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:	Castle Gardens Nursing Home
Name of provider:	Mowlam Healthcare Services Unlimited Company
Address of centre:	Drumgoold, Enniscorthy, Wexford
Type of inspection:	Unannounced
Date of inspection:	19 November 2021
Centre ID:	OSV-0000696
Fieldwork ID:	MON-0034535

About the designated centre

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

Castle Gardens Nursing Home is a purpose-built single-storey facility that first opened in 2008. The centre is situated on the outskirts of Enniscorthy town. The premises can accommodate 64 residents. Bedroom accommodation consists of 54 single and five twin bedrooms and all bedrooms have full en-suite facilities. There is a large kitchen adjacent to the main dining room. There is a large central day room and several other seating areas. Recently the centre has designed a memory care unit within the centre which has 19 of the 64 beds. Appropriate communal areas are provided within this unit as well. Other facilities include an oratory, hair salon and laundry room. All are adequate in size, decorated in a domestic manner and easily identifiable for residents to find. The centre offers nursing care for dependent persons aged 18 years and over, providing long-term residential care, respite, convalescence, dementia and palliative care. Care is provided for people with a range of needs with low, medium, high and maximum dependency. The stated objective of the centre is to ensure that the needs and wishes of residents will be fully taken into account through their involvement in making service decisions. The centre offers 24-hour care and support provided by registered nursing and health care assistant staff with the support of housekeeping, catering, administration, laundry and maintenance staff. Two well maintained enclosed garden areas were available to residents and were freely accessible from a number of locations throughout the centre. Adequate parking was available at the front of the building.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	62

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
Friday 19 November 2021	08:45hrs to 18:40hrs	Catherine Furey	Lead

What residents told us and what inspectors observed

The inspector chatted with a large number of residents, and had detailed discussions with eight residents, to gain an insight into their experience living in Castle Gardens Nursing Home. The inspector also met with three visitors on the day. Overall, the feedback indicated that while residents and visitors were generally satisfied with the service provided, they believed that the standard of care had declined recently, with both staff and visitors citing staff shortages as the main reason for this.

The inspector arrived unannounced to the centre and on arrival was met by a staff member who ensured that all necessary infection prevention and control measures, including hand hygiene and temperature checking were implemented prior to accessing the centre. A brief opening meeting was held with the person in charge, who then accompanied the inspector on a tour of the premises. The inspector saw that the centre was a modern, well-maintained, ground floor building which was decorated to a high specification. A large reception contained a smaller seating area in a sitting-room style with couches, coffee tables and a fireplace. Residents were seen to meet with visitors here and some spent time relaxing as they watched people come and go. Large sitting and dining rooms opened off the main reception area where residents were observed to spend time during the day. There was a private oratory which could be used for quiet reflection. The centre is divided into two distinct areas; the main house where 45 residents live, and the memory care unit which can accommodate 19 residents with varying levels of cognitive impairment. Residents in the centre were complimentary about the building, describing it as beautiful and "as good as home". The inspector noted that many of the resident's bedrooms were personalised with soft furnishings, ornaments and family photographs.

The centre was clean throughout and appropriate signage was in place to prompt staff, visitors and residents to perform frequent hand hygiene and to adhere to social distancing measures. Staff were seen to wear personal protective equipment (PPE) such as surgical masks appropriately. A regular programme of maintenance was in place, and on the day of inspection, corridors were being freshly painted.

The inspector observed staff engaging with residents throughout the day. While all verbal interactions with residents were respectful and supportive, the inspector observed that staff were very busy and that care and assistance provided to residents was at times task-based in nature and lacked a person-centred approach. For example, some staff were observed moving residents in high support chairs to the sitting room without asking the resident's permission or letting the resident know where they were going. Staff were seen rushing to move residents from one area to another using transit wheelchairs with no footrests. This impacted on residents' comfort and safety; one resident was told "keep your legs up". Some residents reported that staff were always busy and there was never enough on duty, and as a result the standard of care provided had declined. Staff reported that they

struggled to cope as the staffing levels were depleted and their workload had increased with a number of recent short term admissions. They reported that it was difficult to get to know the residents who were admitted because they were so busy. A resident who was recently admitted told the inspector "I am supposed to be getting physio, but they don't have time to walk me".

The inspector observed mealtimes in the centre and found that in the main house, lunch time was an enjoyable occasion, with residents seated at nicely laid tables. Residents were seen to be assisted discreetly with their food and drinks where required. There was a choice of main course and dessert. The food served was of a high quality and was attractively presented. Residents in all areas had access to snacks and drinks outside of regular mealtimes. All residents who spoke with the inspector had high praise for the food they received, one resident remarked "it gets five stars ". The chef was knowledgeable about residents personal preferences and food allergies and special requests for vegan and vegetarian diets were facilitated. The dining experience in the memory care unit was observed to be less structured and residents were not consulted about their preferences for their evening meal.

The activities coordinator was seen engaging with a number of residents across both areas of the centre throughout the day. It was evident that she knew the residents well, and vice versa. Residents were seen to engage in arts and crafts, flower arranging and sing songs on the day. Despite the efforts of the staff, the activities on offer were limited and the social needs of some residents were not met. Some residents from the memory care unit were supported to attend group activities in the main house. However, not all residents in the memory care unit were able to do so, due to the varying nature of their conditions. The absence of a dedicated activities coordinator was evident in this area, with no structured activity taking place for these residents on the day of the inspection.

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

Capacity and capability

Improvements were required in the overall governance and management of the service to ensure the service was adequately resourced and effective oversight of this centre. This inspection identified a significant drop in compliance levels since the previous inspection in June 2021. Following this inspection, a cautionary provider meeting was held on the 26 November 2021 to discuss the findings. The registered provider committed to strengthening the governance systems within the centre, including further staff recruitment, staff training and supervision and the overall oversight of the service to ensure safe, suitable and quality care was provided to the residents.

The centre is owned and operated by Mowlam Healthcare Services Unlimited

Company, who are the registered provider. There is a clearly defined overarching management structure in place. The person in charge is supported in the role by a national senior management and operational team which includes a human resource team, a finance team, estates, a director of care services and healthcare managers who each oversee several centres. On a daily basis, the person in charge was supported in her role by an assistant director of nursing, a clinical nurse manager and a team of nurses and healthcare assistants. The assistant director of nursing and the clinical nurse manager spent half of their week as a nurse on duty and the other half in a supernumerary role, supervising care and assisting the person in charge in overseeing the service. A team of catering, domestic, administrative and maintenance personnel provided further support to the centre. There was a company-wide schedule of audits in place including audits of falls, care plans and medication management which were completed on a regular basis by the management team. Records of management and staff meetings were reviewed and found to discuss clinical audit results, ensuring that required actions were scheduled. Some improvements were required with regard to auditing of falls, as discussed under Regulation 23.

This unannounced inspection was carried out following the application of the centre to renew it's current registration. In addition, since the previous inspection, a number of pieces of unsolicited information had been received by the Chief Inspector raising concerns about the care of residents, staff shortages and poor communication with families. The inspector had liaised with the provider in relation to these concerns and received assurances in relation to the issues raised**.** However, the inspector found evidence to support some of the concerns raised which is discussed throughout the report. The inspector also followed up on actions required from the previous inspection and found that not all required actions had been addressed.

The centre is registered for 64 beds. There were 62 residents in the centre on the day of inspection. This included ten short stay residents, recently admitted from hospital for periods of convalescence and rehabilitation. The inspector found that there was insufficient staff on duty to provide the appropriate level of care for the profile of residents in the centre. Healthcare staff spoken with on the day described how the shortage of staff directly impacted upon their ability to properly care for the residents. For example; not providing residents with baths and showers, not having time to talk to residents, not being able to provide additional personal touches that they previously could, such as spending a few extra minutes helping a resident with hair and makeup. This was also reflected in feedback from residents. The audits and systems in place to monitor the quality of the service did not identify these issues. The inspector requested an audit of call bell response times, and this was not available.

The inspector reviewed the centre's training matrix and found that training modules such as moving and handling, fire safety and infection prevention and control were kept up to date for all staff. As discussed under Regulation 16, the inspector identified that additional training was required in some areas to ensure best possible outcomes for residents.

The centre's complaints procedure was prominently displayed and accessible to residents and their relatives. This detailed the persons responsible for overseeing the complaints process and contact details for independent advocacy services. A review of the centre's complaints log identified a number of open complaints which had not been fully addressed. A full review of complaints management was required to ensure that complaints were managed in line with the requirements of the regulation. This is discussed in more detail under Regulation 34.

Registration Regulation 4: Application for registration or renewal of registration

A completed application for the renewal of the centre's registration was made by the registered provider within the required timeframe.

Judgment: Compliant

Regulation 15: Staffing

The registered provider did not ensure that the number and skill mix of staff was appropriate having regard for the assessed needs of the residents, and given the size and layout of the centre. The inspector found evidence to support this finding as follows:

- A review of the staff rosters confirmed a serious and concerning shortage of healthcare staff. For example; in the main house, the staffing model requires six healthcare staff at 08.00am. The rosters for the previous three weeks showed that there was only two days when six staff were on duty. One one occassion there was only three staff on duty, on five occassions there was four staff on duty.
- The centre was not operating in line with the staffing levels outlined in their statement of purpose which states that there is a whole time equivalent of 27 healthcare assistants employed. The number of staff was found to be insufficient to meet the individual and collective needs of the residents.

Judgment: Not compliant

Regulation 16: Training and staff development

Additional training was required to ensure the provision of best practice, evidence-based nursing care with regard to the following;

- wound care management, as discussed under Regulation 6

- the modification of food and fluids, as discussed under Regulation 18

Judgment: Substantially compliant

Regulation 21: Records

All required records were maintained in a manner which made them easily accessible to the inspector. A sample of staff files viewed by the inspector contained the requirements of Schedule 2 of the Regulations.

Judgment: Compliant

Regulation 22: Insurance

The registered provider had an up-to-date contract of insurance in place.

Judgment: Compliant

Regulation 23: Governance and management

The registered provider did not ensure that the centre had sufficient staffing resources to ensure the effective delivery of care in accordance with the centre's statement of purpose. Repeated non-compliance with the regulations were found in respect of staffing and behaviours that challenge. There was no improvement in the compliance with training and staff development, infection control and fire precautions.

The inspector found that the overall management systems in place required strengthening to ensure that the service provided was safe, appropriate, consistent and effectively monitored. A number of staff had left the service and the provider relied on the existing workforce to work additional hours to make up the shortfall. The impact of this over a prolonged period was increase staff dissatisfaction and a decline in the standard of care provided. it was not evident that the provider had picked up on these issues and taken remedial action.

Increased oversight of the following areas was required, as discussed under each regulation: training and staff development, complaints management, written policies and procedures, food and nutrition, infection control, fire precautions, medication management, healthcare, and management of behaviours that challenge.

Some improvement in the centre's auditing procedures were required. For example:

- Following a recent increase in falls, an audit of falls occurring in the centre over the past six months was conducted. While this audit showed that each fall was responded to appropriately, it did not detail the timing of falls, thereby it could not determine if falls were occurring at a particular time, or whether increased staff supervision was required to reduce the occurrence of falls.
- There was no call bell audits completed in the centre, despite this function being inherent in the call bell system within the centre. As a result, it was not possible to ascertain if residents received timely attention.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

The inspector viewed a sample signed contracts of care detailing the services provided to each resident. The type of accommodation for example a single or double occupancy room was stated, along with any additional fees for services which the resident was not entitled to under any other health entitlement.

Judgment: Compliant

Regulation 3: Statement of purpose

The centre's Statement of Purpose was reviewed on October 18 2021 and was submitted as part of the requirement for the application for renewal of the centre's registration. Based on a review of staffing rosters, the inspector found that the management and staffing whole time equivalents in place were less than the staffing levels described in the Statement of Purpose.

Judgment: Not compliant

Regulation 34: Complaints procedure

The inspector found that complaints were not managed in line with the requirements of the regulation.

- Minor complaints and concerns from family or residents were seen to be documented in some instances in the Family Communication section of the resident's electronic. This meant that items were not routinely followed up

under the centre's own complaints policy
- A recent complaint had not been investigated promptly despite being brought to the attention of the management team.
- Records of complaints did not always include details of the investigation into the complaint, the outcome of the complaint, or the satisfaction on the complainant.

Judgment: Not compliant

Regulation 4: Written policies and procedures

All policies and procedures as outlined in Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 were in place. However, some of these policies required further review to ensure that they were updated with the latest evidence-based practices. For example;

- The medication management policy was last updated in 2018 and did not reflect up-to-date guidance on medication management published by the Nursing and Midwifery Board of Ireland (NMBI).
- The food and nutrition policy did not include the new international descriptors for modified food and thickened drinks. The inspector observed that the old descriptors were still in use in some notices and documents which could potentially cause errors in the modifications to food and drinks. Confusion remained amongst staff regarding the new descriptors, as outlined under Regulation 18.

Judgment: Substantially compliant

Quality and safety

Overall, the inspector found that the quality and safety of resident care was compromised by insufficient staffing levels, leading to a service that did not fully support a person-centred approach or the individual rights and choices of the residents. Additionally, further clinical oversight of medication management and the management of wound care was required to ensure residents receive a high level of evidence-based nursing care.

The centre had a detailed preparedness plan in place to manage an outbreak of COVID-19. There was evidence that learning from the company's other centres during the pandemic was shared and contributed to the good infection control procedures seen in the centre. To date, the centre had not experienced an outbreak of COVID-19. Positive cases of COVID-19 among staff had been well-managed in

line with public health guidance. The inspector identified many examples of good practice in the prevention and control of infection throughout the centre. For example; a plentiful supply of alcohol hand sanitiser dispensers throughout, twice daily symptom monitoring for residents and staff, a risk assessment conducted on all visitors the centre on arrival. There were a sufficient number of cleaning staff on duty who displayed good knowledge of best-practice cleaning procedures. Some infection control findings related to the premises required attention, as discussed under regulation 27.

The centre had a risk management policy that set out the specific risks as required by the regulations and the controls in place to mitigate such risk. There were systems in place to manage risk and as part of the risk management strategy the person in charge maintained a risk register. Systems were in place for the monitoring of fire safety precautions in the centre. the inspector reviewed the maintenance and service records of the fire equipment which were up-to-date. Staff had good knowledge of fire safety procedures in the centre and were clear on what action to take in the event of the fire alarm being activated. Each resident had a personal emergency evacuation plan in their bedroom and a copy was available at reception. The fire drill evacuation procedure required improvement to ensure it progressed to a simulated compartment evacuation and to ensure all staff are knowledgeable regarding the procedure.

Residents' records showed that comprehensive pre-admission assessment was carried out for each resident. On admission, validated assessment tools were used to identify clinical risks such as risk of falls, pressure ulceration and malnutrition. These assessments informed detailed care plans which guided staff to deliver person-centred and individualised care. The inspector examined the behavioural support plans for all residents in the memory care unit who displayed behaviours that challenge as a result of their diagnosis. Significant improvements in the content of these plans were seen since the last inspection. The plans clearly identified potential behaviour triggers and detailed the techniques to de-escalate the behaviour to ensure that these episodes were managed and responded to efficiently. Despite this, the inspector observed incidences where residents were not responded to in the manner outlined in their plans, as discussed under Regulation 7.

Residents' medical needs were attended to by a choice of General Practioner (GP) who regularly visited the centre. The GP and physiotherapist were also consulted with regarding the use of restrictive practices such as bedrails. This multi-disciplinary team approach to restraint reduction supported a low incidence of bedrail use in the centre. Residents were supported to access a range of health and social care expertise Where residents required further health and social care expertise, they were supported to access these services such as dietetics,occupational therapy, speech and language therapy and community psychiatry.

A dedicated activities coordinator implemented a varied and interesting schedule of activities. There was ample space for residents to undertake activities in small and larger groups. One-to-one activities were also offered, however, the inspector found that given the size and layout of the centre, one full time activities coordinator was insufficient to meet the social needs of the residents. In particular, residents of the

memory care unit did not have access to the range of therapeutic activation required for residents with a diagnosis of dementia.

Regulation 11: Visits

Visits to the centre were operating in line with current Health Protection and Surveillance Centre (HPSC) guidance. The inspector observed visitors arriving throughout the day. Screening measures were in place for residents visiting indoors. Visits were generally scheduled in advance, but there was flexibility in the arrangements, and short notice visits were seen to be organised on the day.

Judgment: Compliant

Regulation 12: Personal possessions

The single and twin rooms in the centre were seen to have sufficient space for residents to store and maintain their clothes and other personal possessions, including a secure locked facility for residents valuable or private items. Residents' clothing was laundered in the centre and an improved system had been put in place which was efficient. Residents' confirmed that their clothes were returned to them without delay.

Judgment: Compliant

Regulation 18: Food and nutrition

While the food served to residents was wholesome and nutritious, the inspector observed that residents did not have a sufficient choice of menu at all mealtimes. For example; in the memory care unit, each resident received the same plated up meal at tea time. Staff confirmed that they did not consult with residents about their preferences for tea time meal.

Additionally, there was no clear differential between the different levels of modification of diets for residents with a swallowing problem. For example, Level 4 and Level 5 consistency diets were identical. This is important as the level of modification is prescribed by a speech and language therapist based on the resident's individual need.

Judgment: Not compliant

Regulation 26: Risk management

There was a risk management policy in place to inform the management of risks in the centre. This contained reference to the five specified risks as outlined under Regulation 26. Risk reduction records including an emergency plan and an up-to-date risk register were in place. Risk assessments were seen to be completed and appropriate actions were taken to mitigate and control any risks identified.

Judgment: Compliant

Regulation 27: Infection control

The inspector found that the registered provider had not ensured that some procedures were consistent with the standards for the prevention and control of health care associated infections. This presented a risk of cross infection in the centre. For example:

- The memory care unit did not have dedicated sluicing facilities. The sluice room was a considerable distance from the unit. As a result, staff confirmed that they rinsed items such as urinals and wash basins in the sink after use and did not routinely bring them to the sluice room for appropriate cleaning and disinfection.
- Access to staff hand wash sinks were less than optimal throughout the centre. There was a limited number of dedicated clinical hand wash sinks in the centre; those that were in place were not in line with the current recommended best-practice guidelines.
- While efforts were ongoing to address any minor maintenance issues, a small number of the surfaces and finishes including wood finishes on doors, skirting boards, bedrails and lockers were worn and scuffed and as such did not facilitate effective cleaning.

Judgment: Substantially compliant

Regulation 28: Fire precautions

A review of recently-completed fire drills did not provide assurances that residents could be safely evacuated in the event of a fire. The centre has one large fire compartment containing 12 beds. While a simulated drill was carried out in this compartment, it was not timed and did not describe the methods use to evacuate residents or the level of assistance required. Following the inspection, the provider was requested to carry out a fire drill simulating the full compartment evacuation of

this large compartment, with night-time staffing resources. This was submitted with acceptable times. The provider is required to regularly undertake these drills with all staff to ensure all staff are competent to carry out a full compartmental evacuation.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

The inspector observed examples of poor practice with regard to medication management which could potentially lead to errors. For example;

- The inspector reviewed a medication error that had recently occurred due to the mislabelling of a medication from the pharmacy. While this had been identified and followed up on, the inspector observed that two controlled medications in use still had old labels on them which gave differing information to what was currently prescribed by the doctor.
- A sample of the medication records of short-term residents identified that there was no clear prescription in place for these residents. In one instance, there was three different copies of prescriptions for controlled pain-relieving medication which all stated different doses and frequencies of the same drug.
- A resident who had been admitted nine days previously had no prescription on file. The staff were administering the medications based of the administration sheet sent in by the pharmacy. This is not in line with best-practice guidelines.
- The medication management policy required updating as discussed under Regulation 4.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Assessments were completed to assess for various clinical risks including risks of malnutrition, pressure ulceration and falls. Care plans were in place to reflect their assessed needs. Assessments and care plan reviews took place four monthly or more frequently if required. The care plans were person-centred, detailed and updated as a resident's condition changed and in line with regulatory requirements.

There was evidence of residents being involved in the development of their care plan and their review.

Judgment: Compliant

Regulation 6: Health care

A review of residents' wound care charts found that recommended treatment as advised by a specialist wound care nurse was not always followed. A number of the wound care charts reviewed by the inspector had sporadic, inconsistent clinical measurements and dressing changes documented. For example;

- A serious wound had not had a clinical assessment documented for ten days. A brief note had been made that the dressing had been changed during that time, however this was not documented in the wound care chart and there was no detail regarding what dressings were used, whether the wound had improved and no date was assigned for further review or change of the dressing.

This was a repeat finding from the previous inspection and the centre had not implemented the measures that they had outlined in their action plan.

Judgment: Not compliant

Regulation 7: Managing behaviour that is challenging

The inspector observed episodes where staff were not available to provide the specific care requirements as laid out in their behavioural support plans. For example; in the afternoon there was two healthcare assistants and one nurse assigned to the 17 residents living in this area. The inspector observed that the nurse was busy attending to a resident who was unwell, and the two healthcare staff were attending to a high dependency resident's personal care needs in their bedroom. A number of residents were wandering around the corridors, some were becoming agitated and restless.

The inspector was not assured that there was sufficient staff to ensure an adequate level of supervision in this unit, as detailed under Regulation 15.

Judgment: Not compliant

Regulation 9: Residents' rights

The inspector was not assured that the residents had sufficient opportunities to participate in activities in accordance with their interests and capabilities. The centre employed one whole time equivalent activities coordinator who was split between the centre's main house and the memory care unit. Larger group activities took place in the main house, meaning that there was not a full schedule of therapies or

dementia-specific activities in place in the memory care unit. On the day of inspection, while some of the residents of the memory care unit attended activities in the main house, the majority stayed in the memory care unit for the day, which had no scheduled group or one-to-one activities.

Additionally, the inspector found that residents were not always facilitated to exercise choice, as evidenced by the following:

- feedback from staff and complaints log - due to inadequate staffing residents wishes in relation to bathing could not be consistently respected.
- there was a lack of choice at mealtimes, as discussed under Regulation 18.

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	
Registration Regulation 4: Application for registration or renewal of registration	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Not compliant
Regulation 34: Complaints procedure	Not compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 18: Food and nutrition	Not compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Not compliant
Regulation 7: Managing behaviour that is challenging	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Castle Gardens Nursing Home OSV-0000696

Inspection ID: MON-0034535

Date of inspection: 19/11/2021

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:

• The Person in Charge (PIC), supported by the Healthcare Manager will ensure that there is a workforce plan in place to ensure that the staffing complement detailed in the Statement of Purpose is adhered to and that the care and service needs of all residents can be met safely and effectively.

• There is an Assistant Director of Nursing (ADON) and Clinical Nurse Manager (CNM) who provide clinical oversight. Since the inspection, an additional CNM and a Senior Staff Nurse have been appointed to further enhance the clinical supervision in the home.

• The PIC produces and monitors the staff roster which sets out the required staffing numbers and skill mix for the Memory Care Centre and the main house over a 24-hour period. Rosters are produced in fortnightly cycles, and we will ensure that they are published well in advance of the start date so that staff are aware of their rostered shifts.

• The PIC will oversee the rostering of staff to ensure there is always a suitable ratio and skill-mix of clinical staff to residents to enable all care needs to be safely and effectively met; and that effective supervision, support and cohesive teamworking are integral to the culture of the nursing home.

• If rostered staff are unavailable to work due to sickness leave, every effort is made to realign the rosters so that another staff member can cover the shift(s), but if that is not possible, agency staff will be booked to replace the absent staff member.

• If there are vacant posts, we will book agency staff to cover the vacancy until the post has been filled; we will make every effort to ensure that where possible the same agency staff member is available to fill the vacancy to ensure consistency and continuity of care.

• The PIC and Assistant Director of Nursing (ADON) ensure that staff are appropriately deployed and that they are allocated appropriate duties commensurate with their skills, qualifications and abilities.

• An experienced nurse is identified on the roster to be the designated nurse in charge of the nursing home at night.

Regulation 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:

• A formal induction programme is conducted for all new staff and mandatory training courses are provided for them during their induction period.

• The induction programme for nursing and care staff includes a competency assessment of fundamental care skills, including maintaining skin integrity and assisting a resident at mealtimes. Additional training has been scheduled to ensure that all staff are aware of the terminology and descriptors used in the IDDSI framework.

• Further training has been scheduled for nurses in respect of wound assessment, classification, care planning and treatment.

• The appointment of a second CNM has strengthened the management team and this level of managerial oversight will facilitate appropriate mentorship of staff and provide opportunities to improve the quality of individualised care to residents, ensuring a strong focus on a human-rights based approach to care delivery.

• There are weekly management team meetings between the PIC, ADON and CNMs for the purpose of setting priority objectives for the week, and each nurse manager will complete regular safety rounds in the clinical areas to monitor practice and to provide support and guidance to staff.

• Staff training and development needs are discussed during the probationary period, performance appraisal and clinical supervision meetings, and staff are given the opportunity to identify any areas of training they feel would benefit them. Targeted education and training will also be facilitated in the event that there are observed staff skills deficits based on individual training needs analysis.

Regulation 23: Governance and management	Not Compliant

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

• There is a clearly defined management structure in the nursing home, which has recently been supplemented by the appointment of a second CNM since the time of inspection. Supervision will therefore be enhanced.

• We plan to recruit healthcare staff from outside of the EU and several of the currently vacant positions will be filled with these staff. This will enhance the local and national recruitment programme.

• The PIC is aware of all operational issues in the nursing home as there are regular communication meetings, midday Safety Pauses and handover meetings held. Staff discuss any residents who have any change in their needs or health status.

• A comprehensive review of complaints management has taken place and all logged

complaints will be reviewed by the PIC and HCM together, to ensure that the issues and concerns raised have been acknowledged, investigated, addressed and resolved satisfactorily.
• Additional staff education and training will be provided to address fundamentals of care, including management of responsive behaviours, wound care and assistance with meals.
• Weekly fire drills simulating night-time conditions will be conducted in the home to improve compliance with fire safety procedures and increase staff awareness of actions to take in the event of a fire.
• There is an audit schedule in place to monitor key aspects of care in the home and appropriate quality improvement plans have been identified and implemented to address any areas of non-compliance. This includes medication management audits, and the PIC will also undertake a weekly review of medication management in the home to ensure improved compliance and safe administration of prescribed medicines.
• The electronic care record includes a record of all falls incidents, including the location and time of the fall, and identifies the frequency of fall by each resident. We are working to reduce the incidence of falls in the home, and we will monitor falls closely.
• The PIC will complete a monthly call bell audit to analyse the average response times to resident call bells.

Regulation 3: Statement of purpose	Not Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
• The Statement of Purpose has been reviewed and updated to reflect the whole- time equivalent of available staff.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
• The PIC, ADON or CNMs are readily available to residents and relatives, meeting regularly with them to ensure that they have an opportunity to discuss any issues, concerns or suggestions. The management team will be supported and encouraged to foster a responsive attitude and an open and transparent culture in the home.
• The nursing home management team welcome suggestions and feedback from residents, relatives/representatives and visitors, as this provides an opportunity for experiential learning and drives continuous quality improvements.
• We will ensure that all complaints are followed up and assurance given to complainants

that their concerns and complaints are taken seriously. We will assure them of our commitment to investigate fully and respond to the issues raised,, taking corrective action where indicated.
• All complaints will be acknowledged, investigated and addressed in line with the Complaints Procedure in the nursing home.
• We will analyse the feedback from residents and their families, identify any common themes and trends, and implement quality improvements to prevent recurrence.
• We will monitor the satisfaction of complainants following the investigation and response to their complaint and inform them of corrective actions and quality improvements implemented as a result, so that they can be assured that their complaints have been taken seriously and that decisive action has been taken to prevent recurrence.
• The PIC and/or Healthcare Manager will arrange to meet complainants to review individual complaints, discuss strategies to prevent recurrence and provide reassurance that quality of care and service will be improved, and lessons learned from their feedback.
• We will ensure that complainants have access to an appeals process if they remain dissatisfied with the outcome of their complaint.

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
• The most recent versions of the Medication Management Policies were last updated in April 2021 and are available in hard copy and electronically within the centre. These policies include the most up to date guidance in accordance with the Nursing & Midwifery Board of Ireland (NMBI).
• Policy QL-002 Provision of Therapeutic and Modified Consistency Diets March 2020 will be reviewed and updated to reference the most recent IDDSI guidelines in respect of the terminology used for diet & fluid recommendations for people with dysphagia/modified diets.

Regulation 18: Food and nutrition	Not Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
• The PIC has reviewed the service of meals and in particular the choice available to residents in the Memory Care Unit. Meals will be served individually at the point of service as opposed to being pre-plated; this will allow residents to choose from the items

on the menu at the time of their meal and will facilitate appropriate portion sizes based on individual residents' preferences.
• We will ensure that residents are consulted about their preferences for the evening meal, and we will provide sufficient alternatives at teatime.
• Training is planned to ensure that all staff including catering staff are aware of the IDDSI framework used for diet & fluid recommendations and levels for people with dysphagia / modified diets. All previous guidelines and references have been removed.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
• The PIC will ensure that all staff have been inducted to include the procedures they are required to complete as part of their IPC role in relation to the use of sluicing facilities.
• A survey will be completed in relation to the available space for an additional sluice room within the Memory Care Unit.
• A survey will be completed in relation to the installation of handwashing facilities to ensure there are sufficient clinical hand washbasins available within a reasonable distance of the residents' bedrooms.
• A programme of decorative upgrade has commenced prior to inspection and is ongoing; the surfaces and finishes, including wood finishes on doors, skirting boards, bedrails and lockers will be addressed as part of this upgrade plan.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• The PIC will ensure that all staff have participated in a fire drill to ensure staff have the knowledge and skills to safely evacuate residents in the event of a fire.
• A night-time simulated drill will be conducted in the large compartment on a weekly basis; it will be timed, and the methods used to evacuate residents and the level of assistance required will be described in the drill evaluation record.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services: • A pharmacy audit of the medications management and storage has been scheduled. • Internal medication management audits are completed every three months in line with the Company audit management system. • We will ensure that short-term residents have the same format of prescription chart as long-term residents to maintain a consistent approach to the management and administration of prescribed medications. • Twice weekly medication management checks will be commenced which will ensure that all new admissions have a current prescription chart and kardex. • The PIC will ensure that any non-compliances are managed in line with the medication management policy. • A system of record review on admission has been introduced which includes a checklist for the PIC and nurses to check and sign for prescriptions received. • All nurses are to update their medication management training. • The medication management policy in place in hard and electronic copy in the centre was last reviewed in April 2021. All other policies in circulation have been removed.	
Regulation 6: Health care	Not Compliant
Outline how you are going to come into compliance with Regulation 6: Health care: • The PIC, ADON and CNM have provided clinical oversight to ensure that all residents' assessments and care plans including wound care plan, have been reviewed by the named nurses. • Training updates for nurses in relation to wound care have been arranged and will include the assessment of acute & chronic wounds, Phases of Healing, Wound Assessment, Wound Infection, Factors that interfere with healing, Moist wound healing, Cleansing & Swabbing, Types of wound bed & treatment, Dressings, Skin Tears, Burns and Record keeping/care planning. • There is a wound assessment and care plan in the electronic care record, which will be completed for all residents who have a wound. This includes an assessment with photographs and, if required, a body map and a pressure area management plan can be completed, if indicated. This care plan also includes a review date for dressing care and further assessment. • Communication from the Tissue Viability Nurse (TVN) is included in each resident's wound care notes providing further support and direction in the healing of a wound.	
Regulation 7: Managing behaviour that	Not Compliant

is challenging	

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
• Residents who present with Behavioural and Psychological Symptoms of Dementia will be assessed, using an Antecedent, Behaviour and Consequence chart which will be recorded to analyse patterns of behaviour and to identify the triggers for their responsive behaviours and de-escalation techniques.
• A Responsive Behaviour care plan will be drawn up on this basis which will ensure a consistent and sensitive approach by all staff towards the resident.
• The PIC will regularly review the Responsive Behavior care plans to ensure triggers are properly identified. These will be discussed with staff. Through reflective practice discussion, individual strategies to de-escalate and prevent further recurrence will be identified and documented.
• The PIC has reviewed the hours and deployment of staff within the home. This includes additional care hours now allocated to the Memory Care Unit.
• The Social Care Practitioner has been deployed specifically to the Memory Care Unit and has protected hours to facilitate the provision of social care and meaningful activities for the residents.
• A plan of social activities has been developed to meet the needs of the residents in both units based on their choices and preferences. The Activity Coordinator oversees the delivery of activities in the main house.
• We will ensure that when residents' care needs are no longer benefitting from living in the Memory Care Unit, they are transferred to the main house following consultation with the resident and their designated representative/next of kin. This will ensure that a strong focus can be maintained on managing the behavioural and psychological symptoms of dementia for residents in the Memory Care Centre

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• Human rights approach: A human rights approach is in place in relation to the care and welfare of residents. For example, residents will be facilitated, monitored and supported in the home to live as independently and safely as possible. Their rights are always respected, and the PIC will implement a risk-balancing approach to ensure that individual rights, choices and decisions are upheld.
• We will consult with residents and their families to ensure that we respect their choices and preferences.
• The PIC, ADON and CNMs will oversee that the residents have sufficient opportunities to participate in activities in accordance with their interests, capabilities and preferences. They will also oversee that staff offer residents choice in relation to their care needs and menu choices.
• The Social Care Practitioner has protected hours for overseeing social care and activities in the Memory Care Unit; these hours have bee increased, which has enabled

us to introduce 3 sessions daily of dementia-specific activities.
• The Occupational Therapist visits weekly and assesses residents' needs as required.
• The Activities Coordinator is based in the main house and has scheduled group or one-to-one activities.
• The Social Care Practitioner and Activities Coordinator are scheduled to attend training that will enhance the provision of activities in the centre.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	10/01/2022
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	31/01/2022
Regulation 18(1)(b)	The person in charge shall ensure that each resident is offered choice at mealtimes.	Not Compliant	Orange	31/01/2022
Regulation 18(1)(c)(iii)	The person in charge shall ensure that each resident is provided with adequate	Not Compliant	Orange	31/01/2022

	quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietetic staff, based on nutritional assessment in accordance with the individual care plan of the resident concerned.			
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	31/01/2022
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	31/01/2022
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated	Substantially Compliant	Yellow	30/09/2022

	infections published by the Authority are implemented by staff.			
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	10/01/2022
Regulation 29(5)	The person in charge shall ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.	Not Compliant	Orange	28/02/2022
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose relating to the designated centre concerned and containing the	Not Compliant	Orange	

	information set out in Schedule 1.			
Regulation 34(1)(d)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall investigate all complaints promptly.	Not Compliant	Orange	31/01/2022
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.	Not Compliant	Orange	31/01/2022
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where	Substantially Compliant	Yellow	31/01/2022

	necessary, review and update them in accordance with best practice.			
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.	Not Compliant	Orange	31/01/2022
Regulation 7(2)	Where a resident behaves in a manner that is challenging or poses a risk to the resident concerned or to other persons, the person in charge shall manage and respond to that behaviour, in so far as possible, in a manner that is not restrictive.	Not Compliant	Orange	31/01/2022
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and	Not Compliant	Orange	31/01/2022

	capacities.			
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Not Compliant	Orange	31/01/2022