Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	Castlebridge Manor Nursing Home
Name of provider:	Castlebridge Manor Private Clinic Limited
Address of centre:	Ballyboggan Lower, Castlebridge, Wexford
Type of inspection:	Unannounced
Date of inspection:	09 April 2024
Centre ID:	OSV-0005826
Fieldwork ID:	MON-0042663

About the designated centre

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

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

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	86

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 9 April 2024	19:45hrs to 22:45hrs	Mary Veale	Lead
Wednesday 10 April 2024	09:00hrs to 17:45hrs	Mary Veale	Lead
Tuesday 9 April 2024	19:45hrs to 22:45hrs	Caroline Connelly	Support
Wednesday 10 April 2024	09:00hrs to 17:45hrs	Caroline Connelly	Support
Wednesday 10 April 2024	09:00hrs to 17:45hrs	Aisling Coffey	Support

What residents told us and what inspectors observed

This was an unannounced inspection which took place over two days. The first day of inspection was an evening inspection carried out by two inspectors and the following day by three inspectors. Over the course of the inspection, the inspectors spoke with residents, staff and visitors to gain insight into what it was like to live in Castlebridge Manor Nursing Home. The inspectors spent time observing the residents daily life in the centre in order to understand the lived experience of the residents. Inspectors spoke in detail with 20 residents and ten sets of visitors. Residents and visitors expressed that they had seen improvements in staffing levels, the supervision of staff, the quality of the food and attention to personal care. However, a number of residents and visitors told the inspectors that they found it difficult to communicate with staff about their care needs. Similar to previous inspections, the inspectors observed staff practices on Slaney and Ferricarraig units which were task orientated rather than person-centred.

Castlebridge Manor Nursing Home is a two story purpose built designated centre registered to provided care for 95 residents on the outskirts of the village of Castlebridge, in County Wexford. The centre had four units. Amber unit and Eden Vale units were on the ground floor which operated as one unit. Slaney and Ferrycarraig units were on the first floor which operated as two separate units. The inspectors observed both the Slaney and Ferrycarraig units had electronic locked doors which were accessible using a fob device. Each unit had sitting rooms, dining rooms and visitors rooms. The centres oratory was located on Amber unit. Residents had access to a physiotherapy room and hairdressing room on the first floor between Slaney and Ferrycarraig units.

On the first day of the inspection the inspectors were greeted by a member of nursing staff and signed the centre's visitors' log. The inspectors met the clinical nurse manager on duty. Following a brief introductory meeting with the clinical nurse manager, the inspectors walked the centre observing the care environment. The inspectors attended the night handover on both floors. Prior to the end of the handover the person in charge arrived to the centre to assist with the inspection process and to support staff.

Inspectors observed on the evening inspection that the majority of the residents living on the ground floor of the centre were sitting in the day room, some were observed sitting by their bed watching television, reading, chatting to visitors and enjoying a night time beverage. 12 of the 38 residents living on the ground floor were observed in the day room watching television supervised by a staff member prior to the inspectors leaving at 22:45. The first floor was in stark contrast with the ground floor. Here the majority of the residents were either in bed or in their bedrooms. There was one resident up in the day room on Ferrycarriig unit at 20.00hrs and two residents in the day room on the Slaney unit and a further two residents sat on the corridor outside the nurses station. There was a nurse and two care staff on each unit for the night and whilst the nurse administered the night

time medications the care staff provided care and supervision to the residents. The inspectors found and were informed by residents that it was difficult to understand what some of the staff were saying as their standard of English did not support effective communication to take place. Some staff were unable to describe their role in the centre and how they provided care to the residents this is further outlined in the report.

The inspectors saw that the entrance and exit doors of the Slaney unit were locked with fob access and were informed this was for the protection of residents who mainly had a diagnosis of dementia. However, the inspectors found that there were two further sets of locked doors as you progressed through the unit and this was found to be overly restrictive. The inspectors saw that residents were unable to freely move around the unit without asking staff to be left through the doors. The nurses station was at one end of the unit and staff had to go through two sets of locked doors to get to the day room and many of the residents bedrooms. This did not facilitate residents to have easy access to staff or staff to have good access to all residents on the unit. Staff when asked by the inspectors were unable to explain what the purpose of these added locked doors were for.

There were 86 residents living in the centre at the time of inspection. The centre had 77 single rooms and 9 twin rooms all containing en-suite facilities. Bedrooms were nicely decorated and were personalised with residents' belongings such as photos, artwork and ornaments. The ground floor had two enclosed courtyard gardens. The rooms in the centre of the building were arranged around both internal courtyards and were accessible from resident's bedrooms on the ground floor. The inspectors observed that the twin rooms in the centre required reconfiguration. Wardrobes were observed to be in one residents bed space which meant that the other resident sharing the room had to access their personal belongings in the other residents personal space. The privacy curtain divided the room in half with a bed on each side which meant that the resident in the bed by the door was not afforded privacy as the other residents sharing the room had to access this residents bed space to gain access to their bed space. Inspectors observed that residents had access to call bells on both days of inspection.

Residents on the ground floor whom the inspectors spoke with expressed that staffing levels had improved and that staff turn over had significantly reduced following previous inspections. A resident told the inspectors that agency staff had not worked in the centre since Christmas and that they had noted changes to the staff handover which included the attendance of nursing management. Residents spoken with had met the person in charge and said that if they had any concerns they would raise them with the person in charge. Residents said that the call bell response time had improved and that staff were very attentive to their care needs. Inspectors observed that the day room on the ground floor was supervised by a staff member throughout the inspection. On the first floor, some of the residents who were spoken with were complimentary of the staff, management, food, and activities on offer. A staff member supervised the two day rooms and the visitor room while residents read the newspaper, listened to the radio, and watched television.

Residents' spoken with said there were improvements in the activities programme in the centre. Inspectors observed the residents attending the hairdressing salon in the morning of the second day of inspection and attending bingo in the afternoon. The inspectors observed staff and residents having good humoured banter during the activities and some of the staff chatting with residents about their personal interests and family members. The inspectors also observed many residents walking and using mobility aids around the corridor areas of the centre and observed residents reading newspapers, watching television, listening to the radio, and engaging in conversation.

Residents' views and opinions were sought through resident committee meetings and satisfaction surveys. Following the previous inspection the centre had established a resident ambassador who met with the activities team and person in charge regularly. Residents spoken with confirmed that they could bring any concerns or issues to their resident ambassador to discuss with the person in charge and the resident ambassador communicated with residents who could not attend the centres residents meetings. Inspectors observed a notice board located between Amber and Eden units for residents to communicate issues that may arise which could be addressed in a timely manner. Residents committee meeting meetings were available on this board. Residents reported that staff were kind but that they sometimes found it difficult to communicate with some staff. Residents said that they found it difficult to hear staff and sometimes staff spoke too quickly.

The inspectors observed the lunch time experience in the dining rooms on both floors on the second day of inspection. The meal time experience on the ground floor was a social occasion where residents were seen to engage in conversations and enjoying each others company. The dinner time meal appeared wholesome, appetising and the residents were not rushed. Staff were observed to be respectful and discreetly assisted the residents during the meal times. The dinner time experience was a social occasion where residents were seen to engage in conversations and enjoying each others company. On the first floor there was only one dining room in use for the 54 residents who resided on this floor. There was only one meal sitting in the dining room and the inspector observed that there were only 13 residents having their meal in the dining room. The tables were appropriately set and staff sat and assisted those residents that required assistance in a dignified manner. The inspector observed that the remaining residents mainly had their meals in their bedrooms or in the sitting room where they spent most of the day. There were a number of residents in bedrooms where it was difficult to establish if they had had their dinner or not and some residents were observed to have their meal on a bed table over the bed but the resident was not assisted to sit up into a position that would enable them to eat their meal. The inspector also observed a staff member stood over a resident whilst they assisted them to have their meal. The inspectors had to intervene to ensure residents were appropriately positioned as there was no apparent supervision on the floor. This lack of a proper dining experience for a large number of residents on the first floor is further outlined throughout the report.

The centre provided a laundry service for residents. Residents' whom the inspectors spoke with over the days of inspection were mostly happy with the laundry service.

A resident told the inspectors that their clothes were often mixed up with other residents clothes and another resident said that there towels required soften as the towels were very rough on their skin. The inspectors noted that there were a small number of reports of items of clothing missing recorded in the complaints logs and had been highlighted at the residents committee meetings.

Visitors were observed attending the centre late on the first evening of the inspection and throughout the second day. The inspectors spoke with ten sets of family members who were visiting. The visitors told the inspectors that there had been improvements in the centres staffing levels and the care that their family members received.

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

Capacity and capability

The inspectors found improvements in the management systems in the centre since the previous inspection. However; further improvements were required to ensure residents living on the first floor were supported and facilitated to have a good quality of life living in Castlebridge Manor Nursing Home.

This was an unannounced inspection which took place over the course of an evening and the following day by inspectors of social services. This inspection was a risk-based inspection to monitor ongoing compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. The inspectors followed up on the written representation submitted by the provider in respect of the proposed decision to attach a condition to the registration of the designated centre. The inspectors also followed up on the compliance plan submitted by the provider following the inspection of the centre in November 2023, statutory notifications and five pieces of unsolicited information submitted to the Chief Inspector of Social Services.

The inspectors found that the registered provider had progressed the compliance plan from the previous inspection and improvements were found in

- Regulation 5: Individual assessment and care plan,
- Regulation 6: Healthcare,
- Regulation 15: Staffing,
- Regulation 16: Training and staff development,
- Regulation 21: Records,
- Regulation 23: Governance and management,
- Regulation 24: Contracts for the provision of services.

Notwithstanding these improvements further progress was required to comply with

Regulation 9: Residents' rights, Regulation 18: Food and Nutrition, and Regulation 30: Volunteers. Areas of improvement were required in Regulation 8: Protection, Regulation 17: premises and Regulation 23: Governance and Management.

The registered provider was Castlebridge Manor Private Clinic Limited. There had been a change in the directors of Castlebridge Manor Private Clinic Limited in October 2022. The centre is part of a large group that own and manage a number of designated centres in Ireland. There had been a change in the person in charge of the centre since the previous inspection. The person in charge reported to the regional operations manager to which reported upwards to the director of operations who was the registered provider representative. The person in charge worked full-time and was supported by a deputy person in charge and two clinical nurse managers. Inspectors were informed that there was a deputy person in charge or clinical nurse manager (CNM) supernumerary on each floor seven days a week to provide clinical supervision and oversight of residents care needs. In addition the person in charge was supported by a team of staff nurses, healthcare assistants, housekeeping, activities co-ordinators, catering, administration, laundry and maintenance staff supported the person in charge.

Improvements were found in the centres staffing levels, the registered provider had come in line with the whole time equivalents (WTE) as set out in the statement of purpose which Castlebridge Manor Private Clinic Limited was registered against which resulted in better quality of care being delivered. Following the previous inspection the centre had increased nursing staff levels on night duty, there were two nurses allocated to Amber and Eden Vale units, one nurse allocated to Ferrycarraig and one nurse to Slaney unit. Rosters reviewed by the inspectors evidenced that there were four nurses and 19 health care assistants allocated to provide care to residents on day duty. Inspectors observed care staff supervising the residents in the day room on the ground floor throughout the evening inspection and during the following day. There were sufficient staff on duty to meet the needs of residents living in the centre on the days of inspection.

Improvements were found in the oversight of staff training in the centre. The personnel files documented a structured induction received by new staff. Staff had access to education and training appropriate to their role. There was a high level of staff attendance at training in areas such as fire safety, manual handling, safeguarding vulnerable adults, management of challenging behaviour, and infection prevention and control. A number of staff with whom the inspectors spoke with, were knowledgeable regarding fire evacuation procedures and safe guarding procedures. The deputy person in charge had completed infection prevention and control (IPC) training and was the nominated link nurse for IPC. Staff were supervised by the person in charge, the assistant director of nursing and the clinical nurse manager. However; further improvements were required in the supervision of staff, this is discussed further in the report under Regulation 9: Residents rights.

Improvements were found in the governance structure and management systems in the centre. There was a schedule of meetings in the centre. Records of clinical governance meetings and staff meetings which had taken place since the previous inspection were viewed on this inspection. Meetings included head of department

meetings, governance meetings, staff meeting and safety pause meeting. Governance meetings and staff meetings took place monthly in the centre since the change in person in charge. Minutes of meetings were detailed and included resident feedback, resident care needs, complaints, fire safety, falls and restrictive practice. There was evidence of a weekly KPI report record between the person in charge and the regional operation manager which included discussion of key performance indicators (KPI's), training, fire safety, feedback from complaints, and clinical risks. The person in charge monitored key performance indicators (KPI's) on a weekly basis such as falls, skin tears, weights, pressure sores, and restrictive practice. There were detailed analysis of resident's wounds and falls completed monthly. There was a schedule of audits in the centre and the centre was in the process of moving to an electronic auditing system. Since the previous inspection falls audits, fire safety audits, infection prevention and control audits, care planning audits, night time audits and medication management audits had been completed. Records of audits reviewed required improvement as a number of audits for example; care planning and medication management audits were not scored, tracked and trended to monitor progress. This is discussed further under Regulation 23: Governance and management. The annual review for 2023 was available during the inspection. It set out the improvements completed in 2023 and improvement plans for 2024.

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

Inspectors noted that staff records contained all the necessary information as required by Schedule 2 of the regulations; however, no records were available for a volunteer working in the centre. This area requires review to ensure adequate oversight of people involved in the centre on a voluntary basis, which is discussed under Regulation 30: Volunteers.

The registered provider had integrated the update to the regulations (S.I 628 of 2022), which came into effect on 1 March 2023, into the centre's complaints policy and procedure. The management team had a good understanding of their responsibility in this regard. The inspectors reviewed the records of complaints raised by residents and relatives. Details of the investigations completed and communication with the complainants were included. The complaints procedure was available at the nurses stations in the centre. Residents spoken with were aware of how to make a complaint and whom to make a complaint to.

The inspectors followed up on five pieces of unsolicited information that had been submitted to the Chief Inspector since the centre was inspected in November 2023. The unsolicited information received related to a number of areas relating to residents care, for example; individual assessment and planning, healthcare, resident's rights, protection. While some areas were found to meet the requirement of the regulations, other areas required improvement as set out under Regulation 18: Food and Nutrition, Regulation 8: Protection, Regulation 9: Residents' rights,

and Regulation 23: Governance and management.

Regulation 14: Persons in charge

The person in charge worked full time in the centre and met the requirements of Regulation 14. She was aware of her responsibilities under the Act and displayed good oversight of the service and good knowledge of the residents.

Judgment: Compliant

Regulation 15: Staffing

Staffing was found to be sufficient to meet the needs of the residents on the days of the inspection. The registered provider ensured that the number and skill-mix of staff was appropriate, to meet the needs of the residents. There were a minimum of four registered nurses in the centre day and night.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had access to training appropriate to their role. Staff had completed training in fire safety, safe guarding, managing behaviours that are challenging and, infection prevention and control. There was an ongoing schedule of training in place to ensure all staff had relevant and up to date training to enable them to perform their respective roles.

Judgment: Compliant

Regulation 21: Records

A sample of four staff files reviewed by the inspectors were found to be very well maintained. These files contained all the necessary information as required by Schedule 2 of the regulations, including the required references and qualifications. The nursing staff records held evidence of active registration with the Nursing and Midwifery Board of Ireland. Garda Siochana (police) vetting disclosures were in place for all staff, and the management team assured the inspectors that no staff member

commenced employment without this in place.

Judgment: Compliant

Regulation 23: Governance and management

Some systems for monitoring the quality and safety of the service required review to ensure they were consistently informing ongoing safety improvements in the centre. For example:

- The centres audit records did not consistently identify areas for improvement, and a plan for how the improvement was to be achieved.
- The oversight of the management of residents monies were not sufficiently robust to ensure monies were fully safeguarded. This is further detailed under Regulation 8: Protection.
- Supervision of staff on the first floor was not sufficient to ensure good quality care was being delivered at all times as outlined throughout the report.
- Not all residents were able to make choices about how and where they spent their time, this included having access to meaningful activities.This was a particular issue on the first floor.

Judgment: Substantially compliant

Regulation 24: Contract for the provision of services

All residents were issued with a contract for the provision of services. The contracts outlined the services to be provided and the fees, if any, to be charged for such services, they were updated following the previous inspection and now included the room to be occupied and the number of occupants of the room as per the requirements of the regulations.

Judgment: Compliant

Regulation 30: Volunteers

Records concerning a person involved on a voluntary basis within the centre were not available for the inspectors to review ion the day of inspection. Therefore, inspectors were not assured that the volunteer had their roles and responsibilities set out in writing, and had a Garda Siochana (police) vetting disclosure in place.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

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

Judgment: Compliant

Regulation 34: Complaints procedure

The registered provider made available an accessible and effective procedure for dealing with complaints, which included a review process. The required time lines for the investigation into, and review of complaints was specified in the procedure. The procedure was prominently displayed in the centre. The complaints procedure provided details of the nominated complaints and review officer. These nominated persons had received suitable training to deal with complaints. The complaints procedure outlined how a person making a complaint could be assisted to access an independent advocacy service.

Judgment: Compliant

Quality and safety

Overall, the inspectors found that residents living on the ground floor had a good quality of life in Castlebridge Manor Nursing Home. Resident's health, social care and spiritual needs were well catered for and overall the rights were upheld. However; this inspection found that resident's rights were not being met in relation to the supervision of residents living with a cognitive impairment or dementia on the first floor.

There was a good standard of care planning in the centre. In a sample of five nursing notes viewed residents' needs were comprehensively assessed prior to admission by validated risk assessment tools, and had a holistic care plan with specific care needs care plans. Care plans were sufficiently detailed to guide staff in the provision of person-centred care and had been updated to reflect changes required in relation to incidents of falls, infections and prevention of pressure sores. There was evidence that the care plans were reviewed by staff. Consultation had

taken place with the residents to review the care plan at intervals not exceeding four months. Training records evidenced that nursing staff had completed education sessions on care planning since the previous inspection.

Residents had regular access to general practitioner (GP) services. There were referral arrangements in place to services such as, the dietitian, physiotherapy, occupational therapy (OT), speech and language therapy (SALT), dental and opticians. Residents' health and well-being was promoted and residents had timely access to psychiatry of old age and to consultant geriatricians. Residents also had access to a mobile x-ray service referred by their GP. Residents had access to local pharmacy services. Residents who were eligible for national screening programmes were also supported and encouraged to access these.

There was a comprehensive centre specific policy in place to guide nurses on the safe management of medications. Medicines were administered in accordance with the prescriber's instructions in a timely manner. Medicines were stored securely in the centre. Fridge storage for medication had a record of daily temperature recordings. Controlled drugs balances were checked at each shift change as required by the Misuse of Drugs Regulations 1988 and in line with the centres policy on medication management. A pharmacist was available to residents to advise them on medications they were receiving.

Systems were in place to support the identification, reporting, and investigation of allegations or suspicions of abuse. A safeguarding policy detailed the roles and responsibilities and appropriate steps for staff to take should a safeguarding concern arise. The reviewed records found that the centre's policies and procedures had been followed when abuse concerns had arisen. All staff spoken with were clear about their role in protecting residents from abuse. All staff completed safeguarding training. A sample of staff files reviewed by the inspectors provided evidence that Garda Síochána (police) vetting disclosures were in place before the commencement of employment. All residents stated they felt safe and well cared for in the centre. While the provider did not act as a pension agent for any residents, the provider held money belonging to current and deceased residents. The arrangements for safeguarding this money were not sufficiently robust. This is discussed further under Regulation 8: Protection.

While the premises of the designated centre were appropriate for the number and needs of residents, some areas required maintenance and repair to fully comply with Schedule 6 requirements. These matters will be discussed under Regulation 17: Premises.

A choice of home cooked meals and snacks were offered to all residents. A daily menu was displayed and available for residents in the dining rooms. Menus were varied and had been reviewed by a dietician for nutritional content to ensure suitability. Residents on modified diets were observed to receive the correct consistency meals and drinks. The dining experience observed on the ground floor was relaxed. There were adequate staff to provide assistance and ensure a pleasant experience for resident at meal times on the ground floor. Residents' weights were routinely monitored. However; improvements were required to the residents dining

experience and the manner in which food is served and supervised for residents living on Ferrycarrig and Slaney units this is discuss under Regulation 18 Food and Nutrition and Regulation 9: Resident's rights.

A programme of appropriate activities were available. The inspectors saw a number of different activities taking place throughout the second day of inspection. The residents had access to SAGE advocacy services. The advocacy service details and activities planners were displayed on all floors. Residents has access to newspapers, Internet service, books, televisions, and radio's. There were many examples where residents' rights and choices were being upheld and respected. For example; many residents went out accompanied by their families. Residents were consulted with on a daily basis by the management team and staff. Formal residents' meetings were facilitated and there was evidence that relevant issues were discussed. It was evidenced at residents meetings that residents had expressed their difficult understanding staff and residents told inspectors that they found it difficult to communicate their care needs to staff. Residents living on the first floor residents with a cognitive impairment and residents whom had high dependence care needs had limited choice in where they could have a meal and were observed to spent a significant part of their day in bed or in their bedroom. These issues are discussed further under Regulation 9: Residents Rights.

Regulation 10: Communication difficulties

Residents who had communication difficulties and special communication requirements had these recorded in their care plans and were observed to be supported to communicate freely. Residents were also supported to access additional supports such such as assistive technology to assist with their communication.

Judgment: Compliant

Regulation 17: Premises

While the premises were well designed and laid out to meet the number and needs of residents in the centre, some areas required maintenance and repair to be fully compliant with Schedule 6 requirements, for example:

- A toilet in a resident's en-suite toilet was found to be leaking. This was brought to the attention of the nurse in charge, who made arrangements for its repair.
- There was significant peeling of paint on the walls of residents' en-suite and communal bathrooms.
- There were scuffed paintwork on the walls and doors of some resident

bedrooms and communal areas.
- A resident's crash mat was dirty, with footprints and other debris.
- The layout of the Slaney unit with two sets of locked doors in the middle of the unit did not allow residents to move freely throughout this unit

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Although residents reported that the food had improved and the dining experience was good on the ground floor, the dining experience on the first floor and the manner in which the food was served and monitored required action.

- There was only one dining room available on the first floor which was not large enough to facilitate the 54 residents that could reside there particularly as there was only one meal sitting.
- The inspector observed that there did not appear to be any supervision of residents eating in their rooms by the nursing staff particularly on the Slaney unit, as the inspectors saw that a number of residents were not given the opportunity to sit up in bed to facilitate a position to actually eat their meals. The inspector had to intervene as food was left on the bed table and the resident was observed asleep.
- The inspector saw a staff member standing over a resident while assisting them with their meal in their bedroom and this was not conducive to a relaxed dining experience.
- There did not appear to be a robust system in place to show if residents were provided with adequate quantities of food and drink as the inspector saw a number of residents asleep without meals and staff were not able to tell the inspector when asked.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

There was an appropriate pharmacy service offered to residents and a safe system of medication administration in place. Policies were in place for the safe disposal of expired or no longer required medications.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

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

Judgment: Compliant

Regulation 6: Health care

There were good standards of evidence based healthcare provided in this centre. GP's routinely attended the centre and were available to residents. Allied health professionals also supported the residents on site where possible and remotely when appropriate. There was evidence of ongoing referral and review by allied health professional as appropriate. Wound care was well monitored and scientific assessments were seen to measure wounds along with regular photographs enable good monitoring to identify improvement or deterioration of the wound. There was evidence of appropriate referral and review of wound by the tissue viability specialist as required.

Judgment: Compliant

Regulation 8: Protection

While there was a policy in place, and staff had received training, improvements were required in relation to safeguarding residents finances. The provider does not have a separate resident client account, therefore residents' monies are paid into the centre's current account and residents' monies remain in this current account.

A review of information pertaining to the centers current account shown to the inspectors during the inspection showed that it contained a large sum of money belonging to residents of the centre. Four current residents who paid their fees monthly by standing had built up excess monies in the centre's current account. The funds of ten deceased residents, which were in the process of reverting to their estates, remained in the centre's current account while this process was underway. The provider did not have a separate resident client account to safeguard such funds.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The registered provider had not ensured that residents had a right to choice in their daily activities. For example;

- A large number of residents on Ferrycarrig and Slaney units were seen to spend their day in their bedrooms and were not facilitated to attend group activities.
- A significant number of residents were also observed not to be facilitated to avail of the dining rooms on Ferrycarrig and Slaney units at mealtimes. On the second day of the inspection, inspectors observed that only 13 residents attended the dining room and had their meals in their bed bedroom or in the day room where they spent their day. This negatively impacted on the residents choice and opportunities to socialise and engage with other residents.
- The inspectors saw that the entrance and exit doors of the Slaney unit were locked with fob access and were informed this was for the protection of residents who mainly had a diagnosis of dementia. However, the inspectors found that there were two further sets of locked doors as you progressed through the unit and this was found to be overly restrictive. Residents were unable to freely move around the unit without asking staff to be left through the doors.
- Action was required to ensure that a resident may undertake personal activities in private. For example;
- The layout of the twin bedrooms required reconfiguration as they did not ensure residents' needs for privacy and dignity were maintained. Within the five twin rooms viewed by inspectors, the residents in these rooms had to enter other residents' bed spaces to access their clothing, use the en-suite bathroom facilities and enter or exit the bedroom.

Similar to findings of the previous inspection, residents reported difficulties in verbal communication and understanding of some staff when communicating their needs.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 30: Volunteers	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Not compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Castlebridge Manor Nursing Home OSV-0005826

Inspection ID: MON-0042663

Date of inspection: 10/04/2024

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 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
As mentioned in the report, we are transitioning to a computer based audit system. This system ensures that an timebound action plan identifying the responsible person is allocated to manage areas for improvement/compliance. Training is being provided to all CNM/DPIC/PIC on the management of this system.

The supervision of the staff on the first floor of the home has been strengthened with our DPIC coming on board. Their office is based within the Ferrycarrig unit which allows for a bird eye view and enables frequent walkarounds throughout the day to provide oversight into practices by staff. In addition to this, we do have a CNM on duty every day (Monday - Sunday) and we have 4 Senior HCA appointed over the two floors to guide and encourage staff on how to follow best policy and ensure Resident comfort and safety. PIC also engages in frequent walk arounds during the day. Ongoing education pertaining to supervision continues with senior staff. Night spot checks are also conducted to ensure there is adequate supervision at nighttime. Breaks have also been re-arranged to maximise supervision on the floors at all times. Moreover, supervision of specific areas has been added to the daily allocation book thus staff are specifically allocated to supervise a particular area throughout the day/night.

Our activity programme is under constant review and is a topic for discussion at all of our Resident meetings. A monthly satisfaction questionnaire is given to Residents to obtain their feedback in relation to the quality of activities being offered. A new activities programme is currently being devised which outlines a more comprehensive selection of activities. We have been able recently to engage with Residents from all units in large whole home game of Bingo which was well received and are looking into other games/options that can be used in a similar manner to engage more and more Residents. As stated before, a number of our Residents on the first floor, do prefer more quiet times reading in either their room or conversing with smaller groups. We do facilitate this as per their wishes whilst still offering an alternative. Members of the

management team are now attending the Resident's council meetings. The activities supervisor meets with the PIC once per month to discuss areas which are working well and/or require improvements. The activities team are also part of the heads of department meetings and other meetings throughout the month.

The layout of the Slaney unit has been reviewed again and the inner unit doors have been opened and staff are aware that these are to be left open to enable Residents to move about freely as they wish. The doors to access each unit, on ground floor and on the first floor are keycoded and a number of Residents do have access to the code as per their individual risk assessment regarding safety awareness and responsive behaviours. We have placed a "butterfly" image at each door, which has the code to the door within, to further facilitate free movement within the home. Education is ongoing in relation to residents rights.

Regulation 30: Volunteers	Substantially Compliant

Outline how you are going to come into compliance with Regulation 30: Volunteers:
We have reviewed our volunteer policy and have not had any volunteers onsite since the inspection.
We have received assurances from our volunteer group (dog therapy) that all of their volunteers are fully garda vetted and that they hold the vetting at their centre.
We will ensure that each of our volunteers have their role within our home specified along with volunteer supervision when they are onsite. We have a signed memorandum from Irish Therapy Dogs for your review.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
We have a number of bathrooms and ensuites that are scheduled for maintenance and repair – this will be completed by the beginning of June.
Our maintenance teams have been working their way throughout the home repainting and refurbishing many of our corridors/communal rooms and bedrooms as they are available. Our home is a living home so this is a continual process of maintenance.
We have ensured that all accessories within each Residents room are included in the cleaning and deep cleaning schedule for our household staff and our care staff will perform spot cleaning as needed.
The middle doors within Slaney unit have been opened since the inspection and we have "butterfly" images at the keycoded doors, with the code within the wings, to enable use of those doors that are closed.

Regulation 18: Food and nutrition	Not Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
The second dining room on the first floor has been refurbished and offers an alternative dining venue for Residents from either Ferrycarrig or Slaney. We have ordered additional accessible tables for both dining rooms to facilitate chairs/wheelchairs or supportive chairs. Our ongoing training for new and more experienced staff in the mealtime experience continues and is assisted by our senior HCA moving throughout the home. The meal times are further supervised by the CNM/DPIC/PIC on duty. We provide residents with mealtime satisfaction questionnaires and obtain their views in the residents council meetings.

We have many areas throughout the home that Residents may choose to have their meals and therefore, we have developed a mealtime aid for staff to enable them to plan for Residents who are eating in either of the dining rooms, their own room or a quieter room as per their wishes. This is updated daily as per each Resident & the information on whether the Resident ate all/some/none of their meal is also captured. Choices pertaining to where the resident wishes to have their meals will be outlined in their care plans.

Our senior HCA and RGN will all be completing elearning modules regarding nutrition, mealtime experience, nutrition and dementia etc and will be able to direct/redirect some of our less experienced staff in same. Our plan is that all staff will complete the nutritional modules in time.

We have reviewed staffing break times to ensure that the maximum number of staff are available to assist during mealtimes to promote a peaceful and pleasant experience for all of our Residents.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
As noted during the inspection we are not a pension agent for any of our Residents, so we do not "collect" funds from any of our Residents accounts.

As per the regulations we are in the process of opening a "client account" to assist in managing funds that have been paid to the centre by Residents who have since passed

away. In all of these cases we are liaising with their estate management about the timely return of these monies, however some probate arrangements have proven to be lengthy.

For any of our current Residents who have accumulated a large credit balance, these accounts will be managed as per policy.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
A number of our Residents on the first floor in particular have expressed a wish not to attend the dining room or group activities. We have and will continue to offer options to them for an alternative mealtime space & the varied activity plan. As mentioned we have been able to facilitate a full house bingo session somewhat remotely and will review our activity plan to see if there are other options that we can bring to our Residents, to enable them to participate more in activities whilst remaining in the area that they are comfortable in.
We have opened up our newly refurbished dining room in Slaney – which will be an alternative space for mealtimes also for Residents from Ferrycarrig & Slaney.
The mid unit doors in Slaney have been opened & we have butterfly images with code for the doors at each key coded door. Other Resident will have the code and can come and go freely, but some due to their safety awareness and responsive behaviours may need to be accompanied. This will be detailed through their careplan & assessments and their wishes. We do have the main doors to each unit keycoded from a security point of view and have this documented in our restrictive practice register.
We have replanned our twin rooms and have ordered the curtains to enable the reconfiguration to ensure each Residents privacy & dignity is maintained.
With all of our recruitment process and staff development, the ability to communicate freely with our Residents and families is part of the consideration for any staff member. We will endeavor to further enhance our teams communication skills with our safety pause, toolbox and education sessions.

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 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	06/06/2024
Regulation 18(1)(c)(i)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which are properly and safely prepared, cooked and served.	Not Compliant	Orange	30/06/2024
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate,	Substantially Compliant	Yellow	30/06/2024

	consistent and effectively monitored.			
Regulation 30(a)	The person in charge shall ensure that people involved on a voluntary basis with the designated centre have their roles and responsibilities set out in writing.	Substantially Compliant	Yellow	01/06/2024
Regulation 30(c)	The person in charge shall ensure that people involved on a voluntary basis with the designated centre provide a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012.	Substantially Compliant	Yellow	01/06/2024
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Substantially Compliant	Yellow	31/07/2024
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Not Compliant	Orange	30/06/2024
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure	Not Compliant	Orange	30/06/2024

	that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.			
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Not Compliant	Orange	30/06/2024