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:	Castleross
Name of provider:	Castleross Nursing Home Ltd
Address of centre:	Carrickmacross, Monaghan
Type of inspection:	Unannounced
Date of inspection:	10 November 2021
Centre ID:	OSV-0000124
Fieldwork ID:	MON-0034746

About the designated centre

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

Castleross nursing home is a purpose-built premises. Residents are accommodated in for individual houses (Lisdoonan, Broomfield, Creevy and Killanny). In addition, there are two civic centres; the village centre and Kavanagh community centre for communal activities. The philosophy of the designated centre is to preserve the dignity, individuality and privacy of the residents who live in Castleross in a manner that is sensitive to their ever changing needs. To this end management have adopted the 'household model' of care which primarily is based on the principles of home life. Each household is individually staffed and includes a homemaker whose responsibility is to create a homely environment through normal daily kitchen activities and provide a warm welcome to all who pass through.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	121

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 10 November 2021	07:00hrs to 17:30hrs	Nuala Rafferty	Lead
Wednesday 10 November 2021	07:00hrs to 17:30hrs	Sheila McKevitt	Support

What residents told us and what inspectors observed

Overall inspectors observed a relaxed and happy environment. Residents told inspectors they were happy with the care they received within the centre and felt supported to lead a good quality of life in the centre. Residents were observed to be content in the company of staff

Inspectors spent time in each of the four households (Broomfield, Creevy House, Lisdoonan and Killanny) throughout the day and spoke with residents as they went about their daily lives. From interactions with residents and observations made on the day, it was evident that residents were happy living in Castleross and that it was a homely and comfortable place to live.

Residents were positive about the way they were looked after and the efforts that staff made to ensure that they had everything they needed. A comfortable familiarity was seen to exist between residents and members of staff. Those residents who were more dependent and who could not talk with inspectors, appeared comfortable and did not show any signs of anxiety or distress. Inspectors observed a number of visitors entering and leaving the centre, and spoke with some of them. The relatives told inspectors they were satisfied with the care they're loved ones received and that staff kept them informed on their progress.

The inspectors observed that staff knew the residents well and were familiar with their needs and preferences for care. They were familiar with the residents' preferred daily routines, care needs and the activities that they enjoyed. Staff were warm and empathetic in their interactions with residents and were respectful of residents' communication and personal needs.

One resident, who was on the way for breakfast, said staff looked after him very well and always made sure he was dressed comfortably and nicely; he appreciated that staff made the effort to ensure he looked well.

Inspectors were told that a range of individual and group activities were held each day. In the morning the activities support worker visited each unit and delivered papers to residents and each afternoon delivered an activity in one household and the allocated staff members delivered activities in the rest of the households. An activity programme identifying the planned activities was displayed in the sitting room in each household. However, inspectors found that although one or two activities were planned each morning and afternoon, a planned time, location or staff member was not identified to inform residents when, where or by whom, they could expect the activity to take place, in order that they could make a choice on whether they would wish to attend.

The inspectors found that in most households, the morning activities consisted mainly of reading the newspaper or watching television. Inspectors saw some residents were reading the paper but only those who could do so independently.

Many were not actively engaged in any activity and were seen with their eyes closed without any form of stimulation. Structured activities either in groups or individually were not observed in any of the households until the afternoon. Mass took place at 11:00 am in the oratory on a weekly basis but inspectors were told that, due to social distancing requirements only residents from one household could attend each week. This was rotated to ensure the residents from each household could attend on a monthly basis. Residents in other units could view the live Mass on the television.

The activities support worker had developed links with external local groups including the local county council. This had resulted in residents getting involved in a number of county council funded projects. As a result of one of these projects, residents art work was now on display in a local art gallery and was soon to be returned and displayed in the centres large communal hall for all the residents to enjoy.

Residents were consulted with and had opportunities to make choices in their daily lives and were participating in the organisation of the centre through regular resident meetings and other feedback.

Overall, residents were complimentary of the choice, quantity and quality of meals available in the centre. However, some said that the portion sizes were small. All meals were freshly prepared and cooked in the centre's own kitchen. The inspectors observed residents being served breakfast in a number of households throughout the morning, in both the dining areas and in their bedrooms. There were a variety of table sizes so that residents could choose to have a quiet breakfast alone or enjoy the company of others while maintaining social distancing. Tables were set with cutlery and condiments and a homemaker was available in each unit to serve meals to the residents.

There were enough staff available to ensure that residents were supported to eat and enjoy their meals. Staff were observed to assist residents discreetly and respectfully.

The centre is a large one storey building, divided into four households. Each household had a large open plan communal areas for residents to mingle and chat, watch television or enjoy their visitors, there was also access to an enclosed courtyard where residents could sit outside when the weather was clement. At the main entrance there was a small visiting room, large community room and an oratory, shop and hairdressing facility. The majority of bedrooms had en-suite shower and toilet facilities and those that did not were in close proximity to a bathroom on the hallway. These facilities had grab-rails and call bells available to promote independence and safety. However, inspectors found that some residents who had been assessed as being at high risk of falling did not have a call bell in reach when alone in their bedroom.

Bedrooms were personalised with residents' favourite possessions. There was adequate storage space in bedrooms for belongings, including lockable storage for residents' valuables. The majority of bedrooms have low level windows with views

overlooking the courtyard or external gardens.

The governance of the centre will be discussed under the following two sections, capacity and capability of the service and quality and safety of the care and services provided for the residents. The areas identified as requiring improvement are discussed in the report under the relevant regulations.

Capacity and capability

Overall inspectors found that the governance and management arrangements in place were effective and ensured that residents received person-centred care and support. The daily running of the centre was overseen by the person in charge with the support of a senior management team. The services were delivered by a well-organised team of trained competent staff.

The centre has a good history of compliance with the regulations and was found to be mostly compliant under the regulations reviewed on the last inspection. The inspectors found that the provider had been responsive to these findings and had addressed many of the non-compliances found on the previous inspection. However, this inspection identified that further improvements were required in some areas.

Although inspectors were assured that the governance in the centre was good, improvements to the level of oversight were required in order to ensure more robust processes were implemented, to manage and evaluate both clinical and non-clinical risks.

Castleross Nursing Home Ltd is the registered provider of Castleross centre and had taken over the running of the centre in January 2020. The senior management structure consisted of the registered provider representative (RPR), person in charge (PIC) and three persons participating in management (PPIMs). A number of other management supports were available within the centre and also as part of the wider group structure Grace Health Care, including human resources, health and finance management supports. At operational level, within the centre there were also clinical and administrative supports to the person in charge including two care managers, accounts and administration personnel.

A continuous monitoring system to review the delivery of services provided was in place. This included regular reviews of clinical care and risk indicators such as accidents or incidents, use of restrictive practices, skin integrity, nutritional status, and rates of infection. However, some improvements were required to the analysis, evaluation and trend identification processes, so that the data from these key risk indicators were used to improve the safety and standard of care residents received.

There was evidence of contingency measures to meet planned and unplanned absences and that where these occurred staff were usually replaced. However inspectors were not fully assured that there were sufficient staff on duty during the

inspection to meet all the needs of all the residents.

Staff had access to mandatory training in safeguarding, moving and handling, infection prevention and control and fire safety. Training records showed good levels of staff compliance with mandatory training requirements and also included training to enable staff deliver person-centred care such as safeguarding adults at risk, wound care and dementia care.

A review of a sample staff records showed that recruitment procedures were in line with employment and equality legislation including appropriate An Garda Siochana (police) vetting disclosures prior to commencing employment.

All policies and procedures as required under Schedule 5 of the Care & Welfare Regulations 2013 (as amended) were available and regularly reviewed. Relevant policies had also been reviewed to reflect the most recent national guidance contained in 'Interim Public Health and Infection Prevention and Control Guidelines on the Prevention and Management of COVID-19 Cases and Outbreaks in Residential Centres. However, not all policies were being fully implemented and this is discussed further under the relevant regulation in this report.

The centre had an accessible complaints policy and procedure in place and complaints were recorded. There was evidence that these were investigated and responded to and the satisfaction of the complainant, with the response, was reviewed.

An annual review was completed in respect of the manner and standard of services delivered to residents throughout 2020. The report contained evidence of consultation with residents and their families in respect of a food quality audit conducted in early 2020. However, inspectors were told that due to the negative impact of the pandemic restrictions during the year they were unable to complete the annual resident and relative satisfaction survey. This was currently being completed and therefore not included in the annual report.

Regulation 14: Persons in charge

The person in charge was a registered nurse working full-time in the centre who met the requirements of the regulations.

Judgment: Compliant

Regulation 15: Staffing

A full review of staffing was found to be required to ensure safe levels of staff at appropriate grades to meet all the needs of all residents in a safe and timely

manner. Inspectors observed that the residents were negatively impacted as a result and found that further staffing supports were required, in part due to the size and layout of the centre;

- on the day of inspection,inspectors observed that the number of staff involved in providing meaningful occupation to resident required review
- on one household the staff nurse due to numerous competing work priorities, was unable to complete the morning medication round in a timely manner.
- inspectors heard and observed that for some residents it was lunchtime before they received assistance with personal care and could leave their bedroom.

Judgment: Not compliant

Regulation 16: Training and staff development

A good training and development programme was in place for all grades of staff and records viewed showed good level of attendance.

In conversation with them and on observation, inspectors found that staff could apply the principles of their training within their respective roles.

Judgment: Compliant

Regulation 21: Records

Some progress to improve the maintenance and management of records further to the last inspection was found however, further improvements were required in respect of end of life care plans. Although records were available, they did not include all of the detail needed to provide comprehensive nursing care in respect of end of life or management of responsive behaviours for every resident

The nursing records reviewed on inspection did not include detailed plans of the residents' preferences in relation to their end-of-life care. Details of their preferred nursing or specialist health care inputs were not reflected in their comprehensive assessment unless the resident was receiving palliative care, at the time of the inspection. A record was not kept of every residents' end-of-life wishes should their condition deteriorate. This required improvement in view of the current COVID-19 pandemic.

Residents displaying responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) had care plans in place. However,not all records contained adequate details of the care to be provided. For example, some

were generic in the language used, and although some staff spoken with knew what triggered residents' behaviours and what diversional therapies worked for each resident they were not reflected in the residents' care plan.This meant that staff, less familiar with the resident, would be unable to consistently and effectively manage the behaviours in line with the recorded care plan. Additionally, where a resident was prescribed more than one medication as a last resort the care plans viewed did not consistently state which medication staff should administer first.

Judgment: Substantially compliant

Regulation 23: Governance and management

Some aspects of the governance and management systems in place were not sufficiently consistent or effective to ensure a safe standard of care was provided to all residents.

The oversight of practice in a number of areas required to be strengthened, including:

- clinical oversight of staff to ensure a safe standard of quality care is delivered to residents at all times. Areas where improvements were required included supporting residents' rights for choice and meaningful occupation and to manage risks associated with falls, medication administration and responsive behaviours
- risk management processes and improvement systems in place to manage risks associated with falls were not sufficiently robust. Inspectors found that, over a number of recent months, there were a high number of falls that had resulted in serious negative impacts for residents. On the day of inspection, inspectors found that the systems in place to identify, evaluate and analyse risks, or identify trends, in order to implement appropriate and timely measures to mitigate those risks, required considerable improvement.
- similar improvements to the analysis and evaluation of incidents involving residents interactions and management of behaviours which cause upset or harm were also required, specifically the measures in place to manage incidents and whether the measures are sufficiently adequate to prevent recurrence.
- the data obtained from a comprehensive medication management audit completed in October 2021 had not been analysed and an action plan had not been developed with time lines for implementation of the required actions.
- the oversight of fire safety procedures required to be strengthened
- on the day of inspection, inspectors found that all policies were not fully implemented, including policies related to; risk management, medication management and fire safety management

Judgment: Substantially compliant

Regulation 3: Statement of purpose

There was a written statement of purpose that accurately described the service that was provided in the centre. This was made available for the inspector to review and a copy was subsequently forwarded for the Chief Inspector.

Judgment: Compliant

Regulation 34: Complaints procedure

The centre had a complaints policy and procedure in place and a number of complaints were recorded. Complaints had been investigated and closed off to the satisfaction of the complainant.

Judgment: Compliant

Regulation 4: Written policies and procedures

All policies and procedures as required under Schedule 5 of the Care & Welfare Regulations 2013 (as amended) were available and regularly reviewed in the centre. However, it was found that not all were being fully implemented as referenced under Regulation 23 Governance and Management in this report.

Judgment: Compliant

Quality and safety

The quality of service and quality of care delivered to residents was of a good standard. The ethos was one where resident's independence was promoted and their rights were upheld within a social model of care. Overall, the inspectors found that staff worked hard to meet residents' preferences for care and daily routines. However, although residents' rights to dignity and privacy were upheld, improvements were required to fully support and meet their rights for choice, self-determination and autonomy.

Residents had access to medical care and additional treatment and expertise from varied allied health professionals. Residents were closely monitored for signs and

symptoms of COVID-19, and clinical observations were recorded twice daily.

Overall resident's care needs were comprehensively assessed. Care plans were developed to reflect the resident's assessed needs and the majority of the sample reviewed reflected the resident's needs. However the end of life assessments and care plans did not include the residents preferences and wishes to inform staff of their wishes in the event of their death, as discussed under regulation 21.

There was a low use of restraint used in the centre. Those prescribed chemical restraints (as a last resort) were monitored closely and the overall use of psychotropic medication in the centre was audited. Inspectors found that the care plans for those who displayed responsive behaviours were not detailed enough to inform staff of the care they required.

The activities support worker had completed an activities assessment for each of the residents and a "key to me" document which reflected each residents interests, likes and preferences. Residents daily records reflected the activities they participated in on a daily basis. There were adequate facilities available to deliver activities to residents. These facilities included a large communal hall and a wide variety of equipment. However, the inspectors found that many residents did not have adequate opportunities to participate in meaningful activities on a day to day basis within the centre.

Medication management was audited on a three monthly basis and these audits were comprehensive. The practices reviewed on inspection were overall safe, however some improvements were required to ensure the medication management processes were in line with current best practice.

A comprehensive risk management policy, risk register and a risk management committee were in place which included control measures for identified risks. However, the inspectors found that the management of risks associated with falls required improvement, this is discussed under the regulation 23.

An assessment of preparedness and contingency planning for a COVID-19 outbreak was completed by the provider. The contingency plan was regularly updated, it identified key resources and the actions required to ensure their continuous provision in the event of an outbreak.

A record of visitors was maintained to monitor the movement of persons in and out of the building to ensure the safety and security of the residents.

There was evidence that all staff were provided with training in fire safety and evacuation procedures, and an external provider was made available to staff for this training. Evacuation procedures to guide staff, residents and visitors in the event of a fire evacuation scenario were displayed. Records showed regular simulated evacuation practice drills took place with a variety of scenarios to facilitate staff familiarity and develop confidence and competence with fire evacuation procedures. Evidence that the provider had consulted with a fire expert further to the last inspection was viewed. However, some improvements to fire processes were still

required as detailed under Regulation 28.

Regulation 13: End of life

Residents received a good standard of end of life care. They had access to the local palliative care team and those receiving palliative care had the required medication prescribed to ensure their pain was kept under control and all comfort measures were in place. Residents had access to religious and social services to meet their needs when progressing to the end of their life.

There was evidence that the residents' families were kept informed of their condition. Nevertheless some further opportunities for improvements were identified in this respect, specifically in the area of documentation as detailed under Regulation 21.

Judgment: Compliant

Regulation 17: Premises

The premises were appropriate to the number and needs of the residents and were in accordance with the centre's statement of purpose.The centre was well maintained in a good state of repair. It was well laid out to enable orientation and independence, such as space for residents to walk around freely, good lighting, safe floor coverings and handrails along both sides. Layout and type of furniture was appropriate. There was seating provided at intervals along the corridors with areas for diversion, including small enclosed outdoor areas and shelters in which residents may smoke. The décor assisted to orientate residents. The centre was well lit, heated and ventilated throughout. It was tastefully decorated and furnished to a high standard. Windows were fitted with restrictors. All areas were clean and well maintained.

Judgment: Compliant

Regulation 26: Risk management

A risk management policy was in place which met the regulatory requirements. A risk register was maintained in respect of both clinical and non-clinical risks. The register was continuously updated. Improvements were required to risk processes and these are detailed under Regulation 23 Governance and Management.

Judgment: Compliant

Regulation 27: Infection control

Inspectors found that processes were in place to mitigate the risks associated with the spread of infection and to limit the impact of potential outbreaks on the delivery of care. Improvements were implemented further to the last inspection to ensure all staff were aware of the level of precautions to be taken prior to entering the bedroom of a resident with a transmissable infection. The inspector observed some examples of good practice in the management of COVID-19 such as good hand hygiene practices and adherence to good practice when wearing face masks. Staff had access to personal protective equipment and hand sanitisers in all areas. Appropriate systems were in place to ensure the regular cleaning and/or decontamination of communal equipment between each use.

Judgment: Compliant

Regulation 28: Fire precautions

Improvements were required to the fire procedures in place. These included;

- Personal evacuation plans (PEEPS) for each individual resident was available on a computerised basis only and therefore in the event of a fire these would not be easily accessible or available to staff to guide them
- Inspectors were told that a list of all residents in the centre which outlined the individual evacuation procedure to be used was maintained at the main fire panel. Inspectors reviewed the list and found not all residents were included and that the evacuation procedure on this list differed to the PEEPS on the computer for several residents
- The provider had responded to actions required from the previous inspection in respect of two large compartment areas and submitted a report on the standard of containment measures in these areas. However, although the report confirmed compliance with fire safety containment measures on both corridors, it did not reference that these containment measures extended through to the roof space above the walls. Furthermore, it was found that the simulated evacuation training and practices did not include the evacuation of the largest compartments with minimum staffing levels.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

The medication prescription and nurses administration signature chart required review. They did not specify the times for medication administration and both charts used generic terms such as am, lunch, pm, tea and bed.

Residents weights were not recorded on their medication prescription chart.

There was a record book for recording all controlled medications returned to the pharmacy, however there were no records maintained in respect of residents general medications returned to the pharmacy.

There was no record kept of the monthly stock checks completed.

The worktop in the medication room was cramped with equipment and documents. For example, there was a printer on the worktop in the medication room. Hence there was no worktop space available for nurses to use when preparing medications.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

A sample of resident assessments and care plans were reviewed on this inspection. The assessments reflected the residents met on inspection and clearly identified their assessed needs. The care plans reviewed were person-centred and outlined the residents' wishes and preferences. Those residents with wounds had a detailed wound care plan in place and the records reviewed were clear and concise and reflected the condition of the wound each time the dressing was changed.

The assessments and care plans reviewed were updated on a three monthly basis.

There was evidence that residents were consulted with in respect of their care planning reviews

Judgment: Compliant

Regulation 6: Health care

Residents had access to medical and allied heath care services. Residents' general practitioners (GPs) made site visits on a regular basis and all residents were reviewed within a four month time-frame.

There was evidence that nurses engaged in continuous professional development and were informed of current best practice in relation to infection prevention and control as well as the management of residents with suspected or confirmed COVID-

19.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Residents who displayed responsive behaviours received a good standard of care. Staff spoken with knew the residents well and were clearly able to articulate how they prevented and de-escalated situations that challenged them in providing care to this group of residents. Nevertheless improvements were required in respect of associated documentation, as detailed under Regulation 21.

Judgment: Compliant

Regulation 8: Protection

There was a safeguarding policy in place and residents were protected from abuse. Staff spoken with were clear about their role to report any concerns to senior staff as per the policy.

There was a rigorous recruitment procedure in place. Staff had An Garda Siochana (police) vetting prior to starting work in the centre.

The centre was a pension-agent for a small number of residents living in the centre. There were clear processes in place for the management of residents' pensions and monies held on behalf of residents.

These processes were reviewed and the inspector saw that the residents monies were going into a separate bank account in line with the requirements published by the Department of Social Protection (DSP).

Judgment: Compliant

Regulation 9: Residents' rights

The opportunities available to residents to participate in activities were limited as observed on the day of inspection. Inspectors were informed that health care assistants were part of a multi-disciplinary approach to the provision of activities for residents.

However, the inspectors observed that residents spent long periods of time in the

open plan living areas with no stimulation and no interaction with staff. Inspectors observed that the health care assistant team prioritised the delivery of personal care and meeting residents' physical and basic needs. As a result they had limited time to assist in the provision of meaningful activities, social stimulation, engagement and occupation for residents. This was also confirmed by some of the staff who communicated with the inspectors on the day.
Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 13: End of life	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Castleross OSV-0000124

Inspection ID: MON-0034746

Date of inspection: 10/11/2021

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • Castleross will continue with their practice of using an evidence based assessment tool to review the needs of the people who live in Castleross and the staffing requirement appropriate to the needs of the Residents who live there.	
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: - An Audit of care plans was completed. - A review of all Personal preferences and wishes documented for all residents.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Full review of all falls completed • Analysis of all falls completed. The findings and learnings from the analysis will be discussed at all staff meetings to feedback lessons learned. • Castleross Falls committee implemented – weekly meetings ongoing. Completed a Terms of Reference for falls prevention team.	

• Falls policy reviewed and all updates communicated to all staff.
• Education leaflets developed for residents that are deemed to be a risk of falls.
• Education for staff –Enhanced education sessions for all staff on falls prevention including presentation, tool box talks and role and function of falls committee.
• Implemented a falls prevention month for December 2021- falls prevention and information provided on information boards in all houses. Communication was sent to all staff to create awareness.

Mediation management

• Action plan implemented for all houses in response to medication audits completed- December 2021.

Responsive behaviours
• Risk assessment completed for all residents in dementia units in relation to responsive behaviors.
• Quarterly challenging behaviour audits are completed which review incidents, correspondence from GP and input from psychiatry of old age team. Behavioural notes and care plans are analysed and updated as part of audit.
• Ongoing input from Psychiatry of Old Age team who complete regular onsite physical reviews and for those residents who are displaying challenging behaviour, weekly support phone calls from the team.
• Ongoing Input from behavioural specialist who provides training to all staff in the Dementia houses on responsive behaviours.

Fire safety procedures
• Simulated fire drill scheduled for December 2021.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• Fire safety procedures – PEEP assessments in place for all residents. Evacuation report updated with all residents and up to date PEEP assessments. Language used in report is short and concise to easily read in an emergency. This report is available to all staff at the front reception fire panel.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services: • A complete review of medication management for Castleross to be completed with a view to transfer to an electronic system. This will include a review of all medication management policies. • Returns log implemented for residents' general medications in all houses. • Monthly medication stock check being implemented in all houses. • Review of Clinical room space, maintenance to complete shelving to allow sufficient worktop space for nurses to prepare medications.	
Regulation 9: Residents' rights	Substantially Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: - A quality of care and quality of life survey for residents completed and reviewed to include feedback on activities. Any feedback from residents will be implemented in the activity schedule and discussed at monthly activity Meeting. Castleross will continue to review activities on an ongoing basis to ensure that the needs and preferences of the people who live in Castleross are met.	

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	14/12/2021
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.	Substantially Compliant	Yellow	31/03/2022
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service	Substantially Compliant	Yellow	31/03/2022

	provided is safe, appropriate, consistent and effectively monitored.			
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	31/03/2022
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.	Substantially Compliant	Yellow	31/03/2022
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	31/03/2022
Regulation 29(2)	The person in charge shall facilitate the pharmacist concerned in meeting his or her obligations to a resident under any relevant legislation or guidance issued by the Pharmaceutical Society of Ireland.	Substantially Compliant	Yellow	31/03/2022

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 resident's pharmacist regarding the appropriate use of the product.	Substantially Compliant	Yellow	31/03/2022
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Substantially Compliant	Yellow	31/03/2022