will ensure management systems are in place to achieve and maintain full compliance including:
- A full auditing system to monitor and review the service and to identify areas for improvement
- A system which encourages residents to contribute ideas, participate in day to day activities and give regular feedback about the service.
- Quality and Safety meetings and team meetings to review and action areas for improvement and to communicate changes in procedures to all staff
- A robust staff recruitment, induction, supervision, appraisal and training process to ensure staff have the required competencies to manage and deliver person-centred, effective and safe services to all the residents.

An annual review will be completed in line with the regulations. This will be done in consultation with the residents and their representatives, whose needs and preferences will be kept to the forefront of the review. Staff will also be consulted and the data compiled from our quality and safety meetings will also be used. We will assess the level of care delivered and identify areas for improvement. Residents and their families will be

provided with a copy of the review once completed.

Responsibility for the management of information displayed and provided to residents, staff and the public has been assigned to a member of the administration team. This will be audited as part of the monthly quality and safety audits to ensure this information is up to date and relevant.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
To improve our complaints management process we have clarified and communicated to all staff, residents and service users who is responsible for all aspects of the complaints process. The complaints process has now been updated and is on display throughout the building and is reflective of the new complaints officer. We will provide external complaints management training for our complaints officer and all staff commencing on 12/11/2020. This will be extended to all staff by 31/01/2021. This training will cover all aspects of the complaints management process including the importance of logging all complaints, how to conduct and document an investigation into the complaint, and the importance of informing the complainant of the outcome of the investigation in a prompt manner. From now on all complaints will be documented. This will track and trend complaints ensuring that any improvements are made.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The fire compartment map identified has been rectified and now reflects the compartment layout. Staff in this area have been informed of the change.
Fire documentation is now up to date. All records will be kept in a central file in a designated locations and responsibility for keeping them up to date has been assigned and will be monitored as part of monthly quality and safety checks.
Fire drills will be reviewed by the Director of Nursing to ensure they are effectively and consistently performed and recorded throughout each unit.

All fire drills conducted will be documented under the following headings:
1: Date and Time
2: Compartment/Room identified
3: Participants
4: Timing of the evacuation

5: Debrief with participants
6: Learning outcomes identified
7: Actions taken

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:
At the time of the inspection an electronic system for resident documentation management was being introduced. We are currently moving all resident's documentation onto this system using a process whereby we identify which records are still paper based and which have moved to the electronic system as per our risk assessment. Going forward all residents will have a care plan which is based on an ongoing comprehensive assessment of their needs and will be implemented, evaluated and reviewed, and will reflect the residents changing needs. The care plan will be developed in conjunction with the resident and their representatives and will outline the supports required to maximize their quality of life in accordance with their wishes. Audits of the residents care plans will be carried out on a quarterly basis. An external trainer will be sourced to provide training sessions in relation to person centred care planning.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
Since the inspection team meetings have taken place in all units. Our policy of ensuring that the recommendations from allied health care professionals are included and reflected in the resident's care plan was discussed. This will be audited on a quarterly basis as part of the audit of resident records.

We aim to enter into a service level agreement with a private occupational therapist to assist residents who are experiencing long waiting times for a public appointment. We will continue to provide access to physiotherapy, dietician, chiropodist and speech and language therapy.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
We will promote evidence based nursing care where all our residents will be facilitated to make informed decisions, will have access to an advocate and their consent will be obtained in accordance with legislation.

Since the inspection resident forum meetings have been held on all units and will be continuing on a quarterly basis. Our bi-annual satisfaction questionnaire had been sent to relatives just before the inspection and is now in the process of being completed by residents. Comment cards are available for residents and their relatives to complete to give feedback at any time. Residents also have access to Sage advocacy services. The feedback received from the satisfaction questionnaires, comment cards and resident forums will be discussed at our monthly quality & safety meetings and will be used to develop quality improvement plans where areas for improvements in service have been identified.

The new activity team will carry out a care needs analysis in order to put together a comprehensive activity programme. Each resident will be facilitated to engage in meaningful activities that promotes engagement, fulfillment and a good quality of life and reflects their individual preferences and interests.

Through person centred training which will be provided to all care staff we will foster a culture where the residents' choices and wishes are respected and to the foremost in the delivery of care.

All residents will be supported and facilitated to access safe and appropriate outside spaces. A balanced approach will be taken to manage risk and promote independence

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	15/12/2020
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	31/12/2020
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Not Compliant	Orange	01/12/2020
Regulation 23(a)	The registered provider shall	Not Compliant	Orange	31/12/2020

	ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.			
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	31/01/2021
Regulation 23(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.	Not Compliant	Yellow	31/01/2021
Regulation 23(e)	The registered provider shall ensure that the review referred to in subparagraph (d) is prepared in consultation with	Not Compliant	Yellow	31/01/2021

	residents and their families.			
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	Yellow	24/11/2020
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	Yellow	31/12/2020
Regulation 34(1)(b)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall display a copy of the complaints procedure in a prominent position in the designated centre.	Not Compliant	Yellow	31/01/2021
Regulation 34(1)(f)	The registered provider shall provide an accessible and	Not Compliant	Orange	31/01/2021

	effective complaints procedure which includes an appeals procedure, and shall ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.			
Regulation 34(1)(g)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall inform the complainant promptly of the outcome of their complaint and details of the appeals process.	Not Compliant	Orange	31/01/2021
Regulation 34(1)(h)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall put in place any measures required for improvement in response to a complaint.	Not Compliant	Orange	31/01/2021

Regulation 34(2)	The registered provider shall ensure that all complaints and the results of any investigations into the matters complained of and any actions taken on foot of a complaint are fully and properly recorded and that such records shall be in addition to and distinct from a resident's individual care plan.	Not Compliant	Orange	31/01/2021
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	28/02/2021
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.	Not Compliant	Orange	28/02/2021

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	Orange	28/02/2021
Regulation 6(2)(c)	The person in charge shall, in so far as is reasonably practical, make available to a resident where the care referred to in paragraph (1) or other health care service requires additional professional expertise, access to such treatment.	Not Compliant	Orange	31/12/2020
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Not Compliant	Orange	31/12/2020
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with	Not Compliant	Orange	31/12/2020

	their interests and capacities.			
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Not Compliant	Orange	31/12/2020
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned.	Not Compliant	Orange	31/01/2021