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

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| Name of designated centre: | Castlebridge Manor Nursing Home |
| Name of provider: | Castlebridge Manor Private Clinic Limited |
| Address of centre: | Ballyboggan Lower, Castlebridge, Wexford |
| Type of inspection: | Unannounced |
| Date of inspection: | 01 June 2023 |
| Centre ID: | OSV-0005826 |
| Fieldwork ID: | MON-0039930 |

## About the designated centre

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

Castlebridge Manor Nursing Home is a two-storey building, purpose built in 2018, with a ground floor and first floor accessed by lift and stairs. It is located in a rural setting surrounded by landscaped gardens on the outskirts of Castlebridge village near Wexford town. Resident accommodation consists of 77 single rooms and 9 twin rooms. All bedrooms contained en-suite bathrooms and there were assisted bathroom's on each of the two floors where residents reside. The provider is a limited company called Castlebridge Manor Private Clinic Ltd. The centre provides care and support for both female and male adults over the age of 18 years requiring long-term, transitional care, respite or convalescent care with low, medium, high and maximum dependency levels. The range of needs include the general care of the older person, residents with dementia/cognitive impairment, older persons requiring complex care and palliative care. The centres stated aim is to meet the needs of residents by providing them with the highest level of person centered care in an environment that is safe, friendly and homely. Pre-admission assessments are completed to assess a potential resident's needs and whenever possible residents will be involved in the decision to live in the centre. The centre currently employs approximately 98 staff and there is 24-hour care and support provided by registered nursing and healthcare assistant staff with the support of housekeeping, catering, administration, laundry and maintenance staff.

**The following information outlines some additional data on this centre.**

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| Number of residents on the date of inspection: | 89 |

## How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

**1. Capacity and capability of the service:**

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

**2. Quality and safety of the service:**

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

**This inspection was carried out during the following times:**

| Date | Times of Inspection | Inspector | Role |
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| Thursday 1 June 2023 | 09:15hrs to 19:30hrs | Bairbre Moynihan | Lead |
| Thursday 1 June 2023 | 09:15hrs to 19:30hrs | Mary Veale | Support |

## What residents told us and what inspectors observed

Inspectors spoke to a number of residents and in more detail to nine residents to elicit their experiences of living in Castlebridge Manor Nursing Home. Overall, residents expressed concerns to inspectors about the staffing levels in the centre and the turnover of staff. In addition, residents highlighted to inspectors ongoing issues with the choice and variety of food in the centre.

This was an unannounced inspection which took place over one day which was prompted following the receipt of unsolicited information since the inspection in November 2022. On arrival inspectors were greeted by a member of the centres' administration team and signed the centres visitors' book. Following an introductory meeting with the person in charge, inspectors were accompanied on a walk-around of the centre. Inspectors spoke with and observed residents in communal areas and their bedrooms.

The design and layout of the premises met the individual and communal needs of the residents. The centre was a large and spacious two storey building with 77 single bedrooms and nine twin rooms. All of the bedrooms were en-suite with a shower, toilet and wash hand basin. Residents' bedrooms were generally clean, tidy and had ample personal storage space. Privacy curtains in a small number of twin rooms observed did not enclose the end of the resident's bed ensuring the dignity and privacy of that resident. Bedrooms were personal to the residents containing family photographs, art pieces and personal belongings. Pressure relieving specialist mattresses, cushions and fall prevention equipment were observed in some resident bedrooms. Shared communal space included sitting rooms in each unit, dining rooms on each floor, an oratory and visitor's rooms. Shared furniture in communal rooms appeared to be suitable for the residents, comfortable and clean. Corridors were wide and free from clutter with appropriate hand rails. Rooms that were identified on the last inspection as not in use for which they were registered had reverted back to their intended use.

Residents had access to two enclosed courtyard garden areas on the ground floor and a large open garden to the front of the building. The gardens had level walkways, comfortable seating, sensory flower beds, raised vegetable and herb beds and a seed potting station. Inspectors were informed that residents had won an award in the local community for their flowers last year. The enclosed garden areas were in use by residents and visitors on the day of inspection.

Alcohol hand gels and PPE (personal protective equipment) were readily available throughout the centre to promote good hand hygiene. The inspectors observed that there were minimal hand hygiene sinks in each unit and noted there was strong odour on Ferrycarraig suite.

The inspectors were informed by a number of residents that a large number of staff had left employment in the centre and had not been replaced. The residents said

that they missed the comradery and friendships that they had built up with these staff during the COVID-19 pandemic. It was evident through conversations with residents that the reduction in staffing levels in the centre was impacting on the residents care and well being. Examples of these included; A resident told inspectors that they were worried for the residents who required assistance with their care and for residents who used wheelchairs in the day room after 5pm. The resident said that they could not concentrate in the day room as residents were calling for staff and there is no staff available to attend to the residents after 5pm. The resident said that this was causing them a lot of anxiety and they worried for the residents who could not speak for themselves. Another resident told inspectors that sometimes the lack of supervision of residents who walked with purpose was affecting their privacy and dignity; for example this resident was upset that a resident who walked with purpose would enter their bedroom and ensuite bathroom and had removed personal items such as a toothbrush, tissues and sweets. Another resident advised inspectors that there are not enough staff at night and that residents are cold and windows were left open. The resident stated that on occasion the resident had to provide another resident with a blanket as there were no staff around to provide it. Another resident told inspectors that the staff would answer their call bell within an appropriate time frame, however staff would tell the resident that "they would be back to attend to their care" but the resident could be waiting 25-30 minutes for the staff to return to them to provide care. Another resident told the inspectors that due to staff shortages they found it difficult to get staff to assist them to put them on their motor-med bicycle.

Furthermore it was observed that 50% of the residents on Ferrycarraig and Slaney suites were in their bedrooms at 18:30 on the evening of the inspection. 18 of these residents were in their bed, seven were sitting in an armchair in their room and two residents were walking the corridor in their night attire. There were five residents and a staff member in a TV lounge and two staff were attending to personal care in one of the resident bedrooms. A resident informed an inspector that there were only two staff members in Slaney in the evening when staff are on breaks and the resident stated "the staffing is terrible".

On the day of inspection, residents were observed attending a live music event in the afternoon. Residents' views and opinions were sought through resident meetings and satisfaction surveys and they felt they could approach any member of staff if they had any issue or problem to be solved. A number of the residents' who spoke with the inspectors said they were dissatisfied with the activities programme in the centre and voiced their concern of the lack of meaningful activities for residents who had dementia or who were confined to their bedroom. Some residents told the inspectors that there were no activities in the evenings after 5pm or at weekends.

The centre provided a laundry service for residents. Residents' whom the inspectors spoke with on the day of inspection said that the laundry service had improved. One resident said that they had been compensated for items which had been damaged but said that some items of their clothing were put into other residents' rooms by mistake.

Inspector's observed that visiting had returned to pre-pandemic arrangements. The inspectors spoke with three family members who were visiting. A small number of visitors whom the inspectors spoke with said that they were concerned about the lack of staff in the centre and that it was impacting on the care that their family members received. Visitors informed the inspector that they had made complaints to the manager about the lack of basic and personal hygiene care their loved ones received, poor staffing levels particularly in the evening time, night time and weekends. A visitor said that they had noticed that there was no interactions between staff and residents for some activities when the activities staff were not on duty.

The dining experience was observed in Amber and Edenvale unit. Residents were provided with a choice at mealtimes and the menu was on display in the centre. A small number of residents requiring assistance were provided with it. However, an inspector spoke with residents during the mealtime and residents stated they were not happy with the choice of food and the type of food. Residents stated that the "meat is tough" and "the vegetables are not cooked enough". They stated that they have raised it at resident meetings and had met the chef but nothing had improved.

The next two sections of this report will present findings in relation to governance and management in the centre, and how this impacts on the quality and safety of the service being delivered.

## Capacity and capability

This was an unannounced risk inspection carried out to monitor ongoing compliance with the regulations and standards and to follow up on four pieces of unsolicited information that had been submitted to the Chief Inspector of Social Services in relation to healthcare, residents rights, communication, staffing and governance and management. There had been engagement with the registered provider prior to the inspection in relation to two of these concerns and all four were followed up during the inspection. Inspectors also followed up on notifications submitted to the Chief Inspector of Social Services. The provider had progressed the compliance plan following the previous inspection in November 2022 and had submitted an updated compliance plan. Improvements were found in Regulation 3: Statement of purpose, Regulation 5: Individual assessment and care plan, Regulation 7: Managing behaviour that is challenging, Regulation 16: Training and staff development, Regulation 21: Records and Regulation 31: Notification of incidents.

On this inspection, inspectors identified that action was required by the registered provider to address Regulations 23: Governance and management, 9: Residents rights and Regulation 15: Staffing. Areas of improvement were required in Regulation 6: Training and staff development, 27: Infection prevention and control and 29: Medicines and pharmaceutical services. Following the inspection an urgent compliance plan was issued to the registered provider requesting assurances that

the centre was staffed in line with the statement of purpose and to ensure the service was effectively monitored and safe. The registered provider failed to provide assurances that the centre was or would be staffed in line with the statement of purpose and therefore was not accepted by the Office of the Chief Inspector.

The registered provider was Castlebridge Manor Private Clinic Limited. There was a change in the operational management of the centre in October 2022 but the registered provider remained as Castlebridge Manor Private Clinic Limited. The centre is part of a wider group that own and manage a number of centres in Ireland. Reporting relationships were outlined to inspectors. The person in charge reported to a person participating in management. The person participating in management was onsite on the day of inspection and attended the feedback meeting. The person participating in management reported to an operations manager and upwards to the chief executive officer who was also the registered provider representative. Inspectors were informed that the registered provider representative was onsite on the week of inspection and completed a walk-around of the centre. The person in charge worked full-time and was supported by an assistant director of nursing who was supernumery and two clinical nurse managers who worked 12 hours per week each in a supernumery capacity, staff nurses, healthcare assistants, housekeeping, activities co-ordinators, catering, administration, laundry and maintenance staff.

The registered provider had not ensured that staffing in the centre was in line with the statement of purpose with which Castlebridge Manor Private Clinic Limited is registered against. Inspectors were informed that there were two healthcare assistant vacancies on the day of inspection. However, on review of staffing in the centre inspectors identified that the registered provider had approximately 12 healthcare assistant vacancies. The registered provider had failed to identify this gap and recruit staff in line with the statement of purpose. Staff informed inspectors that in recent weeks staffing had been further reduced during day and night time and a trial of a new shift for three staff on duty from 10pm to 10am would provide extra staff in the morning for the centre but in turn the staffing levels would be reduced by three staff in the evening time. Adding to staff shortages was a high level of staff turnover with 42% of staff leaving in 2022 and a high level of unplanned leave. Residents, visitors and staff informed inspectors that staffing shortages were impacting on resident's quality of life in the centre. This was also identified in complaints reviewed. In addition,there was evidence that staff had raised their concerns of staffing shortages at meetings in the centre. Furthermore, 45% of residents in the centre were maximum dependency and 22% of residents were high dependency. However, despite all the indications that there was a shortage of staff that was impacting on the care, welfare and quality of life of residents the registered provider had not addressed it**.**

Improvements were found in the oversight of mandatory training needs. Staff had access to education and training appropriate to their role, however improvements were required in the supervision of staff in the centre. An extensive suite of mandatory training was available to all staff in the centre and training was mostly up to date. There was a high level of staff attendance at training in areas such as fire safety training, manual handling, dementia awareness and infection prevention and

control. Staff with whom the inspectors spoke with, were knowledgeable regarding fire evacuation procedures and safe guarding procedures. Fire safety training, safe guarding training, food safety and modified foods and drinks training were scheduled to take place in the weeks following the inspection. On the day of inspection, the inspectors were informed that staff were undertaking cardio-pulmonary-resuscitation (CPR) training and that fire safety and managing actual and potential aggression (MAPA) training was planned to take place in the centre in the weeks following the inspection.

There was a comprehensive annual review of the quality and safety of care delivered to residents completed for 2022 with an associated quality improvement plan for 2023. It set out improvement plans for 2023 for example; there were plans to increase staff development programmes to reduce staff burnout, policies and procedure would be available electronically and a quality improvement programme was planned to be developed for residents. The registered provider had introduced quality improvement measures for example safety crosses for pressure ulcers and falls which identified the days when there was a fall or pressure ulcer in a unit. These were on display in each unit. In addition, a review of falls was completed 48 hours following the fall and residents were reviewed by the medical officer. However, no trending of the falls was taking place. Inspectors identified that 17 falls had been reported to the Office of the Chief Inspector since the last inspection. 10 of these occurred in one unit. No overall analysis of these had taken place to identify the contributing factors for example; the time of the fall or whether staffing was reduced on that day. The registered provider had a system of audit in place for example; medication audits and infection control audits. Audit findings in relation to medication were also identified by inspectors on inspection. This will be discussed under Regulation 29: Medicines and pharmaceutical services. Systems of communication were in place. Meeting minutes were provided to inspectors. There was evidence of meetings taking place between the person in charge and management from the group, meetings with management from within the centre and staff meetings.

A sample of complaints were reviewed. Themes emerging from the sample reviewed were in relation to care issues and supervision of residents.

Incidents and reports as set out in schedule 4 of the regulations were notified to the Chief Inspector of Social Services within the required timeframes. The inspectors viewed the centres' incident and accident log on an electronic database and found that incidents and accidents were managed in accordance with the centre’s policies.

## Regulation 15: Staffing

At the time of renewal of registration of the centre in 2021 the registered provider had given commitments to provide a specified staffing WTE outlined in the statement of purpose in order to ensure safe care for 95 residents. However, inspectors identified that staffing was not in line with the statement of purpose and

a number of vacancies existed which was impacting on the quality and well-being of residents as discussed earlier in the report. For example; on the evening of inspection, 13 residents were in the sitting room on Amber/Edenvale, a resident was calling out and no staff member was present to attend to residents' needs. A resident informed the inspector that "it is like this all the time".

Gaps between actual staffing levels and what the centre was registered against in the statement of purpose included:

- The centre had a deficit of approximately 12 healthcare assistants. The centre was registered for 52 wholetime equivalent (WTE) healthcare assistants. On the day of inspection there were 36 WTE and seven part-time healthcare assistants.
- There were two WTE staff nurse vacancy posts. Management stated that one staff nurse was recruited and was awaiting commencement.
- A high level of unplanned leave amongst staff was further impacting on staff shortages. Records reviewed indicated there were only six days in May where there was no staff member on unplanned leave. In addition on one day in May there were 6 staff on unplanned leave. Management stated that they had identified trends in unplanned leave and had introduced a return to work meeting with staff.

Judgment: Not compliant

## Regulation 16: Training and staff development

Gaps were identified in staff training. For example;

- 5 staff had not completed training in managing behaviours that challenge.
- 2 staff safeguarding training was out of date.

Judgment: Substantially compliant

## Regulation 21: Records

All records as set out in schedules 2, 3 & 4 were available to the inspector. Retention periods were in line with the centres' policy and records were stored in a safe and accessible manner.

Judgment: Compliant

## Regulation 23: Governance and management

There were inadequate staffing resources in place to ensure the effective delivery of care in accordance with the centre's statement of purpose, as discussed under regulation 15: Staffing. This impacted negatively on the quality of life of residents.

The management systems in the centre required further strengthening to ensure that the service provided was safe, appropriate, consistent and effectively monitored. For example:

- The registered provider had failed to identify and act on information received through a satisfaction survey, residents feedback and complaints that identified staffing shortages and how these shortages were impacting on the quality of life and well-being of residents.
- Trending of incidents was not taking place. 17 falls had been reported to the Office of the Chief Inspector since the last inspection in November 2022. No overall analysis of these falls and all falls had taken place to identify trends.
- While individual complaints were managed in line with the regulation, tracking and trending of complaints was not taking place to identify emerging themes such as complaints relating to care issues and staffing.
- The centre did not have an effective procedure to ensure safe staffing levels in the event of staff absenteeism.

Issues identified on the inspection in November 2022 remained an issue and while efforts were made to address them the issues remained. For example;

- Residents informed inspectors and meeting minutes identified that residents had raised the issues around the quality and choice of food. The registered provider had met with the catering staff and the catering staff had attended a recent residents' meeting however, the issues remained. Furthermore, meeting minutes identified that the registered provider was trying to reduce the food bill in the centre.
- Residents stated that while they had noted an improvement in the laundry, meeting minutes reviewed and inspectors were informed that clothes were getting damaged and on occasion clothes were going missing. The management team were aware of the issues and were endeavouring to address them.

Under this regulation the provider was required to submit an urgent compliance plan to address the urgent risk. The provider's response did not provide assurance that the risk was adequately addressed.

Judgment: Not compliant

## Regulation 31: Notification of incidents

Incidents and reports as set out in schedule 4 of the regulations were notified to the Chief Inspector within the required time frames. The inspectors followed up on incidents that were notified and found these were managed in accordance with the centre's policies.

Judgment: Compliant

## Quality and safety

Overall, residents and visitors expressed dissatisfaction with the level of staffing in the centre and the quality of life. However, residents were complimentary about the staff who worked in the centre and the challenges they faced trying to provide care in an environment of understaffing. Improvements had been noted in the area of care planning, managing behaviour that is challenging and fire safety since the last inspection. On this inspection actions was required in residents rights, infection prevention and control, fire safety and medicines and pharmaceutical services.

Residents' health and well-being was promoted and residents had timely access to general practitioners (GP), specialist services and health and social care professionals, such as psychiatry of old age, physiotherapy, occupational therapy, dietitian and speech and language, as required. The centre had access to a medical officer and GP's from local practices. The inspectors were informed that the medical officer called to the centre most evenings and GP's called to the centre regularly. Residents had access to a consultant geriatrician and a psychiatric team. Residents could be referred to a medical assessment unit if required and had access to local dental and optician services.

The inspectors observed that the resident's pre-admission assessments was paper based and nursing assessments and care plans were maintained on an electronic system. Residents' needs were comprehensively assessed prior to and following admission. Residents' assessments were undertaken using a variety of validated tools and care plans were developed following these assessments. Care planning documentation was available for each resident in the centre. Care plans viewed by the inspectors were comprehensive and person-centred. Care plans were sufficiently detailed to guide staff in the provision of person-centred care and had been updated to reflect changes required in relation to for example; falls. There was evidence that the care plans were reviewed by staff. Consultation had taken place with the resident or where appropriate that resident's family to review the care plan at intervals not exceeding 4 months.

The inspectors followed up on the actions from the previous inspection's compliance plan for managing behaviour that is challenging. The inspectors observed that nursing staff had identified the trigger causing responsive behaviour using a validated antecedent- behaviour- consequence (ABC) tool for residents' with

identified responsive behaviour. There was a clear care plan for the management of resident's responsive behaviour. It was evident that the care plans were being implemented. There were nine bed rails and four lap belt restrictive measures in use. Risk assessments were completed, and the use of restrictive practice was reviewed regularly. The inspectors found that chemical restraint was used only occasionally and as a last resort. Less restrictive alternatives to bed rails were in use such as sensor mats and low beds. External doors and unit doors in the centre were electronically locked. The intention was to provide a secure environment and not to restrict movement. Residents were observed being assisted by staff returning to the centre following a walk on the grounds.

The centre was clean and generally tidy. The overall premises were designed and laid out to meet the needs of the residents. A schedule of maintenance works was ongoing and parts of the centre had been prepared for painting. Most bedrooms were personalised and residents had sufficient space for their belongings. Residents had access to call bells in their bedrooms, en-suite bathrooms and communal rooms. Grab rails were available in all corridor areas, toilets and en-suite bathrooms. The premises mostly supported the privacy and comfort of residents. However; a review of the centres twin room accommodation was required. This is discussed further under Regulation 9: Resident's Rights.

Staff were observed to have good hygiene practices and were not wearing face coverings which was in line with recent changes to national guidance recommendations. Used laundry was segregated in line with best practice guidelines and the centres laundry had dirty to clean laundry which prevented a risk of cross contamination. Infection control audits were completed, however, they were not identifying the issues identified on inspection. Areas for action were required in relation to infection prevention and control will be discussed further under Regulation 27.

Improvements were found in fire safety since the previous inspection. The centre had automated door closures to bedrooms and compartment doors. All staff had completed fire training in the centre. There was evidence of an on-going schedule for fire safety training. Effective systems were in place for the maintenance of the fire detection, alarm systems and emergency lighting. The centres' emergency lighting had been serviced since the previous inspection. Fire doors were checked on the day of inspection and all were in working order. There was evidence that fire drills took place monthly. There was evidence of fire drills taking place in each compartment with simulated night time drill taking place in the centres' largest compartment. Fire drills records were detailed containing the number of residents evacuated, how long the evacuation took and learning identified to inform future drills. There was a system for daily and weekly checking of means of escape, fire safety equipment and fire doors. All fire safety equipment service records were up to date. Each resident had a personal emergency evacuation plan (PEEP) in place which were updated regularly. The PEEP's identified the different evacuation methods applicable to individual residents and supervision required at the assembly area. There was fire evacuation maps displayed throughout the centre, in each compartment. Staff spoken to were familiar with the centres evacuation procedure. On the day of the inspection there were six residents who smoked. A call bell, fire

blanket, fire extinguisher and fire retardant ash tray were in place in the centre's smoking area.

The registered provider had systems in place for the management of medicines. Staff spoken to were knowledgeable about the systems and processes in the centre. Medications were stored securely including medications requiring strict control measures (MDAs). Staff had access to advice from a pharmacist and while not onsite the inspectors were informed that the pharmacist was available to speak to a resident if they requested it. The registered provider had replaced a medication fridge which was identified as leaking on two previous inspections.

Most residents were actively involved in the organisation of the service. There was evidence that resident meetings were taking place. A resident and family satisfaction survey took place in 2022. 59% of residents responded to the survey. 81% if residents said they were happy with the staff however, eleven questions were asked and it is unclear if staffing levels were addressed in the survey. Furthermore, 41% of residents were either neutral or unhappy about the overall care received. An action plan was devised to address individual comments in the survey, however, the overall care was not further explored in the survey results received by inspectors. The residents had access to a SAGE advocate in the centre. The advocacy service details and activities planner were displayed throughout the centre. Some residents whom the inspectors spoke with were disappointed with cost of the activities and did not feel the activities were of value for the money they were paying. Residents confirmed that their religious and civil rights were supported. Mass took place weekly in the centre. A physiotherapist did an exercise class with residents for 30 minutes once weekly. Residents has access to daily national newspapers, weekly local papers, WiFi, books, televisions, and radios. However, improvements were required in relation to the provision of activities for residents with advanced needs. A small cohort of residents did not have opportunities to participate in activities based on their assessed needs.

## Regulation 27: Infection control

While inspectors observed that the centre was generally clean on the day of inspection, improvements were required in order to ensure procedures are consistent with the national standards for infection prevention control in community services. For example:

- Inspectors were informed that staff were disposing of human waste in residents' toilets from bedpans. This procedure increased the risk of the spread of multi-drug resistant organisms, for example; clostridioides difficile. In addition, it posed a risk to staff through splashing of bodily fluids. Furthermore, this practice was not outlined in the infection control policy.
- Two fridges in the centre were unclean. Inspectors were informed that the fridges were on a monthly cleaning schedule.

- Inspectors identified a foul smell coming out of bins placed on a corridor and a small number of resident's rooms.
- A small number of vents located in residents' en-suites and shower drains were dusty and unclean.
- The registered provider was in the process of replacing the hand gel dispensers. The walls where the previous hand gel dispensers were located were in a state of disrepair. Management were aware of this and were in the process of repairing the walls.
- Two crash mats observed were unclean.

Inspectors identified that findings from the inspection in November 2022 had not been actioned. For example;

- A cleaner's mop and bucket were stored in the sluice room. This posed a risk of cross contamination.
- The number of hand hygiene sinks remained unchanged and did not meet the required specifications.
- The temporary closure mechanism on sharps boxes in Amber and Edenvale unit were not engaged on any of the sharps boxes viewed.
- Open but unused portions of wound dressings were observed.
- Housekeeping staff had not received training in the principles and practices of cleaning.

Judgment: Substantially compliant

## Regulation 28: Fire precautions

The provider had good oversight of fire safety. Annual training was provided and systems were in place to ensure fire safety was monitored and fire detection and alarms were effective in line with the regulations. Bedroom doors had automatic free swing closing devices so that residents who liked their door open could do so safely. Evacuation drills were regularly practiced based on lowest staffing levels in the centre’s largest compartment.

Judgment: Compliant

## Regulation 29: Medicines and pharmaceutical services

While overall medication management procedures were good, an inspector observed the following which required review:

- Dates of when medication was opened were not consistently recorded for medications which had a reduced expiry once opened.

Judgment: Substantially compliant

## Regulation 5: Individual assessment and care plan

The standard of care planning was good and described person-centred care interventions to meet the assessed needs of residents. Validated risk assessments were regularly and routinely completed to assess various clinical risks including risks of malnutrition, bed rail usage and falls. Based on a sample of care plans viewed appropriate interventions were in place for residents' assessed needs. Care plan reviews were comprehensively completed on a four monthly basis to ensure care was appropriate to the resident's changing needs. There was evidence that the resident or their care representative were involved in the care plan review in line with the regulations.

Judgment: Compliant

## Regulation 6: Health care

There were good standards of evidence based healthcare provided in this centre. GP's routinely attended the centre and were available to residents. Allied health professionals also supported the residents on site where possible and remotely when appropriate. There was evidence of ongoing referral and review by allied health professional as appropriate.

Judgment: Compliant

## Regulation 7: Managing behaviour that is challenging

There was a centre-specific policy and procedure in place for the management of behaviour that is challenging. A validated antecedent- behaviour- consequence (ABC) tool, and care plan supported the resident with responsive behaviour. The use of restraint in the centre was used in accordance with the national policy. Staff were knowledgeable of residents' behaviours and patient in their approach with residents. Alternatives measures to restraint were tried and consent was obtained when restraint was in use. Records confirmed that staff carried out regular safety checks when bed rails were in use.

Judgment: Compliant

## Regulation 9: Residents' rights

The following actions are required;

- Activities co-ordinators generally worked Monday to Friday and there was no activities available to residents at weekends. Furthermore, in line with findings from the inspection in November 2022 residents in Ferrycarrig unit spent long periods of time in bed. It was a challenge for one activities co-ordinator assigned to Ferrycarrig to provide meaningful activities to the residents on a daily basis.
- Residents informed inspectors that after 5pm in the evening no activities were available for residents.
- Wardrobes were located outside the resident's floor space in some of the twin rooms. As wardrobes were located out side the resident's floor space, residents had to exit their private floor space or enter another residents private space to access their clothing.
- Privacy curtains in twin rooms did not always cover the end of the bed which did not ensure privacy for both residents.
- Meeting minutes reviewed and residents stated that on occasion clothes are going missing and can be damaged on return from the laundry. The registered provider had changed the type of washing powder to try and address the damaged clothes.
- Ongoing issues with the food remained despite residents raising the issues at resident meetings.

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 | Substantially compliant |
| Regulation 21: Records | Compliant |
| Regulation 23: Governance and management | Not compliant |
| Regulation 31: Notification of incidents | Compliant |
| **Quality and safety** | |
| Regulation 27: Infection control | Substantially compliant |
| Regulation 28: Fire precautions | 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 9: Residents' rights | Not compliant |

# Compliance Plan for Castlebridge Manor Nursing Home OSV-0005826

## Inspection ID: MON-0039930

## Date of inspection: 01/06/2023

**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:
As discussed with the inspectors on the day of inspection and at subsequent meetings, we are constantly reviewing our staffing levels. We have submitted an up to date WTE for staffing and a detailed Statement of Purpose which is in line with the nursing home sector norms, and we continue to state that the staffing levels described within the Statement of Purpose attached to the registration is no longer applicable.

Our staffing compliment is supported by the verified Modified Barthel tool – which is widely used in long term care settings to calculate the number of care hours required per resident per day, and which has shown that we have excess staffing hours at present. We continue to monitor and review this and will increase hours as needed.

Whilst there is a very kind and caring team of staff in the home, it is evident that there are some cultural issues relating to excessive unplanned absences and some operational processes.

A change management program has commenced and in order to support the home during the implementation of new processes, there will be an additional 20 hours per week of Clinical Nurse Manager hours added and 6 hours per week of Health Care Assistant hours added. The purpose of the CNM hours is to add another layer of oversight and supervision of the team while changes are being implemented.

The effectiveness of this additional resource will be assessed after 2 weeks and again after 4 weeks, and at any point more hours can be added if assessed as being needed for the safe care and support of our residents.

We will conduct a full gap analysis of the service focusing on the topics of – Medication Management, Nursing documentation and clinical practice, roles and responsibilities and risk assessment and management.

We will continue to review our residents' opinions and concerns and react to them to give assurances and / or increase resources based on evidence and use of verified tools.

We will continue also, to manage our complaints in line with our complaints policy, but we will add a section for the complainant to confirm in writing where possible that they are satisfied with the outcome to provide documented evidence of this going forward.

Castlebridge Nursing Home, like all nursing homes across the country, loses staff to the HSE, and this year a large number of our staff have moved to HSE posts around the country.

To fill these gaps while we recruit suitably qualified and experienced staff, and to assist with the comprehensive induction & guidance for staff within the home we have seconded some more experienced staff from a "sister" nursing home within the group.

The staff, residents and GP's in the home have reported in a very positive way to this action and new methods of work and operational approaches are being used to the benefit of all.

We will continue with our recruitment drive to ensure full cover during busy holiday periods and to allow for the company agreed policy number of reasonable absences.

***An inspector has reviewed the provider compliance plan. This action proposed to address the regulatory non-compliance does not adequately assure the chief inspector that the actions will result in compliance with the regulations***

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| Regulation 16: Training and staff development | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
On the day of inspection, all staff who were available to work were up to date with their safeguarding training.

The 2 staff members who have not completed this were on extended leave. They will complete this training on their return.
2 of the staff who have not yet completed the training on managing behaviour that is challenging are on extended leave. We will ensure that all staff members who have this topic outstanding complete it as soon as possible on their return to work.

We have completed training under 12 different topics this year already to aid our staff to safely and competently manage the changing needs of our Residents and home. We will continue to assess and provide appropriate training for our Staff.

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| Regulation 23: Governance and management | Not Compliant |

Outline how you are going to come into compliance with Regulation 23: Governance and management:
As stated above, whilst there is a very kind and caring team of staff in the home, it is evident that there are some cultural issues relating to excessive unplanned absences and some operational processes.

A change management program has commenced and in order to support the home during the implementation of new processes, there will be an additional 20 hours per week of Clinical Nurse Manager hours added and 6 hours per week of Health Care Assistant hours added. The purpose of the CNM hours is to add another layer of oversight and supervision of the team while changes are being implemented. We will also recruit a second full time Deputy PIC for the home to further support the supervision and oversight of the staff and procedures throughout the home.

We will conduct a full gap analysis of the service focusing on the topics of – Medication Management, Nursing documentation and clinical practice, roles and responsibilities and risk assessment & management. And when that report is complete, a full action plan will be implemented with timelines and regular reviews of the prescribed actions.

We will continue to fully engage with our Residents and families to address their concerns regarding staffing as effected by absences and will investigate the impact of this on our Residents so that any noted impact can be addressed.

We will ensure a quarterly analysis of complaints takes place and is acted upon in a timely manner if gaps are identified.

We have begun the analysis of incidents to understand and react to trends of incidents that have occurred. This is to ensure that we have full understanding of timelines, triggers, and influences on these occurrences so that measures can be taken to mitigate against further occurrences.

We have been meeting with Residents and families on a one-to-one basis to discuss any areas of concern in line with our complaints policy and are actively engaged with them so that they have a full understanding of what we are working towards.

We are continuing to liaise with Residents with regards to our menus, quality and choice of foods. Our Resident meetings will take suggestions from Residents on what they would wish to see on the menu for the coming month and we will endeavor to ensure that all choices are catered for. This will be documented for reference purposes.

There has been no change to the supplier/quality/volume of food ordered for our

Residents. However, we will continue to strive to make the dining experience for all our residents one of delight and suitably nutritious.

***An inspector has reviewed the provider compliance plan. This action proposed to address the regulatory non-compliance does not adequately assure the chief inspector that the actions will result in compliance with the regulations***

| Regulation 27: Infection control | Substantially Compliant |
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Outline how you are going to come into compliance with Regulation 27: Infection control:
Staff will only dispose of bodily waste in the appropriate manner as per policy.
We will review our cleaning schedules in relation to cleaning the fridges, the vents in the ensuites & shower drains and ensure that all areas are documented.
We have already placed the bins which are situated on the corridors on a cleaning schedule to be cleaned and emptied regularly.

The repair of the walls from the previous hand gel dispensers will continue throughout the house as part of our ongoing maintenance schedule.

We have already implemented a cleaning schedule for our Resident support items – chairs/pressure cushions/crash mats.
The cleaners mop & bucket have been removed from the sluice room, we use a flat mop system for cleaning so there is no waste water to be disposed of.

All nurses have been reminded about the correct closure mechanism on the sharps boxes throughout the home.

Any dressings for Residents will be placed in an airtight container and be marked with the specific Resident name, once opened. These will be stored in the Residents room.

Our housekeeping and domestic staff will all undertake the "amric cleaning and disinfecting the healthcare environment and patient equipment" course on HSEland. We will arrange for further training as necessary to equip them to fulfill their role.

All of the above will be part of the review and oversight from the management team in the home.

The wash hand basin in the Clinical room is listed for replacement. In the meantime this has been entered in our risk register.

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| Regulation 29: Medicines and pharmaceutical services | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:<br>We will ensure that the dates when medication is opened is recorded clearly and that the expiration date once opened is identified. | |
| Regulation 9: Residents' rights | Not Compliant |
| Outline how you are going to come into compliance with Regulation 9: Residents' rights:<br>The Activity Calendar is modified to ensure activities are available for residents after 5pm should they wish to attend. Activity staff duty hours are now modified to facilitate this change, and they now work from 10.15 hours – 18.15.<br><br>Through our Resident meetings we will take suggestions about what type of activity they would like to have and for those not attending the meetings, we will discuss on an individual basis to gather their wishes also. These will be documented in our Resident meeting minutes. Resident surveys will be designed and used to support relatives and residents documented opinions.<br><br>We have sought consultation regarding the curtain placement in our twin rooms so that we can ensure each Resident has their own private space – we will rehang the room curtains to ensure this.<br><br>As mentioned in the report, we have already been in contact with the supplier regarding the laundry goods to ensure that stains are removed. We are also replacing our linens on a phased basis.<br><br>We will continue to work with our Residents to ensure that resolution is obtained with regards to food, menus, quality and choice of our meals.<br>Suggestions will be taken at the next meeting for involvement in the next months menu and surveys will be used to gather and retain information that we can then use to design or amend menus.<br><br>It is important to note that we do always offer a choice of meals on the menu and should neither suit our Resident we can offer alternatives as wished. This will be documented for reference purposes. | |

## 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 |
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| 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 | Red | 31/08/2023 |
| Regulation 16(1)(a) | The person in charge shall ensure that staff have access to appropriate training. | Not Compliant | Orange | 31/08/2023 |
| Regulation 16(1)(b) | The person in charge shall ensure that staff are appropriately supervised. | Substantially Compliant | Yellow | 31/08/2023 |
| Regulation 23(a) | The registered provider shall ensure that the designated centre has sufficient resources to ensure the | Not Compliant | Red | 31/08/2023 |

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| | 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 | Red | 31/08/2023 |
| Regulation 27 | The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff. | Substantially Compliant | Yellow | 31/08/2023 |
| 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 | Substantially Compliant | Yellow | 31/08/2023 |

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| | appropriate use of the product. | | | |
| 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 | 31/08/2023 |
| 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. | Substantially Compliant | Yellow | 31/08/2023 |
| 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 | 31/08/2023 |