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:	CareChoice Malahide
Name of provider:	CareChoice Malahide Road Ltd
Address of centre:	Mayne River Street, Northern Cross, Malahide Road, Dublin 17
Type of inspection:	Announced
Date of inspection:	04 June 2024
Centre ID:	OSV-0005205
Fieldwork ID:	MON-0034763

About the designated centre

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

Carechoice Malahide Road Limited operates Carechoice Malahide a modern purpose-built centre situated in north Dublin. The centre is located close to amenities such as restaurants, a hotel and a nearby shopping centre. General nursing care is provided for long-term residents, also respite and convalescence care for people aged 18 years and over. Registered general nurses lead a team of healthcare assistants and support staff to provide all aspects of care. Palliative and dementia care can also be provided and there is access to a specialist geriatrician, psychiatry and a physiotherapist. The centre can accommodate up to 165 residents, and has both single and twin en-suite double bedrooms available on all floors except the fifth floor which is a recreation and training space.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	143

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
Tuesday 4 June 2024	08:00hrs to 16:40hrs	Karen McMahon	Lead
Wednesday 5 June 2024	08:00hrs to 15:10hrs	Karen McMahon	Lead
Tuesday 4 June 2024	08:00hrs to 16:40hrs	Catherine Rose Connolly Gargan	Support
Wednesday 5 June 2024	08:00hrs to 15:10hrs	Catherine Rose Connolly Gargan	Support

What residents told us and what inspectors observed

The overall feedback from residents' was that they liked living in CareChoice Malahide. The inspectors spoke with a number of residents and spent time observing residents' routines and care practices in the centre in order to gain insight into the experience of those living there. Residents' spoken with were complimentary of the staff and said they were very friendly and caring. The inspectors also spoke with a number of visitors. In general visitors were happy with the care their loved ones received in the centre but told the inspectors that sometimes they felt that there loved ones were bored and that there was a lack of social interaction, particularly in the afternoons.

On arrival to the centre, on the first day of the inspection, the inspectors were met by the reception staff, who guided them through the sign in procedure. After a brief introductory meeting with the person in charge and two assistant directors of nursing both the assistant director of nursing and clinical nurse manager escorted the inspectors on a tour of the premises.

The centre premises is built in a mixed residential and commercial area of Dublin city and is set out over six floors. A car park was available on the basement floor which facilitated residents, staff and visitors to park in a sheltered area with direct access to the centre. Residents' accommodation was arranged over the ground floor to the fourth floor. These floors were individually known as Birch, Willow, Rowan, Sycamore and Ash. Resident's accommodation comprised of 147 single and 18 twin occupancy bedrooms. All bedrooms had full en suite facilities

A spacious open plan area on the fifth floor was generally used for residents' group social activities and other events. Residents had access to a number of communal day spaces and a dining room on each floor. The ground floor, which was known as the birch unit was a dedicated dementia unit that provided bedroom accommodation for 17 residents.

The inspectors' observed that most parts of the residents' lived environment was adequately maintained, however, repainting on some damaged wall and door surfaces was needed. There were suitable ancillary services throughout the building, including appropriate hand washing facilities.

The inspectors' visited a number of residents' bedrooms and observed that most were in a good state of repair and were bright, spacious and comfortable. Many of the residents had personalised their rooms with their photographs and other personal possessions from home. However, the inspectors observed that paint on the walls and doors of a small number of residents' bedrooms was damaged and missing and the knob handles to open the wardrobe doors and drawers were loose or missing. The window blinds in some bedrooms were falling on one side. Feedback from both residents and visitors was that some residents were admitted into

bedrooms that were not in a good state of repair. This was validated by the inspectors' findings in some bedrooms.

Although, the bedrooms were spacious, some residents didn't have enough furniture to store their personal possessions. For example, the inspectors saw that in the absence of adequate wardrobe space, one resident had their personal clothing and other other belongings in bags built on top of each other in a space between their wardrobe and the adjacent wall. In the absence of a suitable shelf space, another resident stored their books on a table which meant they could not use this table.

With the exception of the sitting room on the dementia unit, which the inspectors observed was dark even with artificial lighting switched on, the communal sitting and dining rooms on the other floors were bright with large windows that gave the residents views of the surrounding areas of the city. Some residents liked to watch aeroplane traffic flying in and out of the local airport. Resident's artwork was displayed in the communal rooms on each floor and the inspectors observed that this made these areas comfortable and familiar for the residents who liked to spend time in them. Many of the residents were observed up and mobilising around the centre or going out to spend time sitting out to the garden. There was a coffee machine available in the reception area. This facility was availed of by some residents who were observed enjoying a coffee during the day by themselves or with their visitors in the spacious reception area.

The inspectors observed residents' lunchtime meal. Most residents chose to eat their meals in the dining room located on each floor. With the exception of the dining room on the dementia unit, the residents' dining rooms were spacious and well laid out with enough space between the tables for residents to comfortably and safely move around these rooms as they wished. The daily menu included pictures of the meal options and were displayed on boards outside each dining room. There was a choice of hot main meal options and a choice of desert. Residents' lunchtime meal was observed to be well-presented, warm and with ample amounts on the plate. Residents' comments to the inspectors regarding their meals included, 'food is always very nice', ' there is plenty of choice on the menu', ' can have other dishes if don't like the menu options' and 'never hungry here'. There was sufficient staff available in the dining rooms to provide discreet assistance to residents as needed without any delay. There was also a choice of a hot or cold option for residents' evening meal.

The inspectors observed the residents' lunchtime meal on the specialist dementia unit on both days of the inspection. Residents meals were transported to the unit in a heated trolley and then transferred to a serving unit in the dining room for plating by a member of staff. On the first day of the inspection, the inspectors observed that there was not enough dining tables and chairs to facilitate all the residents to sit together during their mealtimes. This was addressed with the provision of an additional table and chairs on the second day of the inspection. While most of the staff were observed to respectively assist residents with their meals the inspectors observed that one resident's expressed wishes regarding their dining choice was not respected by the staff member. The inspectors also witnessed that a staff member did not appropriately respond to and manage another resident's responsive

behaviour during one meal time. The inspectors observed that no senior staff intervened to ensure that these residents' needs were met and their rights were respected.

The inspectors observed many of the residents going out to the large enclosed garden which was readily accessible through doors on the ground floor. The enclosed garden was beautifully landscaped with a variety of colourful flower and shrub beds and small trees. Larger trees along one side of the perimeter provided shelter for the outdoor seating. There were winding pathways throughout which were accessible to wheelchair users. A small greenhouse with raised planting beds was available to residents with an interest in gardening. There was a covered designated smoking area also located in the garden with appropriate fire safety equipment and a call bell facility. However, resident's on the dementia unit, who wished to access this garden or any other outdoor space had to wait for a staff member to unlock the door of the dementia unit for them.

The inspectors observed that residents were meeting their visitors throughout both days. Visitors who spoke with the inspectors said they were always made to feel welcome and they could meet the resident in their bedrooms or in a number of private spaces provided.

The inspectors observed residents participating in the social activities scheduled during both days of the inspection, however, the social activities taking place were limited. For example, during the afternoon, on the first day of the inspection, a large number of residents were observed to participate in a music quiz on the fifth floor. On the second day a number of residents were observed excitedly waiting on transport to take them on a day trip on a tour of a chocolate factory. However, there were no meaningful and socially simulating activities seen taking place on the units for the residents who did not attend the music quiz or go on the trip. Residents were observed in the sitting rooms on each floor. The seating was arranged around the perimeter and across the middle of these rooms and residents were sitting, in front of the televisions or sleeping in their chairs. Two residents in two of the sitting rooms were observed by inspectors to become agitated with other residents. Staff present in the rooms did not intervene and continued to work on hand held computer pads.

These observations were validated by residents. While some residents told the inspectors that they enjoyed the social activities on the fifth floor, other residents' feedback included 'nothing available that interests me', 'I keep myself occupied', 'look forward my family coming in' and 'I go for walks in the garden to pass the time'. Some of the residents told the inspectors that they liked to read and they had reading material available to meet their interests. On the first afternoon, on the dementia unit, the television was on with the sound turned down and music was playing over it. Four residents were sitting around an interactive table, however two of the residents were observed sleeping and the other two residents were not engaging in the interactive activity. While a staff member was present with these residents at the table they were not guiding or encouraging the residents to take part.

The next two sections of this report present the inspection findings in relation to the governance and management in the centre, and how governance and management affects the quality and safety of the service being delivered. The areas identified as requiring improvement are discussed in the report under the relevant regulations.

Capacity and capability

Although, the provider aimed to provide a good service that optimised residents' rights and quality of life, this inspection found that management and oversight systems that were in place did not ensure that the service was safe and appropriate and that residents' quality of life was optimised and that residents were supported to lead their best lives especially those residents living with dementia.

This announced inspection was completed to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). The inspectors also followed up on the actions the provider had committed to take in their compliance plan following the previous inspection in May 2023 and on the statutory notifications and unsolicited information received since the last inspection. The provider had applied to the Chief Inspector for renewal of the registration of Care Choice Malahide and this application was reviewed as part of this inspection.

The registered provider of CareChoice Malahide is CareChoice Malahide Road Limited. The provider was represented by the company's chief executive officer who attended the second day of this inspection. As part of a group who operate a number of designated centres for older people, CareChoice Malahide designated centre benefits from access to and support from the provider group resources including a human resource department, staff training and development, clinical practice development, finance and information technology services.

The designated centre's local management structure consisted of a person in charge who worked full time and was supported by two assistant directors of nursing and five clinical nurse managers, one on each floor accommodating residents. There was an established clinical management team within the designated centre with defined roles and responsibilities. While there were clear deputising arrangements in place for when the person in charge was absent.

On the day of the inspection, inspectors found that there was sufficient staffing levels and skill mix in place. A member of the clinical management team worked in the designated centre every day, including weekends.

There was an ongoing mandatory training programme in the centre. The training matrix provided to inspectors recorded overall high levels of attendance at mandatory training such as infection control and safeguarding. There was a training

schedule in place for the year to ensure all staff training was kept up-to-date. However, improvements were required around the supervision of staff to ensure residents' needs were met and that they were appropriately safeguarded and supported. This is further detailed under Reg 16: Training and staff development.

There was an accessible complaints policy and procedure in place to facilitate residents and or their family members lodge a formal complaint should they wish to do so. The policy clearly described the steps to be taken in order to register a formal complaint. This policy also identified details of the complaints officer, timescales for a complaint to be investigated and details on the appeal process should the complainant be unhappy with the investigation conclusion.

The complaints log was made available to the inspectors for review. There were no current open complaints. A number of the closed complaints were reviewed. Inspectors found one of these complaints reported an alleged safeguarding concern in respect of an act of neglect. While the allegation had been appropriately investigated and dealt with, under the complaints procedure, the allegation had not been recognised as a safe-guarding concern and as a result had not been followed up in line with the provider's safeguarding policy. Furthermore, a review of the records of residents finances and pension agent arrangements, found that an identified suspicion of financial abuse had not been responded to in line with the safeguarding policy. These safeguarding concerns were not notified to the Chief Inspector within the required time frame. They were submitted retrospectively following the inspection.

While information were maintained regarding residents' admissions and discharges, this information was not maintained in a directory that contained the information as specified in Regulation 19: Directory of Residents.

Registration Regulation 4: Application for registration or renewal of registration

A completed application applying for the renewal of the centre’s registration had been received by the Chief Inspector prior to the inspection and was under review at the time of this inspection.

Judgment: Compliant

Regulation 15: Staffing

There were sufficient staff on duty to meet the needs of the residents and taking into account the size and layout of the designated centre. There was at least one registered nurse on duty, on each floor, at all times.

Judgment: Compliant

Regulation 16: Training and staff development

Staff were not appropriately supervised to ensure that they carried out their work to the required standards. This was evidenced by the following findings;

- Staff did not recognise that the overly restrictive practices and routines infringed the rights of many of the residents living in the centre. For example, it was accepted practise the residents on the dementia unit did not have unrestricted access to the fifth floor where residents' social activities were facilitated and did not have unrestricted access to a safe outdoor area.
- Staff did not appropriately respond to and provide adequate support for residents experiencing responsive behaviours. This was not identified by senior staff on the day.

Judgment: Substantially compliant

Regulation 19: Directory of residents

A directory of residents that contained the information as specified in paragraph 3 of the regulation was not available for review by the inspectors.

Judgment: Substantially compliant

Regulation 23: Governance and management

The registered provider's oversight of the management systems in place needed strengthening to ensure the service provided was safe, appropriate, consistent and effectively monitored. For example:

- The oversight of fire safety precautions was not effective and did not ensure that fire safety risks were addressed in a timely manner. These findings are set out under Regulation 28.

- The oversight of a social engagement action plan for the specialist dementia Birch unit which had been implemented in March 2023 had no robust plan for evaluation. As a result the provider could not be assured that the initiative was being having a positive impact for the residents. On the day of inspection inspectors observed the same issues with social engagement on this unit, as highlighted in the reasoning for the action plan.
- The oversight of incidents failed to identify two incidents that constituted safeguarding concerns. As a result these incidents/complaints were not followed up in line with the provider's safeguarding policy to ensure residents were protected. These findings are set out under Regulation 8.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

Inspectors reviewed a sample of four contracts of care between the resident and the registered provider and saw that they clearly set out the room occupied by the resident, details of any fees payable by the resident and services that were not covered by the Nursing Home Support Scheme thus incurred an additional charge.

Judgment: Compliant

Regulation 31: Notification of incidents

Not all incidents required to be notified to the Chief Inspector were notified. During the inspection, the inspectors identified that two notifiable incidents had occurred; however, the Office of the Chief Inspector had not received the appropriate notification. The person in charge submitted the required notification retrospectively.

Judgment: Not compliant

Regulation 34: Complaints procedure

There was a policy in place that was reflective of regulatory requirements. There was information about the complaints process displayed on the walls in the centre.

Judgment: Compliant

Quality and safety

Overall, the inspectors found that residents' clinical and nursing care needs were being met to a satisfactory standard. However, actions were necessary to ensure residents were adequately supported to participate in meaningful social activities that met their interests and in line with their individual capacities. Whilst staff knew residents well in the dementia unit, the inspectors observed that care provided for these residents was predominantly task orientated which did not ensure their quality of life was optimised or that their rights were respected.

The inspectors found that restrictions on residents' access were not in line with the national restraint policy. Keycode locks on the passenger lift prevented a number of residents from independently accessing their private and communal accommodation during the day and limited their opportunities to participate in the social activities taking place on the fifth floor. Restrictions in the dementia unit also could not access the enclosed outdoor garden without the assistance of staff to unlock the secured door into this unit. This was having a negative impact on residents' quality of life and well being and did not uphold their rights to determine how and where they spent their day.

Residents were provided with satisfactory standards of nursing care and had access to timely health care from their general practitioner (GP) and to allied health professionals and psychiatric services who attended the residents in the centre as necessary. The provider employed a physiotherapist who provided treatments for residents on five days each week. This service optimised residents' health, continuing independence and clinical well being.

Residents' care documentation was not kept up-to-date and consequently could not be relied on to clearly direct staff on the care they must provide to meet each resident's needs.The inspectors' findings are discussed under Regulation 5: Individual Assessment and Care Plan.

A number of residents with dementia experienced responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). While staff had completed training to support them with responding to and managing residents' responsive behaviours, this training was not effective as staff were observed by the inspectors to fail to appropriately respond to residents' responsive behaviours on the days of the inspection.

Although, measures were in place to safeguarded residents residents' from abuse, the systems in place including staff training were not effective and witnessed safeguarding incidents were not identified and appropriately addressed to ensure residents' safety.

The inspectors found that ongoing maintenance was necessary to ensure all areas of the premises were in a good state of repair and were adequately maintained for the

comfort and safety of the residents. Actions were also found to be necessary to ensure that there was adequate storage available for residents' assistive equipment and personal storage in their bedrooms.

While, measures were in place to protect residents from risk of fire, the inspectors were not assured regarding residents' safe evacuation and protection from the risk of fire. Furthermore, the provider had developed a document referencing the risks identified in a fire safety risk assessment completed in 2023, but a time-bound plan to address the risks identified in this fire safety risk assessment was not clearly established and therefore the provider could not be assured that the identified risks were effectively addressed and fire safety in the designated centre.

The designated centre's risk management policy was received and reviewed by the inspectors prior to this inspection and was found to include all information as required by the regulations.

Residents had access to local and national newspapers and radios. Although, staff made some efforts to provide residents with opportunities to participate in meaningful activities to fulfil their interests and capabilities, there was limited meaningful social activities available on the day of the inspection for many of the residents including residents with dementia. This was also reflected in feedback from a number of residents who mostly occupied themselves with looking at the television. These findings are set out under Regulation 9.

Regulation 10: Communication difficulties

A number of residents had communication needs and while most residents' needs were identified and addressed in their care plans, the information in the care plan of one resident with significant visual needs, did not clearly set out the supports and assistance this resident needed from staff to meet their communication needs and their safety including an appropriate assessment of the resident's environment.

Judgment: Substantially compliant

Regulation 12: Personal possessions

Three bedrooms viewed by the inspectors over the two days of inspection did not have enough storage for residents to store their personal belongings.

Furthermore, residents in one twin bedroom did not have a suitable shelf surface to display their personal photographs and other items of value to them.

Judgment: Substantially compliant

Regulation 17: Premises

The designated centre did not conform to all of the matters set out in Schedule 6 of the regulations. For example;

- There was not enough storage space provided for residents' assistive equipment. For example, the inspectors observed storage of hoists, clean linen and used linen trolleys stored along the corridors used by residents on each floor. This storage hindered residents' access to the handrails along the corridors and posed a risk of injury to residents accessing these corridors.
- Grab rails were not in place on both sides of the toilets in many of the resident' en suite toilet facilities. This finding did not promote residents' independence and safety.
- The paint on the wall and door surfaces in a number of residents' bedrooms was damaged and missing. This meant that these surfaces were unsightly for the residents and could not be effectively cleaned.
- Emergency calls bells were not fitted in the toilets signposted for 'visitor and staff' use which were located on each floor and in the reception area. The inspectors observed that these toilets were being used by residents on both days of the inspection. This posed a risk of delay with seeking staff assistance in an emergency.
- The knobs on the doors and the drawers on a number on residents' wardrobes were missing or were loose.
- Parts of the wooden radiator covers on a number of radiators including in residents' bedrooms were in need of repair.
- The water tap in the visitors and staff toilet on the ground floor was not fitted securely to the sink.

Judgment: Substantially compliant

Regulation 26: Risk management

An appropriate risk management policy was in place and in accordance with the regulations.

Judgment: Compliant

Regulation 28: Fire precautions

The registered provider was failing to meet the regulatory requirements on fire precautions in the centre and inspectors were not assured regarding residents' safe evacuation and protection in the event of a fire emergency. This was evidenced by the following findings;

- Effective containment of fire and smoke in the event of a fire in the centre was not effective. The inspectors found that there were gaps in a number of cross corridor fire doors. This non compliance was identified in a fire safety risk assessment (FSRA) completed in 2023 by the provider and had not been addressed at the time of this inspection.
- Inspections of fire doors which were completed on a monthly basis and not weekly as recommended were not effective.

The simulated emergency evacuation drills could not be relied on for assurances regarding residents' safe evacuation in the event of a fire in the centre as evidenced by the following findings;

- There was no reference to calling the emergency services.
- There was no reference to supervision of residents with assessed post evacuation supervision needs due to their cognitive impairment.
- The number of staff who participated in the simulated night time emergency evacuation drills did not reference all of the staff available in the centre at the time the evacuation was simulated.
- A recent simulated evacuation drill identified areas needing action which included an error regarding the incorrect mapping of one bedroom in the fire alarm system. There was a delay of nine days with effectively addressing this error. It was not clear whether the other areas needing improvement were addressed at the time of the inspection.
- A two-way radio system was used to support the centre's emergency evacuation strategy but no reference was made to use of this system in the records of the emergency evacuation drills to allow evaluation of its effective use.

There was no clear time bound action plan to address the findings of the fire safety risk assessment that was completed in 2023. As a result the provider could not provide adequate assurances that they were addressing the risks in a timely manner.

The fire safety risk assessment had not identified the risks associated with storing combustible items in a cupboard accommodating the information technology equipment wires. As a result there was no risk management plan in place to address this risk.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

While, each residents' needs were regularly assessed, actions were necessary to ensure that residents' care documentation was updated to clearly direct staff regarding the care interventions they must complete to meet each resident's assessed needs and to ensure that pertinent information regarding each resident's care is effectively communicated to all staff. For example;

- one resident's care plan stated that they were independent with eating and drinking but inspectors observed that they were provided with full staff assistance with maintaining their nutritional needs.
- while a number of residents' skin integrity care plans stated the relevant information regarding the type of pressure relieving mattress on their beds, the pressure dialled into the pump on the mattress on one the resident's bed significantly exceeded their weight. This resident had developed a pressure ulcer in the designated centre.
- the pressure relieving mattress on the bed of another resident who had developed a pressure ulcer in the centre, was not as referenced in their care plan.
- a number of residents' personal care plans did not include adequate detail regarding their individual preferences and usual routines to ensure their needs were met.

Although, information was detailed in residents' care regarding a social activity programme, this was not informed by a meaningful assessment of their interests and capacities. As a consequence, many of the residents did not participate in the social activities facilitated in the centre as confirmed by the inspectors' observations, the records maintained of the social activities residents participated in and residents' feedback.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had timely access to their general practitioner (GP), allied health professionals, specialist medical and nursing services including psychiatry of older age, community palliative care and tissue viability specialists as necessary. An on-call medical service was accessible to residents out-of-hours, as needed. A physiotherapist was employed to complete residents' mobility assessments and provide treatments on five days every week. This had a positive impact on residents' well being and continuing independence. Residents were supported to safely attend out-patient and other appointments.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

The inspectors observed that one resident experiencing responsive behaviours was not appropriately supported by staff.

Restrictions posed by keycode locks on the doors to the passenger lifts on each floor was overly restrictive and did not reflect national policy guidance. These restrictions did not ensure that residents could mobilise between the floors and access the fifth floor where social activities for residents were taking place without having to seek staff assistance to unlock the keycode lock on the passenger lift doors.

Furthermore residents in the dementia unit could not access their outdoor space as they wished without having to wait for staff to assist them with opening the keycode lock on the entrance door to the dementia unit. A risk assessment was not in place for each resident to record what the risks were and what non-restrictive interventions were tried to manage the risk prior to implementing restrictions preventing residents from freely accessing their lived environment.

Judgment: Not compliant

Regulation 8: Protection

While staff had access to safeguarding training, this training did not ensure that all staff had adequate knowledge and skills to protect residents. Despite a high record of attendance at safeguarding training inspectors found records of two safeguarding incidents which had not been recognised and responded to in line with the registered provider's safeguarding policy. This failure to recognise safeguarding concerns creates a significant risk for residents.

Judgment: Not compliant

Regulation 9: Residents' rights

There was an overall lack of meaningful social activities available for residents in the centre, which meant that, for the most part, residents were not participating in activities that interested them and in line with their capacities. For example:

- Not all residents had equal access to the social activities scheduled on the days of the inspection. For example, a live music session on the fifth floor was scheduled for residents in the dementia unit on one afternoon but only one resident was supported to participate in this activity. The inspectors were told that not all residents could attend as there was not enough staff available to support them.
- An accredited sensory focused programme for residents living with dementia was no longer available as staff trained in this programme no longer worked in the centre.
- Many residents were seen to be sleeping in chairs or sitting in front of the television for long periods, throughout the days of inspection.
- Records available of individual residents' participation in social activities were limited and not consistently recorded. The records available did not demonstrate that residents had regular access to social activities reflecting their interests and capacities.
- Activity rooms were available on most units in the centre but, notwithstanding the communal area on the 5th floor, they were observed not to be used throughout the inspection.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 4: Application for registration or renewal of registration	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication difficulties	Substantially compliant
Regulation 12: Personal possessions	Substantially compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for CareChoice Malahide OSV-0005205

Inspection ID: MON-0034763

Date of inspection: 05/06/2024

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 16: Training and staff development	Substantially Compliant

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

• As of 16.7.24 Safeguarding training will be delivered face to face.to improve the effectiveness of the training delivered. Toolbox Talks on Restrictive Practices and Residents' Rights will be a part of the daily huddle.
• A designated trained Dementia link person (CNM) is in place to deliver continuous education, monitoring staff practices and to oversee various aspects of Dementia Care.
• A Practice development programme has been commenced to improve practices and to support staff supervision.
• The ADON/CNMs are enrolled in HSELanD safeguarding training on safeguarding for designated officer due to be completed on 4th September 2024.
• As of the 01.07.24 the ADON's/CNM are allocated specific floors/units to increase staff supervision. The Restrictive Practice usage is regularly monitored through weekly/monthly KPI. A restraint register log is maintained on all units and the staff are aware of the Restrictive Practice usage and control measures in place.
• Access to the 5th Floor and to the outdoor area for residents in the Dementia unit is facilitated in a safe manner and a keypad lock system is in situ. Butterfly codes are displayed for all residents and visitors who wish to access these areas independently/or accompanied by family/friends. Where a resident require assistance, staff are available to assist them to access to this area in a safe manner. The coded doors are deemed as environmental restraint and is included in the HIQA quarterly submissions.

Regulation 19: Directory of residents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 19: Directory of residents:

• A Directory of residents is available in digital format on electronic recording system which contains all information required and can be accessed at any time. On the day of inspection, the inspector was informed that the Centre moved from the paper format to an electronic format in 2019.
• A full review of the Digital Directory of residents was completed to ensure that all records specified as per as per Paragraph 3 of the regulation is available to access when required.

Regulation 23: Governance and management	Not Compliant

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

• The findings that are pertaining to fire safety is addressed under Reg 28: Fire Precautions.
• A review of the social engagement plan in the Dementia Friendly unit that was completed in 2023 and any outstanding actions are being reviewed. Capital investment project underway to address the outstanding action.
• The PAL assessment is being reviewed by CMT in conjuction with Governance team. CMT will trial the PAL assessment and evaluate the effectiveness of this before implementation.
• All residents currently have a Meaningful Activity Assessment, A life story, Barthel index, MMSE and Comprehensive assessment completed on admission, and this is reviewed on a minimum four monthly basis. These assessments are in place to assess the residents' ability to engage in social activities and are documented in the resident care plan. Activity coordinators will collaborate with the nursing team to capture the changing needs of the residents to ensure that each resident's ability to participate in the social engagement programme is gauged on a regular basis.
• The findings pertaining to Safeguarding incidents are addressed under Regulation 8: Protection.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:

• Resident behaviours and related changes are documented in the electronic recording system and subsequently reviewed by the clinical management team. All incidents are recorded and reviewed by CMT to ensure necessary actions are taken in response to any alleged abuse. Where a peer-to-Peer Incident has occurred, it is notified to HIQA in line with the regulations.
• Monthly review of incidents and complaints will be completed by Regional Director of Clinical Operations and monitored by Governance team to ensure that all Safeguarding incidents are notified to HIQA in a timely manner.
• The PIC has submitted the NF06 retrospectively for the alleged neglect by a family member of a resident which was raised by the resident advocate as a possible concern. The PIC will ensure all notifiable incidents are notified to the Chief Inspector within the timeframes as set out in the Regualtions.

Regulation 10: Communication difficulties	Substantially Compliant

Outline how you are going to come into compliance with Regulation 10: Communication difficulties:

• The Careplan on the resident who required asisstance due to limited vision that was flagged in the report has been completed and is now updated to include the level of assistance required by the resident.
• A full review has been conducted into all resident's communication careplan to ensure all relevant information is available for staff to meet the resident's needs.
• Residents care needs including those with communication difficulties, change in baseline etc. are discussed at daily handover, this will also ensure that all staff are aware of the resident's changing care needs.
• All staff receive careplan training on induction and are supported in developing person centred careplans by the CNM/ADONs. The care plans are audited monthly by CMT and any gaps noted are shared with the team for learning/ continuous improvement.

Regulation 12: Personal possessions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:

• The storage in resident bedrooms was reviewed, all residents are supplied with furniture and storage equipments in line with the Regulations, any specific resident who require additional storage will be reviewed and catered for where appropriate. A risk assessment will be comducted prior to addition of extra furtniture to ensure that a safe enviroment is maintained for residents at all times.
• Twin bedrooms will be provided with a shelf fitted to enalble resdients to store their personal photographs and other items valuble to the residents.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

• Training has been conducted with staff for the correct use of designated charging points for hoist, storage of hoists and mobile clean and used linen trolleys, so as not to hinder residents' access to handrails.
• Works have commenced on the installation of grab rails on either side of toilet in ensuite bathrooms in Birch Unit. The rest of the building has been reviewed and grab rails will be installed in all bathrooms by January 2025.
• Gaps identified regarding the general decoration of the home (Painting, Door surfaces, general upgrade etc.) are being addressed in a refresh programme that is commencing in Aug 2024.
• Full review of the emergency call bells in 'visitor & staff' use toliets will be undertaken to ensure the compliance to DDA requirements are met, this will include call installation where needed.
• All bedrooms inspected and missing knobs on the doors and drawers have been replaced in June 2024.
• Schedule in place to repair and paint damaged radiator covers and replace with new ones where necessary, expected start date from Aug 6th , 2024.
• The tap in the visitors toilet on the ground floor has been replaced in June 2024.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:

• All staff undergo a structured training program to guarantee their familiarity with evacuation protocols and escape routes. This mandatory training is provided to all staff prior to their commencement of employment, and annually thereafter. Fire drills are completed to ensure that staff possesses the knowledge and capability to understand and adhere to fire safety procedures, escape routes, and evacuation protocols.
• All Staff Nurses, CNM's, ADON's, GSM and DON have completed a fire Warden training course.
• A recent planned mainatence survey on compartmental fire doors has been undertaken by a competent external contractor in June, 2024. Minor adjustments were made at the time of the survey, additional recommended work have been identfiied and is awaiting a quotation from the supplier.
• We have undertaken a review of the inhouse mainatence personell competency and further training will be organsied to address any deficit in knowledge/skills identified.
• The training/ fire drill process has been reviewed in consulation with external traiining providers to ensure that all highlighted gaps in the fire drill are included in the training modules, additioanl simulations on areas flagged as gaps will be included.

• The incorrect mapping of one bedroom in the fire alarm system is rectified by the external contractor in June, 2024.
• Additional Fire drills were organised to bridge the gaps flagged in the report and are completed monthly, unannounced night drill scheduled for 21st August 2024.
• Any outstanding actions that were identfied in the risk assessment completed in 2023 will be actioned by October, 2024.
• All combustible items have been removed on the day of inspection and this will be checked on a regualar basis by GSM. A COSHH risk assessment will be completed to address risk related to storage of combustible items.

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 are personlised to include resident preferrences, likes and dislikes , and this enables staff to deliver care that meets resdients individual needs. Changes in residents care needs are updated in the careplans and are discussed at daily handover, this will ensure that all staff are aware of the resident's care needs.
• All Nutritional and Skin integrity careplans are currently being reviewed, any gaps indentified on the day inspection were immediately addressed.
• All care plans are completed on admission and updated as required or at a minimum of 4 monthly. Careplan meetings are held with residents and with families with the consent of the resident.
• Residents care plan has details of resident's weight and mattress type and relevant settings. Pressure relieving mattresses are audited monthly by CNMs this will be monitored by the Nurse on each unit. Spot checks will be conducted during the daily walkabout by the site manager to ensure that settings are appropriate to residents' needs.
• Care plan training is provided to all Nursing staff on induction and a refresher training has been scheduled for August 2024. Each nurse has received a care plan toolkit on how to complete assessments and care plans. There is a process in place for the allocation of resident's assessments and care plans to the nursing team and these are audited on an ongoing basis by CMT and feedback is shared with Nurses.
• The PAL assessment is being reviewed by CMT in conjuction with Governance team, CMT will trial the PAL assessment and evaluate the effectiveness of this before implementation.
All residents currently have a Meaningful Activity Assessment, a life story, Barthel index, MMSE and Comprehensive assessment completed on admission and is reviewed on a minimum four monthly basis. These assessments are in place to assess the residents' ability to engage in social activities and are documented in the resident care plan. Activity coordinators will collaborate with the nursing team to capture the changing needs of the residents to ensure that each resident's ability to participate in the social engagement programme is gauged on a regular basis.

Regulation 7: Managing behaviour that is challenging	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:

• The incident identified on the day of inspection in relation to gaps in managing residents with responsive behaviours was reviewed by CMT. Staff coaching completed, educational Tool box talks on responding to responsive behaviour was delivered to all staff.
• An initial review was conducted and to ensure safe access to these areas will require consultation with planning and building consultants to assess for suitable for safe access.
• All residents in the centre have had and continue to have entry to the garden and the Fifth floor through a keypad lock system. The doors and the lift doors are secured with butterfly codes and all residents can access the codes. Staff are accessible at any time to help residents and their families whenever required.
• Each resident has an individual risk assessment completed and all residents in the Dementia Friendly Unit have been reassessed with respect to their access to outdoor space/garden.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:

• ADON/CNM enrolled in HSEland safeguarding training on safeguarding for designated officer due to complete on 4th September 2024.
• DON/ADON/CNMs have oversight of all safeguarding incidents, any learning outcomes are disseminated to all staff through daily huddles and regular staff meetings.
• The Clinical management team will complete daily walks of the home reviewing staff practices and staff engagement with residents. Ongoing support will be given to staff in early identification of safeguarding risks.
• Safeguarding training is now delivered face to face. Training commenced on 16/07/2024 and will be continued monthly to ensure all staff are retrained in safeguarding.
• Toolbox Talks regarding Safeguarding have been completed and continue to be completed with all new staffs to increase the awareness and to assist in early recognition of any safeguarding concerns.
• As of the 01.07.24 the ADON's/CNM are allocated specific floors/units to increase staff supervision. The Restrictive Practice usage is regularly monitored through weekly/monthly KPI. A restraint register log is maintained on all units and the staff are aware of the Restrictive Practice usage and control measures in place.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:

• A full review will be completed into the activity schedule and activity staff allocation to ensure that all residents have equal access to social activities and to fully utilise the available acivtity rooms for social engagements.
• An Organisational Activty Strategy has been agreed and is currently being rolled out. This strategy will advance and develop social events and prgrammes that integrate residents hobbies and interests and support individual choices. This strategy will help deliver an extensive range of activity programmes that will allow residents to participate in events both internal/ external to the home based on their indivdual choices and capacities.
• An activity survey has been commenced where residents are asked what activities they would like to see included in the programme and this will be collated and used to determine the range of activities that are made available for residents.
• On the day of inspection, there was full complement of staff on duty and residents were informed of available activities. Some residents declined to attend activities on day of inspection and this is documented in residents daily notes.
• Staff allocation is updated daily and designated staff are allocated to inform residents of activities of the day and to assist with social acivities on each floor. All staffs are reminded of their responsibilities in encouraging residents to attend daily activities.
• A staff member has been identified to complete Sonas training in September 2024.
• Each resident is assessed by the activity team on admission, who write up the recreation & social aspect of the resident's in the care plan with the assistance of the nurse. We have a member of the activity team on duty six out of seven days of the week. Over the week engagement is made with each resident. A monthly activity calendar is devised which offers a range of activities. Feedback from residents is sought quarterly at the Residents' Meeting. For residents who do not like group activity, our team will provide one to one activity time for these residents in their own rooms or take people out in the garden or to the local shops.

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 10(2)	The person in charge shall ensure that where a resident has specialist communication requirements, such requirements are recorded in the resident's care plan prepared under Regulation 5.	Substantially Compliant	Yellow	01/07/2024
Regulation 12(c)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that he or she has adequate space to store and maintain his or her clothes and other personal possessions.	Substantially Compliant	Yellow	11/08/2024

Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	04/09/2024
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	31/01/2025
Regulation 19(3)	The directory shall include the information specified in paragraph (3) of Schedule 3.	Substantially Compliant	Yellow	01/07/2024
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	30/11/2024
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Substantially Compliant	Yellow	30/11/2024
Regulation 28(2)(iii)	The registered provider shall	Not Compliant	Orange	01/07/2024

	make adequate arrangements for calling the fire service.			
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.	Not Compliant	Orange	30/11/2024
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	06/06/2024
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Substantially Compliant	Yellow	01/11/2024
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph	Substantially Compliant	Yellow	01/11/2024

	(3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.			
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.	Not Compliant	Orange	30/06/2024
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.	Not Compliant	Orange	15/09/2024
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Orange	01/07/2024
Regulation 8(2)	The measures referred to in paragraph (1) shall include staff training in relation to the detection and prevention of and responses to abuse.	Substantially Compliant	Yellow	15/09/2024
Regulation 9(2)(a)	The registered provider shall	Substantially Compliant	Yellow	01/08/2024

	provide for residents facilities for occupation and recreation.			
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	01/10/2024