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:	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:	23 November 2022
Centre ID:	OSV-0005826
Fieldwork ID:	MON-0037874

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.

Number of residents on the date of inspection:	88

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 23 November 2022	09:45hrs to 17:45hrs	Bairbre Moynihan	Lead
Thursday 24 November 2022	09:20hrs to 16:30hrs	Bairbre Moynihan	Lead

What residents told us and what inspectors observed

The inspector arrived to the centre in the morning to conduct an unannounced inspection to monitor ongoing compliance with the regulations and national standards. From the inspector's observations and from speaking to residents, it was clear that the residents received a good standard of care. Residents were complimentary about the staff, the cleanliness of the centre and the care they received but a small number of residents expressed dissatisfaction with the food.

On arrival the inspector was met by the person in charge. The centre is registered to accommodate 95 residents with 88 residents on the day of inspection. The inspector spoke with a number of residents and spoke in greater detail with seven residents to gain their feedback on their lives in Castlebridge Manor nursing home. The centre was a purpose built nursing home, laid out over two floors and contained four units. On the ground floor was Amber Unit and Edenvale and on the first floor was Slaney and Ferrycarrig unit. The centre had 77 single rooms and 9 twin rooms all containing en-suite facilities. The ground floor had two enclosed gardens. Residents rooms were personalised with photographs, pictures and personal belongings from home. Communal facilities included a large open plan sitting and dining room on the ground floor where residents from all four units gathered to take part in activities. In addition each unit contained a sitting room and dining rooms. However, there was no communal facilities available for residents to receive their visitors in private other than their bedroom.

The centre had three activities co-ordinators. One for Amber and Edenvale and one each for Slaney and Ferrycarrig. The inspector observed a number of activities taking part over the two days of inspection including bingo, live music where a large number of residents were singing and dancing to the music and hand painting. Roman catholic mass was celebrated on the second day of inspection in the centre. Residents were generally enthusiastic about the activities and the inspector spoke to a number of residents who did not take part and expressed that it was by choice. The activities calender was displayed in residents' bedrooms and was up to date. There was a plan for residents to go into the local town to view the Christmas decorations in the coming weeks. Each unit got a national newspaper each day and if residents chose they can purchase their own newspaper. Wifi for residents was available in the centre if required.

Feedback from residents was received through residents meetings and a satisfaction survey. Meetings were completed monthly and it was evident from the review of the minutes that residents were vocal with their thoughts and concerns about the centre. However, in three consecutive sets of minutes residents raised concerns about the laundry. Furthermore, a small number of residents informed the inspector that they were not satisfied with the food. This was also raised at a residents meeting. In addition, a residents survey conducted in 2021 asked residents if they were happy with the food. 38 residents participated and 12 expressed that they were not happy with the food. Management were aware of residents concerns and

had commenced addressing the issues at the time of inspection. Residents spoke to the inspector about the new registered provider. There was a sense of apprehension among residents about the change. Representatives from the new provider had met some of the residents and were onsite three days per week during the transition.

The dining experience was observed in the three units. The majority of residents attended the dining room in Amber and Edenvale. A number of residents in Ferrycarrig remained in bed and required assistance and the remaining residents attended the dining room. The tables in Ferrycarrig were decorated with a Christmas theme. Residents in Slaney were divided between two areas for their dining experience. Staff were in attendance during lunchtime and provided assistance where required in a discreet manner.

The centre had an open visiting policy and a number of visitors were observed throughout the two day inspection. It was evident that visitors were welcome in the centre.

The next two sections of the report present the findings of this inspection in relation to governance and management arrangements in place in the centre and how these arrangements impacted the quality and safety of the service being delivered.

Capacity and capability

This was a risk based unannounced inspection to monitor compliance with the regulations and national standards. Additionally, the inspector followed up on unsolicited information received since the last inspection. The inspector assessed the overall governance of the centre and establish if the actions outlined in the centre's compliance plan following the inspection in April 2022 had been implemented. Overall, the inspector found that improvements were required in the governance and management of the centre.

The registered provider was Castlebridge Manor Private Clinic Limited. There had been a change on 7 October 2022 in the operational management of the centre but Castlebridge Manor Private Clinic Limited remained the registered provider. The centre is now part of a wider group that own and run a number of centres throughout Ireland. Reporting relationships were outlined to the inspector. The person in charge reported to a person participating in management who reported to the chief executive officer who was also the registered provider representative and a director of the company. The person in charge worked full-time and was supported in the role by an assistant director of nursing and two clinical nurse managers, all of whom were supernumery. There was currently one clinical nurse manager vacancy. In addition, these roles were supported by staff nurses, healthcare assistants, housekeeping, activities co-ordinators, administration, laundry, maintenance and catering staff. The centre had sufficient staff nurses and healthcare assistants to meet the assessed needs of the residents given the size and layout of the centre, however, due to unexpected absences on occasion, staff expressed to the inspector

that sometimes it was short staffed. In addition, meeting minutes reviewed identified that these concerns were raised by staff. Management provided assurances that the centre had a full complement of staff and if unexpected absences occur that these shifts were always covered.

Staff were knowledgeable of each resident's individual needs. There was a programme of training available for staff in the centre and uptake of training was monitored by the management team. A training matrix was available for the inspector to review. Good practices were seen in safeguarding training and medication management training where training was fully completed. However, gaps were identified which will be discussed under Regulation 16: Training and staff development.

The inspector reviewed the records of a sample of files to ensure that the actions outlined in the compliance plan from April 2022 were completed. The provider had introduced an interview form to capture any gaps in staff curriculum vitaes. This was observed in two of the files. However, staff who were employed prior to this introduction continued to have gaps in their curriculum vitaes. Contracts of care were reviewed. The weekly fee was now included in the sample of contracts reviewed. This was an action following the inspection in April 2022. In addition, the contracts outlined the number of residents in a room (single or twin) and the additional fees for residents for example hairdressing, hip protectors and a weekly fee for in-house therapies. The contract stipulated that this list was not exhaustive, however, it did not include resident slings for which residents were required to pay for.

There was evidence that monitoring of the service was taking place through audit. Audits were completed monthly and included environmental audits, medication audits, weight loss audits and bell audits. Not all audits were comprehensive enough to identify the issues. For example: no actions were identified following the medication audits. However, this was not the finding on the day of inspection. These will be discussed under the domain of Quality and Safety. The provider had completed an annual review for 2021 using the HIQA template. The review contained an action plan with actions identified including placing a feedback form on the website and to provide housekeeping staff with access to the information technology system.

Systems of communication were in place. Weekly meetings were taking place attended by the new person participating in management and the outgoing registered provider representative to ensure a smooth transition. Ward meetings were held monthly with a standing agenda. Meeting minutes outlined what was discussed. However, no action plan accompanied any of the meeting minutes reviewed.

The majority of incidents were recorded on an information technology system. Medication incidents were recorded separately. A number of incidents that met the criteria for reporting to the Office of the Chief Inspector were not reported in line with regulatory requirements. These will be discussed under Regulation 31:

Notification of incidents.

Complaints identified in documentation reviewed on inspection were not logged in the complaints log in the centre. This will be further discussed under the relevant regulation.

Regulation 15: Staffing

The centre had a clinical nurse manager vacancy. The inspector was informed that there was no plans at present to fill the vacancy. In the interim a senior staff nurse was assigned to assume the duties of the clinical nurse manager on a temporary basis.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Gaps in training and staff development included:

- Seven out of 29 staff had not completed cardio pulmonary resuscitation training or it was out of date.
- Eight staff had not completed manual handling training.
- 13 staff fire training was either out of date or not completed.
- 18 staff had not completed training on managing behaviours that challenge.

Judgment: Substantially compliant

Regulation 21: Records

Two files reviewed of staff members that were employed prior to the introduction of the new interview form which was introduced since the last inspection continued to have gaps in their employment history.

Judgment: Substantially compliant

Regulation 23: Governance and management

Improvements were required in the assurance systems in place so that the

registered provider could be assured of the quality and safety of care delivered to residents. For example:

- Tracking and trending of incidents was requested on the day and not received. Management stated that this was completed at year end. However, greater oversight of incidents was required on a more regular basis to identify incidents that required reporting to the Chief Inspector and identify trends in reported incidents so that these could be mitigated and learning shared with staff.
- Time bound action plans did not accompany audits and meeting minutes reviewed.

Judgment: Substantially compliant

Regulation 24: Contract for the provision of services

A sample of contracts was reviewed. Contracts included the fee to be set out on a weekly basis, the number of persons accommodated in the room for example single or twin. An appendix at the back of the contract included additional fees for example: newspapers, hairdressing and hip protectors.

Judgment: Compliant

Regulation 3: Statement of purpose

The layout of the centre was not in line with the statement of purpose and the floor plans. For example:

- The oratory on Amber was in use for the storage of personal protective equipment (PPE)
- A room registered as a visitor's room on Ferrycarrig was in use as a staff room on the day of inspection.

This was discussed with management at the feedback meeting and they stated that the had planned to revert the rooms back in line with the floor plans and statement of purpose the week following inspection.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The inspector identified six incidents that had not been notified to HIQA and met the criteria for notification to the Office of the Chief inspector. These were submitted following the inspection.

Judgment: Not compliant

Regulation 34: Complaints procedure

No complaints were logged in the complaints log since the last inspection in April 2022.

A complaint from a resident's relative was identified in the narrative in the residents file but this had not been logged as a complaint although the issue had been addressed.

Judgment: Substantially compliant

Quality and safety

Overall, residents were supported and encouraged to have a good quality of life which was respectful of their wishes and choices. Resident had access to a high level of medical and nursing care. In addition, residents had timely access to health and social care providers. However, improvements were required in the majority of regulations inspected.

Visiting had resumed as normal in the centre. Visitors were not required to book in advance or complete questionnaires. Both residents and visitors confirmed that there were no restrictions around visiting.

Castlebridge Manor nursing home was a purpose built centre which opened in 2018. The centre was generally clean on the day of inspection. An up-to-date infection control policy was in place however, not all practices in the centre were in line with the policy. Residents' laundry was carried out onsite. A dirty to clean flow was in place for the management of the laundry. Staff had access to infection control training through HSELand. However, while housekeeping staff were able to describe their role and identify residents with transmissible infections they were unsure of the correct cleaning products to use. Housekeeping staff had not completed training on the principles and practices of cleaning. Additional areas for improvement will be discussed under Regulation 27: Infection control.

Meals were prepared onsite. Residents were offered a choice at mealtimes. Staff confirmed to the inspector that residents on modified diets also received the same choice. Residents stated that if they did not like something on the menu that they

could ask for something else. Refreshments and snacks were provided in between mealtimes. Management stated that they had timely access to a dietitian from once the resident was referred. However, a small number of residents expressed that they were not happy with the food. This was confirmed in residents' meeting minutes reviewed and a satisfaction survey in 2021.

Systems were in place for monitoring fire safety. The fire alarm system met the L1 standard which is in line with the current guidance for existing designated centres. Servicing of the fire alarm and fire extinguishers were up to date, however, quarterly servicing of the emergency lighting had not taken place. The inspector was informed that the maintenance team replaced any bulbs that were broken with the emergency lights. Fire safety training was taking place yearly which had increased from two yearly. In addition, improvements were seen in the fire drills. These were taking place monthly on both the day and night shift. The drills recorded the timing of the fire drill, number of staff and residents who took part and areas for improvement. The weekly checking of fire doors was now taking place. Gaps were identified in the daily and weekly checks. Further improvements required will be discussed under Regulation 28: Fire Precautions.

The centre had systems in place for medication and pharmaceutical services. Staff had completed training in medication management. Medications requiring strict control measures (MDAs) were stored securely. However, the medication trolley in Amber was not secured at all times. Staff had access to advice from a pharmacist if required. The inspector was informed that medication reviews of all residents took place at six monthly intervals by the pharmacist and general practitioner.

The inspector observed a sample of care plans and validated assessment tools. These were found to be updated at least at four monthly intervals or if not sooner. However, while care plans were dated as being updated the information in the care plans was not always resident specific. This will be further discussed under Regulation 5: Individual assessment and care planning.

The centre had an up-to-date policy on managing behaviours that challenge. Staff were knowledgeable of residents' behaviours, and were observed to be compassionate and patient in their approach with residents. Daily progress notes outlined when a PRN (as required) psychotropic drug was administered, and how distraction techniques were used prior to administration of the medication, however, documentation including care plans did not outline residents' responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). Validated assessment tools were not in use such as antecedent- behaviour-consequence (ABC) tool in the centre despite the policy outlining that they should be used for seven days on admission. There was no evidence in records reviewed that these were completed.

Castlebridge Manor nursing home residents were articulate about the positive and negatives aspects of their care in the nursing home. Residents raised a number of issues through the resident meetings and satisfaction survey. Residents had access to WIFI, newspapers and independent advocacy services with contact details

displayed in the centre. Activities were taking place in the centre and residents wishes were respected if they did not want to take part. However, a cohort of residents remained in bed for long periods of time without stimulating activities.

Regulation 11: Visits

There was no restrictions on visiting and a number of visitors were observed in the centre on the days of inspection. Issues identified regarding the provision of visiting facilities is discussed under Regulation 04: Statement of Purpose.

Judgment: Compliant

Regulation 18: Food and nutrition

Residents and a small number of visitors informed the inspector that improvements were required with the food. This had been raised in the residents meeting in August and October 2022 where residents raised concerns around the quality of the food. Management stated that they had met with catering staff to discuss improvements in the menu.

In addition, on both days of inspection residents in Slaney were not aware of the menu for that day as the menu boards had not been updated.

Judgment: Substantially compliant

Regulation 27: Infection control

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

- The temporary closure was not engaged in any sharps boxes observed by the inspector. This was brought to both the person in charge and a staff nurse attention during the inspection.
- Clinical waste bins were in appropriately placed in treatment rooms and on a corridor in Ferrycarrig unit for the disposal of masks. In addition two of the sluice rooms observed did not contain clinical waste bins.
- Hand hygiene sinks did not meet the required specifications.
- Cleaning equipment for example buckets were stored in two sluice rooms observed.

- The centre was using chlorine based solution for routine cleaning. This was not in line with the centres' own policy.
- The centre had a number of upholstered chairs. Management stated that they were cleaned on the first of every month, however, there were no records available to confirm this. Furthermore, a small number of residents told the inspector and meeting minutes from a resident's meeting stated that residents were not happy with the cleanliness of the upholstered chairs.
- Open, but unused portions of wound dressings were observed. This was brought to management's attention and removed. It was identified on an environmental audit that staff were unaware of what the symbol for "single use only" meant.
- Housekeeping staff had not received education on the principles and practices of cleaning.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Areas for action were identified including:

- Weekly and daily inspection of for example; means of escape, were not consistently completed. For example: on weekends and bank holidays gaps were identified.
- Quarterly and yearly service of the emergency lighting was not completed. Following the inspection management stated that the registered provider has engaged with a company to carry out quarterly inspections next year with one scheduled for January 2023. In addition management stated that a weekly check of emergency lighting was completed by a person onsight and any lights requiring replacement were replaced.
- A room containing heat pumps was also a store room which contained boxes of storage, clean curtain, empty bins and towels.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

While the centre had many good practices around medication and pharmaceutical services. Areas for improvement were required. For example:

- Insulin pens were not stored in line with manufacturers recommendations. This was brought to management's attention on the day and removed and disposed of.
- In line with the finding from the last inspection two fridges reviewed

contained water and some items stored in the fridge were wet.
- Temperature checks of the fridge was not consistently completed in Amber unit.
- While the medication trolley and cupboards containing medications in Amber unit were in a treatment room, there was no lock on this door. In addition, the inspector observed that the medication trolley was unlocked and keys were in a cupboard that contained medications.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

The inspector reviewed a sample of care plans and validated assessment tools. All care plans and validated assessment tools reviewed by the inspector had been reviewed within the previous four months in line with regulations however, not all care plans were person centred. For example: a care plan stated that the resident needed to be encouraged to read alone or in groups, however, this particular resident had maximum dependency needs. In addition, a care plan stated that a family are unable to visit due to COVID-19 restrictions. However, the centre had no restrictions on visiting at the time of inspection.

Furthermore, a resident who was losing weight was required to have weekly malnutrition universal screening tool (MUST) completed, these were not completed.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had access to a local general practitioner who attended twice weekly. In addition, the provider had a medical officer who attended the centre on a daily basis. The medical officer attended family meetings and out of hours if required as the medical officer was familiar with the residents. If the medical officer could not attend an out of hours service was contacted.

Physiotherapists attended three times weekly which was privately paid for by the resident requiring physiotherapy. A weekly group session was provided by the physiotherapist which was paid for by the provider. Management stated that there was minimal waiting times for access to other health and social care providers either through the HSE or a private company. Residents attended a dentist if required in Wexford town.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

- Some residents had responsive behaviours. While staff were able to describe behavioural triggers and distraction techniques used for particular residents, improvements were required in the documentation of these in care plans. Behavioural assessments were not completed for episodes of responsive behaviour. Opportunities were therefore not always identified or documented which would support staff to work therapeutically with residents, to manage the behaviours effectively and improve the residents' quality of life.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Action was required by the registered provider to ensure that residents' rights were respected and their social care needs were met. Areas to be addressed included:

- The inspector observed that residents in Ferrycarrig unit spent long periods of time in bed with minimal stimulation.
- In addition, on the first day of inspection 14 of the 28 residents in Ferrycarrig Unit were in bed by 1720hrs. This did not offer residents a choice of their bedtime.
- The inspector reviewed meeting minutes of residents' forum meetings which identified a number of recurring issues raised by residents. For example: in three sets of minutes reviewed residents raised issues around the laundry. There was nothing to indicate through the complaints process or resident forum meetings that the issues were addressed as such it remained an issue for three consecutive months.

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	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Castlebridge Manor Nursing Home OSV-0005826

Inspection ID: MON-0037874

Date of inspection: 24/11/2022

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	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: We use the modified Barthel index to assist us in planning our rosters with our Residents care needs and as you can see with just our planned rosters, currently we are amply staffed. We will be reviewing our staffing levels in the new year however at present, we are confident that we are able to meet the assessed needs of our Residents. On the days of the inspection our care hours as per the modified Barthel index were as follows: Resident Care needs – 1770p/w RGN & HCA – 2768p/w A Senior staff nurse is assigned to the ground floor unit where there is presently a Clinical Nurse Manager vacancy. Any unexpected staff absences due to illness are covered by staff who can be called in at short notice or a member of our supernumerary team (2 CNM & 1 DPIC). Our deputy person in charge supports and assists the senior staff nurse in monitoring the care needs / supervisory role of the ground floor unit.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: We are fortunate to have a number of in-house trainers amongst our staff who can cover the following topics; CPR, MAPA, Manual Handling & Fire Safety. This also enables us to capture the educational needs of our newer staff members. We have reviewed our Training matrix to ensure that all staff members – particularly our newer staff members are up to date with all relevant training & education.	

Since the inspection we have completed the following:
All CPR training has been completed on the 20.12.22. This will be renewed on a bi-annual basis.

Staff due for manual handling training will be complete on 19.01.23.

Any staff member who has not completed their fire and safety training will do so on the 19.01.23.

Staff were able to attend training days on the 08.12.22 and 12.12.22 for Managing Behaviours that Challenge. We will run a further date on the 12.01.23 to enable any staff member who were unable to attend in December to catch up on this day.

We are in the process of reviewing our training matrix and planning for our requirements for 2023. This is completed in conjunction with our HR and PIC to ensure that all staff are included and these needs are incorporated into our rosters.

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
Since May 2022, we have a new interview assessment form in use. This clearly identifies/ explains any gaps in a staff members employment history. Files prior to that will be audited and any gaps found will be addressed. Audit of employee files prior to May 2022 will be completed by 20.01.23.

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
In addition to our annual review of incidents, we have introduced a robust audit tool that will be use from January 2023. This will ensure that all incidents are reviewed in a timely manner and that action plans and timelines are completed and reviewed.
A modified meeting minutes template has been introduced to enable staff to easily follow up with any issues from any previous meeting. We will document also when feedback has been given to Residents.

Regulation 3: Statement of purpose	Substantially Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of purpose: Any room that we have re-purposed during our previous outbreaks have been returned to their original designation.	
Regulation 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: As previously stated, a new audit tool will be used from January 2023. This will ensure that all incidents are reviewed in a timely manner and action plans are carried out to ensure high quality and safety care is delivered to residents all the time. We will ensure that all incidents are appropriately notified to HIQA as required.	
Regulation 34: Complaints procedure	Substantially Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: We are reviewing our complaints policy and procedure and this will be a topic that will be addressed in staff education in the first quarter of 2023 to ensure full compliance. Any issues – complaints had been logged on our nursing software system as a "concern". All of these had been addressed as per our policy and have been closed off.	
Regulation 18: Food and nutrition	Substantially Compliant
Outline how you are going to come into compliance with Regulation 18: Food and nutrition: Due to a changeover of staff, the menu board in some of our units had not been	

updated. We have drawn up a checklist for our chef to ensure that this is completed daily.
Any suggestions/issued that have been raised by our Residents regarding foods/menus etc are communicated directly to our chef via email and enables them to address these issues promptly. Our Chef will attend our regular Resident meetings to speak with Residents directly as required. With our modified meeting minutes template, we will be able to ensure that these issues are documented and followed up appropriately in a timely manner.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
An education session has been completed for all nursing staff regarding the importance of temporary closure of sharps box; education will be repeated based on training need analysis.
We have reviewed the placement of clinical waste bins and have made changes as required. All units that require a clinical waste bin has one that is stored in their sluice room.
A review of our cleaning products and practices has been undertaken and we are using products as per our policy.
The cleaning equipment stored in the sluice room for management of spillage of fluids has been moved to a more appropriate storage area and all staff are fully aware of both its usage and whereabouts.
We have completed an education session for staff nurses about the single use dressing materials /proper storage and management of open dressing materials.
All housekeeping staff completed mandatory training on principles and practices of cleaning by 30th December 2022 and will attend refresher training every 2 yearly .

Risk assessment is completed in relation to use of existing Hand Hygiene sinks , Risk assessment is placed in risk register with a plan to upgrade in future.

The cleaning log is updated to indicate which designated days is scheduled for upholstery chair cleaning.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Both our maintenance staff and our staff nurses each complete a daily inspection of our

fire escapes. These are documented separately to each other. For the nurses – this will be discussed at handover to ensure completion at each shift.

The quarterly and yearly service of all emergency lighting will be completed by an external company from Jan 2023 onwards.
Our Heat pump storage rooms will be cleared of any surplus items by 10.01.23.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
We have amended the daily check list for our CNM to cover the supervision of storage of medicines including insulin pens, checks on fridge and review of medication management systems.
All of our treatment rooms are lockable and part of the education sessions previously mentioned in Reg 27, included emphasis on ensuring that all staff nurses are aware of locking the medication trolleys and treatment rooms.

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
All care plans and assessments are reviewed 4 monthly. Any that require changes are updated as required. The CNM will continue to carry out monthly documentation audit that will focus on individualized and person-centered care plans. We will monitor these audits and identify any staff member who may need further training in careplanning skills.

All residents who were noted to have weight loss, were on a weekly weight monitoring chart and weekly MUST renewal. However some residents with challenging behaviors are noncompliant with this plan. This has resulted in a breach of compliance with the suggested guidelines and policy. Staff were instructed to document these refusals clearly and take a repeated approach to ensure the residents are monitored on a regular basis.

Regulation 7: Managing behaviour that is challenging	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
We have commenced the use of assessment tool called " ABC tool for assessing challenging Behavior" for Residents with responsive behaviours. The 4 monthly, Cohen Mansifed agitation inventory assessment tool is also in use to identify the responsive behavior for all residents. This will assist with identifying the opportunities that can be utilized to work therapeutically with Residents.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
The majority of residents in Ferrycarrig unit have either maximum dependency or high dependency level. Out of 28 residents ,8 residents have expressed their preference and choice to remain in bed due to their multiple comorbidities. Even with lots of encouragement, they had refused to come out of bed, they prefer to mobilize by chair for weekly hair dressings, mass, or any therapeutic interventions such as physiotherapy, chiropody treatment etc.
Other residents who were in bed or were settled to bed early on the days of inspection had pressure sore prevention care plans in place and maximum time allowed for them in chair safely was for 3 - 5 hours. Their care plans were formulated as per their care needs.
Staff respected their wishes and ensured that these residents are approached every 2 hourly and repositioned 2 hourly.
The activity co- Ordinator ensured that these residents are consulted and provided with one-to-one care.
As previously mentioned, modified meeting minutes template (that addresses and review previous meetings action plan) will be used from January 2023. This will help in reminding the resolution of any re occurring issues.

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.	Substantially Compliant	Yellow	03/01/2023
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	31/01/2023
Regulation 18(1)(c)(ii)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which are wholesome and nutritious.	Substantially Compliant	Yellow	03/01/2023
Regulation 21(1)	The registered provider shall	Substantially Compliant	Yellow	20/01/2023

	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.			
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.	Substantially Compliant	Yellow	01/01/2023
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	30/12/2022
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	10/01/2023
Regulation 28(1)(c)(iii)	The registered provider shall make adequate arrangements for testing fire equipment.	Substantially Compliant	Yellow	31/01/2023
Regulation	The registered	Substantially	Yellow	31/01/2023

28(1)(d)	provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.	Compliant		
Regulation 29(4)	The person in charge shall ensure that all medicinal products dispensed or supplied to a resident are stored securely at the centre.	Substantially Compliant	Yellow	03/01/2023
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	Substantially Compliant	Yellow	03/01/2023

	pharmacist regarding the appropriate use of the product.			
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose relating to the designated centre concerned and containing the information set out in Schedule 1.	Substantially Compliant	Yellow	03/01/2023
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence.	Not Compliant	Orange	01/01/2023
Regulation 34(1)(f)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.	Substantially Compliant	Yellow	31/01/2023
Regulation 5(4)	The person in	Substantially	Yellow	31/01/2023

	charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Compliant		
Regulation 7(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.	Substantially Compliant	Yellow	31/01/2023
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	01/01/2023
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	01/01/2023
Regulation 9(3)(d)	A registered	Not Compliant	Orange	28/02/2023

	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.			